

# Effective practice-based commissioning: engaging with local people

MARCH 2006

# EFFECTIVE PRACTICE-BASED COMMISSIONING: ENGAGING WITH LOCAL PEOPLE

This guidance presents research into the views of the public, health professionals and primary care trusts about the issue of patient involvement. It outlines the benefits of Patient and Public Involvement (PPI) for Practice Based Commissioning (PBC), puts PPI in context and offers guidance on what issues to consult on for effective PBC.

## INTRODUCTION

Developing health services in the community through PBC offers an opportunity for GP practices, Primary Care Trusts (PCTs) and local people to work together. These partnerships could benefit from the added value patient and public involvement (PPI) can bring to the development of services. Successful models could pave the way for future developments in PPI.

There are opportunities to develop more appropriate pathway-based care and more efficient services through local community engagement. However the evidence suggests that, despite a general feeling that users should be involved, views of local communities are rarely taken on board with PBC.

To develop a view of current attitudes towards PPI three surveys have been carried out by Developing Patient Partnerships and the NHS Alliance

- health professionals' attitudes to PPI
- the public's attitudes to PPI
- PCTs' approaches to PPI and PBC.

## VIEWS ON PATIENT AND PUBLIC INVOLVEMENT

### Primary Care Trusts' views of PPI in PBC.

Our survey of PCTs suggests that some practices are experiencing barriers to involving patients in the early phases of PBC, even though there may be adequate mechanisms to facilitate this.

- 299 responses were received to a survey of primary care trusts. Of these, 172 said there was already active practice based commissioning in their areas.
- Seven out of 10 PCTs say that PPI can have a positive impact on PBC and around the same number say they have good mechanisms for engaging with local people.
- Yet just 29% of those who already have active PBC in their areas say they have moderately or well functioning PPI in PBC
- 71% of PCTs who already have active PBC say there is little or no public and patient involvement in it.

*“There have been several meetings of practice representatives to identify priorities that they would like to tackle through practice based commissioning. .... I would anticipate that, once practices start working on these specific services, we will find appropriate ways to involve patients and the public.”*

*“already have long standing PPI group which I think we will call on to get involved in PBC when appropriate. Plans are no more detailed than that as yet.”*

*“This is where I have a concern for commissioning groups. I am fairly sure PPI is NOT high on their agendas and I know of no plans to put it there”*

## Professionals' and the public's attitudes and experience of PPI

The results of our surveys of health professionals and the public demonstrate that, although there is an increasing amount of involvement and a positive approach by professionals, the actual experience of patients seems to be poor, highlighting a general lack of awareness of PPI and a pessimistic view of how they can have an influence.

- Most (93%) health professionals say that ordinary people should have a say in how their local health service is run and feel that involving patients would improve services.
- Over two thirds (67%) of GPs (and 70% of practice nurses) have actually asked for their patients' views at some time.

*“We believe that effective communications and established relationships with stakeholders, representative groups and individuals will ensure that people understand what is happening within the NHS and how they can influence decision making. The outcomes for patients should be that they are fully engaged in their own care and have some influence over decisions.”*

- 74% of the public want to have a say in how their surgery is run. However, 50% think that ordinary people can't influence their local health service.
- 76% have never been asked for their views.
- Furthermore, 68% of people do not know how to feed in their views.

These results suggest it is timely to offer some guidance on PPI and PBC, and to open up a dialogue with the public on this issue.

## BENEFITS OF INVOLVEMENT FOR PRACTICE BASED COMMISSIONING

**Effective demand management:** when users are involved in discussions about demand management or rationing, and when they have received clear information about the issues, they may become better able to offer helpful and supportive solutions.

**Improved care pathways:** experience suggests that involvement in defining and designing care pathways improves flow and appropriateness of care. Again, where care pathways are going to involve volunteers and community activity in parts, this is a good way of getting buy in and recruitment by involving the public in early commissioning decisions. The Clinical Governance Support Team are a good source of evidence and experience.

**An involved public is an informed public,** enabling people to make decisions about their health and well-being.

**Cost-neutral improvements are often recommended,** contrary to the fears of NHS staff. Usually lay people do not ask for expensive changes, but mainly for culture/attitudinal shifts from professionals. The National PALS programme has evidence of this.

**Prevention of social exclusion** together with the reintegration of those who have become excluded back into society. <sup>1</sup>

**Partnership working** between local services with a better fit between “top down” and “bottom up planning”. <sup>2</sup>

**Improved services:** experience shows that involving local people at an early stage can lead to improved design, the saving of time and the development of new services.<sup>3,4</sup>

**Involvement in planning may enhance Choice.** If a group of patients have been involved in commissioning a service then they may be more likely to have ownership and spread the message. This would be helpful not only for the use of the service but also in terms of public perception about how services are commissioned and the credibility of the commissioner.

**Involvement in planning can help users and carers understand regulatory and self-regulatory systems** and access these, especially BME groups

**It is likely that, by working with communities, PCTs will find solutions to problems that might otherwise be seen as intractable.** Engaging with the public needs to be seen as a solution to a problem rather than a problem to be solved. This is most obviously the case with the issue of mental health where a community's understanding of a problem that is pressurising it, for example safety and crime, may help to explain what has only otherwise been seen as an individual problem of mental health.

## SUPPORTING SELF-CARE AS PART OF THE PPI AGENDA

We know that improving self-care improves outcomes and reduces the demand on primary and secondary care services. There are a number of practical ways in which self care can be encouraged:

Shared decision making supported by decision aids through health kiosks (offering information about health and access to records) in the waiting room.

Access to personal records both in kiosks at the practice and on the net. The DPP questionnaire results highlighted strong public support for patients having access to their own health information. 71% were in favour of having access to their records. Despite strong evidence for the safety and benefits of record access, we found that only 39% of clinicians think access to electronic patient records is essential to PPI.

Active health education in the surgery and community using printed, on-line and audio visual resources. The DPP survey showed 78% of people would like to have more access to information about health.

Responding to QOF patient questionnaires to incentivise better relationships and consultation technique.

Patients as Teachers programmes to train clinicians in effective care from the patients' points of view. Expert Patients would be very effective here.

The approach to patients with Long-Term Conditions to support other patients by encouraging self-help by offering more relevant information, using group appointments, patients having access to their GP health record.

Approach patients with long-term conditions and support them to self-help by offering more relevant information, group appointments and access to their health records

Encourage individuals and patient groups to become volunteers (or recruit volunteers) for health initiatives that go beyond expert patients such as Time Banks and Green Exercise.

Community development can be harnessed to support self-care: many groups support healthy eating, gardening, self-help in a range of conditions.

## LEGAL FRAMEWORK

Section 11 of the Social Care Act 2001 says that health care organisations must ensure that people for whom services are being or might be provided should be involved and consulted in:

- the planning of the provision of those services,
- the development and consideration of proposals for changes in the way those services are provided, and
- decisions to be made by that body affecting the operation of those services.

For clear guidance on this and a number of other related topics see: “Strengthening Accountability, Involving Patients and the Public, Policy and Practice Guidance to Section 11” (DoH 2003)

## WHAT DOES INVOLVEMENT MEAN?

Looking at the literature about patients views on particular issues. The King’s Fund or RCGP are good places to start – they will do free literature searches.

Having patient groups on key committees – this might be community development groups that are in touch with many different agencies or PPI forum members.

Having users with particular health problems on pathway groups focusing on their problems and services.

Holding Discovery Interviews vii (where patients are able to speak without being lead by the interviewer) – and using the results.

Working with existing groups to carry out a user-focused needs assessment – and using the results.

Providing effective health information that users are involved in developing.

**Ideally there has to be a clear public and transparent mechanism for ensuring that user views are received and responded to.**

## THE ISSUE OF REPRESENTATIVENESS.

Finding a cross section of local representatives is challenging. Indeed, there is a similar problem with the representativeness of the professionals involved – often GPs are represented by the same faces and nurses and allied health professionals may have very little influence.

A study of users involved in social services work, showed different approaches to the issue of representation; most said they were not a representative but a few said they did feel this was part of their function. All said they brought a user perspective and sensibility to the role. Some stressed that they were more than a user.

One approach is to consider users as patient involvement advisors whose role is to ask key questions and ensure that the group as a whole responds to local people appropriately.

There are various approaches that can help:

- Working with a group and encouraging them to consult with a wider population
- Running local awareness raising campaigns to show local people the benefits of being involved and how to do it
- Looking at the literature on:
  - what is already known about user preferences in the field under consideration, for instance the cardiac failure pathway. The Kings Fund can be very helpful here.
  - What is already known about effective interventions in this arena
- Harnessing the PCT's existing mechanisms for engaging with users – some PCTs have excellent systems already in place. PPI Forums and PALS are good places to start. There may be a number of local voluntary groups who have good links with whom the commissioning groups could work.
- Doing a survey of the users concerned with the issue or pathway.

*"A fully inclusive integrated commitment to PPI in organisational and individual terms. Rolling programme of involvement with a range of hard to reach groups: active engagement with Patients' Forum: PCT Patients' Panel: partnerships with multi-agency groups in disadvantaged areas taking part in integrated neighbourhood planning, and feeding into Choosing Health priorities work led from these groups and through engagement with local councils."*

## WHAT STRUCTURES COULD SUPPORT PPI IN THE WORK WITH PBC?

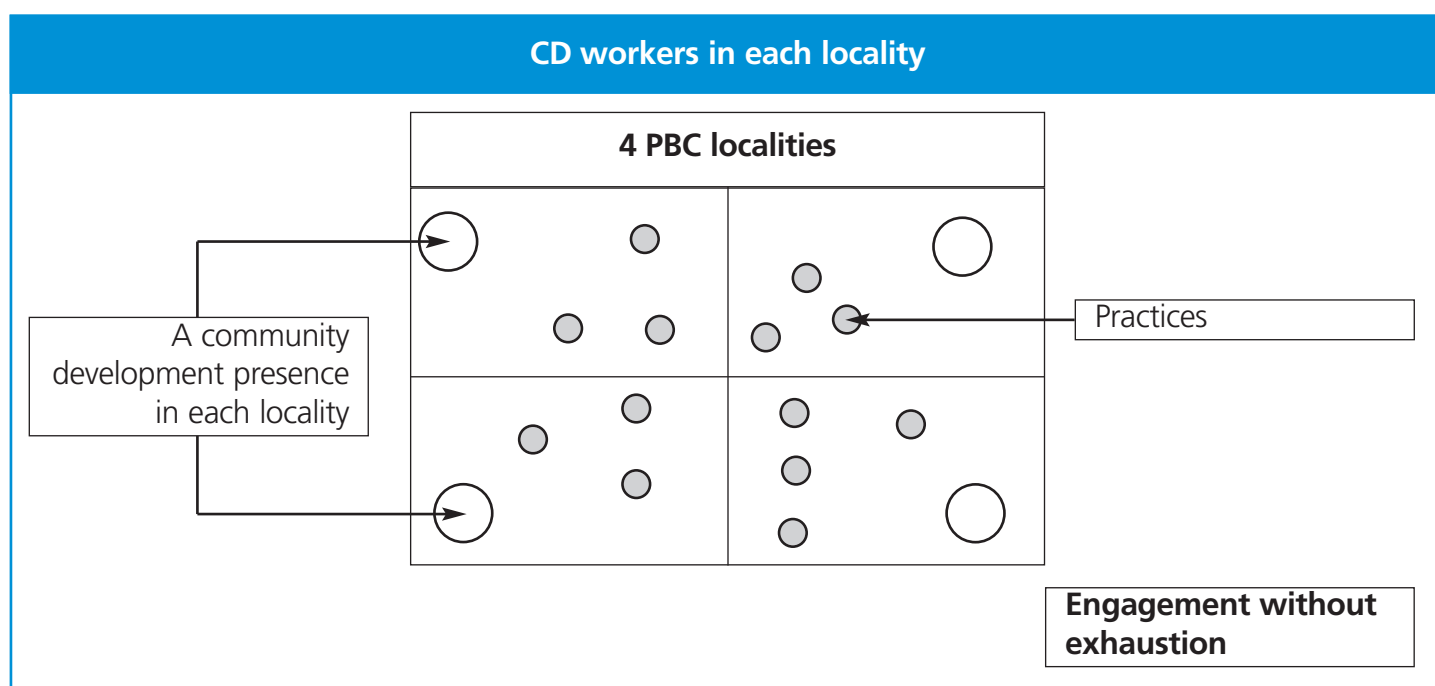
Here we offer suggestions that build on current PCT experience as seen in the Alliance Acorn awards. They offer slightly different avenues for linking PBC with existing community-based activity.

### Working with community development workers

One approach is to work with existing community development workers or Health Trainers to gather local views on behalf of the cluster or practice.

Community development workers are trained to do outreach work in the neighbourhood to identifying key local issues in health, and work with health organisations to discuss implementing their recommendations. The PCT may already have funded such workers and the local authority is also likely to employ some.

One arrangement could be that a community development worker is attached to each cluster, brokering a dialogue between local people, local community groups and local practices.



Experience has shown that such arrangements can foster the development of a range of improvements in provision of care without exhausting either practices or the public.

The community development workers, alongside the voluntary agencies could be represented on the PBC groups as advisors and participants, helping to draw users into relevant sub-groups where needed.

### Patient Participation Groups/Critical Friends.

Patient participation/patient critical friends groups could be attached to each practice as commissioner. Where collectives of practices commission together, there could be a democratic forum composed of representatives from all the individual practice groups. Much of the detailed work is likely to be done by sub committees of particular patient groups looking at care pathways in their own particular specialities.

### A not-for-profit organisation.

Practices can band together in a formal structure similar to a company with a Board including patient representatives. This can then have an outer shell of members to offer a more representative approach, along the lines of a hospital Foundation Trust.

## INVOLVE EARLY

All the evidence shows that patient groups welcome becoming involved early, before decisions are set.

*“We have a robust PPI framework which means we are fully engaged with local representative groups, PP forum, Overview and Scrutiny Committee, User and Carer Forum. We also have mechanisms to communicate with a cross section of our population and we always ensure that PPI principles are embedded into all new policy such as practice based commissioning.”*

## ABOUT WHAT ISSUES SHOULD WE CONSULT?

All, if possible. If you involve people early, then they would be considering the same questions as everyone else, at the same time. The key issues, however, probably include the following.

**What pathways or issues are the PBC group going to start with? There may be a few of equal importance and local people can help choose.**

*“Service Level Agreements - patient choice will ultimately shape the SLAs that the PCT commission - we are working very closely with primary care, patients and the public to ensure the decisions they make over care pathways are right for them.”*

The PCT should be able to provide the following simple data for each pathway under consideration:

- The number of patients
- Which hospitals are involved
- Likely savings that could be made by intervening in different ways
- Likely benefits and inconveniences for patients of each intervention

With this information, it should be easier to have a debate with local people about which pathways to begin with.

### **The convenience and problems of existing services**

The aim is to identify the main problems experienced by patients that need to be corrected as part of the commissioning process.

Patients views are key here. Discovery interviews<sup>V</sup> can be effective but time consuming.

A patient panel or PPG would probably be able to offer advice rapidly if the pathway was a common one used by many patients. It would be quite reasonable to use one or two practices' patients' experience for the whole PCT.

Problems experienced by patients are important, but they also need to be set next to those experienced by clinicians and administrative staff too.

**Commenting on the design of new approaches and developing new approaches that the group has not thought of before.**

*“PBC is just beginning with a focus on developing the process PBC will follow in order to influence planning and commissioning. PPI has been integrated fully into the process ensuring that the production of commissioning intentions and the drawing up of Business Cases including Service Specifications is fully informed by patient and public opinion. Work streams are currently underway looking at 4 patient pathways, these work streams have ensured patient and public involvement, but are only part way through the process.”*

This may be difficult for lay people if the pathways involve technical discussions. However, it is often possible to obtain a useful dialogue if local people are specifically asked about pathways from their experience.

**Organising around governance issues: how will quality be guaranteed and measured? Can local people be involved in the measurement?**

Patients can be involved in developing two main processes:

- Developing standards for practices and others
- Monitoring some of these standards in conjunction with the PCT clinical governance programme

**Principles of engagement**

1. Involving patients should be easy and safe for practices and the public – for instance confidentiality is maintained.
2. Patients’ time is paid for. “Reward and Recognition: The principles and practice of service user payment and reimbursement in health and social care” (DoH, 2006) should be referred to.
3. Involving patients is carried out in a way that is not confrontational.
4. The recommendations of patients are seen as a discussion point.
5. A monitoring process can be carried out in different ways, including visits, questionnaires, panels, focus groups or “mystery shopper” contacts.
6. Feedback is handled in a non-threatening and facilitative manner.
7. Any processes will be transparent: the more open the discussion process is, the more likely that consensus will be reached and will stick.

It may also be helpful to set out some good practice arrangements for the two processes with which users are to be engaged:

## Setting standards

- Users should set standards from their points of view, initially without recourse to professionals' views.
- Users can only set standards in areas in which they have had direct experience.
- The process by which users set standards needs to be facilitated so that views can be collated and summarised.
- The standards are set out in a document for discussion by the PCT and commissioning group.
- Standards can be process indicators (fewer interruptions during consultations) or outcomes (80% of patients should know the results of their investigations and what they mean).

Standards might become part of a performance management process for the PCT or commissioning group as a whole.

## How can quality be introduced into SLAs and what will that quality consist of?

Quality in contracts has two components: criteria derived from clinical or managerial issues and those derived from patient views. The latter need to be explicitly sought – they may overlap with clinical issues or they may not.

Generally, we know that key outcomes from the patients' perspectives are:

1. Getting better, feeling better (outcomes of care).
2. Getting the right care from the right people (clinical quality).
3. Being treated as a human being (humanity of care) – includes respect, dignity, valuing people's feelings, etc.
4. Information, communication and having a say (involvement) – from receiving information through clear explanations to being able to decide on treatment options.
5. Being supported – practical and emotional support through statutory and voluntary sector, e.g. getting counselling, access to self-help groups, money matters.
6. Support for carers and relatives
7. A safe, clean, comfortable place to be (environment of care) – includes privacy, hygiene, food.
8. The right treatment at the right *time* (access 1) – Receiving prompt response to emergency; timely access to care when I need it; short waits, etc.
9. The right treatment in the right *place* (access 2) – convenient locations; transport; parking, etc.
10. Not being passed from pillar to post (continuity of care) – smooth 'journey' between primary and secondary care, etc.
11. Continuous care – 'after care', support in the community, etc.

These, therefore, could be integrated into all care that is commissioned. And they would need to be monitored through patients' views through the mechanisms outlined above.

## How we spend the savings

Involvement in this decision is very important. It may be that savings need automatically to be earmarked for a community-based service, having been saved from the hospital to provide that service.

However, if there are net savings, which are owned by the practice/practices and their patients, a decision may need to be made as to where the funds are applied. This might be a choice between, say, orthopaedic issues and diabetes. These are essentially ethical choices that need to be underpinned by data of effectiveness and equity. There is no reason to suggest that lay people cannot make a valuable contribution to these decisions. Public health should be a resource to challenge/support their priorities and views.

Local people could also play a role in other difficult ethical decisions. The practice group or local people, perhaps in the shape of the community development worker, may challenge service decisions.

## Arbitration

A variety of views can lead to a variety of disputes. There may need to be a process of arbitration which could be led by NEDs and clinicians from the PCT Board.

## CONCLUSION

PBC offers an enormous opportunity to put to good use the experience of PPI that has already been gained across the country. The Alliance has already identified through its Acorn awards excellent examples of engagement with individuals and communities to improve health and health care.

We now need to harness these skills and expertise to ensure that neighbourhoods can participate in developing and implementing the services that they themselves use. A common barrier to involvement is the fear of revealing a less than positive situation to the local patient community. However, local people not only have a right to know the reality of the situation and are increasingly likely to find out, but also need to know in order to take some responsibility and be able to contribute to improving service use and provision.

We hope that this paper will help practices to tackle the issues of involvement with resolve and with less anxiety. Sharing the future with our patients – engagement without exhaustion!

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**Written and produced by DPP: Developing Patient Partnerships. Tavistock House, Tavistock Square, London WC1H 9JP.**

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