

# **Readiness of CCGs to embed patient and public engagement in local commissioning**

## **1.0 Introduction**

1.1 This is a submission to the Health Committee's enquiry "Implementation of the Health and Social Care Act 2012". It focuses on the state of readiness and capability of CCGs to embed patient and public engagement (PPE) in local commissioning and what support they need to do this well.

1.2 In late 2012, we conducted 18 in-depth qualitative interviews with clinical, management and lay leaders of 6 CCGs. These were 2<sup>nd</sup> and 3<sup>rd</sup> wave authorisations in the West Midlands, South East London, South East and North East England, and Yorkshire.

1.3 This research was commissioned by the Department of Health and undertaken on behalf of the NHS Commissioning Board by The Millar Adamson Craig Partnership (MAC) and *InHealth Associates*.<sup>1</sup>

## **2.0 Summary of top line findings**

### **2.1 There is enthusiasm and hope for the future**

CCGs are under no illusions about the scale of the challenges to "do better with less" but are keen to grapple with it and talk to as many people as possible about how to achieve it. They want to know what's important to local patient and communities especially seldom-heard groups and reflect their perspectives in commissioning decisions. But they may not have the right tools and skills available quickly enough before they have to start taking crucial decisions. They wanted timely organisational development across their activities to maximise the value of engagement to their business as commissioning bodies. They were unsure whether this should come from large Commissioning Support Units exclusively, as this might risk them losing control, timing and local sensitivity.

### **2.2 CCGs "get it" with PPE**

They understand the centrality of good engagement, but in practical terms they may not be innovative or responsive enough to maximise the assets represented by patients and communities in order to leverage change of the scale and pace that will be needed. Building on existing patient participation groups in GP practices which some wish to do will certainly help, but it will not be sufficient to the task.

### **2.3 Lay member roles on CCG Boards lack clarity**

The roles of CCG lay members and lay people generally – which includes "lay representatives" and "patient leaders" involved with the CCGs – were unclear and variable. There was some concern about being 'insiders' who might support a Board's decisions and thus risk external legitimacy amongst their "community constituency".

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<sup>1</sup> A full report can be found at [www.networks.nhs.uk/nhs-networks/documents/documents/ppe](http://www.networks.nhs.uk/nhs-networks/documents/documents/ppe)

People wanted support for lay members (and other lay representatives and patient leaders) to build the skills to be effective and there were some calls for a network of lay members on CCG boards to be developed.

#### **2.4 There is a hunger of metrics to measure engagement effectiveness**

CCG leaders knew that embedding engagement in everything they do is essential if they are to make commissioning decisions and service changes with broad user and carer understanding and community support. They were hungry for metrics to measure the impact of their engagement efforts.

**2.5 Our conclusion** from this sample of 6 CCGs who were not in the “pathfinder wave” was that they were in the process of embedding PPE, but it was not complete and might not be completed before they were flung into difficult decision making situations where local understanding and support for change was essential. They were desperate to avoid confrontation and wanted to work in partnership - many were already doing so - but they realised that they could be hemmed in by swiftly changing events.

The most obvious need was for organisational development support now for better engagement. Specific suggestions are in Section 5 below. This should be delivered in a tailored and targeted way in order to address local issues and achieve quick results so that trust can be developed and their room for manoeuvre does not become restricted.

### **3.0 Engagement activities and impact**

#### **3.1 Early enthusiasm**

On the whole, interviewees were optimistic about engaging patients and the public. They felt that their CCG was taking engagement seriously, was better positioned for success than PCTs had been and more committed to engagement prior to decisions being taken. Many interviewees reported that they were still setting up PPE arrangements and forming new relationships between, and across teams.

They wanted to work with taxpayers and service users to make difficult decisions about services and money. But the consequences of 'getting it wrong' (i.e. opposition to changes) troubled several people. An underlying concern was that the patient interest could be side-lined, despite the good intentions, because of urgency to make decisions.

#### **3.2 CCGs as listening organisations**

CCGs said they need to 'explain themselves' as new organisations and that their 'educational' task includes explaining new NHS structures and government decisions to local people. They wanted to have 'conversations' with a broader range of local people and communities and aim to be responsive 'listening organisations'. This does not always sit comfortably with the need to make tough commissioning (and de-commissioning) decisions. Several people mentioned that these tensions seem

difficult to handle and that they did not feel well equipped to carry out these multiple, and perhaps contradictory, roles.

They realised a need to scale up communication with huge numbers of people and to focus on what's important to the population and to ensure local perspectives feed in to commissioning decisions. Interviewees seemed ambitious, wanting to work with seldom heard groups, such as children and young people, people from diverse communities and those who don't often access GP services, or participate in governance structures or participate in Patient Participation Groups (PPGs).

### **3.3 Engagement activities and challenges**

Even in these six CCGs, the picture was mixed. Five out of the six CCGs were able to give us examples of targeted engagement activities and processes to help improve services, for example in services for people with dementia, mental health issues and HIV and in redesigning emergency/urgent care services and designing virtual wards in the community. Many were having conversations with communities about needs and experiences and prioritising services and investment. Some were communicating explicitly about the need for change (e.g. deriving from poor patient experience and/or 'inappropriate' use of services). This was all productive.

Key challenges included ensuring a broader range of people are involved, having an infrastructure to collect data, capability to interpret it, and the will to use data to drive decision-making. Perennial PPE challenges cropped up - inadequate resources and time.

### **3.4 Partnership working**

Several interviewees stressed the benefits of partnership working (e.g. with local government, HealthWatch, etc). These CCGs felt supported by partners and stakeholders - local government, LINKs and HealthWatch groups. Local Authorities in some places were providing access to citizen panels, virtual groups, and other engagement mechanisms (including, for example paying people to gather information from other groups). Some mentioned support from voluntary organisations as good partners too. One CCG was seeking innovation funding to capture and implement good ideas.

### **3.5 Making a difference?**

Interviewees could identify what success might mean, in terms of *processes* (e.g. diversity of people participating; quality of dialogue; people's views considered; honest feedback about decisions) and *impact* (improved services; service utilisation). We also heard some markers described for an embedded engagement *culture*:

- Reaching difficult decisions that are comfortable for patient representatives;
- Everyone asking what the public thinks before making a decision;
- A Board confident that decisions have been developed through engagement;
- Having the right 'intelligent information' that leads to and supports action.

## **4.0 Engagement cultures and systems**

## **4.1 Not yet embedded**

PPE is not yet embedded in emerging cultures and systems. We heard no examples of PPE in relation to the requirements of Domain 2 of the authorisation process and few specific examples of PPE in the authorisation process beyond open events with local representatives. Only one lay member of the six we interviewed spoke of being involved in the authorisation process.

## **4.2 Lack of shared understanding**

Despite a range of emerging activities, some admitted PPE is seldom defined in principle or embedded in practice. There seemed to be a lack of clarity about what it might mean to be 'patient-focused' or 'patient-centred'.

Only one or two people mentioned that PPE was important in strategic planning. People were not explicit about the different possible purposes of PPE throughout the commissioning cycle.<sup>2</sup> However, several examples were provided of engaging the public in planning (stage two of the Engagement Cycle) and working with patients to improve services or redesign pathways (Stage Three). Few mentioned engaging communities in identifying needs and aspirations, or Joint Strategic Needs Assessment (Stage One) or people involved in contracting and procurement (Stage Four) or in monitoring and performance management (Stage Five).

## **4.3 Engagement Structures and Governance**

Most CCGs we spoke to are using patient participation groups (PPGs) as building blocks for locality engagement structures that feed into the CCG Board. The assumption is this 'hub and spoke' model can ensure more meaningful 'local' input into commissioning decisions, partly as it mirrors a 'GP and practice-led' commissioning model.

Most also realised the limitations of this. Some CCG Boards were drawing on a wider membership (e.g. appointing lay members independently). Others pointed to the fact that PPG members often come from particular walks of life. They have volunteered for specific practice-based activities and face multiple challenges moving from a focus on individual GP surgeries (as providers) to locality-wide issues (as commissioners). They have lacked power in the past and needed to develop leadership skills.

## **5.0 Support for engagement**

### **5.1 PPE practitioners and specialist expertise**

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<sup>2</sup> The Engagement Cycle is a model developed for commissioners to enable them to understand who needs to do what to engage patients and the public at five different stages of commissioning <http://engagementcycle.org/>

We heard a need for strong local relationships developed over time and concerns that 'PPE practitioners' and expertise were at risk through more centralised commissioning support arrangements. For some, it was not clear who was providing 'communication' and who was providing 'engagement' support locally. There were issues raised about relationships with commissioning support bodies and worries that the CCG could lose control and local knowledge if engagement were outsourced.

## **5.2 Building patient leadership**

There is a lack of clarity about the role of CCG lay members (and “lay representatives” generally) and some concern as to the degree they are 'insiders'. They might support a Board's decisions and thus risk external legitimacy amongst their 'community constituency'. Special support for lay members was identified and not just by lay members. What people wanted was support for lay people to build the skills to be effective, such as analytical skills, insight and metrics. There were some calls for a network of lay members to be developed.

Practical support (resources, logistical support, training) for lay input was hugely variable. Some lay members had contracts and were paid expenses, while others remained “volunteers”. One CCG lay Member said he'd been promised expenses and/or pay and had not received either. We heard that there was a need for guidelines about how to support lay people in these roles.

## **5.3 Building clinical and professional leadership**

Building the capacity of GPs and other professional staff to lead PPE is crucial, though what this means in practice is not yet clear. Several interviewees noted the wide variation in interest for the PPE agenda. Some GPs, we were told, actively 'champion' the work, while others remain noticeably uninvolved or uninterested (unless financially incentivised) and many practices lack a functioning PPG.

It was notable that no-one identified specific support requests for Accountable Officers. Special support to clinicians was mentioned by lay and clinical leads and included supporting clinicians to capture intelligence about services via everyday patient conversations. More widely, suggestions included support for their 'public role' (e.g. facilitating meetings, speaking in public). Interviewees felt that changing clinical practice towards engagement at 'individual level' would help patients and support a culture change across the CCG.

## **5.4 The need for organisational development**

We did not find a consistent pattern of support for engagement, but did encounter useful examples. One CCG was undertaking individualised board member training. Another mentioned board development based on a skills audit.

People wanted a menu of support options for engaging well rather than a 'one size fits all' approach. Despite a wide-spread sense of being “too busy” to attend more meetings, many wanted face-to-face support (possibly provided by the NHS Commissioning Board) and opportunities to share learning.

Interviewees spoke about different approaches to learning (e.g. action learning sets, regional workshops, bespoke specialist advice and support). Specific requests included:

- Sharing good practice about methods to reach people. This includes how to sustain 'conversations' with the public over time.
- Learning about specific techniques, such as participatory budgeting, ethnographic research and social marketing and learning from other industries that are able to do market research and have excellent customer relations.
- How best to engage the community and voluntary (third) sector and other partners in order to align effort and avoid duplication.
- Working with data - gathering data, turning it into useful information, making commissioning decisions, evaluating those decisions, and understanding how to communicate within and outside the CCG at each point. Some people wanted more support for using the Engagement Cycle.
- How to embed PPE into the culture and systems of the CCG and in the locality (i.e. including working with Commissioning Support Organisations).
- and evaluation of PPE's impact and effectiveness

## **5.5 Support requested from the NHS Commissioning Board**

Interviewees asked for support from, and positive relationships with, the NHS Commissioning Board (NHS CB) that itself could be a role model for PPE.

Interviewees wanted local commissioning meetings to reflect good engagement, and not treat PPE as an add-on to main business.

Other issues relevant to the role of the NHS CB were the following:

- Incentivising PPE - some thought financial or other incentives might aid clinicians to engage with PPE. A specific suggestion was this could build on the principle used for CQUIN (Commissioning for Quality Innovation) where payments are made to providers achieving quality improvement objectives.
- Data and insight - some interviewees want wider access to data, such as population data that can be shared between and within regions, localities and CCGs. CCGs need to understand what data is available. A specific suggestion was that local questions might be added to national surveys in order to obtain feedback about issues that matter locally, such as service changes;
- Clarifying expectations - several people felt that CCGs' role could be clearer, (e.g. on expectations about being "responsible and publically accountable"). One idea was for CCGs to report to the NHS CB on PPE and good practice.
- Measurement and metrics - a specific suggestion was the creation of a self-assessment tool for CCGs to measure PPE effectiveness, identify gaps and be able to choose from a menu of support resources to address those gaps. This might be linked to using the Engagement Cycle more effectively.

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