



**Framework for patient and public
participation in primary care
commissioning**

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Framework for patient and public participation in primary care commissioning

Version number: 8.0

Prepared by: Patient and public partnerships specialist, Public Participation Team

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SUMMARY OF KEY POINTS AND ACTIONS FOR PRIMARY CARE COMMISSIONERS

- Primary care services are required by the whole population; not everyone is registered with a GP and the needs of under-represented and 'seldom heard' groups need particular consideration in respect of primary care. More than any other part of the NHS, primary care has the potential to reduce health inequalities in the population.
- Patient and public participation is an essential component of commissioning, and should be considered at all stages of the commissioning cycle (planning, buying and monitoring health and care services).
- NHS England and Clinical Commissioning Groups need to work in partnership with other commissioners and providers to make primary care services joined up and effective for patients and the public.
- Consider the need for – and best approach – to participation depending on the situation, the population in question, and existing sources of information and insight; these sources may be national, regional or local.
- Keep good records of your approach to participation including how you have assessed the legal duty to involve the public in commissioning.
NHS England commissioners are required to document their assessment of whether Section 13Q (the legal duty to involve the public in commissioning) applies using the [standard form](#) available on the NHS England intranet.
- Plan for participation – including identifying benefits (with measures of impact where appropriate) and costing participation activity; participation plans need to be factored in to overall business planning and programme planning.
- Involve people early on, not as an afterthought.
- Involve people in ways that are appropriate to their needs and preferences, and provide them with the necessary information, resources and support to enable them to participate.
- Work with partners in involving people, including other commissioners, providers, Patient Participation Group (PPG) networks, Healthwatch, and the voluntary and community sector.
- Feed back to those you have involved about the impact of their participation. Explain how their participation has influenced commissioning, and if not, why not.
- Document and report on participation activities and **impact** for assurance and quality improvement purposes, publicising and celebrating success and sharing learning.

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2 Introduction

This framework is a guide for primary care commissioners - **and anyone who is interested**, including patients and the public, the voluntary sector, and providers of health and social care services – on how to involve patients and the public in the commissioning of primary care services. Our definition of ‘patients and the public’ includes service users and carers, and participation in primary care commissioning refers to how people are involved in planning (including policy making and relevant programmes), buying and monitoring primary care services. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

Whilst participation is an essential consideration in our work, and is not merely a ‘nice to do’ task, we recognise that it can take many different forms. For example, patients and the public may be involved through a consultation, by being sent a newsletter, or through a face to face meeting.

Complementary and less detailed information (including an ‘easy read’ version) for patients and public on how they can get involved in primary care commissioning is available on the [NHS England website](#). Together, these resources are designed to support transparency, inclusiveness and accountability in how primary care is commissioned in England.

Clinical Commissioning Groups (CCGs) will find the framework of relevance, particularly in relation to co-commissioning (see section 4.4). They are likely to use many of the same approaches, networks and insight sources outlined in this framework, and NHS England and others, such as local Healthwatch, may refer to it when working with CCGs on public involvement in primary care commissioning.

The framework is designed to be read in conjunction with the NHS England [Patient and Public Participation Policy](#) and the [Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning](#).

The policy sets out our ambition to strengthen patient and public participation in all of our work, and how we intend to achieve this, in line with the vision for the NHS set out in the [Five Year Forward View](#). Our values are rooted in the [NHS Constitution](#), which states that the NHS belongs to us all. Our policy and associated documents are based on the belief that health services and outcomes are better when people who need, use and care about services have meaningful opportunities to be involved in them.

The Statement of Arrangements is for NHS England commissioners working in all areas of direct commissioning (primary care, public health, health in justice, specialised services and services for the armed forces). It identifies where our legal duty to involve the public in commissioning under **Section 13Q of the Health and Social Care Act 2006 (as amended)** applies. It sets out guidance for commissioners on how to involve the public, including:-

- Principles for fair and proportionate involvement.
- When public involvement should take place.
- Case studies, many of which refer to primary care commissioning.

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This framework is designed specifically for NHS England commissioners working in primary care commissioning. It has been co-designed with members of the Working Group for Patient and Public Participation in Primary Care Commissioning (see membership at [Appendix 1](#)). Stakeholder feedback has also been taken account in the development of this framework; this was gathered from an engagement exercise outlined in [Appendix 2](#). It has taken into account learning from development of participation approaches in other areas of the organisation (such as specialised services commissioning) and the wider health and social care system (such as Clinical Commissioning Groups).

3 Context

3.1 Primary care services

Primary care services form the largest part of most people's experience of health care, providing the first point of contact in the health care system and acting as the 'front door' of the NHS. They comprise approximately 13% of the overall NHS England commissioning budget.

General practice accounts for the bulk of primary care services and is delivered on the basis of 'registered lists' of patients for individual practices, with over five million GP consultations taking place every week. General practice is wider than just GPs; it includes practice staff such as nurses, pharmacists, receptionists and practice managers, as well as community based staff.

Primary care services are under increasing pressure relating to demographic changes (notably an ageing population), tighter budgets, a changing workforce profile, developing medical technologies, and increasing public expectations.

Other significant changes affecting primary care services are:-

- moves to devolve health and social care planning and budgets in some geographic areas (such as in Greater Manchester);
- co-commissioning (see section 4.4);
- development of federations, where GP practices are coming together to provide additional services and share some functions like administration and support systems;
- proposals for new ways of providing care for people in local areas, being developed as part of the Five Year Forward View (2014);
- development of social prescribing and GPs involving volunteers as health champions to improve health, provide social, non-clinical support, and help with GP workforce pressures.

The changing context for primary care commissioning gives rise to both a need and an opportunity to develop participation in this area in line with the different relationship with patients and communities described in the Five Year Forward View.

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Case study

The work of [Altogether Better](#) demonstrates how patients, carers and citizens can work with general practice staff to create a new sustainable model of care in general practice. "The great story is lives have been transformed. We reach hundreds and hundreds of people every week. People are no longer isolated; they have made new friendships and use services differently. We have increased our patient list by 4,500 people, that's a 57 % increase, and we have seen no increase in demand for either primary or secondary care consultations because we do things differently." Mev Forbes, Managing Partner, Robin Lane Medical Centre, Leeds.

3.2 Population needs for primary care

There is evidenceⁱ that some people and groups do not experience easy access to primary care and do not experience the same health outcomes as the rest of the population. Commissioners of primary care should have arrangements for hearing the voices of these people and groups. Participation in decisions about general practice and primary care more generally needs to extend to people and groups who might not be registered.

Example

[Bevan Healthcare in Bradford](#) has won awards for its approach to involving excluded groups in primary care provision, and supported involvement of people at national level too. Find out more in this [short film](#).

There are groups who face specific barriers to participation in primary care commissioning, and whose specific needs must be taken into account. Examples of these groups are children and young people, carers, and patients and service users with disabilities and long-term conditions. There are also groups that experience poorer access to primary care and poorer health outcomes, e.g. insecurely housed people, Gypsy Traveller groups, refugees, asylum-seekers, migrants, sex workers, and people with mental health problems, learning disabilities, low health literacy, and drug and alcohol problems. This includes people who may not be registered with GP practices or 'visible' in the primary care system.

NHS England recognises the importance of taking into account these groups when planning and implementing public involvement in primary care commissioning. Reaching groups and individuals who are further away from existing participation mechanisms requires time, resources and the development of relationships. This is supported through:

- National public involvement initiatives and partnerships to reach out to communities and service users from different backgrounds, e.g. the NHS England Youth Forum and Health and Social Care Voluntary Sector Strategic Partners Programme.
- Working with Clinical Commissioning Groups and other local partners such as local Healthwatch who access local networks of potentially excluded and vulnerable groups
- Support and resources, for example as set out in the bitesize guide to [diverse and inclusive participation](#) and the [Patient and Public Voice Expenses policy](#).

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- Using a range of involvement approaches, e.g. health champions groups and outreach to different groups and communities and the organisations that support them. Voluntary and community sector and social enterprise (VCSE) organisations often work with the most disadvantaged communities - both in geographical areas and with 'communities of interest' (groups of people who have a common interest/need, for example in a particular health condition, such as diabetes).
- Equality and health inequality impact assessments¹.

Example

St Helens local GP practices were concerned about their role in providing services for migrants. The CCG worked with the local authority to develop a guide that would help new migrants to the area to understand how to register at a GP practice and where to go for help.

4 Governance, reporting and assurance of participation in primary care commissioning

4.1 The commissioning cycle

NHS England is committed to involving patients and the public at each stage of the commissioning cycle for primary care services. The cycle refers to the different activities which make up the process of planning and buying services, ensuring that they meet the needs of the population and are being delivered to the right quality standards and within the available financial resource.

For primary care commissioning, the terms on which services are commissioned from providers are governed to a significant degree by legislation and are the product of national contract negotiations with legally recognised representatives of the professional groups.

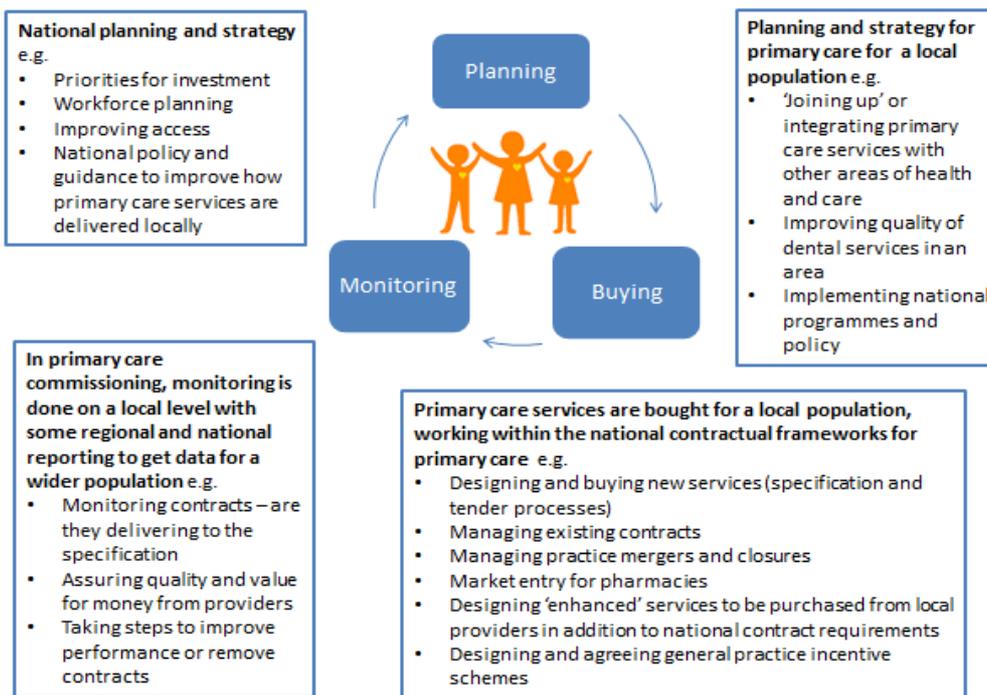
However, decisions on the commissioning of primary care services for local populations, such as how many GP practices or dental surgeries are needed and where they should be located, are taken locally.

NHS England commissions primary medical (i.e.GP) services, though increasing numbers of CCGs are taking on greater responsibility for this (see section 4.4). NHS England also commissions primary and secondary care dental services, pharmaceutical services under the Community Pharmacy Contractual Framework and NHS optometry services. Other organisations also commission services from community pharmacy, including local authorities (for example public health services such as needle exchange and support to stop smoking) and CCGs, such as access to palliative care medicines.

¹ [NHS England intranet resources](#) for impact assessments can be accessed by staff.

Case study

Wessex Community Voices, a partnership between NHS England in the Wessex area and other local groups including Healthwatch, has produced a toolkit ‘[Choosing and Buying Services Together](#)’. It gives step by step guidance on how to involve the public in planning, designing, buying and monitoring services, and advice on how to work with Healthwatch and voluntary sector organisations. NHS England has used the approach to involve patients in a re-procurement of primary care services in Basingstoke and Southampton.



Note: the lists above are not exhaustive but are intended to give an idea of what happens where in the primary care commissioning cycle.

4.2 How NHS England involves people in primary care commissioning at national level

At national level NHS England has corporate arrangements and involvement initiatives which build patient and public participation into the way the organisation carries out its business. These are fully described in the [Statement of Arrangements](#).

In addition to these organisation-wide arrangements, NHS England uses a range of ways to involve people in specific national programmes of work in relation to primary care. Examples include, but are not limited to:

- Analysis of existing patient insight data (see section 6.3)
- Bespoke engagement events, e.g. patient and public workshop to influence the national GP contract².

² Changes to the General Medical Services (GMS) contract are negotiated with the British Medical Association representing GPs. Most contractual changes have to be enacted through legal

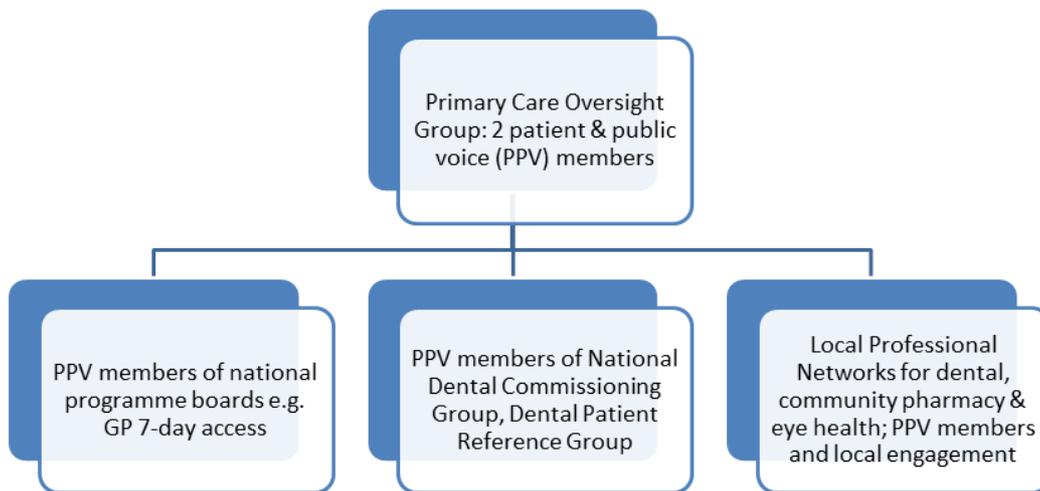
- Digital engagement, e.g. [online consultations](#), use of social media.
- Patient and public reference or co-production groups, e.g. the Dental Patient Review Group and the Patient Online Patients Working Together Group.
- Sharing national involvement opportunities with the networks of CCGs, provider trusts and voluntary sector partners.
- Patient and public voice in decision-making and assurance/quality improvement processes.

Case study

When NHS England developed an [Orthodontics Commissioning Guide](#), it involved children and young people via a combination of digital involvement (tweetchats) and face-to-face focus groups. The insight gained was used in the commissioning guide and it is intended that it will also inform specifications, tender and monitoring processes, and development of Patient Related Experience Measures.

There are two places for patient and public voice members on the NHS England Primary Care Oversight Group (PCOG), and there are also representatives on other national primary care programme boards and panels. Patient and public voice representatives bring fresh perspectives, independent scrutiny and challenge, strengthening decision making, and advising on patient and carer needs, interests and methods of engagement. This helps NHS England commissioners work towards a co-production approach (see [Appendix 3](#)) where patients work in equal partnership with commissioners when decisions are being made.

Diagram: simplified governance structures for primary care commissioning



Patient and public participation reporting and assurance processes are currently being developed in conjunction with the Primary Care Oversight Group for NHS England’s direct primary care commissioning at national, regional and local level.

regulations or directions so ultimate decisions on this lie with Government, which can limit NHS England’s ability to make changes to the contract.

A key part of reporting and assurance is the [assessment by NHS England primary care commissioners](#) or programme leads of whether the Section 13Q duty applies.

How NHS England involves people in primary care commissioning at local level

- It involves them in decision-making and governance, for example:
 - Procurement and quality monitoring groups.
 - Decision-making panels for prioritising funding.
 - Pharmaceutical Services Regulation Committees (decision-making panels on pharmaceutical applications and fitness to practice issues for community pharmacy).
 - Patient boards to influence regional commissioning.
- It organises targeted communication and involvement exercises, such as writing to the registered patients of a dental practice when it is proposed to move premises, and aiming to focus on groups and parts of society which are harder to hear.
- It takes account of feedback on primary care services, e.g. from local and national surveys such as the GP Patient Survey, the Friends and Family test, and online feedback.
- It works with partners and networks to facilitate involvement (see section 6.2).
- Patients and the public can be members of [Local Professional Networks](#) (LPNs) for dental, community pharmacy and optometry (eye health) services. LPNs are organised by NHS England to bring together a range of partners to improve these services and ensure that they are well integrated with other services and into care pathways.

Case study

NHS England's London region led a programme to evaluate the strength of London's primary care, produce a case for change and define a commissioning framework for primary care transformation. Members of the public were involved at all stages including public meetings to review the need for change and as members of expert panels and focus groups which defined the aspects of care which mattered most to patients.

4.3 Co-commissioning with CCGs

NHS England is currently responsible for commissioning primary care services under the legislation governing the NHS. However, through its co-commissioning programme, NHS England is encouraging CCGs to take on more involvement in commissioning primary medical services. Co-commissioning aims to support the development of a locally led vision for primary care, with increased clinical leadership and public involvement.

The scope of co-commissioning may expand over the coming years into wider primary care services (e.g. community pharmacy, dental and eye health services). Any expansion of co-commissioning would be considered with full and proper engagement of the relevant professional groups.

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Co-commissioning can take three forms:

- **Delegated commissioning** arrangements;
- **Joint commissioning** arrangements; or
- **Greater involvement** in primary care decision making

Under **delegated commissioning**, NHS England delegates full responsibility and funding for the commissioning of primary medical services to CCGs. While NHS England retains ultimate liability for the exercise of all of its functions, including those delegated to CCGs, the CCGs are bound by their own public involvement duty in respect of the services they commission (section 14Z2 of the Act). The Delegation Agreement and Terms of Reference make clear that it is the responsibility of CCGs to involve the public in the commissioning of services. In this case, CCGs will take the lead in making arrangements to involve the public in the decisions they make about primary medical services. NHS England will seek assurance (through CCG assurance processes) that the duty to involve the public is being discharged effectively by the CCG.

Case study

South Worcestershire CCG has fully delegated responsibility for commissioning GP services for its population. The CCG needed to develop its model of primary care. It involved local people in that process through a range of channels including representation in governance structures, public meetings, co-production workshops, targeted engagement with specific groups, and seeking views via a local authority survey. This involvement has supported patient focus and innovation in the development of new models. The public appetite to change and improve primary care has also encouraged local GP practices to be more open to change.

Under **joint commissioning**, NHS England and CCGs establish joint committees to make decisions about primary medical services. NHS England and CCGs have separate but virtually identically worded duties (see section 14Z2 of the Act) to involve the public and these duties will run concurrently. In this case NHS England and CCGs will both be responsible for making arrangements to involve the public in the decisions they make about primary medical services and in practice this is likely to be approached on a joint basis by NHS England and CCGs.

Under **greater involvement**, NHS England and CCGs work together to commission the specified services (currently primary medical services). However, NHS England retains the legal responsibility for commissioning the services and the duty to involve the public. In this case NHS England will be responsible for making arrangements to involve the public in decisions about primary medical services, though NHS England may still seek the CCG's views and support with involving the public.

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5 What are my responsibilities for patient and public participation as a policy/commissioning manager for primary care?

Primary care commissioning managers and those working on national policy and programmes affecting how primary care is commissioned should consider participation as an integral part of commissioning, i.e. at **all stages** of the commissioning cycle (See section 4.1).

Planning for participation as part of the commissioning process involves consideration of how the success of participation will be measured, and whether this can be evaluated in relation to health or other outcomes (e.g. cost savings, improved reputation) and the costs involved in participation itself. Costs and benefits should be factored into business and programme planning processes. Typical costs for participation in primary care commissioning include printing costs for leaflets and posters, postage for surveys, expenses for people to attend meetings and honorarium payments for patient and public voice representatives/advisors on decision-making groups.

In planning policy, programmes, and services, commissioners should ensure that they are aware of their legal duty to involve the public in this area of work, and take action as appropriate.

For NHS England commissioners, the [Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning](#) applies using the standard [NHS England form](#). If the duty does apply, the form should also outline the proposed participation plan; if the duty does not apply, there should still be consideration of whether participation would be beneficial. CCGs will make their own arrangements for meeting their duty.

Participation should be carried out **if appropriate** (it may not always be necessary or beneficial), and to the **extent** that is appropriate to the situation. Commissioners have significant flexibility to use a range of different participation approaches, from simply providing information (putting up posters in a surgery waiting room) through to co-production (see [Appendix 3](#)). For example, a co-production approach could involve service users, advocates and front-line staff in designing the specification of a new dental service for people with learning disabilities and in the procurement of the new service. Guidance on [various different participation approaches](#) is available, indicating what time and resources may be required, and these should help commissioners to select a proportionate approach to participation.

A key principle is to **review and analyse existing information** at the start of any public involvement planning process (see section 6.3). Commissioners should be alert to the potential for gaps in existing information (for example, being aware of groups within the population, such as homeless people, who are not registered with a GP, may not be counted in official statistics, or who those may be under-represented in surveys, for example children and young people). In primary care commissioning at local level, it is particularly important for NHS England commissioners to work with

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partners who have good knowledge of their local population, notably CCGs and the VCSE sector.

Case study

In Croydon, NHS England worked with AYPH (Association for Young People's Health) to develop a set of 'prescriptions' from young people on how GP services could work better for them. AYPH have produced a [GP Champions toolkit for primary care](#).

Assumptions about what level or type of participation will be most effective should be treated with caution. Where appropriate, commissioners should **ask people about if (and how) they would like to be involved**, so that participation can be designed around their needs and preferences, and made as easy and convenient as possible for them. For example, if commissioners need to understand the views of Asian women whose first language is not English, on local pharmacy services, they may find that the best way is to attend an existing group meeting with an interpreter, rather than expect the women to complete a written survey in pharmacy premises.

It is important that appropriate feedback is given to patients and the public who have been involved in a participation exercise. This includes showing them the product of the process, for example, a report and explaining (preferably within that report) how existing information and participation activities have been used to inform the findings and influence any recommendations or decisions. In the event that participation has not influenced outcomes, the reasons why should be explained to those who have given their time and opinions.

Documenting and reporting on insight and participation is also essential for **assurance and quality improvement** purposes within NHS England. In addition to reporting on participation activity, **focus on the impact (or difference) that insight and participation has made**. Commissioners should **share learning** from experience and publicise and celebrate successful participation with partners. This can be done across NHS England through the [Public Participation Team](#) in the national support centre if appropriate.

Case study

The Prime Minister's £50 million Challenge Fund was designed to test innovative ways of providing primary care services, with a focus on improving access. An [evaluation has been published](#) to share key lessons from four pilot sites in engaging their patient population. These include the importance of early involvement, creative communication channels, and reporting on progress to the people involved.

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6 Resources

6.1 Information and web-based resources

Both staff and members of the public need information and support to make participation in primary care commissioning successful. Key resources on the NHS England website for patients and the public which primary care commissioning staff need to be aware of include:-

- [‘How do I get involved in primary care commissioning?’ Information for patients and the public and easy read version](#)

Commissioners will need to refer to:-

- [NHS England Patient and Public Participation Policy](#)
- [NHS England Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning](#)
- [Transforming Participation guidance](#)

Further resources to support participation include the following:

- [Bite size guides to participation.](#)
- [Templates for recruiting members of the public into participation roles.](#)
- [Smart guides to engagement.](#)
- [NHS England Patient and Public Voice expenses policy.](#)
- [Policy books](#) for the four areas of primary care commissioning, which set out a suite of policies and procedures including an outline the legal duties on public involvement in the context of all legal duties (e.g. the public sector equality duty and the need to reduce health inequalities).
- Information about induction and further training opportunities (including online courses) for both staff and members of the public.
- [Events](#) and workshops.
- Communications support to enable members of the public to participate e.g. information in ‘easy read’ and other accessible formats, and interpreting support.
- Involvement opportunities advertised locally and nationally.
- Patient leadership training offered by many national and local organisations including CCGs, Healthwatch, NHS England regions, voluntary sector.
- The [‘Consultation Hub’](#) – where people can contribute their views to surveys and apply for Patient and Public Voice representative roles.

Case study

[Wessex Community Voices toolkit ‘Choosing and Buying Services Together’ includes a useful checklist for supporting members of the public to engage in meetings, conferences and committees, and an outline training plan to empower them to develop their knowledge of commissioning and their skills in being a patient representative or lead. The programme also supports training for commissioners in participation.](#)

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6.2 Key partner organisations and networks with an interest or involvement in patient and public participation in primary care commissioning

Below is a list of key organisations and networks which may be able to provide relevant information and/or support participation at different levels of the NHS. It is not exhaustive.

Organisation/Network	Local	Regional	National
Patient Participation Groups (PPGs)	✓	✓	
N.A.P.P. – national network of PPGs			✓
CCG involvement infrastructures	✓		
Provider involvement networks (e.g. Foundation Trusts Network)	✓		
Local authority participation infrastructures (e.g. learning disability partnership boards)	✓		
Clinical Commissioning Groups (CCGs)	✓	✓	✓
CCG lay member network			✓
Social Prescribing Network			✓
Healthwatch	✓	✓	✓
Voluntary and community sector	✓	✓	✓
Strategic Clinical Networks & Senates		✓	
Health and Wellbeing Boards	✓		
Local professional networks (eye health, dental, pharmacy)	✓	✓	
Networks for specific groups (e.g. carers, children and families)	✓		✓
Scrutiny networks	✓		✓
Health Education England		✓	✓
Care Quality Commission	✓	✓	✓
Public Health England		✓	✓

Examples

Many CCGs have patient reference groups and support locality networks of PPGs as a way to involve local people in commissioning. These networks can be valuable for primary care commissioning and should be used by NHS England commissioners as well as CCGs

NHS England has supported N.A.P.P. to produce 'Building better participation' a resource to support PPGs – whether long-standing or recently formed, whether large or very small, whether in a single practice or as part of a federation of practices – to reflect on what they do. This will also be a useful tool for GP practices and CCGs seeking to support effective PPGs.

6.3 Insight sources

It is important to make the most of existing information (for example population statistics and public health reports) and insight to inform all stages of the commissioning cycle. Insight material provides evidence that can be used to inform change and development. A range of methods, both quantitative and qualitative, should be used to gather patient experience insight and ensure there is a genuine dialogue.

Insight sources that already exist include:

- National surveys such as the [GP Patient Survey](#).
- Local surveys e.g. carried out by CCGs, Healthwatch or local authorities.
- [Friends and Family Test](#).
- [NHS Choices](#) data and feedback comments.
- [NHS Citizen Gather website](#) and other online patient feedback websites such as [Patient Opinion](#).
- CCG intelligence from local engagement.
- Patient organisations and charities.
- Social media, such as Facebook and Twitter.
- Complaints via the [NHS England Customer Contact Centre](#), CCGs and national Ombudsman's reports.
- CQC inspection reports, Healthwatch reports, local scrutiny committee reports.
- Information from Patient Participation Groups and other patient representative groups.
- The [Equality Delivery System](#) for the NHS (EDS2) and engagement feedback from patients and communities.
- Case studies.

Each of these sources has strengths and weaknesses, and some are more appropriate than others for particular purposes.

National surveys like the [GP Patient Survey](#) are good at producing comparative data on specified questions (determined by national policy) which can be useful for measuring the success of policy implementation or in identifying performance issues for further investigation, e.g. identifying unusual results or outliers. However, they are less helpful at establishing a dialogue that allows patients to identify issues of concern to them, or producing practical locally based solutions.

Where an issue or problem is identified, survey results can be used to map change over time, or the impact of new initiatives. The results of national surveys should be used with caution, but it is possible to compare and contrast service providers with other similar size and type service providers, the national average, or the top and bottom performers. This can be particularly useful to identify benchmarking partners or to 'buddy' organisations that are performing well with organisations looking to improve. Exploring issues that other organisations, facing similar problems, have successfully tackled may identify transferable solutions and some 'quick wins'.

The [Friends and Family Test \(FFT\)](#), on the other hand, does not produce comparative data, but can be used to collect qualitative insight through its open free

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text questions which can be tailored to identify and gather feedback on local areas of concern, including views on how things could be improved. FFT is a contractual requirement for providers, giving every patient the opportunity to comment and potentially providing a good source of regular feedback, but there are still social and cultural reasons why some people will be reluctant or unable to use it.

Qualitative insights such as patient stories, focus groups and other dialogue can be valuable in understanding the issues underlying the statistics and developing shared solutions to problems.

It is very important that commissioners are clear about how they use feedback and how it has made a difference to services and outcomes. Commissioners should also be aware that:

- People not accessing primary care will not be included in this type of survey feedback.
- There are groups such as people with disabilities or those who cannot speak English for whom these feedback channels are less accessible.

There are, therefore, strong arguments in favour of going beyond existing insight sources, e.g. holding focus groups discussions or using targeted qualitative methods (specialist surveys).

6.4 Further advice, training and support for primary care commissioning/managers

In addition to the resources outlined at 6.1, advice, training and support on public participation are available from the following. It should be noted that there is some variability in regional and local arrangements due to structure differences.

- NHS England regional communication and engagement teams and patient experience teams.
- NHS England Public Participation Team in the central support centre (developing a programme of training for commissioners on participation including the expenses policy).
- NHS England central support team for equalities and health inequalities (especially when looking at reaching equalities protected groups and groups that experience inequalities in access to services and outcomes).
- Commissioning Support Units.
- Engagement/involvement specialists in CCGs.
- External partners such as Healthwatch, voluntary sector organisations, local authorities.
- Patient and public participation expert advisers who are involved in governance and assurance roles.
- In highly complex and/or high profile situations, it may be necessary to seek legal advice through the NHS England Legal Team and/or specialist communications and engagement expertise through contracting services.

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7 Equality and health inequalities analysis

NHS England has completed an equality and health inequalities analysis of patient and public participation in its work which can be found on the [NHS England website](#). Several themes in relation to primary care commissioning were highlighted during co-production and wider engagement on this framework.

- It is important that commissioners use a flexible range of methods to hear and engage with potentially excluded groups, or there is a risk that participation will reinforce inequalities in access to primary care services and health outcomes. For example, some methods such as digital engagement may exclude certain groups that do not have access to technology, and enable others who might find it hard to attend a face to face meeting. Some practical approaches are outlined in section 4.
- Planning involvement proactively (including identifying resources and support, and working with partners) helps commissioners to reach people with protected characteristics and those that experience health inequalities. A planned approach will maximise involvement from different groups and reduce the risk that participation activities will engage the same groups and individuals. This should include budgets to support accessible engagement.
- Activities should be planned and adapted to ensure equitable access to public participation opportunities regardless of a person's cultural, linguistic, religious background, communication and accessibility needs.
- Commissioners are required to support the [Accessible Information Standard](#). This mandatory standard aims to make sure that disabled people have access to information that they can understand and any communication support they might need. External stakeholders have highlighted the importance of ensuring that opportunities for people to participate in primary care commissioning are accessible to people with communication support needs.
- Commissioners should connect with existing patient, service user and voluntary sector organisations to reach and develop relationships with diverse communities, and especially with people whose voices can be harder to hear.
- Auditing and monitoring participation of equalities protected groups, e.g. in events and formal governance roles, supports commissioners to manage and improve performance in involving a more reflective range of people.
- Engagement on the framework has uncovered examples of good practice in inclusive participation in primary care, for example for people with learning disabilities. These are being shared through this framework and other channels such as training and online resources³.

³ See reference to [internal resources](#), footnote 1

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Case Study

Turning Point, Strengthening Healthy Communities in Worcester
 South Worcestershire CCG and Warwickshire County Council used the Connected Care methodology to engage the community in three of the most deprived areas in Worcester city with the aim of helping people with chronic health problems better self-manage. A team of local residents, trained by Turning Point, used their own links within the community to reach people not currently engaged with services. They were able to present a picture of the demands on people's lives and health locally that formed the basis of three community-led pilot projects: a community wellbeing campaign including 200 peer to peer 'wellbeing conversations', a 'time to talk' drop-in delivered by Community Champions at the GP surgery providing peer support and sign posting and a five week lifestyle course and peer support group for people living with a long term condition. Evaluation of the pilots found: demonstrable gains in wellbeing and reduced social isolation; increased uptake of local services including health trainers and health checks; and improvements in health management towards healthier eating, moderate exercise and reduction in smoking. The project was a finalist in the 2014 NHS England Excellence in Participation Awards and the CCG has rolled out the 'time to talk' drop-in across five GP surgeries. The success of this project has also been captured in a [short film](#).

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Appendix 1 – Membership of the Working Group for Patient and Public Participation in Primary Care Commissioning

Thanks to the members of the working group that produced this framework and supported NHS England to test it with a wider audience.

Working Group members

Olivia Butterworth (co-chair)	NHS England
Sarah White (co-chair)	Sense
Claire Aldiss	NHS England
Melanie Lee	NHS England
Sally Brearley	Sutton CCG
Phil Brough/Eugene Quinn	Healthwatch England
Anna Calderwood	NHS England
Neil Cleeveley	National Association for Voluntary and Community Action (NAVCA)
Paul Devlin	National Association for Patient Participation (N.A.P.P.)
Jo Farey	South Tyneside CCG
Sara Geater	NHS England
David Geddes	NHS England
Tim Gilling	Centre for Public Scrutiny
Martin Howard	South West CSU
Helen Jones	Leeds Gypsy and Traveller Exchange (GATE)
Elizabeth Kerwood	Portsmouth, Fareham and Gosport and South Eastern Hampshire CCG
Saiqa Iqbal	NHS England
Gill Littlehales	NHS England
Chris Branson	NHS England
Frances Newell	NHS England
Marie Scouse	North Derbyshire CCG
Mark Smith	NHS England
Louise Swain	North Derbyshire CCG
Patricia Wilkie	N.A.P.P.
Candy Perry	Healthwatch Birmingham
Claire Feehily	Healthwatch Gloucestershire
Vanessa Todmann	Healthwatch England
Gillian Garratt	NHS England
Carol Wood	NHS England
Cathy Stuart	NHS England
Amanda Stocks	NHS England

Appendix 2 - Engagement on the development of the framework for patient and public participation in primary care commissioning.

The draft framework was available for comment on the NHS England website between 6 January and 12 February 2016. We are very grateful to all those who took the time to respond to the public engagement on the draft framework. There were nearly 100 online and email responses covering a range of perspectives including NHS England staff, CCG staff, voluntary sector organisations, local Healthwatch staff and volunteers, and individuals such as Patient Participation Group members, carers, and CCG lay members. In addition the Public Participation team and working group members supported face to face and outreach engagement with over 20 additional groups and networks.

NHS England's Learning Disability Engagement team supported outreach to people with learning disabilities and their carers and advocates. This has provided insights into a range of issues around access and good practice in primary care commissioning in relation to this group, which will be connected to the work of the Learning Disability Programme in reducing inequalities.

Key points from the public engagement feedback

- Respondents were generally supportive of the framework and its proposed target audience (primary care commissioners). Following engagement feedback and in the context of co-commissioning developments, the framework has been positioned as being advice, support and resources for all commissioners of primary care, whether NHS England or CCGs.
- Respondents emphasised the need for public facing information on how to get involved in this area of commissioning, which has been produced. They wanted to see more examples and links to case studies, good practice and resources, which have been added.
- Many respondents highlighted the role of GP practice Patient Participation Groups (PPGs) and networks for this area of public participation, and the need to support and strengthen them. The framework references the recent work NHS England has done with the National Association for Patient Participation to support stronger PPGs (section 7.2)
- The engagement exercise provided a range of insights relating to equalities and health inequalities impacts, which have informed section 8 and the full equality and health inequalities analysis of patient and public participation in NHS England.
- There were also many constructive ideas to support implementation of the framework.

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Appendix 3 – NHS England co-production model

Co-production – Five Values and seven steps to make this happen in reality

Co-production can be defined as a way of working which involves citizens and communities in equal partnership; engaging groups of people at the earliest stages of co-design, co-development and evaluation of services. The concept is built on the acknowledgment that people who have lived experience of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. When co-production works well, it is an approach which helps to ground discussions in reality and maintain a person-centred perspective.

Co-production is part of a spectrum of participation approaches.

It is a cornerstone of self-care, person-centred care and health coaching methodologies.

Five values and behaviours that will create a climate where co-production can flourish

- An organisational culture of openness and transparency.
- Commitment to sharing power and decisions with citizens.
- Senior leaders and staff have ownership of co-production programmes.
- Clear communication and plain English.
- An accessible and inclusive environment where people are valued and respected.

Seven practical steps to make coproduction happen in reality

- Establish leadership commitment to co-production.
- Recruit and select diverse groups of citizens to support co-production activities, including perspectives which represent families and communities as well as the lived experience of individuals who use services.
- Create systems to allow reward and recognition of the citizen contribution.
- Develop a co-production strategy in discussion with citizens, explaining what co-production means to the organization.
- Work with citizens to strategically identify areas of work where co-production can have a genuine impact and get people involved at the earliest stages of development.
- Provide training and development of staff and citizens to create an environment where co-production can thrive.
- Regularly review and report back on progress – modelling co-production by moving from the “You said, we did” approach to a “We said, we did” approach.

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8 References

ⁱ Equalities and health inequalities references:

[The Marmot Review, \(2010\)](#). Fair Society, Health Lives. London: The Marmot Review.

[Patient access to general practice: ideas and challenges from the front line.](#)

[RCGP and University of Birmingham, \(2013\). Improving access to health care for Gypsies and Travellers, homeless people and sex workers. London: RCGP and University of Birmingham.](#)

Inclusive Practice: Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: [A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital.](#)

Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, L. R. [Confidential Inquiry into premature deaths of people with learning disabilities \(CIPOLD\)](#). Final report. Bristol: Norah Fry Research Centre, 2013.

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