



discussion paper

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Patient and public engagement in the new commissioning system

Key points

- In the NHS, patient and public engagement (PPE) refers to the involvement of individual patients in their own care; involvement of users and carers in service design and evaluation; and engaging communities and the public in prioritisation and planning.
- Effective PPE can lead to more patient-centred care, a greater sense of ownership among patients and moderated demand for healthcare resources.
- Clinical commissioning groups (CCGs) will need to look beyond their practice lists in order to engage whole populations.
- Effective PPE is a rewarding and valuable component of being a highly effective commissioner.

Achieving effective patient and public engagement (PPE) has been a cornerstone of NHS policy for many years. Successive governments have worked to embed the principles of engagement in health service design and delivery, most recently with the 2011 Health and Social Care Bill, which seeks to increase democratic accountability and patient voice in the NHS.¹

This paper draws on a round-table discussion held by the NHS Confederation in August 2011 to consider the critical issues which clinical commissioning groups (CCGs) will need to address in developing approaches to meaningful and effective PPE. The discussion included examples of effective PPE work already undertaken by new and existing NHS commissioners.

Introduction

The first part of this paper provides some background information on the involvement of patients and the public in NHS commissioning to date. It then focuses on some key issues and challenges to embedding PPE in emerging commissioning structures.

As such, it is not intended to be an exhaustive study of the area, but rather a starting point for those considering how to build PPE into clinical commissioning.

Case studies are included to illustrate how some of the ideas discussed might work in practice.

Why is PPE important?

GPs and managers with experience of involving patients and members of the public in commissioning have reported that while successful engagement may seem challenging initially, it can provide extremely valuable information to assist in procuring high-quality services.

PPE at the collective level is about ensuring patients, and potential future patients, have a chance to shape the care that they receive, and about involving taxpayers and the public in decisions about how NHS resources are deployed. It can take various forms, ranging from engagement in activities to

measure quality or proposals to change specific services, to ongoing strategic input into decisions about the priority given to different interventions and outcomes.

At an individual level, PPE can mean involving patients in decisions about their own care and giving them more control over their treatment. For many years, PPE has been an important requirement for the NHS. The NHS Act 2006 places all statutory NHS organisations under a legal duty to involve patients and their representatives in decisions about services. This emphasis looks set to remain under the provisions of the proposed Health Bill, which will see several local and national bodies created to encourage greater democratic accountability and public engagement. CCGs will be expected to have put an approach to engagement in place in order to achieve authorisation by the NHS Commissioning Board. Pathfinder CCGs will already be working with PCT clusters on engagement activity, for example, related to the phased roll-out of extended patient choice of Any Qualified Provider.² Clearly, it will be important for CCGs to give early consideration to how they intend to engage with patients and the public.

How PPE can add value in commissioning

Good PPE can be invaluable, both from the perspective of commissioning and providing services. There is much experience within the NHS of using PPE to drive improvement. Involving patients and the public in individual and collective decisions about their care has been cited as a way of securing a more patient-centred approach to healthcare delivery, fostering

Case study: Connected care in Hartlepool

Health and social care organisation Turning Point launched its Connected Care model of community commissioning in Hartlepool in 2006. 251 residents were interviewed by researchers who had been recruited from the local community and supported by Turning Point and local agencies.

One-to-one interviews, focus groups and a community 'have your say' event were used to identify what people wanted from services. The community said their priorities were good information, more choice, and better access to local services with continuity and

joined-up communication between agencies.

The results of the audit were used to develop a series of services, including a navigation scheme to help people solve problems with care, a service to support access to independent living, a volunteering service and supported accommodation for young people.

An evaluation of the scheme concluded that services were more accessible to local people, take-up had improved and people were less likely to disengage from the system.⁷

a sense of ownership among patients and moderating demand for healthcare resources.³ The evidence for the effectiveness of PPE in commissioning is less clear. However, there are some examples of effective engagement adding value. For example, one piece of research showed that integrated early intervention programmes, stemming from community-led commissioning, generated resource savings of over £2.50 for every £1 spent.⁴ There is also evidence that schemes which involve people in 'co-creating' services can significantly benefit the individuals themselves and across schemes.⁵

PPE work undertaken by NHS commissioners has enabled constructive dialogue between commissioners and community groups, whose positions may at first have seemed intractably opposed. For instance, NHS South Gloucestershire's engagement work with several local groups

who were campaigning against the reconfiguration of an acute hospital was so successful that they were able to move from a position of confrontation to one where campaigners even jointly agreed press releases sent out by the primary care trust (PCT). This meant that media stories about the proposed changes caused less controversy than they might have done otherwise.⁶

While good engagement can add value and enable commissioning organisations to become more accountable to the populations they serve, poor engagement can pose serious risks to organisations. A failed PPE project can damage trust and lead populations to disengage, treating invitations to join consultation exercises with cynicism. For this reason, it is essential that engagement work is embedded in commissioning activity effectively, genuinely contributing to decision-making and represents good utilisation of resources.

Good engagement is:

- focused on culture rather than structures or techniques
- integral to all activity
- strategic, clear and coordinated
- open and transparent
- well resourced and supported
- inclusive and representative
- flexible
- collaborative
- sustained
- focused on improvement.⁸

Using engagement activity in commissioning

The 'commissioning cycle' model splits commissioning into three broad activities: strategic planning, procurement and management.⁹ PPE has an important role to play in the decisions NHS commissioners make at each of these points. Further detail about the contribution of engagement at all stages in commissioning – including information on the 'engagement cycle' can be found in the Department of Health's *Better health, better experience, better engagement*.¹⁰

Strategic planning can benefit from whole health economy input and should relate to the joint strategic needs assessment process in which CCGs will need to participate. This could, for instance, include involving patients and the public in determining priorities for investment. Work around specifying outcomes and procuring services can benefit from feeding patient perspectives into dialogue between commissioners and incumbent and potential providers about service

redesign. However, it is essential that correct process relating to procurement law is followed. The Cooperation and Competition Panel's *Procurement guide for commissioners of NHS-funded services* recommends that to get maximum benefit, "engagement should be with both current and potential providers and take place as part of an ongoing exercise, i.e. it should not just be limited to procurement activity".¹¹ CCGs should familiarise themselves with these requirements in order to avoid the challenge that some potential providers have been given an unfair advantage.

Incorporating PPE into the management of demand and performance can be challenging, but techniques to capture patient experience, including complaints analysis, surveys and mystery shopping, can work as a means of gathering intelligence about service quality from patients.

PPE in use in the NHS

There are a number of methods of engaging patients and the public which are already in wide use in the NHS. Figure 1 (overleaf) sets out some of the more commonly used techniques and their advantages and disadvantages. It is not exhaustive and there are a wide range of mechanisms which can be used in engagement work. In a typical public consultation, it is likely several techniques will be used, targeting different patient and public groups.

Round-table discussion

The rest of this paper draws on the round-table discussion to explore particular issues and challenges faced by commissioners, and to consider how CCGs might adopt different approaches to engagement.

What can CCGs hope to achieve both through ongoing patient engagement work in commissioning activity and specific engagement exercises?

Participants in the discussion felt that significant commitment to and enthusiasm for PPE already existed within many CCGs. However, the approaches used to date by the NHS all require an investment of time, capacity and money to be successful. Depending on the level of management allowance made available to CCGs, they may not have sufficient resources to undertake extensive engagement work in relation to every aspect of their commissioning activities.

Possible solutions to this problem include: undertaking PPE work at a 'federated' level (across several CCGs) in order to make it cost-effective, drawing on any available PCT cluster resource; being innovative in identifying other funding locally or nationally; and using existing local groups.

Participants felt that one of the most urgent priorities for CCGs related to mapping and understanding the range of existing local PPE mechanisms and sources of intelligence already available and to working them into commissioning activity.

GPs and practice staff already have extensive experience of engaging with patients, whether in consultations, conversations at reception, or through patient participation groups. Many practices are at present participating in a two-year directed enhanced service (DES) which focuses on patient participation, and many have a patient participation group (PPG) in place, enabling clinicians and practice staff to engage with registered patients from a provider perspective.

Figure 1. Common techniques used in engagement work

Approach	Description	Advantages	Disadvantages	Example uses
Patient participation group (PPG)	Panel of patients that provides ongoing engagement in practice decision-making	<ul style="list-style-type: none"> • Provides a reservoir of actively engaged patients • Provides opportunities for continuous patient input into activity 	<ul style="list-style-type: none"> • Participants self-select • In primary care, usually based on practice population rather than resident population, so excludes those not registered with a GP 	<ul style="list-style-type: none"> • Ongoing practice-level input • Specific consultation exercises
Membership model (foundation trust membership approach)	Panel drawn from the population served by host organisation, which provides ongoing engagement in decision-making	As above, but designed to cover a larger population	<ul style="list-style-type: none"> • Can be expensive to run • Participants self-select as above 	<ul style="list-style-type: none"> • Ongoing strategic input from membership • Specific consultation exercises
Patient advocacy group¹²	Organisation – usually not-for-profit – that focuses on representing the interests of specific groups of patients	<ul style="list-style-type: none"> • Can have significant expertise in relevant area • Can help provide access to relevant patients 	Generally condition-specific, which can pose a challenge when setting priorities across multiple disease areas	Strategic or consultation input from the perspective of a specific sub-group of the patient population
Citizen's jury¹³	Small panel of non-specialists modelled on the structure of a jury, which examines an issue and delivers a "verdict"	<ul style="list-style-type: none"> • A high-profile demonstration of public engagement • Can provide an informed public view and generate wider public debate 	<ul style="list-style-type: none"> • Expensive and time-consuming to run • Only involves a small group – those not taking part can still feel disengaged in the process • Rejecting the jury's verdict can be problematic 	One-off consultation exercises, particularly where a contentious issue is being discussed
Focus group¹⁴	Group interview that uses communication between participants in order to generate data	<ul style="list-style-type: none"> • Useful for exploring people's knowledge, experiences and thought processes • Can encourage contributions from "unresponsive patients" 	<ul style="list-style-type: none"> • Articulation of group norms may silence individual voices of dissent • Can be expensive to run 	For detailed exploration of a particular issue or issues and to examine patients' experiences of disease and health services
Complaints analysis	Scrutiny of complaints received to identify common themes	Provides high-quality data about existing services	<ul style="list-style-type: none"> • Generally only covers negative feedback • Groups who tend not to complain will be under-represented 	Monitoring service quality
Experience-based design¹⁵	Focuses on capturing service users' and carers' experiences through their stories and involving them alongside clinicians in redesigning experiences rather than just systems and processes	Incorporates patient experience into the heart of service design	Can pose challenges in terms of defining the scope of the process and not being able to influence factors outside the control of the participants	Service design/redesign
Public meeting	A meeting to explore public and patient opinion about a specific proposal	Brings people together to discuss the issue under consideration	<ul style="list-style-type: none"> • Turn-out can be low • Risk that the meeting becomes confrontational if the issue is communicated badly 	<ul style="list-style-type: none"> • Service design/redesign • Reconfiguration

CCGs will be able to build on existing arrangements to engage patients through PPGs. However, GPs' new responsibility for commissioning health services means they will need to consider some additional issues in relation to PPE. For instance, the DES mentioned above only relates to patient engagement at practice level. The approach CCG leaders will need to take may differ markedly from the kinds of conversations GPs have had with patients in relation to the provision of primary care services.

Many mechanisms for consulting patients and the public are already in place and available to CCGs. PCT clusters will be able to support CCGs in developing new architecture for PPE, where pathfinders have identified this as a priority and have the leadership in place to support effective engagement. In many cases, PCTs will be able to signpost CCG members to existing patient engagement mechanisms in local areas. There are challenges, however, in moving beyond the success of pathfinder projects and ensuring PPE is embedded in everyday practice.

"Our society is changing and does want to get much more involved in services as opposed to delegating through the ballot box to a group of people to do that for them."

Christopher Long, chief executive, NHS Humber Cluster

In addition to existing practice-based PPGs, commissioners can make use of community-based organisations working to improve health and social care services. Local improvement networks (LINKs), local HealthWatch bodies (which are to be set up as part of the Health and Social Care

Bill's national mechanism for patient engagement and will ultimately replace LINKs) and third sector organisations will all be important partners. Local foundation trust memberships also provide a route to engagement, though commissioners will need to interpret their views within the context of members' affiliation to their foundation trust. In addition, local authorities may have existing engagement mechanisms which can be used to inform strategic planning. And, no doubt, health and well-being boards, which will have their own statutory responsibilities, will play a role. As well as using strategic patient and public input, CCGs will also be able to build networks of people who they can

engage at short notice where a quick response is necessary. For instance, clinicians will know individual patients and carers, voluntary sector groups working in particular areas and people who, whilst not wishing to join formal groups, may be willing to provide views via email or telephone. However, care needs to be taken that this is not a substitute for systematic engagement. Where difficult and controversial decisions are being taken by CCGs, systematic engagement will be essential to ensure the legitimacy of commissioners' decisions in the eyes of the public, and can create an environment where it is possible to have more constructive conversations about the need for change.

Case study: NHS Hull membership scheme

NHS Hull built a 'social movement' to involve the people of the city more closely in the work of the PCT, encourage residents to think more carefully about their own health, and participate in decisions about how health services should be structured and managed.

The PCT set up a membership scheme, based on the foundation trust member model. In the first year, 2,500 people, or 4 per cent of the population, were recruited, and within four years this had increased to 8,500 people.

The PCT then launched a £250,000 listening exercise focusing on prioritisation. They used volunteers from the membership scheme to go to different locations such as supermarkets, community centres and residential homes. Participants were asked to specify their priorities for the health service. As a result of the listening exercise, the PCT put forward a set of proposals.

The PCT also enlisted volunteers from its membership to consider each stage of individual care pathways, from prevention, detection and diagnosis through to treatment and ongoing care, to provide input into service design work. The PCT brought member volunteers into meetings with providers to put forward a patient perspective.

Through the scheme, the PCT increased its accountability to its population, and dialogue between patients and staff was greatly improved.

Unfortunately, the PCT had to scale back the work in order to meet efficiency savings targets in 2010/11. PCT leaders recognise that the scale of investment in the scheme is not replicable in straitened financial times, but believe that some of the scheme's achievements can be replicated by using existing mechanisms such as foundation trust memberships and local authority engagement routes.

What are the limits of engagement approaches which focus on and build upon practice PPGs? How should GPs respond to the need to reach beyond the patient list?

Participants felt that while successful PPGs provide a valuable resource, CCGs will need to look beyond practice lists in order to reflect the needs of geographical populations which may encompass many different characteristics. These populations will be even broader than an aggregate of all member CCG practice lists and may include groups that are not always well represented in engagement exercises, patients who are not at present registered with a GP and people who are not themselves receiving treatment. Examples of under-represented groups could be Gypsy and traveller communities, some Black and Minority Ethnic (BME) groups, homeless people, and people whose first language is not English. Carers should also be included in engagement work.

How can patient representatives act as a proxy for other groups? How can they fulfil their role as a critical friend and a conduit for community perspectives?

There are many dilemmas attached to the role of the patient representative – should they or can they represent the views of wider communities? How can individuals draw upon their own experiences yet understand other dimensions of patient experience? Participants felt that competencies for patient representatives could include knowing the “broad dimensions” of what matters to the wider patient population, coupled with knowing the right questions to ask to ensure conversations remain

“The starting point is being able to meet people where they are and give them a sense of aspiration and confidence that things can be different.”

Hilary Samson Barry, director,
Turning Point

focused on patients. One example of this is pressing commissioners on how particular proposals relate to specific patient groups. In order to carry out this role, patient representatives require a clarity of role, learning and support.

Individual community members can be enabled to take on roles as patient leaders, equipped with the skills and qualities to represent the views of broader groups of patients and acting as a ‘critical friend’ by

asking the right questions about engagement. But people need to be provided with the right influencing and negotiation skills to be able to take on such roles, which again requires capacity and investment. However, CCGs will have to consider budgetary constraints in planning this kind of activity.

GPs participating in the round-table discussion questioned how elements of the local population currently under-represented in engagement activity might be encouraged to participate. Suggestions included approaching community organisations and community leaders, who already have significant levels of community engagement, as ‘intermediaries’.

Case study: *In*Health Associates and Southend Estuary Pathfinder CCG

*In*Health Associates and the Southend Estuary pathfinder CCG (population 50–60,000) explored what good PPE might look like in a CCG setting.

The ‘practice-based model’ included a patient-public reference group (PPRG) on which each member practice has a representative. A nominated PPRG member would become a non-voting member of the CCG Board. A LINK/HealthWatch Member would also become a non-voting member of the Board. The PPRG would meet on a quarterly basis and input into commissioning plans and QIPP plans and play an outreach role. In addition, the CCG Board would have two voting members, recruited to be ‘patient and public advisors’ able to play the role of

‘critical friend’ (ensuring the CCG maintained a patient-focus) and ‘community channel’ (able to draw on networks in order to articulate patient and community interests). The CCG might also develop a wider community membership from which to draw upon for other activities (eg QIPP).

The shared decision making work used action learning sets¹⁶ with patient representatives, practice managers and GPs. Various activities were undertaken, including developing the PPRG concept, a website with resources on shared decision making, a survey on experiences of people coming out of hospital, support for developing PPGs and a mapping of local engagement activity.

There was a view that, in some cases, under-represented groups could be cynical about consultation because previous consultation exercises had yielded little in the way of changes to practice. CCGs will need to ensure that they communicate effectively about the outcome of the engagement with the participants.

“A lot of wasted resources are going into useless engagement because people lose track of purpose and don’t think about where the data is going to land and how it’s going to be put together.”
David Gilbert, director, *InHealth Associates*

Achieving successful PPE

Regardless of the approach selected, participants felt that some components would always be required in order to ensure that PPE work is a success:

- top-level support must be available from the leaders of the commissioning organisation to demonstrate commitment and show that input is valued
- clarity of purpose is essential
- a range of levels of engagement should be available – not everyone will wish to be part of a time-consuming process

- the ethos of PPE should be embedded across the commissioning organisation in order for it to have a demonstrable impact
- engagement work requires time and effort – this commitment should not be underestimated but should ultimately reap long-term rewards
- opportunities for staff and lay representatives to learn about engagement and advocacy should be available
- PPE work must be underpinned by principles of partnership working and equality and diversity
- CCGs should identify what they already know about the views of patients and the public in their area and the engagement mechanisms already available before embarking on new PPE activity.

Confederation viewpoint

This paper reflects the views of round-table participants and is intended to stimulate discussion rather than provide an exhaustive guide to implementing PPE. In addition to the issues covered in this paper, there are other factors which CCGs may wish to consider. For instance, social media and

IT can play a valuable role in engagement activity.

However, PPE will be a critical component of the work of CCGs both in the run-up to authorisation and thereafter. Commissioners will need to ensure that patients and the public are fully engaged in working to achieve the efficiency savings set out for the NHS in the ‘Nicholson Challenge’ by NHS chief executive Sir David Nicholson. CCGs will achieve most benefit by undertaking a thorough evaluation of existing PPE mechanisms before embarking on new approaches.

Existing tools such as the engagement cycle – and experience currently located in PCT clusters – are available to support CCGs as they develop their plans to engage patients and the public. Ultimately, round-table participants agreed that effective PPE is a rewarding and valuable component of being a highly effective commissioner.

For more information on the issues covered in this paper, contact helen.crump@nhsconfed.org

An audio recording of the round-table discussion is available at www.nhsconfed.org/publications/discussion-paper/pages/PPE.aspx

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