Embedding patient and public engagement in local commissioning

Summary report on learning from interviews with CCG leaders

This report summarises key messages from in-depth qualitative research undertaken with 18 Clinical Commissioning Group leaders (Clinical Lead, Accountable Officer and Lay Board Member) across six organisations. These CCGs were either second or third wave, in terms of authorisation. We focused on "what support CCGs need to embed patient and public engagement". The research was undertaken as part of follow-up work on developing the Smart Guides series on patient and public engagement.¹ It also sought to assist thinking about what the NHS Commissioning Board and others might do to support PPE in the future.

The research was carried out on behalf of the Department of Health by InHealth Associates and Moore Adamson Craig Partnership (MAC).

¹.0 Engagement activities and impact

¹.1 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. But they want support to build on this early enthusiasm. These are early days. Many interviewees reported that they were still setting up PPE arrangements. New relationships between, and across teams, was a feature of many interviews. Some interviewees (Accountable Officers especially) had worked with commissioning and PPE before, but others had not.

Many seemed anxious about the urgency of events and short timetables for decisions. They want 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. Would the patient interest be sidelined, despite the good intentions? This was an undercurrent to several interviews.

¹.2 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. Many interviewees want 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.

From what we heard, CCGs acknowledge a need to scale up communication with huge numbers of people. They are keen 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. Several noted that the people they want to have conversations with are not those who normally participate in governance structures and/or through fora such as Patient Participation Group (PPGs).

1.3 Engagement activities and challenges

Even in these six CCGs, the picture is 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 are having conversations with communities about needs and experiences and prioritising services and investment. Some are communicating explicitly about the need for change (e.g. deriving from poor patient experience and/or ‘inappropriate’ use of services). This has fostered productive discussions.

Key challenges, mentioned several times, include 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 regularly - inadequate resources and time, for example.

1.4 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). We heard of one local authority viewed by a clinical lead as a role model of collaboration that affects the CCG’s ‘working spirit’. Some mentioned support from voluntary organisations as good partners too. One CCG was seeking innovation funding to capture and implement good ideas.

1.5 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.
2.0 Engagement cultures and systems

2.1 Not yet embedded

PPE is not yet embedded in emerging cultures and systems. Perhaps this is unsurprising, given that these are 'early days'. But, 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.

2.2 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. 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).

2.3 Engagement Structures and Governance

CCGs in this sample are developing 'practice-based models' of engagement. Most are using patient participation groups (PPGs) as building blocks for locality engagement structures (with representation from the tier 'below') that feed into the CCG Board. Some people assume that 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 though were realistic about the limitations of such a model. Some CCG Boards are 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 need to develop leadership skills.

3.0 Support for engagement

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2 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. [www.institute.nhs.uk/tools/the_engagement_cycle/how_to_use_the_engagement_cycle.html](http://www.institute.nhs.uk/tools/the_engagement_cycle/how_to_use_the_engagement_cycle.html)
3.1 The Smart Guides

During interviews, we found that the Smart Guides were liked by the majority of those we talked to. On the whole, people liked the brevity of the format and practicality and relevance of the content.

Some mentioned that the guides may be more useful for those at a preliminary stage in their PPE understanding. Some Guides were mentioned more than others as being of particular benefit, for example those dealing with the benefits of engagement and how to work with lay members and lay representatives. Interviewees also gave examples of other issues they would wish to see developed as part of a second tranche of the series.

3.2 PPE practitioners and specialist expertise

From where will CCGs receive PPE support? We heard a need for strong local relationships developed over time; also 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.

Resources are seen as scarce. Some thought the Department of Health and the Commissioning Board had a specific role to play. This could be by subsidising or supporting PPE activity. There were mixed views on whether support should come directly from national bodies or through funding of the CCGs to support PPE.

3.3 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 to lay members was identified by a number of interviewees, not just by lay members. What people wanted was support for lay members (and other patient representatives) to build the skills to be effective. There were some mentions of specific skills, such as analytical skills, insight and metrics, and also some calls for a network of lay members to be developed.

Practical support (resources, logistical support, training) for lay input is hugely variable. Some lay members have contracts and are paid expenses, while others remain pure volunteers. One CCG lay Member reported having 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.

3.4 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.
And 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 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.

3.5 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 seem to want a menu of support options 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).
- Measurement and evaluation of PPE.

3.6 Support 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 and 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.

This document is available online at [http://bit.ly/Wt56j7](http://bit.ly/Wt56j7)

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