HIGH IMPACT CHANGES FOR CCGs.
FEEDBACK FROM THE
NHS ALLIANCE/NHS COMMISSIONING BOARD MEETING

1. BACKGROUND

The government, in the Mandate, the Constitution and the Health and Social Care Act, is consistent in its vision of transparency and responsiveness for the NHS. The vision is also enshrined in the Duty to Respond, the Duty of Candour and the new Social Value Act for Public Services.

The framework is good. We now need to embed these powerful ideas in the day to day running of the system.

That was the primary focus for a workshop between the NHS Commissioning Board (NHS CB) and the NHS Alliance PPI Group with the intention of generating suggestions for practical interventions that would make it as easy as possible for CCGs and the NHS Commissioning Board (CB) to be both transparent in their functions and responsive to the communities they serve. We focused exclusively on collective involvement.

The workshop was attended by members of the NHS Alliance PPI Group and members of the NHS CB. We worked collaboratively to answer the questions listed in Appendix 2.

This paper sets out the changes recommended by the group for how the NHS CB can support and encourage CCGs to do ' best collective involvement' in commissioning. The group identified:

- **three high impact changes**
- **three enabling approaches**

If implemented systematically, these would make it highly likely that 'collective voice' directly influenced CCG decision making. The suggestions here are not NHSCB policy.

2. MAKING CHANGE HAPPEN

"Raise less responsive CCGs up - rather than criticising poor ones."

We have an opportunity to build on the work begun with authorisation on the six domains; especially the first two. We see the practical ideas described here becoming a routine part of the continuing authorisation process and the oversight of CCGs by the CB.

Good practice cannot be achieved by dictat.

We recommend that the development programme for domains 1 and 2 include the three high level principles of commissioner behaviour outlined here. They should be developed into an 'improvement framework' that recognises standards of current CCG practice based on an analysis of the CCG authorisation 'baseline' data and starting position at December.

The improvement framework would be the vehicle for implementing these and complementary ideas that are currently being developed. So, starting with this report and other contributions that begin to define what good collective involvement and participation looks like, we would like to see CCGs working collaboratively with each other and with national organisations such as NHS Alliance and National Voices and Centre for Public Scrutiny to find the best ways of putting these concepts into practice.

Existing examples of this approach include National Service Frameworks where definitions and implementation were achieved collectively. And the current process for embedding online patient record access which has involved clinicians and organisations across the spectrum.

3. HIGH IMPACT CHANGES

These describe a vision of what good could look like where CCGs do excellent engagement work, followed by examples of KPIs that the NHS CB would need to have in place to support and encourage these behaviours.

3A. SYSTEMATIC APPLICATION OF CO-PRODUCTION AND ASSETS BASED THINKING

"We need to see communities as solutions - not a set of problems."

WHAT GOOD LOOKS LIKE
The group was clear that all CCGs should take an assets-based approach (see Appendix 1) and work with people and communities to solve problems rather than, as now, adopt a deficit based model with people as passive recipients of care. We would like to see a system that builds on local people's willingness to be involved in commissioning and their expertise gathered from experience to shape all aspects of care - including primary care services and systems.

All CCGs demonstrate to themselves and the NHS CB that their current commissioning operating model includes an asset-based approach. CCGs:

- Undertake asset and social capital mapping before and as a systematic part of the JSNA, health needs assessment and routine monitoring.
- Commission evidence-based coproduction approaches such as community development
- Publish community development plans, working with partners e.g. Public Health and the Health and Well-Being Board (HWB)
- Recognise those aspects of services people value such as care, confidence; reassurance; hope and connection as well as clinical quality

- Routinely measure social value as an outcome from investment in line with legislation[1]

- Demonstrate a proactive approach to listening that goes beyond consultation[2]

- Ensure provider recognition and incentivisation of investment in coproduction and social value e.g.
  - GP practices that put in place a coproduction agenda with local community rewarded;
  - Investment in embedding shared decision making AND
  - A measurable shift in peoples' experiences of consultations transforming into shared decisions rewarded (this provides a strong incentive for clinicians to change practice)[3].

- All CCG constitutions and commissioning intentions include evidence of these ideas

- CCGs continuously pose questions such as: "What do you want/need/feel/think matters most?" NOT: “what do you think of our ideas/what we want to do?"

- NHS CB direct commissioners and CCGs can demonstrate the shift (as perceived by their community) from:

  - ‘consultation’ - culture based on ‘us and them’
  - ▼
  - ‘conversation’ - culture based on ‘face to face’
  - ▼
  - ‘co-production’ - culture based on ‘side by side’

- Have a participatory commissioning model that involves local people, front line caregivers and providers (current and qualified). For instance, CCGs operate an 'open door policy' for both providers and local people and use commissioning process to harness peoples' natural willingness to help and be involved.

Possible levers that the NHS CB could consider:

- An increasing proportion of these behaviours to be demonstrated by CCGs through the continued authorisation process
- The CCG Quality Premium rewards evidence of assets based/ coproduction approaches.

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[1] http://www.legislation.gov.uk/ukpga/2012/3/enacted

[2] http://www.institute.nhs.uk/tools/the_engagement_cycle/the_engagement_cycle_introduction.html

[3] http://www.advancingqualityalliance.nhs.uk/resource-pack/

3B. RESPONSIVENESS OPENS DOORS FOR COMMISSIONERS

"We will only sign off your commissioning plans when you prove they have community, legitimacy and ownership"

WHAT GOOD LOOKS LIKE

CCGs struggled, during the authorisation process, to show how local people's recommendations had changed commissioning intentions. Responsiveness needs to remain a key focus in CCG development work and can be accelerated now.

The group recommended that when CCGs and the NHS CB are responsive and demonstrate *'you said, we did'*, achieving progress should feel easier for them.

Having proved responsiveness, commissioners can be rewarded with greater freedom and access to additional resources. In the absence of having proved responsiveness, commissioners will be less able to move forward with their plans.

CCGs can show themselves and the NHS CB how their current commissioning operating model is responsive to the communities it serves in these ways:

- The commissioning organisation's constitution enshrines responsive commissioning. The constitution ensures that changes are made in response to the needs and recommendations of the communities served.

- CCGs can demonstrate that they have proactively sought citizen, carer, and patient input, including through the third sector, into needs assessment and have based commissioning on both qualitative and quantitative data from the variety of communities in their area, including those hard to hear.

- Commissioning intentions represent what patients tell commissioners. CCGs can demonstrate that patients help to set the agenda and the priorities of the CCG as a whole.

- Commissioners can demonstrate that what citizens, carers and patients said matters and that they have responded.

- CCGs can demonstrate how the HWB and local authority scrutiny committees are involved as commissioning partners and in shared sign-off of commissioning plans in line with the expressed needs and recommendations of the communities all serve

- Local people are involved in commissioning before any financial commitments are agreed

- Commissioners routinely ensure that provider contracts include KPIs for shared decision-making, self-care, responsiveness (the extent to which users feel consulted and involved in improving the service) and patient experience

- There is a compelling narrative in place that appeals to clinician's self interest that helps drive responsiveness. For instance:
    - It is a fundamental quality improvement tool – the key to helping you do the job better.
    - It provides the opportunity to get out from behind your desks and get to know your communities
    - It is the key source of legitimacy for your decisions, especially the toughest ones – e.g. decommissioning
    - In a world of institutional failure and declining trust in institutions, it is a key protector of your integrity and reputation:

Possible levers that the NCB could consider:

- Financial penalties (or removal of management freedoms) for commissioners who fail to demonstrate responsiveness.
- Evidence of a compelling narrative in place that appeals to clinician's self interest that helps drive responsiveness.
- The CCG Quality Premium system rewards delivery of responsiveness.
- Evidence that CCGs design provider payments based on patient controlled/evaluated 'CQUINs' (or similar).

3C. COMMISSIONERS SEE THEMSELVES AS 'ADVOCATES' AND HAVE AN ONGOING RELATIONSHIP WITH PEOPLE WHO USE SERVICES

"This work is best seen as a continuum; an open dialogue with local communities about their health, lives and services."

WHAT GOOD LOOKS LIKE

Participation and accountability to the local community makes commissioners feel proud and engenders a strong sense of loyalty amongst those working for NHS organisations. Advocating great patient care defines NHS commissioning and the teams and organisations tasked with delivering it. The new commissioning system is clear and the people who work within it understand that their first loyalty is to people who use services - not to their employer organisations. Commissioners see their job as championing the interests of those who use services. This is a reciprocal relationship and likewise, people and communities recognise their responsibility for fair use of health services.

CCGs can show themselves and the NHS CB how they work with and for the communities they serve:

- Commissioners' advocacy role is valued as highly in the assurance processes as is coming in 'on budget'.
- The commissioning organisation's constitution enshrines its advocacy role and also the principle of transparency.

- Everyone (including finance teams and clinicians) have obligations, objectives and a code of conduct in their contracts that make clear their personal responsibility towards the local community; starting with induction and continuing as part of CPD and training.

- Everyone (including finance teams and clinicians) has delivery objectives that include a responsibility and contribution towards improving the health of the local community.

- All commissioning staff regularly go out into the community; experience and spend time with different groups and people - on their turf, not on the NHS's turf.

- Commissioners can demonstrate that they have an organisational culture (and there is a valid tool that measures this independently) that is focused on advocacy for the people and community served.

- Local people say that the NHS commissioning conversation with the community is always an adult to adult one.

- CCGs address inequalities by:
    - harnessing the Marmot principles
    - working closely with communities to encourage social capital
    - deeply understanding what life is like for people.

- Commissioners and community leaders know each other's names and have built the constructive rapport that comes from working regularly together (relationships trump structures every time).

- Costs of medication, clinical and other interventions commissioned are shared with people and families e.g. printed on prescriptions.

CCG Board behaviour

- Board meetings start with stories drawn from local patient experiences
- As a basic principle, all commissioning decisions involve local people, clinicians and managers
- Governance frameworks and constitutions include commitments to responsiveness and transparency
- CCGs act as patient champions (they have shifted their position from protecting the system to representing the patients and the public)
- There is full transparency in CCG 'business' with all meetings held in public (ideally recorded and available on line); publication of risk registers; 14 transparency about what is going on (including sharing 'unpleasant' information as well as good news)

Possible levers that the NCB could consider:

- If commissioners come in on budget and have not done this work, they will still be deemed to have 'failed' within the assurance process.

4. ENABLERS

4A MEASUREMENT

Key to this work will be the development of new/adapted, validated, organisation-based outcome measures that benchmark and track change in:

- Person centred culture and values based commissioning
- Responsiveness and advocacy
- Social capital development and creation of social value
- Shared decision making spread. [4]

These tools can be used to assure both commissioning and provider organisations.

We believe that tools already exist that could be adapted for use as part of NHS assurance processes.

When they have been validated, these tools should be systematically used to track progress and improvement across CCGs.

Alongside these, 'surrogate' measures like those identified above under section three can be applied.

4B TRAINING AND DEVELOPMENT FOR LAY PEOPLE AND COMMISSIONERS

Training for non-professionals:
As well as investing in clinical leadership, the NHS should invest in developing community and patient leadership so that local people feel more confident about working with commissioners as equal partners and contributing to finding and implementing solutions

The group suggested:

- an. independent training centre, training lay advocates and leaders.
- lay leaders to be supported to reach out into the community and feedback directly to commissioners, thus becoming, in effect, a lay part of the engagement architecture.

Training for commissioners:
Training for commissioners will be needed to encourage commissioning that enables frontline caregivers, local people and clinicians and managers to come together as equals, each playing to their strengths and contributing their unique perspectives. This assumes that people are able to contribute if NHS processes open the door and give them an equal voice. It draws on learning from community development, Experience Based Co-Design and other similar improvement processes.

Whether it is through leadership training or commissioning process redesign, there are many ways in which the practice of commissioning can be improved and the NHS CB will play a key role in championing innovation in commissioning management practice, moving forward and supporting both CCGs and their communities and lay leaders to learn from each other.

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[4] http://www.advancingqualityalliance.nhs.uk/resource-pack/

There are many existing assets to build on in this regard, including the Person and Community Centred Commissioning (PC^3) [5] Learning Set that has already been given seed funding by The Department of Health.

4C. EXPERTISE IN USING INFORMATION AND INSIGHT

A core area for commissioner competency development is building understanding, knowledge, capacity and capability to triangulate complex data, information and insight. Specifically, this includes CCGs getting more skilled at routinely using 'soft' qualitative data to contextualise and complement the more common 'hard' quantitative data upon which most commissioning decisions are currently made. Both types of data need to be valued equally moving into the new commissioning landscape and this is undoubtedly an area where commissioners will have development needs.

APPENDIX 1
DEFINITIONS

ASSET-BASED COMMUNITY DEVELOPMENT
CD is defined within the National Occupational Standards for CD [6] as: a long term value- based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion. The process enables people to organise and work together to:

- identify their own needs and aspirations
- take action to exert influence on the decisions which affect their lives
- improve the quality of their own lives, the communities in which they live, and societies of which they are a part.

Key roles in the field of health could include:

- Developing social networks
- Developing and supporting groups
- Developing an agenda for change from the views and recommendations of local people and decision-makers
- Bringing people together to respond to those needs themselves, so far as possible, while at the same time:
- Working with decision-makers in health to ensure that local views are taken into account and responded to.
- Impacting on entrenched Health Inequalities nationally

NICE uses the terms 'community engagement' and 'community development' almost interchangeably[7]. However, the terms can be distinguished by saying that community engagement is the *top-down* effort to involve people in a given agenda, while community development is the *bottom-up* stimulus and facilitation for people to become involved through their own priorities.

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[5] http://www.nhscc.org/

[6] http://www.lluk.org/documents/cdw_nos.pdf

[7] http://www.nice.org.uk/Guidance/PH9

ASSET-BASED APPROACHES, IN CONTRAST TO DEFICIT APPROACHES

The WHO European Office for Investment for Health Development uses the term "health assets" to mean the resources that individuals and communities have at their disposal which protect against negative health outcomes and/or promote health status. These assets can be social, financial, physical, environmental or human resources; for instance education, employment skills, supportive social networks, natural resources, etc. [8]

Working together, asset based approaches complement the conventional model by:

- Identifying the range of protective and health promoting factors that act together to support health and well being and the policy options required to build and sustain these factors.
- Promoting the population as a coproducer of health rather than simply a consumer of health care services, thus reducing the demand on scarce resources.
- Strengthening the capacity of individuals and communities to realise their potential for contributing to health development.
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

Morgan recommends an asset-based approach to responding to health inequalities. [9]

EXPERIENCE-BASED CO DESIGN

For full details about the Experience Based Co Design approach, go to: The Kings Fund: http://www.kingsfund.org.uk/projects/point-care/ebcd?gclid=CJnytom-kLQCFbMbtAodeTgA3w

COPRODUCTION

Co-production is said to be a simple idea: it's about individuals, communities and public service organisations having the skills, knowledge and ability to work together, create opportunities and solve problems. The central idea in co-production is that people who use services are hidden resources, not drains on the system, and that no service that ignores this resource can be efficient [10]

Key ideas within the concept are:

- People as assets, not problems to be solved
- Neither government nor citizens have access to all the necessary resources to tackle problems on their own.
- Individuals, organisations and statutory services working together to improve civil life
- Both local people and statutory services have skills that need to be combined for maximum effectiveness.

Coproduction is seen to be an approach distinct from traditional responses to social problems: voluntarism, paternalism or managerialism [11]

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[8] Falk I and Harrison L. 1998. 'Indicators of Social Capital: social capital as the product of local interactive learning processes'. Launceston: Centre for Research and Leaning in Regional Australia. p23

[9] http://ped.sagepub.com/content/14/2_suppl/17.full.pdf+html

[10] Boyle D. The Challenge of Co-production. Discussion paper. NESTA Dec 2009

[11] Horne M and Shirley T. Coproduction in public services: a new partnership with citizens. Cabinet Office Strategy Unit Discussion Paper. March 2009

Edgar Cahn, who defined the concept of Time Banking expressed it pithily “No society has the money to buy, at market prices, what it takes to raise children, make a neighbourhood safe, care for the elderly, make democracy work or address systemic injustices... The only way the world is going to address social problems is by enlisting the very people who are now classified as ‘clients’ and ‘consumers’ and converting them into co-workers, partners and rebuilders of the core economy.” [12]

APPENDIX 2
THE QUESTIONS ANSWERED BY THE GROUP

- **What is the equivalent of the smoking ban in public places?** What changes in structure, incentives and disincentives need to be in place to embed being responsive in the NHS?
- **What will be happening when CCGs are being deeply responsive? What will be happening when CCGs are failing at this?** What can we measure to demonstrate success/failure? Who should measure it? What action should be taken? By whom? e.g. personal consequences accountable officer, CCG freedoms, performance related payments
- **What assets/organisational capacity/strengths around responding to collective voice do CCGs have already? What do they need to build?**
- **What will be happening when CCGs are being deeply responsive? What will be happening when CCGs are failing at this?** What can we measure to demonstrate success/failure? Who should measure it? What action should be taken? By whom? e.g. personal consequences accountable officer, CCG freedoms, performance related payments
- **What are the bold steps we need to take to shift CCG culture towards responsiveness?**
- **Describe the management system and relationship between NHS CB, Local Teams and CCGs that makes being responsive to collective voice as important as financial balance**
- **How do we accelerate adoption of proven methodologies that tap into the 'wisdom of crowds'? (virtual and face to face)** e.g. community development, crowd sourcing, coproduction, experience based design? Incentives, training, evidence, payment by (real) results?
- **Who should our role models be?** Who excels at being responsive and democratic accountability? Are there models that we could copy? Electing Boards/Chairs? A Hospital Trust structure? Parent-governors of schools?
- **What do we need do to reframe PPI as 'the most exciting and rewarding' part of commissioning?**
- **How do we engage clinicians and staff so they feel being responsive is an essential part of what they do?**
- **How do we minimise inequality through responsiveness?**

[12] http://timebanks.org/wp-content/uploads/2011/08/CoreEconomyOp-Ed_001.pdf