



## **RESPONSE FROM THE MOORE ADAMSON CRAIG PARTNERSHIP TO THE HEALTH SELECT COMMITTEE FOLLOW-UP ENQUIRY INTO COMMISSIONING IN THE HEALTH AND SOCIAL CARE BILL – February 2011**

### **“NO COMMISSIONING FOR ME WITHOUT ME”**

#### **1. Summary:**

- 1.1 The Bill must make a clear distinction about different types of accountability within the Health Service: accountability to patients as individuals is one thing, accountability to the public as the “moral owners” of the service is another. The ways in which people should be involved in decision-making are different in each case.
- 1.2 Patient and public engagement should begin where the people are: in GP practices and information gathered there should be aggregated up to higher levels as required.
- 1.3 Patient and public engagement has value and credibility only if it can be clearly shown that it has a direct impact on the provision of services. It must not become a tickbox exercise and an end in itself. In their role as commissioners GPs now have a new duty to involve the public as well as patients and this means talking to the well, the young and those who are not well known to the practice or frequent users of its services.
- 1.4 Patient participation groups in practice can be very useful but require an ongoing investment of time and energy if they are to be sustainable. There are many other ways to find out what people are thinking.
- 1.5 Consortia board membership needs to include representatives of both patients and the public. It is important that they represent a significant proportion of the membership and that the culture of the board ensures that they do not play a tokenistic role.
- 1.6 Local Healthwatch must have a central role in commissioning but should not be seen synonymous with effective patient and public involvement which can only be achieved through practices and consortia working directly with their own patients and users of their services. We strongly oppose HealthWatch taking on direct responsibility for complaint handling or complaint advocacy.
- 1.7 In order to address health inequalities it is vital that commissioners at all levels find ways of involving people who are on the margins and whose voices are not easily heard. This challenge will be met only by close partnership working in localities.
- 1.8 We fully support calls for an independent health scrutiny function separate from whatever scrutiny powers are taken on by the HWBB. This LA function should involve not just elected councillors, but independent lay people appointed as “assessors” to the scrutiny committee.
- 1.9 Joint working between health services and Councils will only work if there is an acknowledgement of the culture differences between them and a determination to change the culture of both.

## **2. Background to The Moore Adamson Craig Partnership LLP (MAC)**

We are an independent consultancy which specialises in user and public participation in a range of areas where decisions are made that have a direct impact on peoples' lives. At present we have a particular focus on health and education.

We train lay and user participants and we support service providers in increasing and improving public involvement in the design and delivery of public services. In recent years we have worked with Primary Care Trusts, GP practices, GP consortia, Foundation Trust governors and a wide range of patient groups including Local Involvement Networks (LINKs) to promote effective user and public engagement in health service delivery.

As individuals, all our partners are active participants as well as consultants, investing their time in membership of participatory bodies such as a GP patients' liaison group, a community health services Provider Board and a residents' right to manage company, and as a lay member on the PEC of a PCT.<sup>1</sup>

## **3. Accountability in the Health and Social Care Bill**

With our focus on user engagement in health services, we welcome the stated aim of the Bill to increase and improve public and patient involvement in the design and delivery of services. However, we remain unconvinced that the Bill as currently framed will in fact bring this about. We support the principle of "no decision about me without me" but would like to see it extended into "no commissioning for me without me".

The NHS Constitution says that the NHS belongs to the public but fails to elaborate on what this ownership means in practice. The fundamental confusion about what accountability means in relation to the health service is reflected in the Bill and as a result GP consortia stand to be pulled in numerous different directions by the National Commissioning Board, the local Health and Wellbeing Board, possible Overview and Scrutiny and (lest we forget) the patients and the public.

The Bill fails to make a clearer distinction between the accountability of a clinician to a patient and the accountability of the NHS to the public. Although inter-related, they are not the same thing and people will respond differently depending which role they are fulfilling.

In our work with practices we increasingly find it useful to encourage service providers to think of patients and their families as customers and to develop their services with the needs of these customers in mind. This takes the relationship away from one of dependency to one of service and quality in which patients have choice and influence: one where what matters to the patient matters to the doctor whether it is the colour of the wallpaper in the waiting room or the quality of end of life care.

The relationship between GP commissioners and the public they service is entirely different. This is a relationship in which the public should be seen as the "moral owners"<sup>2</sup> of the service as a whole and where the governance relationship is about commissioners making decisions about how money is spent in partnership with, and on behalf of, the public.

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<sup>1</sup> For further information about MAC partners and to read our blog, visit [www.publicinvolvement.org.uk](http://www.publicinvolvement.org.uk)

<sup>2</sup> We borrow this term from Carver Policy Governance® model which aims to promote owner accountable, ethical and effective governance.

#### **4. Start at the bottom: in GP practices**

The emphasis on responding to the views and needs of patients means that we have to start where the patients are. GP practices provide one of the most useful proxies for the local patient population and it is our view that both patient and public involvement in the health service needs to start in practices.

Bearing in mind the caveat mentioned above about the interests of patients and the public often being different, new commissioning arrangements mean that practices will need to start seeing the people on their lists as both patients and members of the public. It will therefore not be enough to engage only with the sick, those with long term conditions and those who regularly attend the practice. Practices will also need to find ways to engage with the well populations on their list, the young and those who seldom visit their GP, and to talk to them in their role as moral owners of the service as well as recipients care.

Information gathered in practices should be aggregated up to consortium level and to higher levels such as the local authority or nationally as required by the different needs of commissioning.

#### **5. Involving patients and the public in decision-making at all levels**

The key to all successful involvement in decision-making is for the focus to be on the ends rather than the means. There is a tendency in the NHS to focus on processes and new initiatives without measuring their impact. This has been particularly noticeable in the area of patient and public involvement/engagement in recent years. Unless public and patient involvement can be shown clearly to have influenced outcomes then it should be deemed to have failed. It is vital to demonstrate clearly to people that their input has been taken into account. Conversely, repeatedly failing to act on the intelligence which patients and the public provide has the effect of making people cynical. "Involvement" activity becomes a "tickbox" exercise and an end in itself resulting in initially highly committed people becoming disinclined to engage and more likely to be publicly critical. As these people often have complex and influential networks within local communities this can be very damaging both to reputation and morale for providers and commissioners.

#### **6. Looking beyond patient participation groups**

Debate about how best to involve patients (and the public) in GP practices often focuses on patient participation groups (PPGs). Our experience has shown us that such groups can work well but they are few and far between and those which succeed depend very heavily on the support of key individuals within the practice, usually a practice manager or one committed GP. On the whole however practices find these groups hard to sustain and demanding of time and energy.

Many GPs are resistant to setting up such groups because they believe that they are unrepresentative of patients and a whole and that they focus on the "wrong" issues. Whilst we would not necessarily agree with this analysis we recognise that such perceptions take time and effort to overcome.

We are in favour of such groups where they can be made to work well: group members are often highly committed and have much to offer representing not only their own interests but those of others very effectively. With the right support and investment in their capacity to deliver, PPGs are capable of informed debate and of making important contributions on a wide range of issues from the day-to-day delivery of care to high level commissioning decisions.

However, without considerable ongoing support and the dedication of significant resources such groups can become both expensive and unproductive. We are well aware of the frustrations often felt by patients and members of the public who are members of groups that do not function well and where their input is not valued and used.

It is vital that the processes which are established ensure “penalty free” participation and that people are able to see how they are making a difference. The question of reward and recognition for lay people needs serious consideration. Although some people prefer to contribute their time on a voluntary basis, others are unable to take part unless their basic expenses are covered. At some higher levels payment should be considered both because it demonstrates that the individual’s input is valued as highly as that of the other paid people in the room and because it increases the likelihood of attracting high calibre individuals and those not in the sort of paid employment that allows them paid time off work for such activities. Another important benefit in kind which should be afforded to lay people is high quality training and opportunities for personal development including appraisal and feedback. Lay people contributing to practice groups and other time-consuming activities such as focus groups should be treated as valued members of the team whether they are paid or acting in a voluntary capacity.

Although patient groups will have their place in some practices, the onus should be on practices both as providers and commissioners to develop other and different approaches to seeking patient input such as texting, virtual groups, social networking and other simple methods for staff to gather feedback directly from patients.

## **7. Governance arrangement in consortia**

The governance models adopted by commissioning consortia should start from the basis that patients and the public are the moral owners of the services. We therefore support the views put forward by other respondents that the boards of consortia need to be constituted in such a way as to ensure that the interests of the wider population are foremost. We are concerned that, as with current NHS governance arrangements, there is a risk that board decision-making will be dominated by clinicians and managers keen to ensure that their particular specialisms and interests are represented. If this happens the public interest will inevitably take second place.

We are strongly of the view that the boards of consortia must not have tokenistic representation of patients and the public. There is little value in having one “lay” person at a table full of “professionals” and it is an invidious position for any individual to be in. But even with a majority of lay and public members (such as on PCTs) it can be seen that clinical and executive status and expertise trumps lay and public status in very many cases. This will only be changed if there is a significant shift in attitudes and behaviours of boards. As this will be new territory for many GP commissioners, there are opportunities to make such changes from the outset.

In our “bottom up” model described above, we would see public and patients in practices represented on the board. There has been much emphasis on clinical and managerial leadership in GP commissioning and we would like to see this complemented by strong lay leadership which is valued and supported by commissioners and nationally. Lay leaders will need recognition, support, training and rewarding – just like their opposite numbers.

No matter how boards are constituted in terms of the individuals who sit on them, the important thing is that there is a constant onus on the whole commissioning process to make decisions based on proper health intelligence gathered from a range of sources of which public and patient views and experiences form an important part.

While many methods can (and should) be used to gather this information it is what is done with the data that matters most. Patient experience data and patient and public views should be gathered systematically both by providers and by commissioners.

## **8. Integration between HealthWatch and other patient/lay involvement**

Local HealthWatch is important but it is essential that it is not by default seen as a synonym for effective patient and public involvement. There must be much more than simply a viable Local Health Watch. More work needs to be done as to how the new HealthWatch bodies will be integrated into GP commissioning structures. At a local level, we would like to see a stronger and more diverse membership of HealthWatch properly engaged in commissioning decisions as of right. However we think that this needs to be complemented by GP practices and consortia having direct “listening” relationships with their own patients.

We have argued strongly against Local HealthWatch taking on a direct responsibility for complaints handling or complaints advocacy, as such functions would skew LHW’s main purpose.

HealthWatch England as a subset of the Care Quality Commission needs to have a strong and clear remit - complementary to that of the National Commissioning Board – to ensure that effective patient and public involvement happens in each consortium and HWWB in England.

## **9. Involvement to address health inequalities**

Healthwatch, GP practices, local commissioning consortia and local authorities should all be finding new and better ways of gathering the views of those whose voices are seldom heard. Many of these will be the people most affected by health inequalities. There should be a requirement to demonstrate that this is happening and that these people are having a direct impact on service planning and delivery. This work presents real challenges but this is an area where close working with other agencies (social services, education and 3<sup>rd</sup> sector bodies etc) will pay real dividends.

## **10. Local government scrutiny of health service**

We fully support calls for an independent health scrutiny function separate from whatever scrutiny powers are taken on by the HWBB. This LA function should involve not just elected councillors, but independent lay people appointed as “assessors” to the scrutiny committee. These assessors should be publicly recruited to a uniform job description and rewarded on a national basis consistent with local authority best practice. They should be accountable to their appointing Council for discharging their function fairly and impartially.

## **11. GP commissioners and local authorities working together**

There are significant cultural differences between Councils and health services and although there are examples where LAs and PCTs have worked well together, they are still the exception because of differing cultures. Joint strategic planning will have no impact unless the culture can be changed. Where GPs are concerned, for many, their Council is foreign territory even though they depend on its social care and other social services functions every day. It is therefore going to be very important for Councillors to get out and visit the new commissioners.

The JSNA process will act as a unifying experience and the positioning of public health with LAs will assist the process, since nothing can be achieved without public health intelligence. This is the key ingredient to put with user-led intelligence to achieve intelligent commissioning.

The Moore Adamson Craig Partnership LLP  
17 Lordship Park  
London  
N16 5UN

[caroline@mooreadamsoncraig.co.uk](mailto:caroline@mooreadamsoncraig.co.uk)  
020 8802 2833 (landline) 07967 961997 (mobile)

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