Ipsos MORI
Social Research Institute

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CCG 360° Stakeholder Survey

National report

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Contents

1 Introduction

1.1 Background and purpose

The CCG 360° Stakeholder Survey was initially commissioned by the Department of Health on behalf of NHS England (then the NHS Commissioning Board) in 2012 as a key component of the authorisation process through which aspiring CCGs applied for formal establishment and authorisation to discharge their statutory duties.

Five years on from the authorisation process, the role of CCGs continues to change and broaden in response to challenging financial positions and changes within the commissioning landscape. NHS England has a statutory responsibility to conduct an annual assessment of each CCG and specifically to consult each relevant Health and Wellbeing Board on the CCG's contribution to the delivery of any joint health and wellbeing strategy. In 2017, this assessment has been conducted against the CCG improvement and assessment framework 2016/17[1].

A central part of the assessment process is the 2017 CCG 360° Stakeholder Survey, the findings of which are presented in this report. A key aim of the survey is to enable NHS England to assess whether CCGs are operating effectively in partnership with key organisations in the local health system to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

Additionally, the results from the survey also provide longitudinal data to help improve CCGs' ongoing organisational development, enabling them to continue building strong and productive relationships.

1.2 Methodology

The CCG 360° Stakeholder Survey was conducted by Ipsos MORI on behalf of NHS England, and all 209 CCGs in England took part in the survey. Each CCG provided Ipsos MORI with a list of stakeholders to be contacted for the 360° survey. The following stakeholder groups were included in every CCG's list:

- GP member practices;
- Healthwatch and other patient groups / organisations / representatives;
- NHS providers (acute, mental health and community);
- Upper tier or unitary local authorities;
- Health and wellbeing boards;
- Other CCGs they collaborate with; and,

[1] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf

- Wider stakeholders[2]

CCGs were provided with a stakeholder sample framework which specified the maximum number of stakeholders required within each stakeholder group. To account for the fact that relationships with stakeholder vary between CCGs, within each stakeholder group, CCGs were provided with some flexibility to choose the specific individuals they would like to invite to the survey.

This year, there were two major changes to the stakeholder sample framework. Firstly, CCGs were invited to include one representative from the Care Quality Commission (CQC) in their sample. CQC representatives were only asked a small set of questions but for the purpose of analysis they have been included in the 'wider stakeholders' group. Secondly, federated CCGs were invited to provide one 'federated' stakeholder list, including all those stakeholders who see the federation of CCGs as a single body *and* a separate stakeholder list provided by each of the CCGs within the federation, including those stakeholders whose relationship is with one of the individual CCGs within the federation. More details of the specific requirements for each stakeholder group are included in the technical note in Chapter 14.

The survey was primarily conducted online. Nominated stakeholders were initially invited to participate via email, with up to six reminder emails targeted at those who did not respond to the survey. Two weeks after the initial invites, those stakeholders who had not responded to the email invitations were telephoned by Ipsos MORI interviewers over a further four-week period, in order to encourage response and offer the opportunity to complete the survey by telephone. (In the first two weeks of fieldwork it was still possible for stakeholders to complete the survey over the phone on request). Many CCG leads also played a key role by proactively encouraging their stakeholders to complete the survey and supporting them through the process.

Within the survey questionnaire, stakeholders were asked a series of questions about working relationships with the CCG. In addition, as stakeholder groups had different areas of experience and knowledge, they were presented with a short segment of the questionnaire that contained questions specific to the stakeholder group they represented (except those classed as wider stakeholders or other CCGs). Each question was linked to one of the four domains set out in the CCG improvement and assessment framework 2016/17.

The questionnaire was standardised across the CCGs, although the name of the CCG was included within the question wording to ensure stakeholders (who were sometimes completing surveys for multiple CCGs) were clear which CCG they were answering about. In addition, the wording for GP member practices differed slightly to that for other stakeholders to reflect their status as a constituent member of CCGs rather than external stakeholders[3].

Where CCGs chose to include them, up to five bespoke questions were asked of all stakeholders at the end of the survey. These questions were in a standardised format, but CCGs were able to tailor them to focus on issues of local importance. In practice, these statements were often about localised activities that CCGs had carried out.

[2] This is a varied group of stakeholders from other organisations not listed in the core list. CCGs had the opportunity to include up to ten additional stakeholders from other organisations. This year, for the first time, CCGs were allowed to invite one contact from the Care Quality Commission (CQC).

[3] For this group the survey was referred to as the '*CCG member practice survey*'.

Fieldwork for the CCG 360° Stakeholder Survey began on the 16th January 2017 and ended on 28th February 2017. This fieldwork period was two weeks longer than in 2016. This was so as to ensure stakeholders had as long as possible to complete the survey.

In total, 13,691 stakeholders were invited to take part in the survey and 8,516 of these stakeholders went on to complete it. Consequently, the final overall national response rate was 62.5 % compared with 59% for 2016. The response rate varied across CCGs and stakeholder groups; further details are provided in Chapter 12.

On completion of the survey, Ipsos MORI produced the following reports for each CCG, before annual assessment conversations were scheduled to take place between NHS England and CCGs:

- a full PowerPoint report comprising the findings from all of the closed questions in the survey with a breakdown by different stakeholder groups; and,
- a document detailing stakeholders' verbatim responses to the open-ended (free-text) questions

To support transparency and openness NHS England has recommended to CCGs they publish their reports / key findings from the survey on their websites.

1.3 Interpreting the data

NHS England is committed to ensuring that the process of assessment, and the key sources of information which inform it, continue to develop and mature in the spirit of ongoing co-production with CCGs. The CCG 360° Stakeholder Survey should be viewed from this same perspective. The findings of the survey provide a 'snap-shot' at a particular point in time to inform how CCGs can continue to build and improve relationships with stakeholders in the future.

Where relevant and appropriate (i.e. consistent question wording across surveys) comparisons with the 2016, 2015 and 2014 CCG 360° Stakeholder Surveys have been included. Comparisons with the 2012 survey, which was conducted prior to authorisation, have not been included in this report. This was deemed appropriate because, when the 2012 survey was conducted CCGs were in the process of establishing themselves as organisations.

Because a sample of stakeholders, rather than the entire population of stakeholders, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. See Section 12.5 for more details on these sampling tolerances.

Throughout the report, statistically significant differences (either between 2015, 2016 and 2017 results or between results across different stakeholder groups) are denoted with red or green arrows on the relevant chart. Throughout the report, wherever a *change* across years, or a *difference* between stakeholder groups is referred to, this indicates a statistically significant difference.

Strictly speaking however, the significance testing used throughout the report applies only to random samples, so these tolerances should be treated as indicative only. In addition, for this particular survey, the size of the population of stakeholders is unknown for the most part, so again the figures below should be treated as indicative only.

Where percentages in this report do not sum to 100, this is due to computer rounding. Throughout the report an asterisk (*) denotes any value of less than half of one per cent, but greater than zero.

1.4 Structure of this report

The purpose of this report is to provide an overview of findings across all 209 CCGs. It highlights areas where CCGs are performing well and also outlines potential areas for improvement. The report also provides details of the survey process, to serve as a record of the research methodology.

This report is largely structured around analysis of individual stakeholder groups. However, the 'overall findings' chapter explores responses to the general questions about engagement, working relationships and CCG plans and priorities that were asked of all stakeholder groups. There is a summary of the overall findings for each stakeholder group at the beginning of every corresponding chapter. The report is structured as follows:

Chapter 1: Introduction – providing an overview of the background to the survey and how it was conducted

Chapter 2: Summary findings – a chart summarising the key findings from the survey

Chapter 3: Overall findings – an overview of engagement and relationships, including analysis of how perceptions have changed between 2015, 2016 and 2017

Chapter 4: GP member practices – perceptions of internal governance arrangements within the CCG, CCGs' plans and priorities and perceptions of primary care co-commissioning

Chapter 5: Healthwatch and other patient groups – perceptions of the way in which CCGs communicate and engage with patients and public

Chapter 6: NHS providers – understanding how well CCGs and NHS providers are working together in a number of areas

Chapter 7: Upper tier/unitary local authority – exploring collaborative arrangements between local authorities and CCGs, including arrangements for safeguarding adults and children and integrated commissioning

Chapter 8: Health and wellbeing boards – focusing on views of the role CCGs play in the operation of health and wellbeing boards, along with CCGs' and local authorities' integrated commissioning

Chapter 9: Other CCGs – an overview of engagement and relationships for this group of stakeholders

Chapter 10: Wider stakeholders – an overview of engagement and relationships for this varied group of stakeholders

Chapter 11: Regional variation - this chapter outlines whether any discernible differences emerged across the four NHS England regions.

Chapter 12: Technical information – providing more detail about the methodology for the survey and response rates

Chapter 13: Project learnings – this chapter suggests some directions in which the survey could develop for the future

Annex: The annex of this report contains tables showing, for each question discussed in the 'overall findings chapter' a breakdown of responses across each stakeholder group.

1.5 Acknowledgements

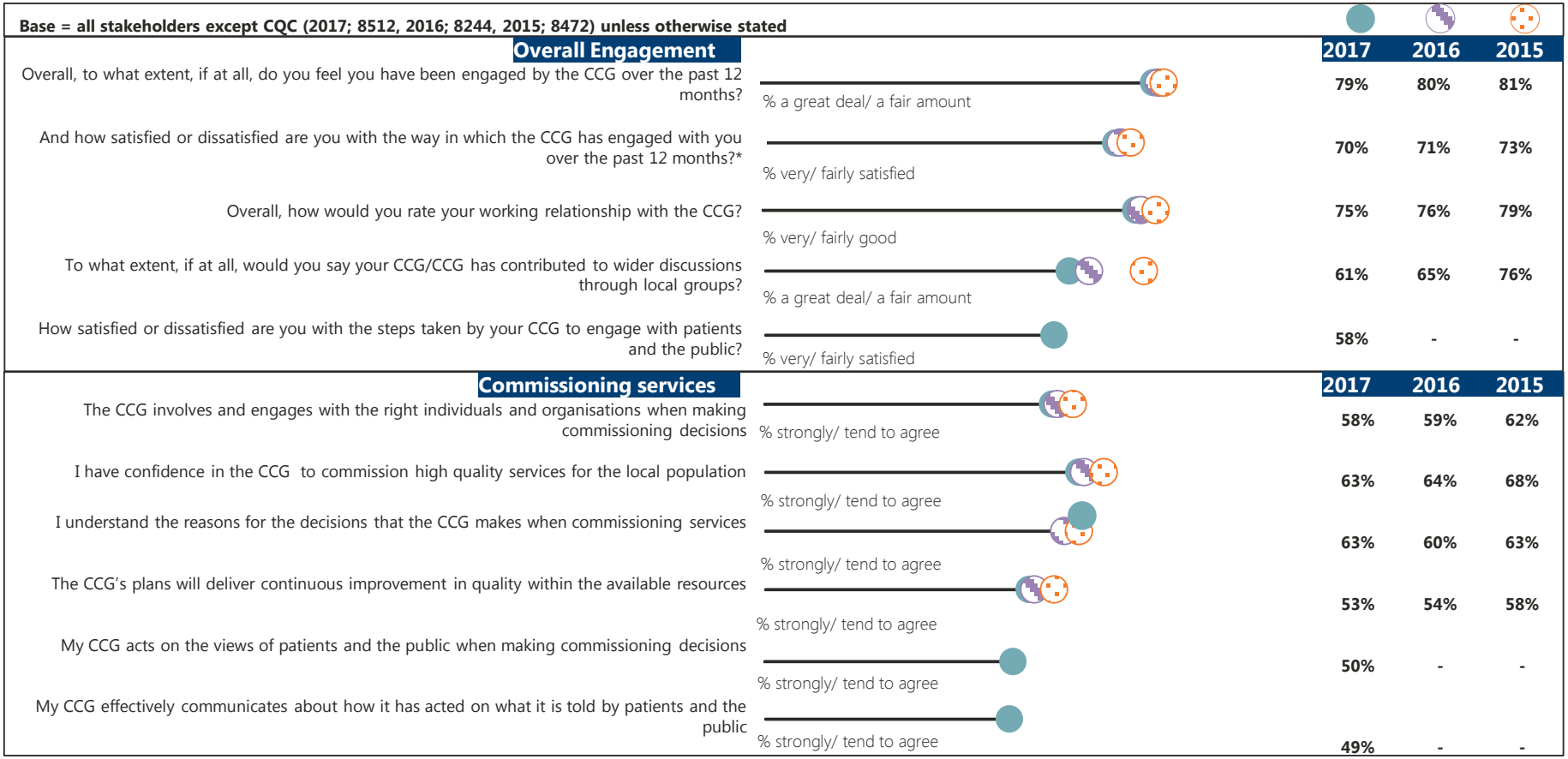
The survey would not have been possible without the willingness of the 8,516 stakeholders and GP member practices to engage with the survey and tell us in detail about their relationship with their CCG. We would like to thank everyone who took part in the survey for their time.

We would also like to thank the CCG leads who took part in the survey engagement group for their time and the invaluable insight they gave when designing this year's survey. Additionally, we would like to express our gratitude to all the CCG leads for their help compiling the stakeholder samples and encouraging their stakeholders to participate in the survey.

Finally, we are also grateful to Sarah Briggs, Joanne Cooke and Victoria Chapman, as well as the wider CCG Advisory Group at NHS England for their support and feedback throughout the project.

2 Summary findings

The following chart presents the summary findings across the CCG for the questions asked of all stakeholders. This provides the percentage of stakeholders responding positively to the key questions, including year-on-year comparisons where the question was also asked in 2016 and 2015.



***Base = all who feel they have some level of engagement with CCG (2017; 8297, 2016; 8046, 2015; 8320)**

***Base = all stakeholders (2017; 8516, 2016; 8244, 2015; 8472)**

3 Overall findings

Summary

- **The overall performance of CCGs remains high, with the majority of stakeholders expressing positive views on the various indicators, and with some indicators showing in excess of 70% satisfaction. It is encouraging to see that CCGs' performance on most measures has remained stable since the 2016 survey was conducted, following widespread declines in ratings between 2015 and 2016.**
- **Any changes at the national level tend to be reflected in the pattern of change at the individual CCG level. However, many indicators have remained stable since 2016, and very few individual CCGs show shifts that are statistically significant. This confirms the generally settled picture that is evident at the national level.**
- **In some cases, CCGs score very highly. For instance, almost all stakeholders (97%) feel they have been engaged by their CCG in the last 12 months – this is consistent with perceptions of engagement in 2016 (98%). Also consistent with 2016, the majority (70%) were satisfied with the way in which engagement has taken place.**
- **Similarly, ratings of working relationships have remained stable, with three in four (75%) reporting a very good or fairly good working relationship with their CCG (compared with 76% in 2016).**
- **The majority of stakeholders continue to report positive opinions about the commissioning decisions made by their CCG. While this year's findings are generally consistent with 2016, a higher proportion of stakeholders now report that they understand the reasons for the decisions their CCG makes when commissioning services (60% in 2016 compared with to 63% in 2017).**
- **Confidence in several aspects of CCGs' overall leadership has fallen slightly since 2016, continuing a longer-term decline. Specifically, confidence has fallen in relation to delivering improved outcomes for patients (from 59% in 2016 to 56%), delivering plans and priorities (from 62% in 2016 to 60%), and delivering continued quality improvements (from 57% in 2016 to 55%).**

- **Stakeholders are positive about the extent to which they feel able to raise concerns with their CCG about the quality of local services (84% feel able to raise concerns). Stakeholders tend to be less positive about how effectively their CCG monitors the quality of services it commissions (61%) and about how it acts on feedback it receives about the quality of services (65%).**
- **Stakeholders' knowledge of their CCG's plans and priorities is generally high, with around three in four (77%) reporting a great deal or a fair amount of knowledge. Most stakeholders hold positive views on different aspects of their CCG's plans and priorities. For example, more than three in five (63%) agree that their CCG has effectively communicated its plans and priorities. However, only half of stakeholders (48%) feel that their comments on the plans and priorities have been taken on board.**
- **Although the majority of stakeholders (61%) remain positive about their CCG's involvement in local groups such as the Quality Surveillance Group, Urgent Care Working Group or Council for Voluntary Services, there has been a decline in this measure since 2016 (from 65%), continuing a long-term decline. This decline is apparent across most stakeholder groups.**
- **This year, new questions were added about the way that CCGs engage with patients and the public. The majority of stakeholders (58%) are satisfied with the steps taken by their CCG to engage with patients and the public, although a third (33%) are neutral or do not give an opinion.**

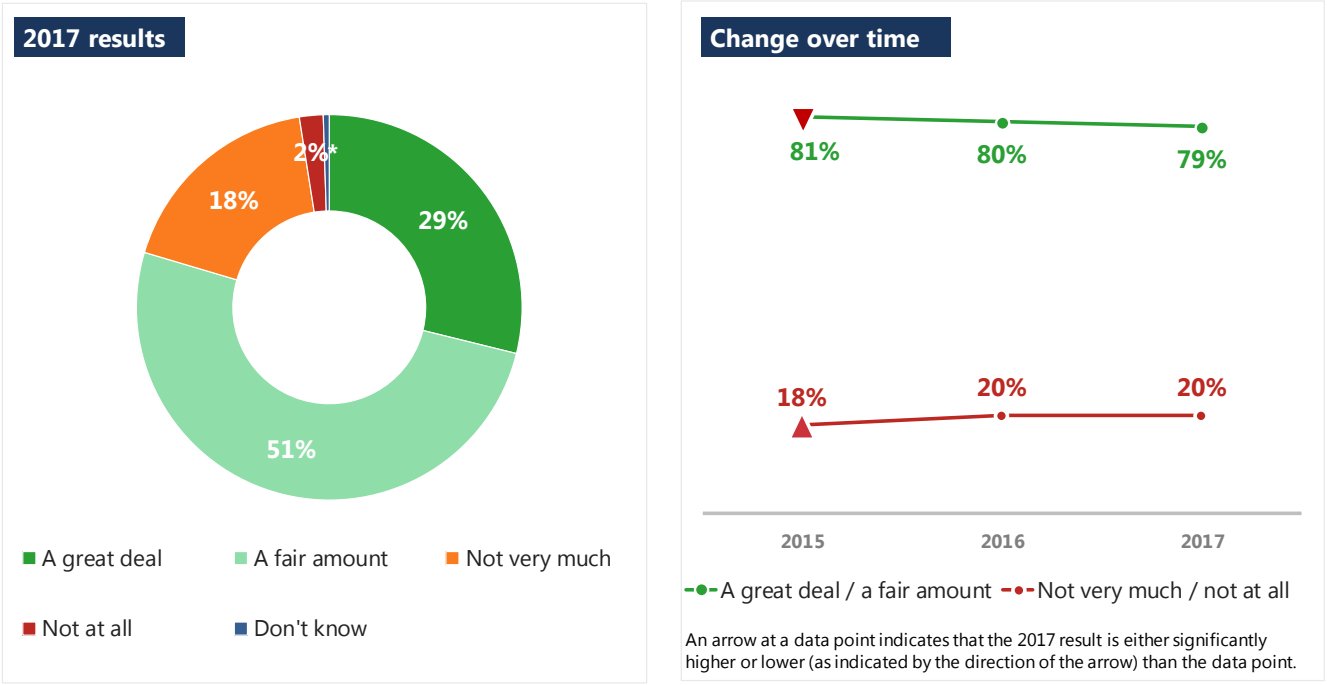
In addition to questions relevant to their specific role, all stakeholders were asked a range of questions about general engagement, communications and working arrangements with their CCG – which are all key to developing and maintaining productive working relationships.

The following discussion shows how CCGs at the overall level are performing on these key areas, and how this performance has changed over time. It is worth noting that changes at the overall level may mask important changes happening at the level of individual CCGs. As such, analysis of responses at the CCG-level has been incorporated throughout this chapter. This analysis includes both discussion of the number of CCGs whose scores have increased or decreased at an absolute level, and also of the number whose scores have increased or decreased at a statistically significant level. In many cases, due to the small base size for individual CCGs, relatively large changes in individual CCG's scores across years are not statistically significant – this is highlighted throughout the chapter and should be borne in mind when interpreting the data.

3.1 Engagement with stakeholder and partner organisations

Almost all stakeholders (97%) feel that they have been engaged by their CCG, with the vast majority (79%) feeling engaged either a great deal or a fair amount. This compares with 80% in 2016 and 81% in 2015.

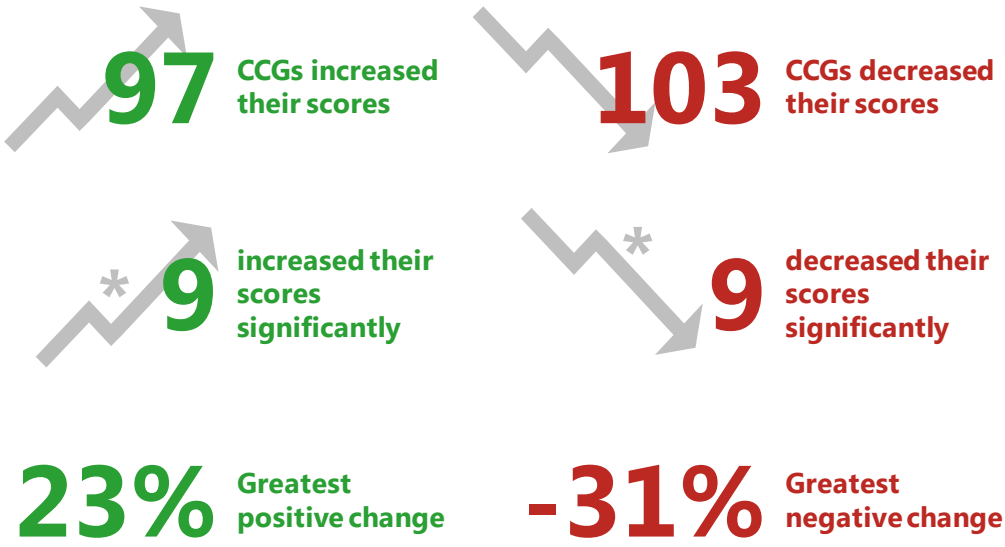
Figure 3.1: Overall, to what extent, if at all, have you been engaged by the CCG over the past 12 months?



All stakeholders: 2017 (8,512); 2016 (8,244); 2015 (8,472).

The results for this measure indicate that stability at the overall level is not based on consistency across all CCGs, but rather on a similar number of CCGs having seen their scores increase as the number seeing a decrease; 97 CCGs saw ratings of their engagement with stakeholders increase from 2016 to 2017, while 103 CCGs saw their scores decrease. Of the CCGs that saw changes in their scores, nine experienced a statistically significant increase and nine experienced a statistically significant decrease. The greatest positive change for this measure was an increase of 23%, while the greatest negative change was -31%.

Figure 3.2: Overall, to what extent, if at all, do you feel you have been engaged by the CCG over the past 12 months



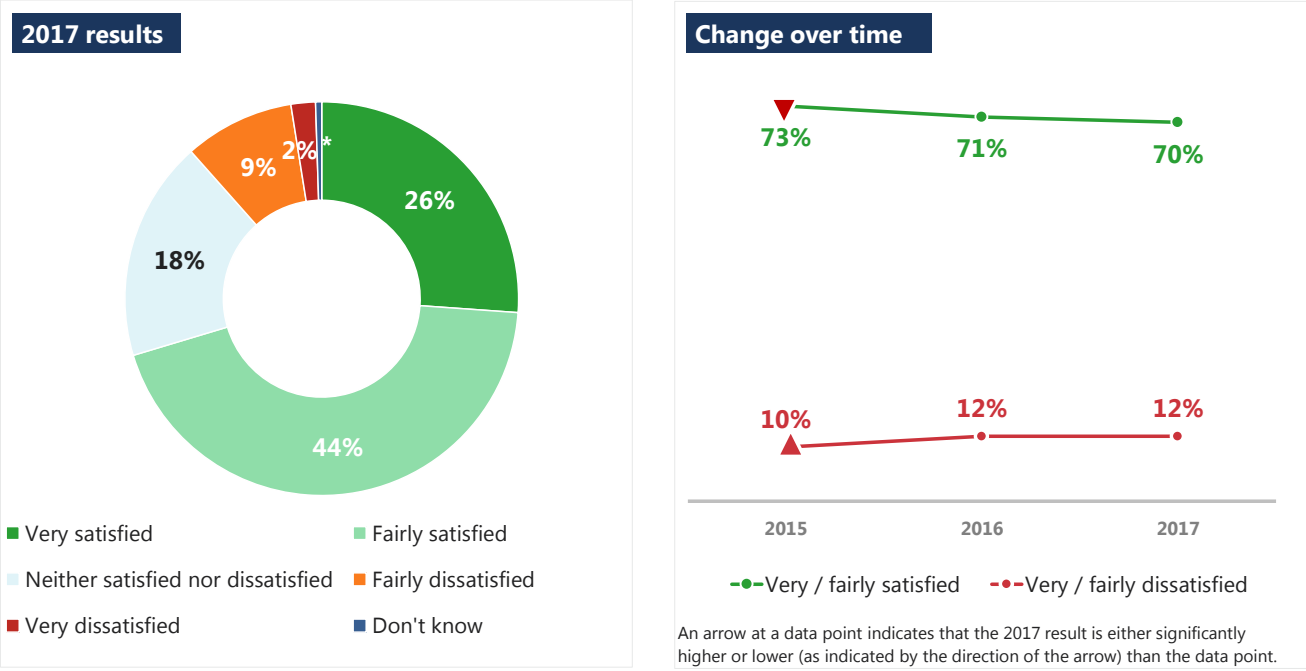
On the whole, a decreased score on this measure – the extent of engagement that has taken place over the last 12 months – is an indicator that a CCG is likely to have decreased scores on other measures. For example, of the 103 CCGs who saw their scores decrease at this measure:

- 79 also saw a decrease in the proportion who felt the CCG engaged the right individuals when making commissioning decisions
- 75 also saw decreases in the proportion saying they had confidence in the leadership to deliver plans and priorities.
- 80 also saw a decrease in the proportion who have confidence in the CCG to act on feedback it received on the quality of services.

Further details of the shifts that have taken place at a CCG level can be found in the annex.

Of the 97% of stakeholders who feel they have been engaged, the majority (70%) are satisfied with the way in which this engagement has taken place. This has remained constant since 2016 (71%), although there has been a very minor decline in satisfaction since 2015 (when 73% were satisfied).

Figure 3.3: How satisfied or dissatisfied are you with the way in which the CCG has engaged with you over the past 12 months?



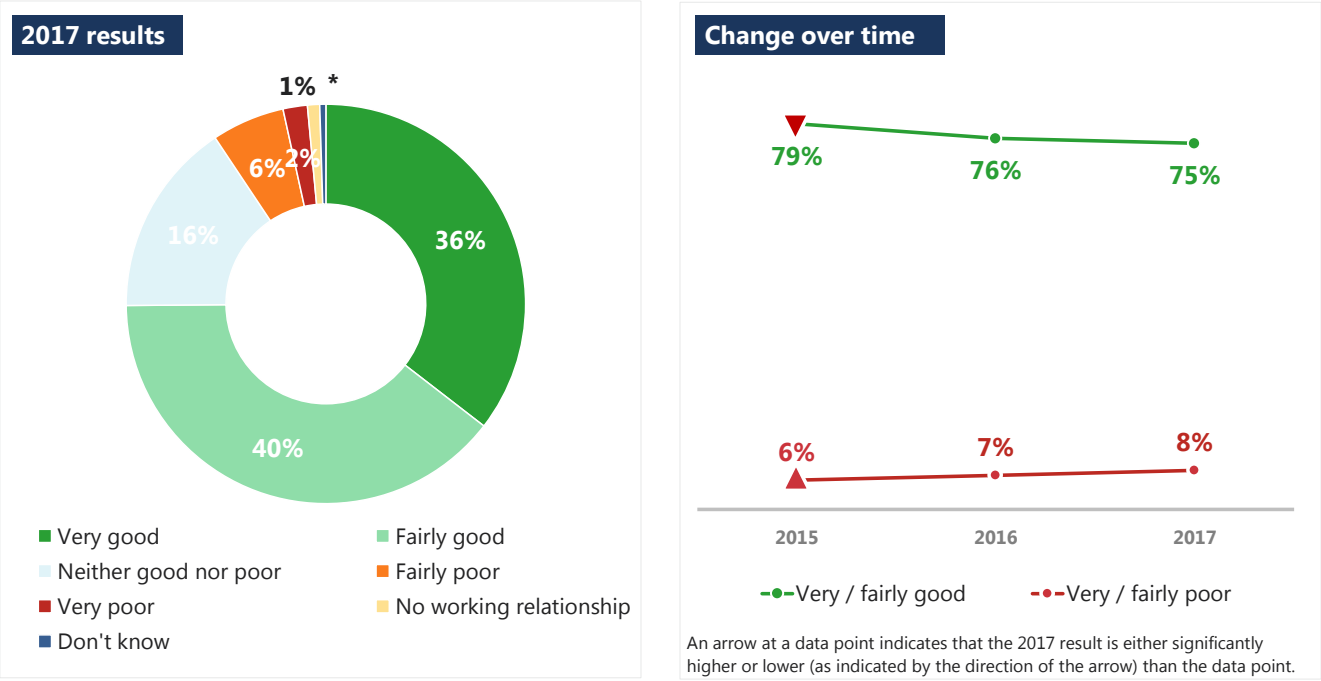
All who feel they have had some level of engagement with CCG: 2017 (8,297); 2016 (8,046); 2015 (8,320); 2014 (8,852).

Again, the overall stability since 2016 masks the changes at the individual CCG level, with 99 CCGs having seen their scores improve (five significantly so), compared with 100 whose scores decreased (eight significantly so).

3.2 Working relationships

Whilst ratings of working relationships declined between 2015 and 2016, this year the proportion of positive ratings has remained stable at 75% (76% in 2016). Fewer than one in ten report a poor relationship with their CCG (eight per cent).

Figure 3.4: Overall, how would you rate your working relationship with the CCG?



All stakeholders: 2017 (8,512); 2016 (8,244); 2015 (8,472); 2014 (9,018).

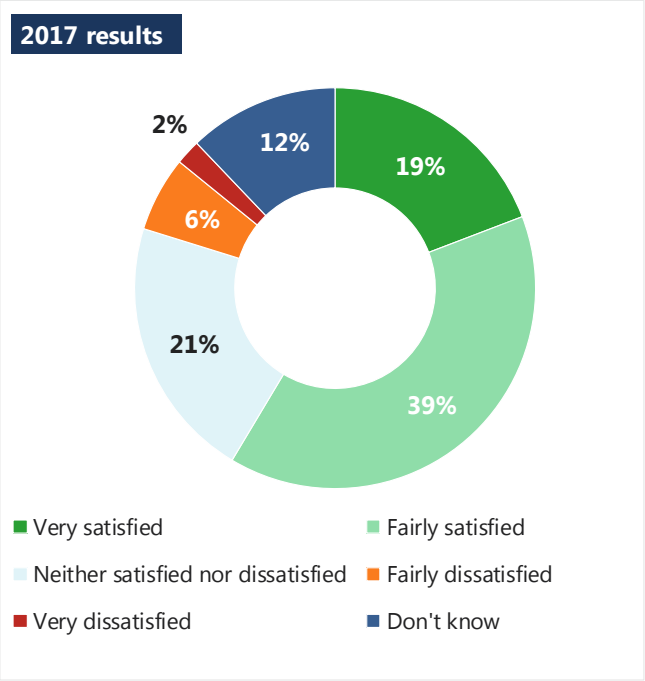
The level of change at the individual CCG level is similar to previous findings. While 96 CCGs saw ratings of their working relationships increase (nine of these significantly so), 101 CCGs saw their ratings decrease (six significantly so).

3.3 Engaging with patients and the public

Stakeholders are broadly positive about the way that CCGs engage with patients and the public.

More than half of stakeholders (58%) are satisfied with the steps taken by their CCG to engage with patients and the public, while just nine per cent are dissatisfied. A relatively large proportion (33%) are neutral or did not give an opinion. This question was asked for the first time in the 2017 survey.

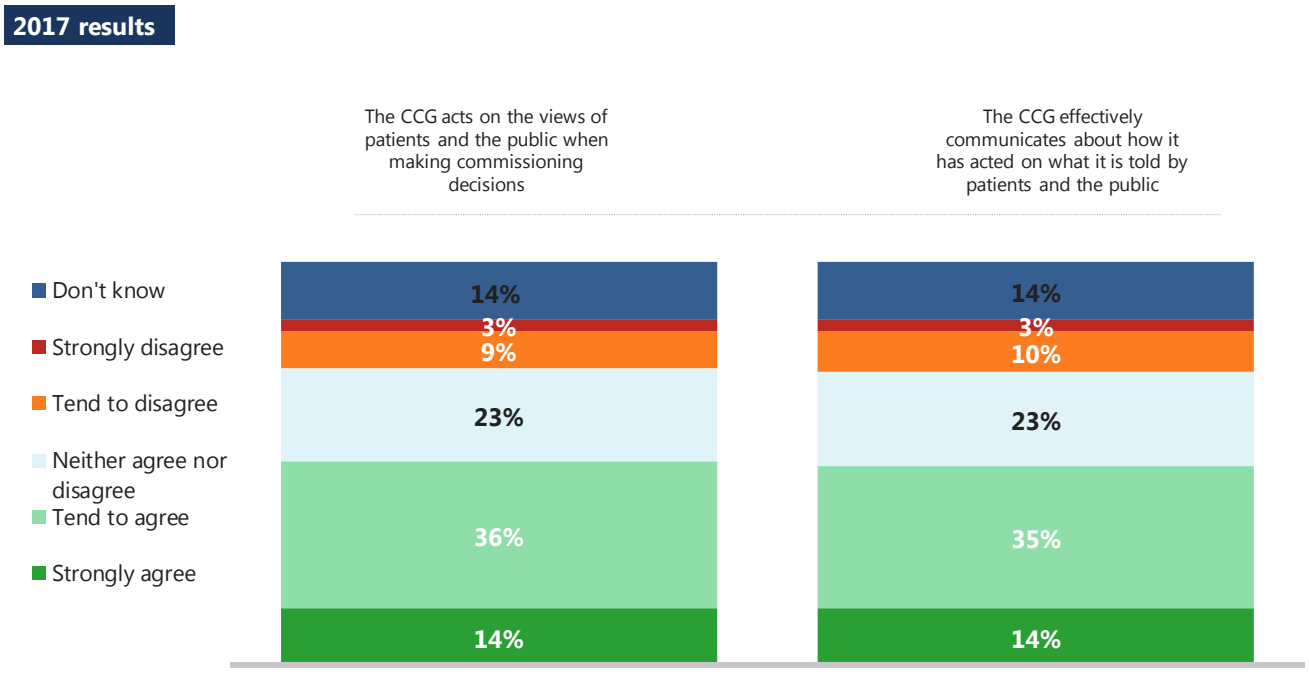
Figure 3.5: How satisfied or dissatisfied are you with the steps taken by the CCG to engage with patients and the public?



All Stakeholders except CQC: 2017 (8,512)

Half of stakeholders (50%) agree that their CCG acts on the views of patients and the public when making commissioning decisions, and a similar proportion (49%) agrees that their CCG effectively communicates about how it has acted on what it is told by patients and the public. In each case, around one in eight stakeholders hold negative views (12% and 13% disagree respectively). These questions were asked for the first time in 2017.

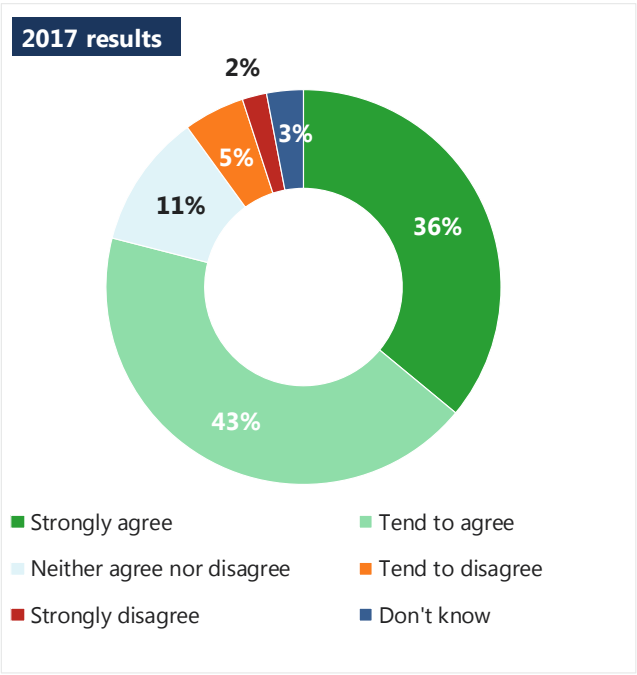
Figure 3.6: To what extent do you agree or disagree that each of the following statements apply to the CCG?

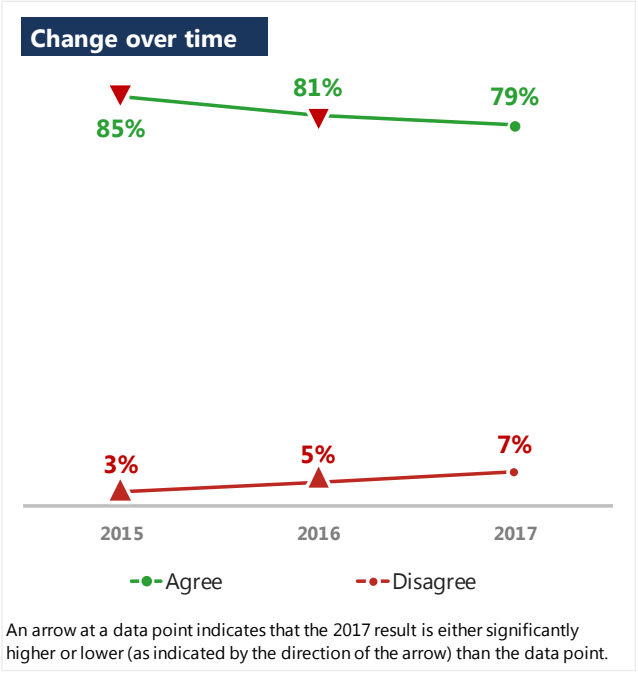


All stakeholders except CQC: 2017 (8,512).

Four in five stakeholders (79%) agree that improving patient outcomes is a core focus for their CCG. However, the proportion agreeing has decreased slightly this year (from 81% in 2016), and this is part of a longer-term decline (85% in 2015). The proportion that disagrees has also increased from five per cent in 2016 to seven per cent this year. The decline since 2016 is driven by small but significant changes among GP member practices and Healthwatch and patient groups.

Figure 3.7: To what extent do you agree or disagree with the following statement…? Improving patient outcomes is a core focus for my CCG.

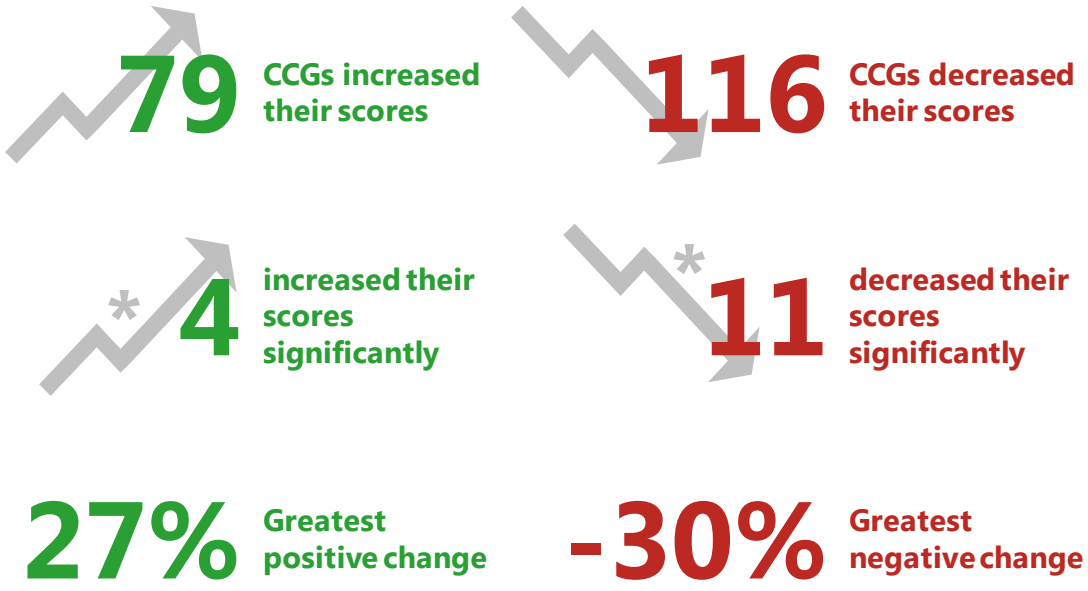




All Stakeholders: 2017 (8,512); 2016 (8,244); 2015 (8,424).

Reflecting this overall decline, a larger number of CCGs have seen a fall in the proportion of stakeholders who agree with this statement (116), than have seen a rise in the proportion (79). The number of CCGs that have seen statistically significant decreases is also greater than the number of significant increases (eleven compared with four).

Figure 3.8: To what extent do you agree or disagree with the following statement…? Improving patient outcomes is a core focus for my CCG.

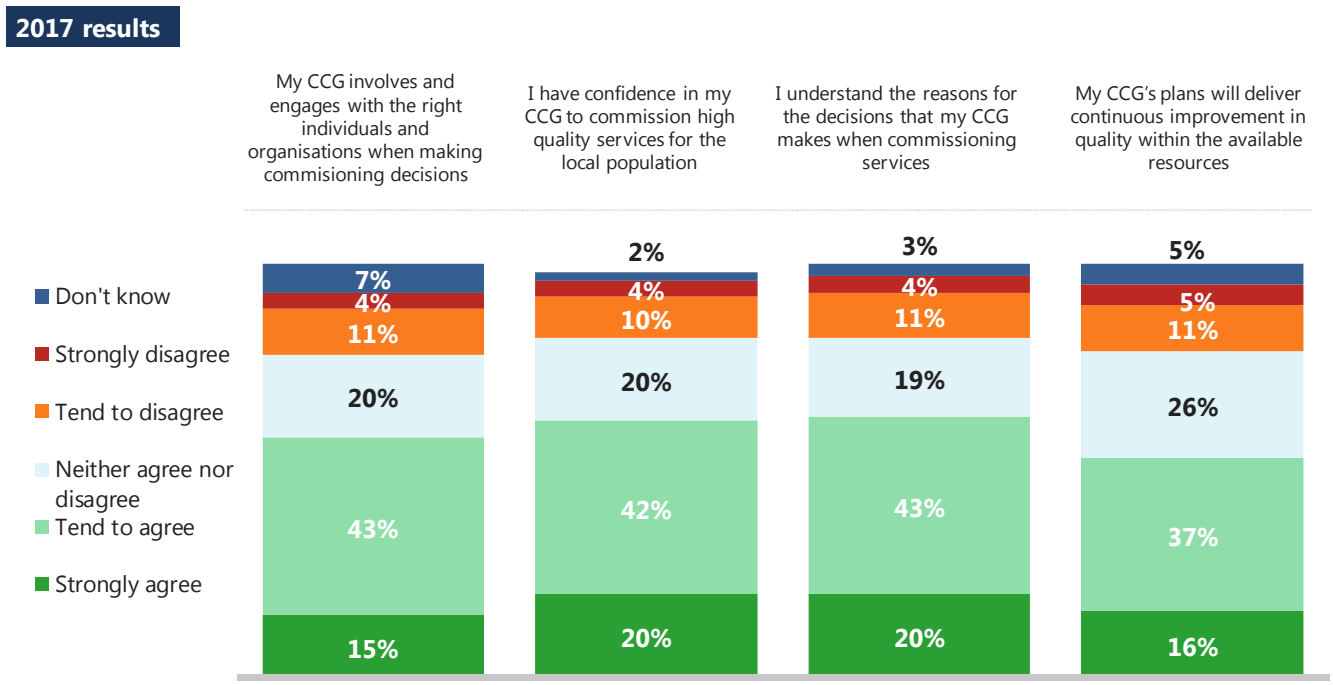


3.4 CCG commissioning decisions

The majority of stakeholders continue to report positive opinions on the way their CCG makes commissioning decisions.

Around three in five stakeholders agree that they understand the reasons for the decisions their CCG makes when commissioning services (63%), that they have confidence in their CCG to commission high quality services (63%), and that their CCG engages with the right individuals and organisations when making commissioning decisions (58%). Stakeholders are slightly less likely to agree that their CCG's plans will deliver continuous improvement in quality within the available resources (53%).

Figure 3.9: To what extent do you agree or disagree with the following statements about the way in which the CCG commissions services?



All stakeholders: 2017 (8,512).

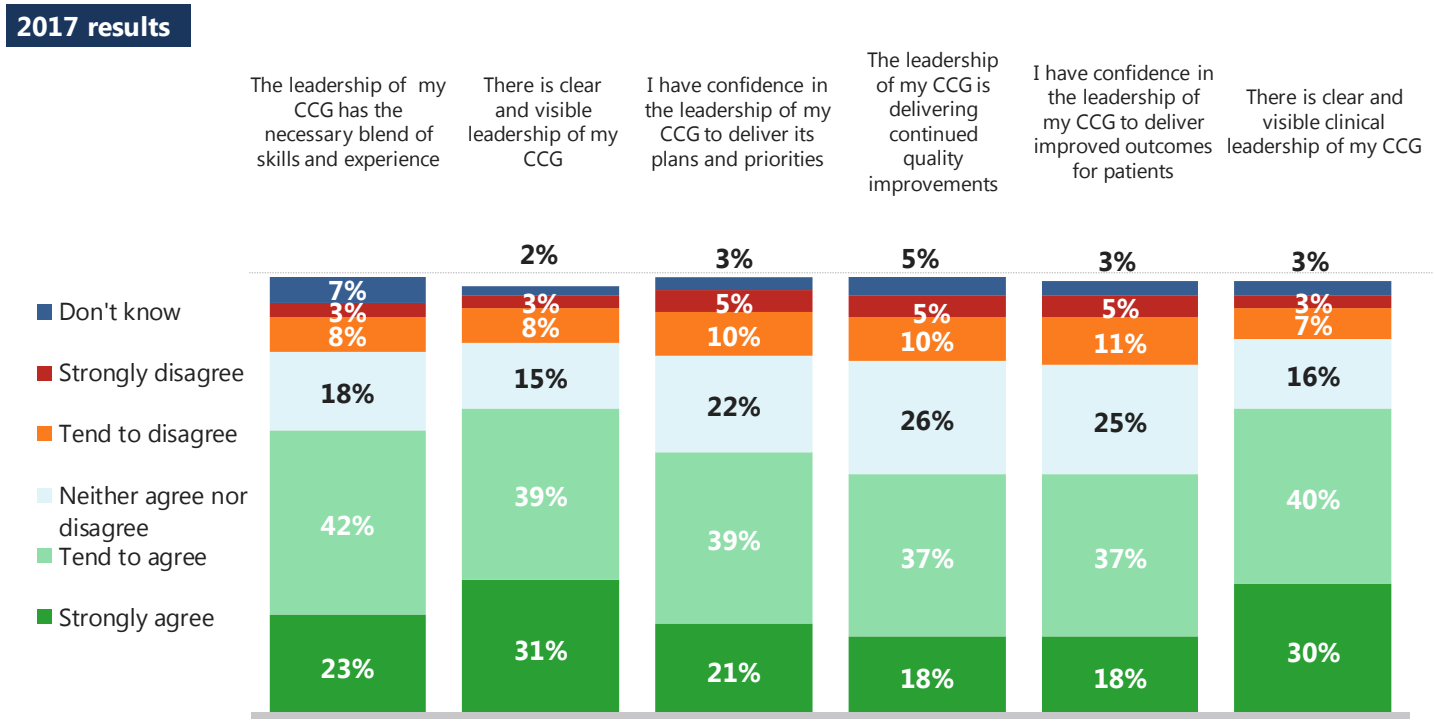
This year's results are generally consistent with 2016, following a decline between 2015 and 2016. The main change this year is an increase in agreement that stakeholders understand the reasons for the decisions their CCG makes when commissioning services (from 60% in 2016 to 63%). This change is driven by GPs, NHS providers and wider stakeholders. There have also been some small but significant declines since 2016; stakeholders are now slightly less likely to agree that they have confidence in their CCG to commission high quality services (from 64% in 2016 to 63%), and are slightly more likely to disagree that their CCG's plans will deliver continuous improvement in quality (from 15% in 2016 to 16%).

On each of the measures, there have been changes at the individual level, with typically around 100 CCGs showing an increase in agreement, and a similar proportion showing a decrease. However, the number of significant changes is small, with no more than eight CCGs showing a significant shift (positive or negative) on any of the measures.

3.5 Leadership

As was the case in 2016, the majority of stakeholders report having confidence in the leadership of CCGs. Around seven in ten stakeholders (71%) agree that there is clear and visible leadership of their CCG, while two in three agree that the leadership of their CCG has the necessary blend of skills and experience (65%). Three in five (60%) agree that they have confidence in the leadership of their CCG to deliver its plans and priorities. Slightly smaller proportions have confidence in the leadership of their CCG to deliver improved outcomes for patients (56%) or to deliver continued quality improvements (55%).

Figure 3.10: To what extent do you agree or disagree with the following statements about the overall leadership of the CCG?



All stakeholders: 2017 (8,516).

Confidence in three aspects of CCGs' leadership has fallen slightly since 2016, continuing a longer-term decline. Specifically, agreement has fallen regarding confidence in leadership to deliver improved outcomes for patients (from 59% in 2016 to 56%), confidence in leadership to deliver its plans and priorities (from 62% in 2016 to 60%), and the leadership delivering continued quality improvements (from 57% in 2016 to 55%). These declines reflect small decreases among most of the stakeholder groups. However, there has been a slight improvement on one aspect of leadership; stakeholders are now less likely to disagree that their CCG's leadership has the necessary blend of skills and experience (from 12% in 2016 to 11%).

Across the three measures where ratings have declined since 2016, there have been similar movements in ratings at an individual CCG level. Across these three measures, around half of all CCGs (between 108 and 119) saw their scores decrease (8-9 CCGs significantly so), while a smaller number (between 81 and 93 CCGs) saw an improvement (only 4-6 of which were significant rises).

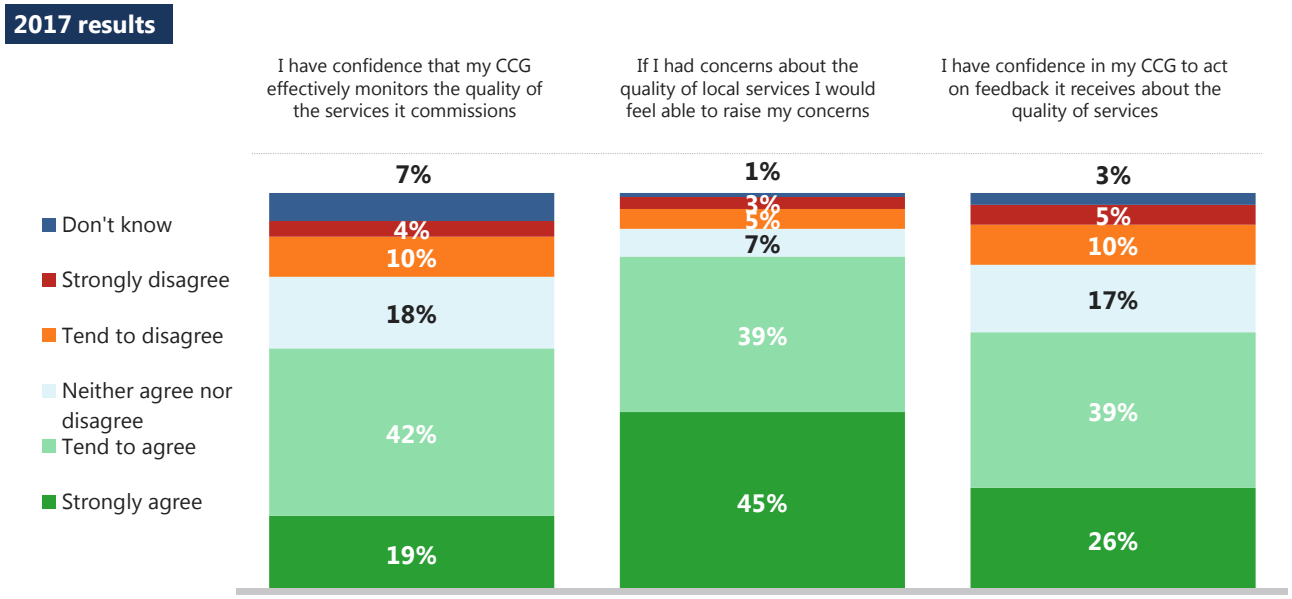
Stakeholders were also asked specifically about their CCG's clinical leadership. Views here are broadly in line with views on leadership more generally, with the majority of stakeholders (70%) agreeing that there is clear and visible clinical leadership of their CCG. Findings have remained stable on this measure since 2016 (71%).

3.6 Monitoring and reviewing commissioned services

Stakeholders were asked for their views on the way in which their CCG monitors and reviews the quality of commissioned services, including whether or not their CCG listens and responds to feedback. In line with findings elsewhere, overall confidence remains relatively high.

Stakeholders are most positive about the extent to which they feel able to raise concerns with their CCG on the quality of local services, with 84% agreeing they would feel able to raise any concerns. However, stakeholders tend to be less positive about how effectively their CCG monitors the quality of services it commissions (61%), and how it acts on feedback it receives about the quality of services (65%). Notably, the proportion of stakeholders answering 'neither agree nor disagree' or 'don't know' to these two statements is significantly higher than those giving these answers for the question on confidence when raising concerns. This indicates that while stakeholders feel confident raising issues with their CCG, they may not be aware of their CCG's internal processes for monitoring services and acting on feedback.

Figure 3.11: To what extent do you agree or disagree with the following statements about the way in which the CCG monitors and reviews the quality of commissioned services?



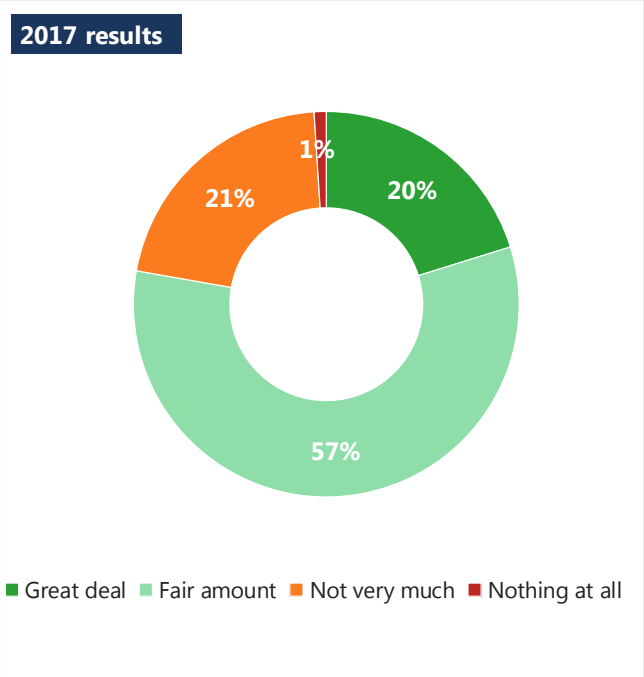
All stakeholders: 2017 (8,512).

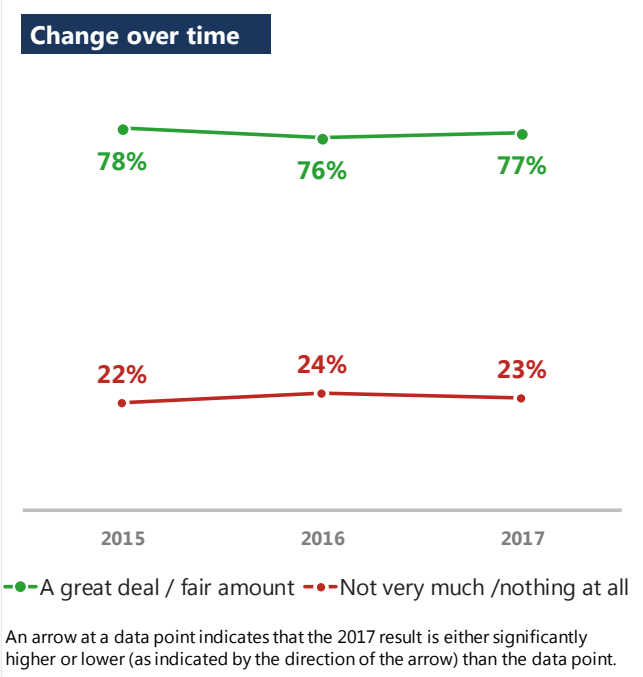
Stakeholders' opinions have remained stable since 2016, although there has been a small decline in confidence in their CCG to act on feedback it receives about the quality of services (14% disagree that they are confident, up from 13% in 2016). On this measure, 86 CCGs saw their score improve (but just one significantly so), while 119 CCGs saw a decrease (nine significantly so, including one fall of -43%).

3.7 Developing plans and priorities

Stakeholders were asked a range of questions about their CCG's plans and priorities. Stakeholders' level of knowledge is generally high, with around three in four (77%) reporting a great deal or a fair amount of knowledge about their CCG's plans and priorities. Around one in five (23%) however, report not knowing very much, or knowing nothing at all, about their CCG's plans and priorities. The findings have remained broadly stable since the 2016 survey.

Figure 3.12: How much would you say you know about the CCG's plans and priorities?



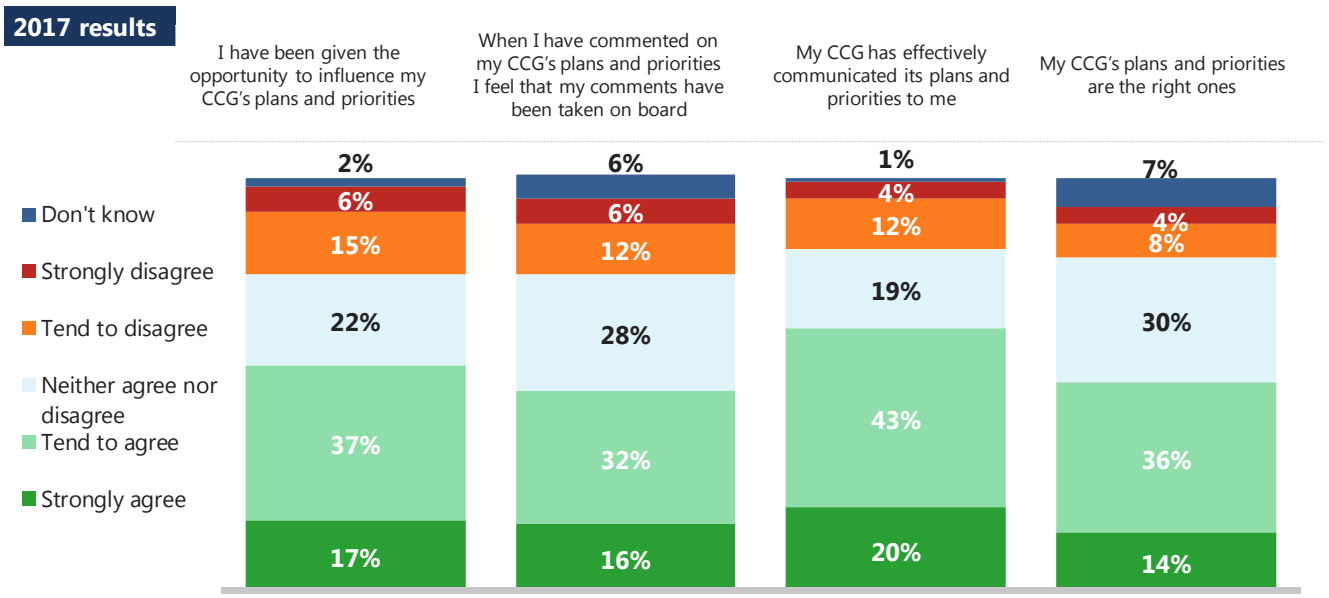


All stakeholders: 2017 (8,512); 2016 (8,244); 2015 (8,472).

Although many individual CCGs have seen a change since 2016 on this measure (110 positive and 88 negative), there have been very few significant shifts (2 positive, 2 negative), confirming that findings for this measure are generally very stable.

Stakeholders generally hold positive views on specific aspects of CCGs' plans and priorities. More than three in five (63%) agree that their CCG has effectively communicated its plans and priorities, while more than half agree that they have been given the opportunity to influence those plans and priorities (54%). There is room for improvement in how CCGs act on comments that are given to them however, as only half of stakeholders (48%) feel that their comments on the plans and priorities have been taken on board. Possibly linked to this, only 50% of stakeholders feel that their CCG's plans and priorities are the correct ones.

Figure 3.13: To what extent do you agree or disagree with each of the following statements about the CCG's plans and priorities?



All stakeholders: 2017 (8,512).

Ratings on some of these statements have fallen slightly since 2016, continuing a general pattern of declining levels of agreement over the longer term. There has been a decrease in the proportion of stakeholders who agree they have been given the opportunity to influence their CCG's plans and priorities (from 57% in 2016 to 54%), and the proportion agreeing that their CCG's plans and priorities are the right ones (from 52% in 2016 to 50%). In addition, stakeholders are now more likely to disagree that their comments on the plans and priorities have been taken on board (from 16% in 2016 to 18%). This last change reflects a rise in disagreement among GP member practices, while the other changes are caused by shifts across a number of different stakeholder groups.

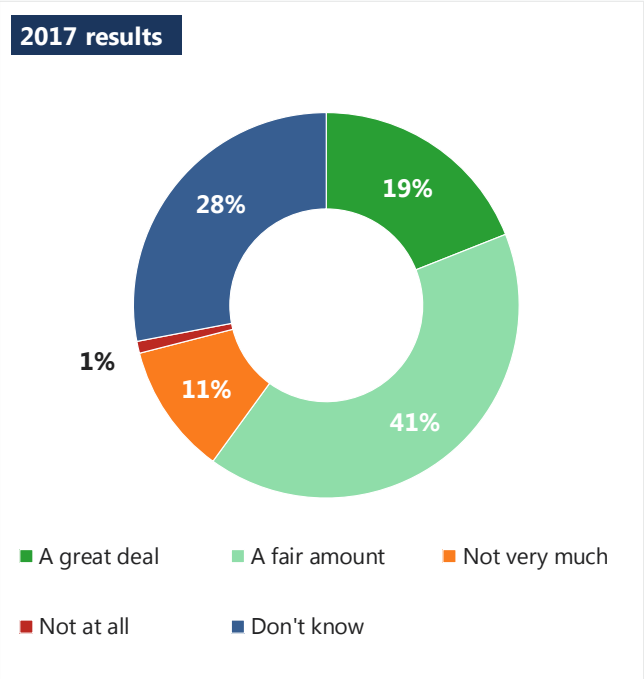
Findings at the individual CCG level reflect those seen at other questions. On each of the measures, around 200 CCGs show a change (between 84 and 102 positive, and between 100 and 121 negative), although the number of significant changes is small. For example, as seen above, there has been an overall decline in the proportion agreeing that their CCG's plans and priorities are the right ones, but only four CCGs show a significant decrease (compared with three showing a significant increase). There has been a greater level of change in relation to having the opportunity to influence their CCG's plans and priorities. This measure also shows a slight decline at the overall level, and ratings have decreased significantly for 11 CCGs (compared with six that have increased), including one CCG that shows a decrease of 47%.

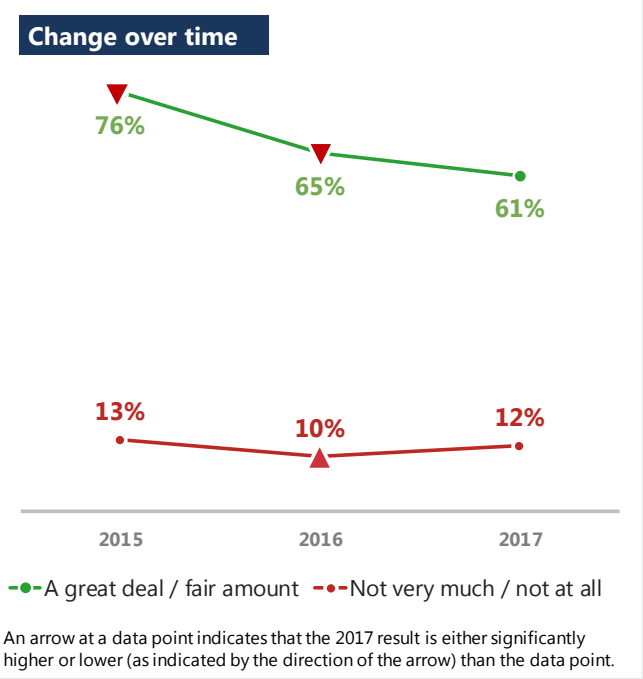
3.8 Contribution to wider discussions

Stakeholders were asked about the extent to which they would say their CCG has contributed to discussions about the wider health economy in their area through groups such as the Quality Surveillance Group, Urgent Care Working Group, Council for Voluntary Services, Strategic Clinical Networks and Clinical Senate Assemblies.

Although the majority of stakeholders remain positive about their CCG's involvement in these groups (61%), there has been a decline in this measure since 2016 (from 65%), and this is part of a larger shift since 2015 (from 76%). As was the case in the 2016 survey, the decline in this measure is apparent across the different stakeholder groups.

Figure 3.14: Please now think about discussions that take place about the wider health economy in your area, through local groups. To what extent, if at all, would you say the CCG has contributed to wider discussions through these groups?





All stakeholders: 2017 (8,512); 2016 (8,244); 2015 (8,472).

The significant decrease seen at the overall level on this measure is reflected in changes at the individual level. For this measure there is a large difference between the number of CCGs whose scores have increased (64 – two of them significantly so) and the number of CCGs who saw their scores decrease (139 – 11 of these significantly so). This is reflective of the fact that, at the overall level, a greater drop in percentage points was seen on this measure than on any other at the overall level.

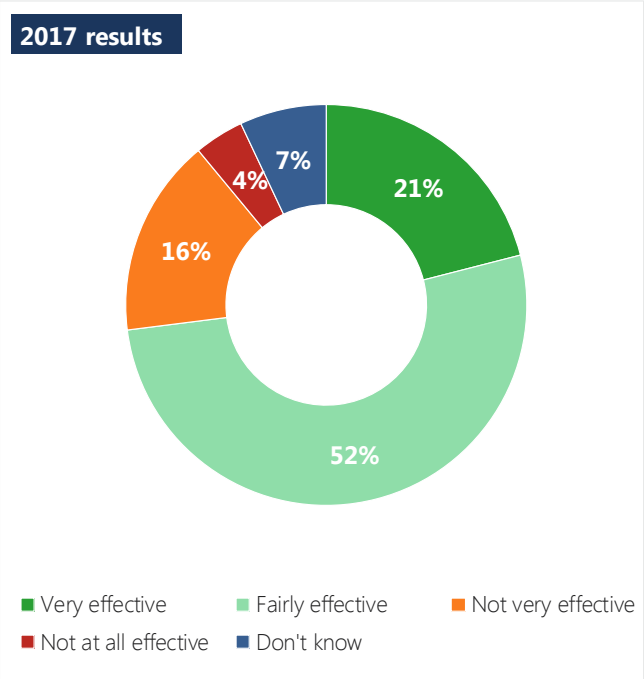
Figure 3.15: Please now think about discussions that take place about the wider health economy in your area, through local groups. To what extent, if at all, would you say the CCG has contributed to wider discussions through these groups?

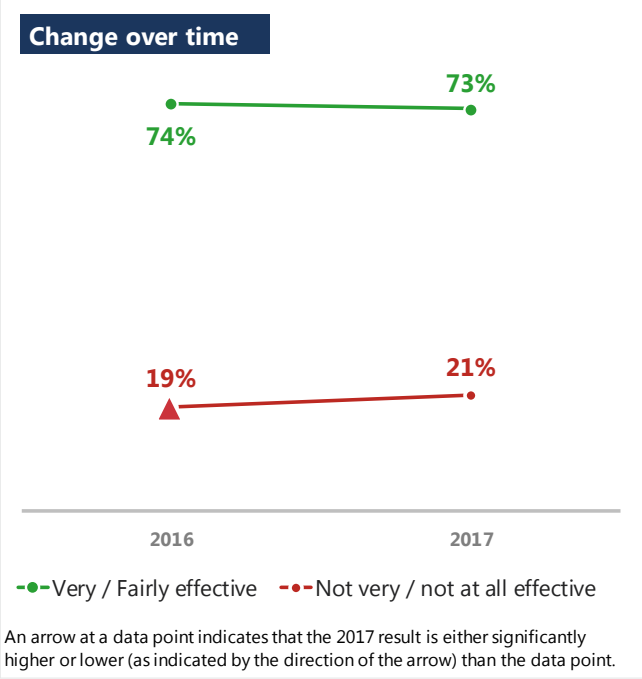
3.9 The CCG as a local system leader

Stakeholders were asked to assess the extent to which CCGs are effective as 'local system leaders'. The definition of 'local system leader' which was provided to stakeholders incorporates many of the characteristics that are measured throughout the earlier questions in this chapter; for example, working proactively and constructively with others and seeking the best health and wellbeing outcomes for their CCG's population.

Results are generally positive, with around three in four stakeholders (73%) reporting that their CCG is very or fairly effective as a local system leader. However, one in five (21%) say that their CCG is not very or not at all effective. There has been a small negative shift since 2016, with stakeholders now more likely to see their CCG as not very or not at all effective (from 19% in 2016).

Figure 3.16: How effective, if at all, do you feel the CCG is as a local system leader? By 'local system leader' we mean that the CCG works proactively and constructively with the other partners in its local economy, prioritising tasks-in-common over formal organisational boundaries, to seek the best health and wellbeing outcomes for its population.





All member practices: 2017 (8,244); 2016 (8,512).

4 GP member practices

Summary

- **While GPs are still, on the whole, positive about the engagement they have received from their CCG, they are consistently among the least positive stakeholder groups. In contrast to previous surveys where positivity among GP member practices has declined, there has been no decline since 2016 in positivity about engagement.**

- **The majority of GP member practices say their CCG has engaged with them over the past 12 months, with three in four (76%) reporting that they have been engaged at least a fair amount by their CCG. Satisfaction with this engagement is also reasonably high, with two in three GP member practices (64%) reporting that they are very or fairly satisfied with the way in which their CCG has engaged them. These findings are consistent with 2016, but are lower than the overall stakeholder average.**

- **GP member practices report the lowest level of knowledge of their CCG's plans and priorities, with 74% reporting that they know a great deal or a fair amount (compared with 77% overall). However, this is an increase from 2016 (71%), and views have also become slightly more positive regarding their understanding of the reasons behind their CCG's commissioning decisions.**

- **Most GP member practices are positive about the arrangements for member participation in decision-making in their CCG (59%), and this proportion is unchanged from 2016.**

- **However, only one in three GP member practices (32%) report feeling able to influence their CCG's decision-making process a great deal or a fair amount, while one in four (25%) report that they are not able to do so at all.**

- **There has been a slight increase since 2016 in confidence in the clinical leadership of CCGs to deliver plans and priorities (from 61% in 2016 to 63% in 2017).**

- **Also increasing since 2016 is the proportion of GP member practices that agree that value for money is a key factor in their CCG's decision making (from 76% in 2016 to 78% in 2017).**

- **Two thirds of GP member practices (65%) say they are very or fairly familiar with the financial position of their CCG. This represents a clear increase since 2016, when 59% were familiar with their CCG's financial position.**

- **Half of GP member practice (50%) say that they are familiar with their CCG's plans for primary care co-commissioning, in line with 2016 findings (49%).**

4.1 Overall engagement of GP member practices

The majority of GP member practices feel that their CCG has engaged with them over the past 12 months, with three in four (76%) reporting that they have been engaged at least a fair amount by their CCG. Satisfaction with this engagement is also relatively high, with two in three GP member practices (64%) reporting that they are very or fairly satisfied with the way in which their CCG has engaged them. These findings are consistent with the 2016 survey, although there has been a downward trend since 2015.

As in previous years, GP member practices are consistently among the most negative groups on all aspects of their CCGs, including CCG engagement.

GP member practices are also among the stakeholder groups least likely to report a good working relationship with their CCG. The proportion of GP member practices (69%) that says their relationship is very or fairly good has remained stable since 2016.

More than half of GP member practices (56%) are satisfied with the steps taken by their CCG to engage with patients and the public. This proportion is slightly lower than the average across all stakeholder groups (58%), and the same applies to other questions about engaging with patients and the public: the way in which their CCG acts on the views of patients and the public when making commissioning decisions (48% compared with 50% overall), and how effectively their CCG communicates about their actions (47% compared with 49% overall).

The majority of GP member practices (75%) agree that improving patient outcomes is a core focus for their CCG. However, this is lower than the average across all stakeholder groups, and positivity has declined since 2015; specifically, the proportion that disagrees that this is a core focus has increased from seven per cent in 2016 to 10% this year.

GP member practices generally hold positive opinions on how CCGs make commissioning decisions, although once again the proportion that are positive tends to be lower than for most other stakeholder groups. While the findings have tended to remain stable since 2016, views have become slightly more positive on a number of measures. For example, understanding the reasons behind the decisions made by CCGs has increased three percentage points since 2016, to 60%.

GP member practice stakeholders are generally positive about the overall leadership and the clinical leadership of their CCG. For example, three in five (62%) agree that the leadership of their CCG has the necessary blend of skills and experience. However, on all aspects of CCGs' leadership, GP member practices are among the least positive when compared with other stakeholder groups.

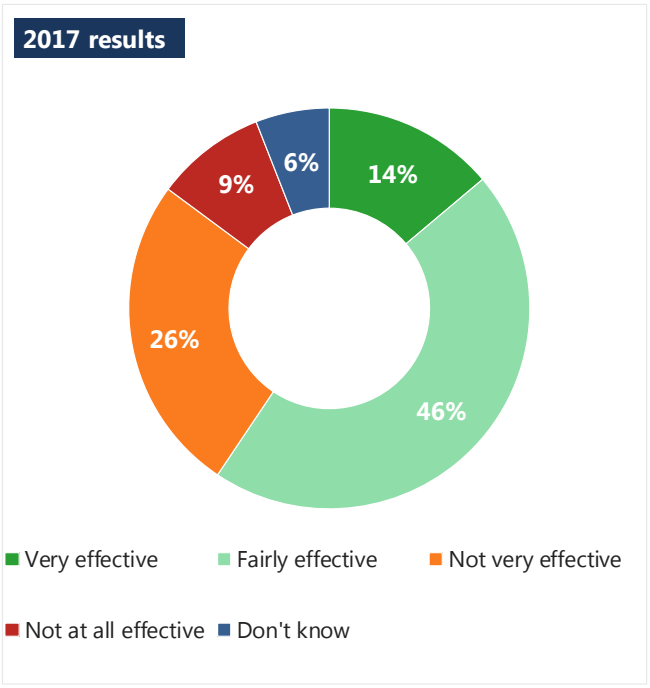
GP member practices report the lowest level of knowledge of their CCG's plans and priorities, with three in four (74%) reporting that they know a great deal or a fair amount (compared with 77% overall), although this is a slight increase on the 2016 figure (71%). GP member practice stakeholders are also among the least likely to agree that their CCG's plans and priorities are the right ones (44% compared with 50% overall).

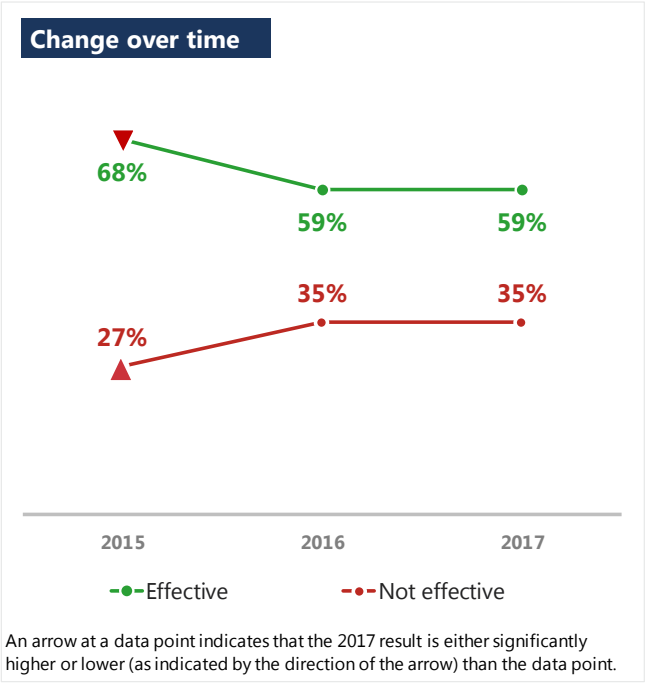
4.2 Views of governance structures

Under their CCG improvement and assessment framework, CCGs are required to ensure that two-way accountability is in place between the CCG and its members, and that member practices have a voice within the CCG. In order to understand how GP member practices are involved in decision-making, the survey asked a range of questions about CCGs' internal governance structures.

The majority of GP member practices (59%) remain positive about the arrangements for member participation in decision-making in their CCG. This proportion is unchanged from 2016, following a decline between 2015 and 2016 (from 68% to 59%).

Figure 4.1: How effective, if at all, would you say the arrangements are for member participation in decision-making in the CCG?





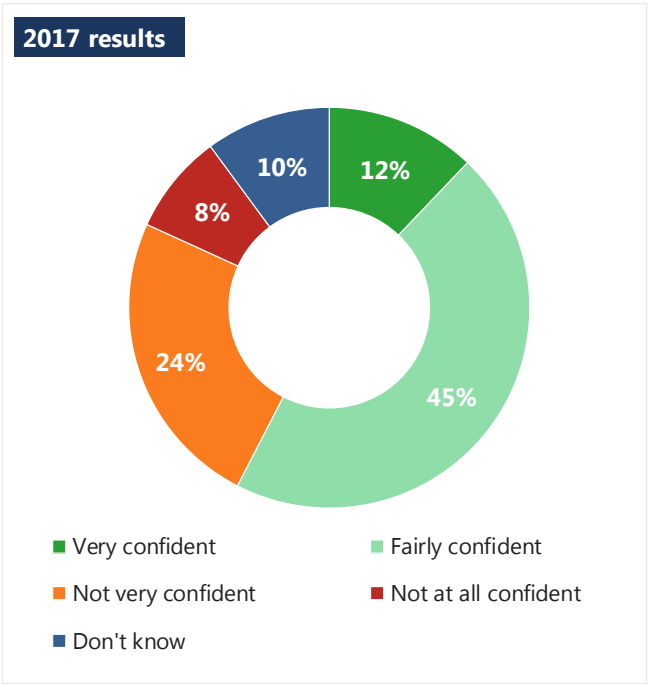
An arrow at a data point indicates that the 2017 result is either significantly higher or lower (as indicated by the direction of the arrow) than the data point.

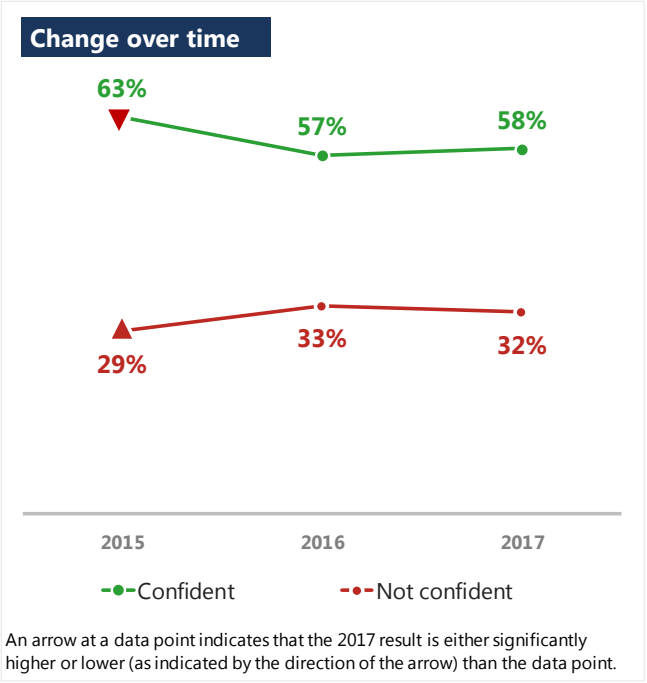
All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

Only one in three (32%) GP member practices report feeling able to influence their CCG's decision-making process, while one in four (25%) report that they are not able to do so at all. Findings have remained stable since 2016.

More than half of GP member practices (58%) say they are confident in the systems to sustain two-way accountability between their CCG and its member practices, while one third (32%) are not very or not at all confident. Findings have remained stable since 2016, following a fall between 2015 and 2016.

Figure 4.2: How confident are you, if at all, in the systems to sustain two-way accountability between the CCG and its member practices in CCG?





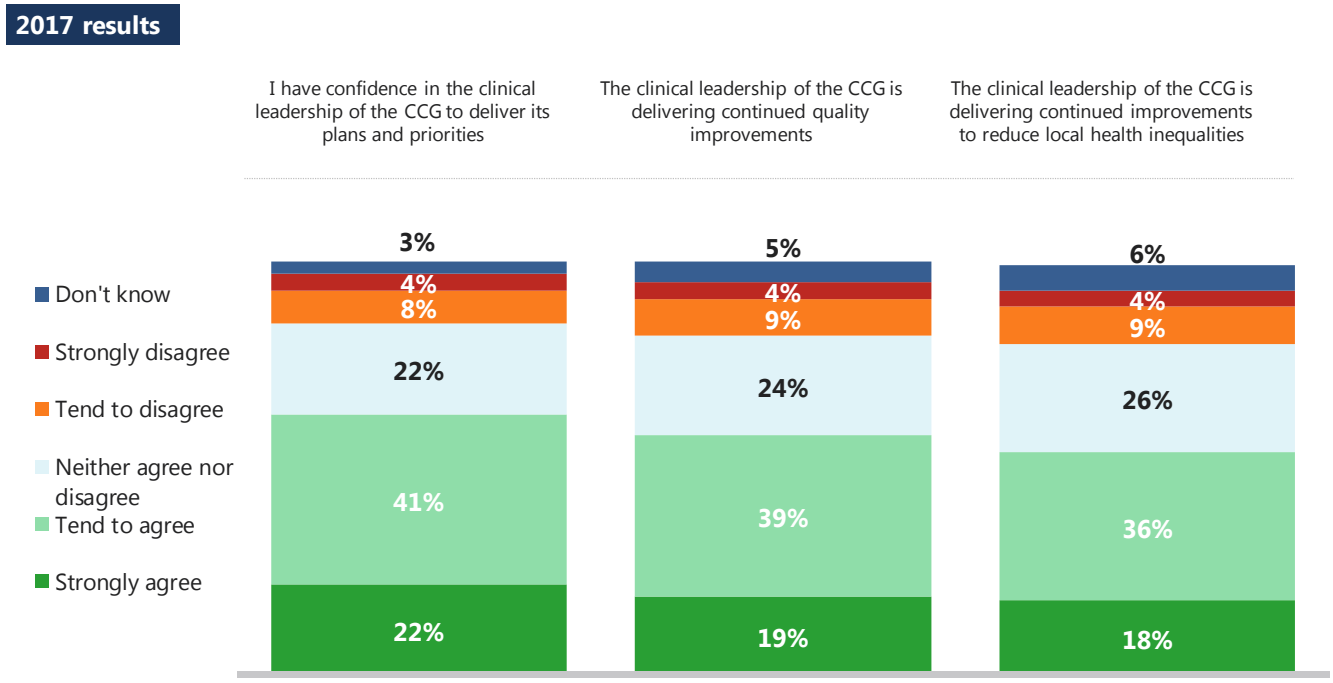
All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

4.3 Leadership

The survey asked GP member practices their views on the clinical leadership of their CCG. More than three in five GP member practices (63%) agree that they have confidence in the clinical leadership of their CCG to deliver its plans and priorities, a slight increase on the 2016 figure (61%). The proportion that disagrees with the statement has also fallen (from 14% in 2016 to 12%).

More than half of GP member practices agree with the other statements: that the clinical leadership of their CCG is delivering continued quality improvements (57%), and that the clinical leadership is delivering continued improvements to reduce local health inequalities (54%). Once again, these findings show a slight improvement on the 2016 figures, specifically in the proportions that disagree with the statements: down from 15% in 2016 to 14% in relation to continued quality improvements, and down from 16% in 2016 to 14% regarding improvements to reduce local health inequalities.

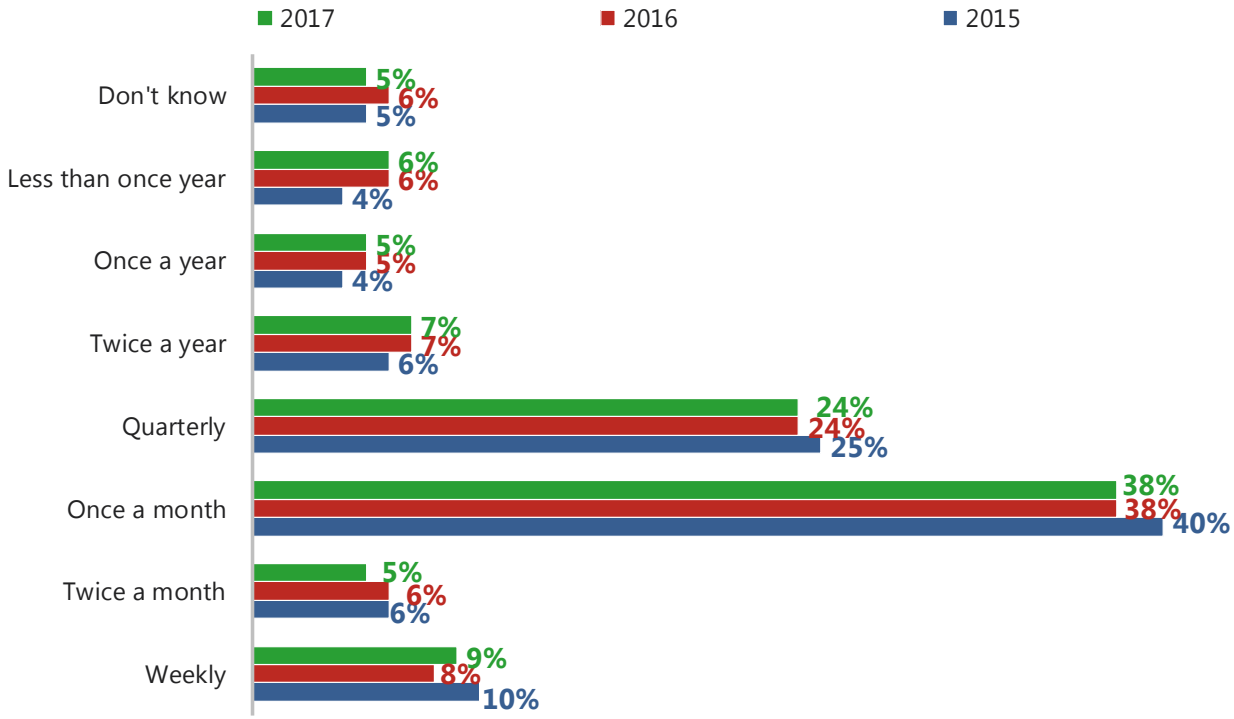
Figure 4.3: To what extent do you agree or disagree with the following statements about the clinical leadership of your CCG?



All member practices: 2017 (4,733).

The survey also asks how often GP member practices were given the opportunity for direct discussions with their CCG's leaders. Responses were broadly positive, with 14% having the opportunity for direct discussions more than once a month, 38% reporting that they were given the opportunity once a month, and 24% reporting that they were given the opportunity quarterly. These findings are consistent with the 2016 survey.

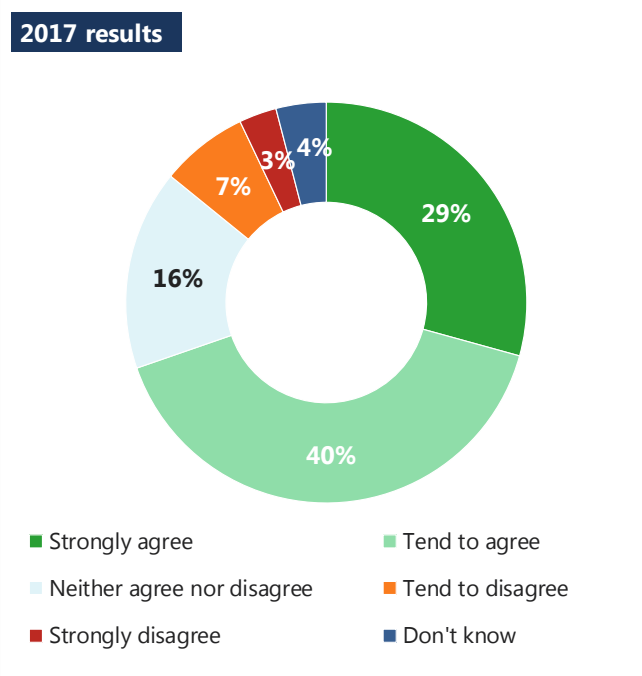
Figure 4.4: Approximately how often, if at all, do you have the opportunity for direct discussions with your CCG's leaders?

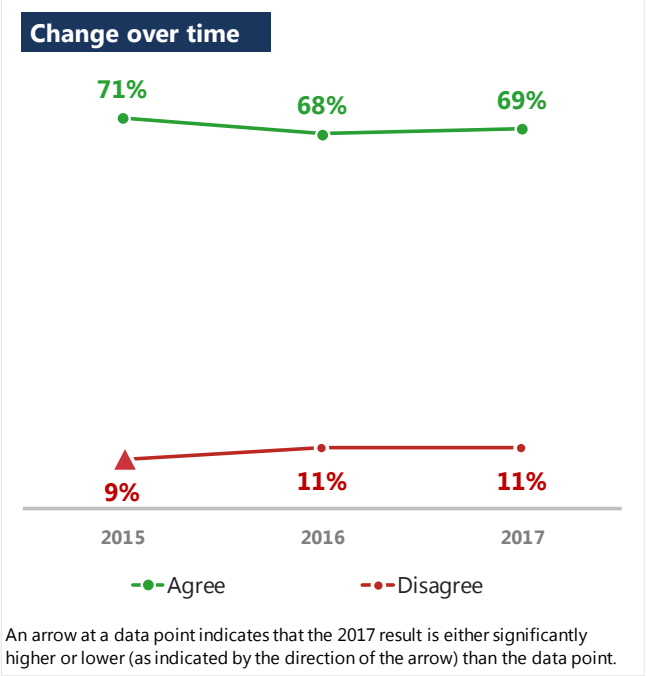


All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

GP member practices are mostly positive about the opportunities to take a leadership role within their CCG. Seven in ten member practices (69%) agree that they would be able to take a leadership role within their CCG if they wanted to, while just 11% disagree. Agreement has remained stable since 2016 (when 68% agreed).

Figure 4.5: To what extent do you agree or disagree that representatives from member practices are able to take a leadership role within the CCG if they want to?





All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

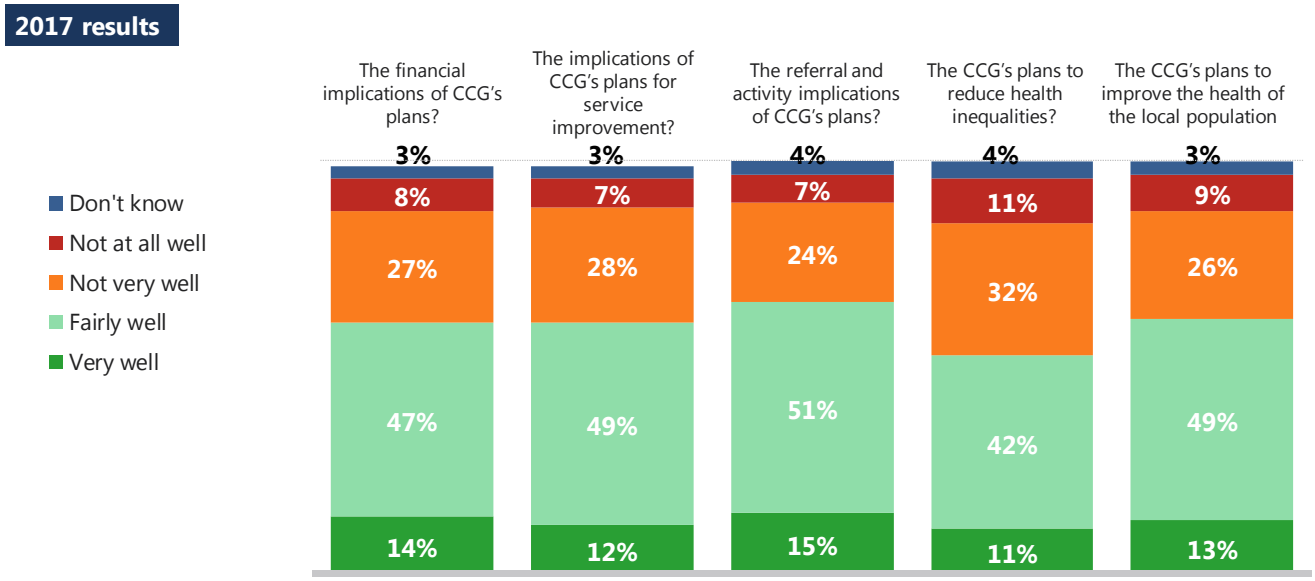
4.4 CCG plans and priorities

GP member practices were asked about their awareness of their CCG's plans and priorities.

GP member practices are best informed about the referral and activity implications of their CCG's plans, with two thirds (65%) reporting that they are very or fairly well informed; this is an increase on the 2016 figure of 62%. As is the case for knowledge of all aspects of CCGs' plans, however a sizeable minority report little or no knowledge (31%).

A slight majority of GP member practices (53%) report that they are very or fairly well informed about their CCG's plans to reduce local health inequalities, and this represents a slight decline since 2016 (from 56%).There has also been a slight fall in the proportion that feel well informed about their CCG's plans to improve the health of the local population (from 64% in 2016 to 62%).

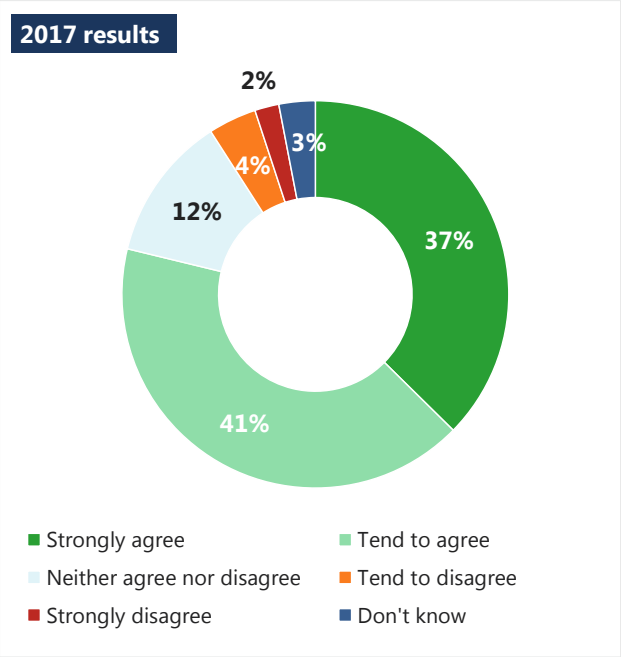
Figure 4.6: How well would you say you understand...

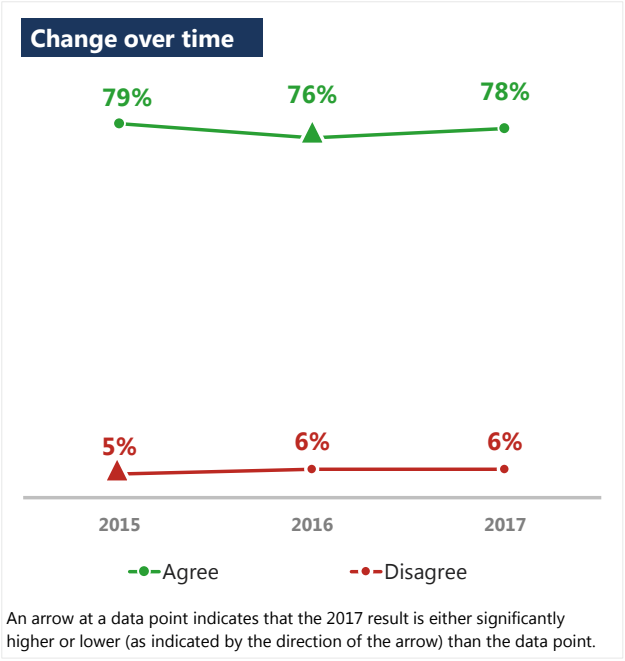


All member practices: 2017 (4,733).

Around four in five GP member practices (78%) agree that value for money is a key factor in decision making when formulating their CCG's plans and priorities; an increase from 76% in 2016.

Figure 4.7: To what extent do you agree or disagree that value for money is a key factor in decision making when formulating the CCG's plans and priorities?





All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531); 2014 (5,060).

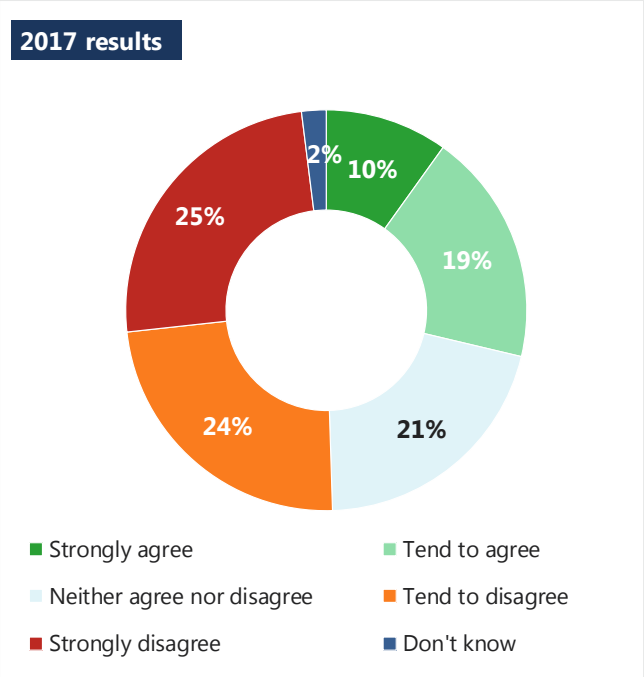
4.5 CCG finances

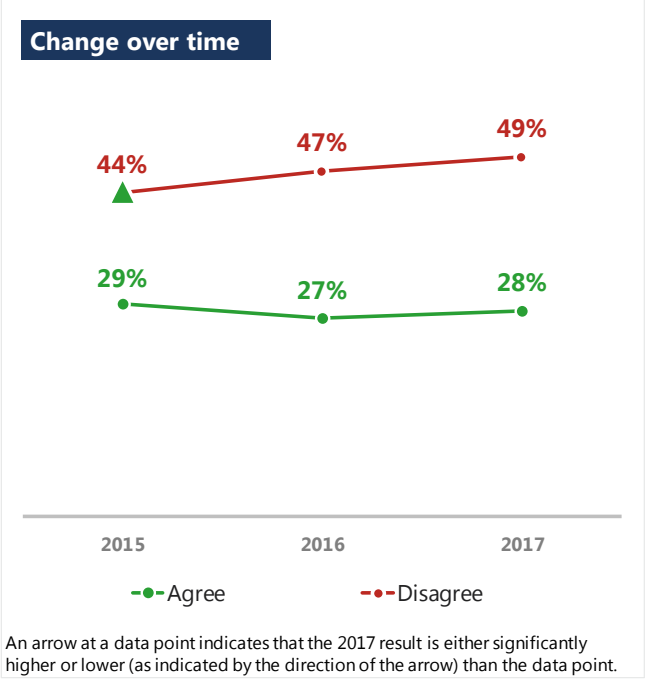
The survey also asked GP member practices about their knowledge of their CCG's financial position. This is an important indicator of GP practices' involvement as member organisations of their CCG.

As shown in the previous chart, around three in five GP member practices (62%) agree that they understand the financial implications of their CCG's plans very or fairly well. This represents an increase since 2016 (58%).

Member practices are unlikely to say that they are regularly involved in discussions regarding the management of their CCG's finances, with three in ten (28%) saying they tend to agree or strongly agree with the statement. This shows no significant change since 2016 (27%).

Figure 4.8: To what extent do you agree or disagree that you are regularly involved in discussions regarding the management of the CCG's finances?

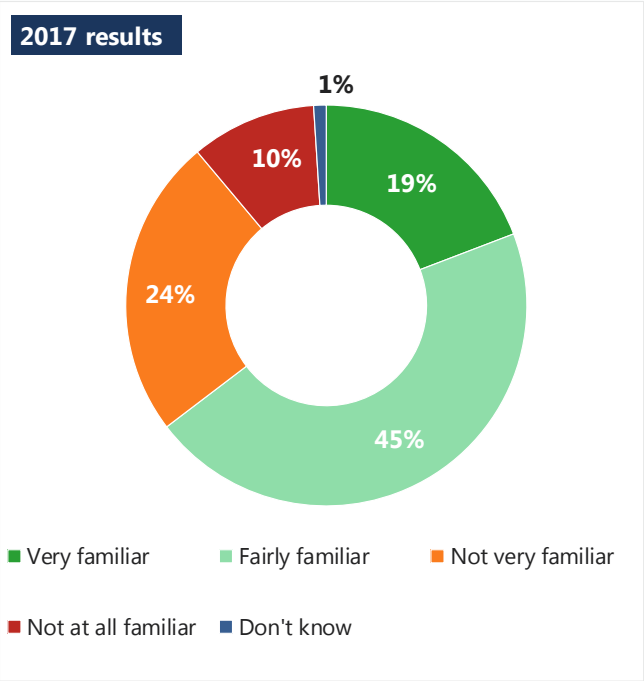


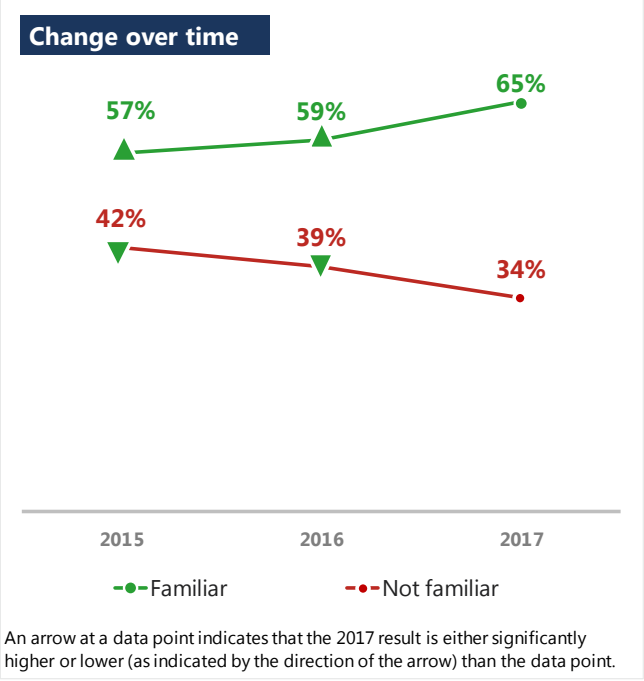


All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

Two thirds of GP member practices (65%) say they are very or fairly familiar with the financial position of their CCG. This represents a clear increase since 2016, when 59% were familiar with their CCG's financial position.

Figure 4.9: How familiar are you, if at all, with the financial position of your CCG?





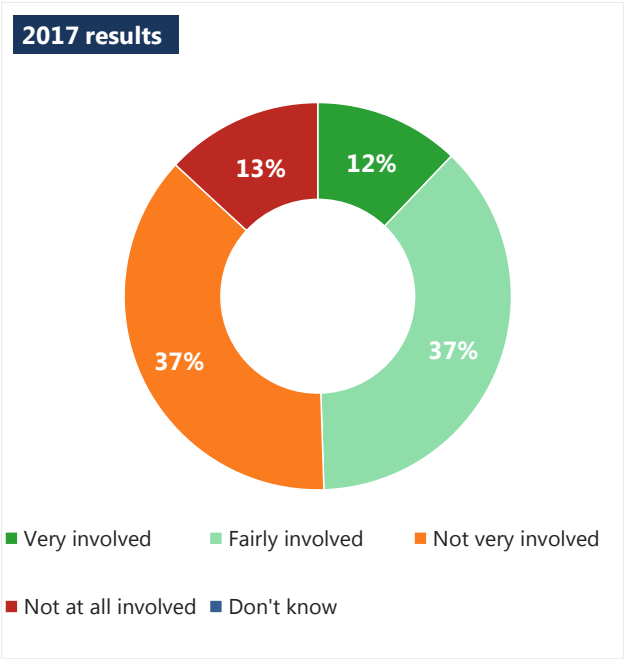
All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

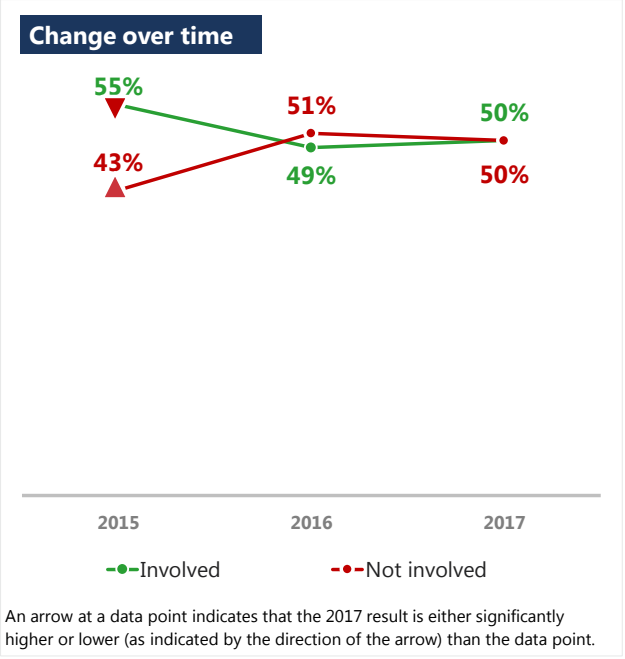
4.6 Primary care co-commissioning

It is important to examine how well CCGs are preparing for primary care co-commissioning, and to identify how member practices view those preparations, as the introduction of primary care co-commissioning will have a large impact on GP practices. As such, GP member practices were asked how involved they have felt in their CCG's plans for primary care co-commissioning.

Half of member practices (50%) feel very or fairly involved in discussions about primary care co-commissioning, while the other 50% feel that they have not been very or at all involved in discussions. Findings are consistent with the 2016 survey (when 49% felt involved).

Figure 4.10: Overall, how involved, if at all, do you feel you have been in discussions about your CCG's plans for primary care co-commissioning?





An arrow at a data point indicates that the 2017 result is either significantly higher or lower (as indicated by the direction of the arrow) than the data point.

All member practices: 2017 (4,733); 2016 (4,341); 2015 (4,531).

5 Healthwatch and other patient groups

Summary

- **Stakeholders from Healthwatch and patient groups are among the most positive of the various stakeholder groups. However, ratings on some aspects have declined slightly from the levels seen in 2016.**
- **Levels of engagement are high among Healthwatch and patient groups, although there has been a slight decline since 2016 (from 88% to 84%). The majority are also satisfied with the way in which their CCG has engaged them (78%), maintaining the levels of satisfaction seen in previous years, and again higher than the stakeholder average.**
- **Healthwatch and patient groups are positive about the overall leadership and the clinical leadership of their CCGs. Ratings are higher than for most other stakeholder groups and have remained stable since 2016.**
- **Two thirds of Healthwatch and patient group stakeholders (64%) are satisfied with the steps taken by their CCG to engage with patients and the public. However, ratings are somewhat lower regarding whether CCGs act on the views of patients and the public when making commissioning decisions (53% agree), and whether CCGs communicate effectively about their actions (49% agree).**
- **Just under half of Healthwatch and other patient groups (44%) feel that their CCG engages with seldom heard groups a great deal or a fair amount, which is consistent with 2016 (46%) and previous years.**
- **Most Healthwatch and patient group stakeholders (64%) agree that their CCG listens to and acts on any concerns, complaints or issues that they raise. However, this is a fall from the 2016 figure (70%).**

The perspective of patients and the general public should be taken into account by CCGs when making commissioning decisions. In order to achieve this, maintaining relationships with local Healthwatch and patient groups within their locality is crucial. The CCG 360° survey therefore asked questions to assess the extent to which CCGs undertake active and meaningful engagement with patients and wider communities.

CCGs were asked to provide Ipsos MORI with details of the chair of their local Healthwatch, along with up to three representatives from local patient groups / organisations or individuals. The response from these representatives was high, with 73% of those invited to take part completing a survey (compared with 62% overall).

5.1 Overall engagement of Healthwatch and other patient groups

Stakeholders from Healthwatch and patient groups tend to be positive about their relationship with their CCG. The vast majority of Healthwatch and patient group stakeholders (84%) feel they have been engaged by their CCG in the last 12 months. While this is higher than the average across all stakeholder groups (79%), it represents a slight decrease since 2016 (88%). The majority (78%) are also satisfied with the way in which their CCG has engaged them, maintaining levels of satisfaction seen in previous years, and again higher than the stakeholder average.

The vast majority Healthwatch and patient groups (84%) are also positive about their working relationships with their CCG, which is consistent with previous years, and higher than stakeholders overall (75%).

Two thirds of Healthwatch and patient group stakeholders (64%) are satisfied with the steps taken by their CCG to engage with patients and the public. This proportion is higher than the average across all stakeholder groups (58%). Levels of agreement are slightly lower for other questions about engaging with patients and the public: whether their CCG acts on the views of patients and the public when making commissioning decisions (53% agree), and whether their CCG communicates effectively about their actions (49% agree). On both of these issues, the proportions of Healthwatch and other patient group stakeholders that agree are in line with the stakeholder average.

The majority of Healthwatch and patient group stakeholders (83%) agree that improving patient outcomes is a core focus for their CCG. Although this is higher than the average across all stakeholder groups, ratings have declined slightly since 2016 (when 88% agreed).

Healthwatch and patient groups tend to report positive opinions on how CCGs make commissioning decisions. Opinions are in line with, or slightly higher, than other stakeholder groups, and have either remained stable since 2016, or in some cases have declined slightly. For example, disagreement has risen regarding whether CCGs engage with the right individuals and organisations when making commissioning decisions (from 12% in 2016 to 16%).

In terms of the way in which CCGs monitor and review the quality of commissioned services, Healthwatch and patient group stakeholders' ratings are consistent with 2016, and either in line with, or slightly above, the overall stakeholder average.

Healthwatch and patient group stakeholders are generally positive about the overall leadership and clinical leadership of their CCGs, with three in four (74%) agreeing that there is clear and visible leadership of their CCG. Ratings are in line with, or higher than, most other stakeholder groups and have remained stable since 2016.

Healthwatch and patient group stakeholders report a relatively high level of knowledge of their CCG's plans and priorities, with 83% reporting that they know a great deal or a fair amount (compared with 77% overall), consistent with the 2016 figure. Healthwatch and patient group stakeholders also report among the highest levels of agreement that their CCG's plans and priorities are the right ones, and that communication and consultation over plans and priorities have been effective.

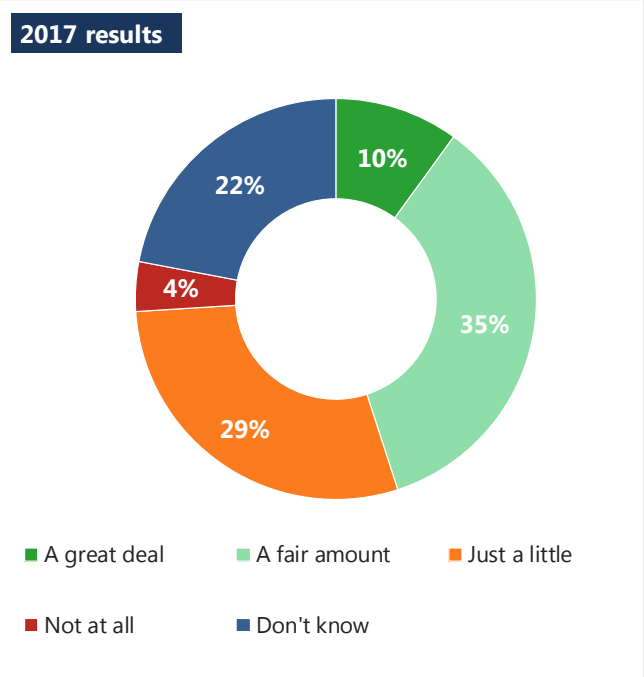
5.2 Engaging with seldom heard groups

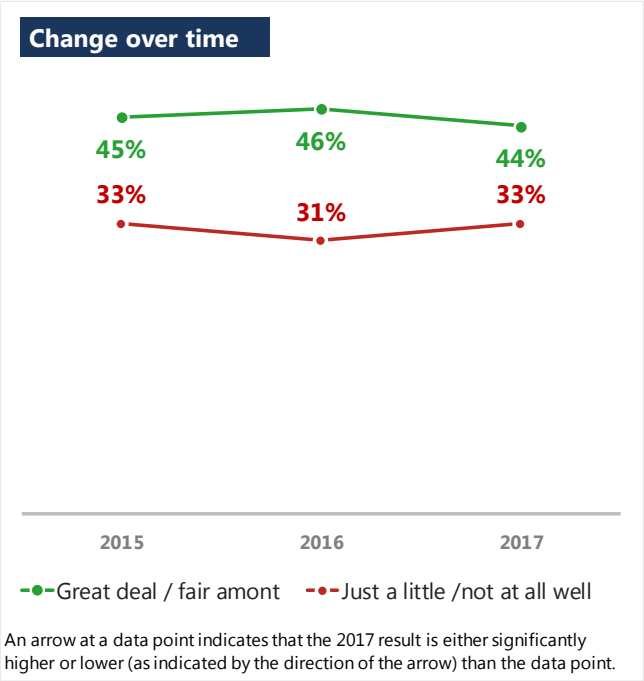
Healthwatch and patient group stakeholders were asked about the extent to which their CCG engages with 'seldom heard groups' – a term used to describe groups who may experience barriers to accessing services or are under-represented in healthcare decision making. Just under half of Healthwatch and patient groups (44%) feel that their CCG

engages with seldom heard groups a great deal or fair amount, which is in line with 2016 (46%) and previous years. One in three (33%) report that their CCG has only engaged with seldom heard groups a little or not at all. Again, this is consistent with 2016 (31%).

Nearly a quarter (22%) say they don't know the extent to which their CCG has engaged with seldom heard groups. This is a similar proportion to 2016 (23%) and indicates that there is still more that CCGs can do, both to engage these groups and to promote any engagement they are carrying out.

Figure 5.1: To what extent, if at all, do you feel that the CCG has engaged with seldom heard groups?



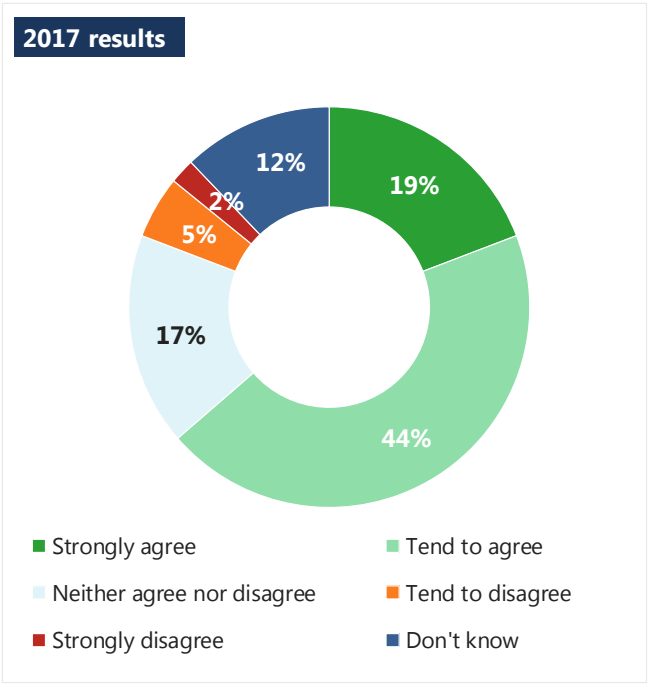


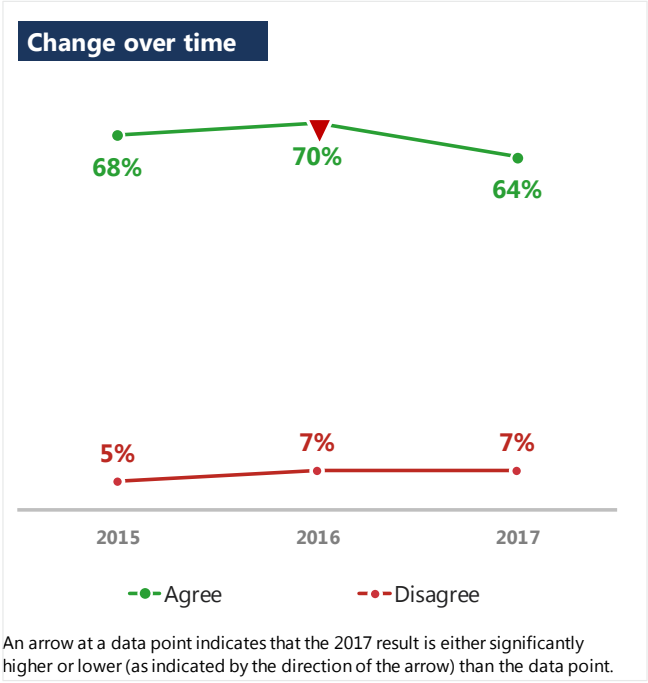
Healthwatch and patient group stakeholders: 2017 (798); 2016 (799); 2015 (693).

5.3 Listening and acting on concerns

Most Healthwatch and patient group stakeholders (64%) agree that their CCG listens to and acts on any concerns, complaints or issues that they raise. Only a small percentage disagree with this (7%). However, agreement this year has declined since 2016, when 70% agreed that their CCG listened to their concerns, complaints or issues.

Figure 5.2: To what extent do you agree or disagree that the CCG listens to and acts on any concerns, complaints or issues that are raised?





An arrow at a data point indicates that the 2017 result is either significantly higher or lower (as indicated by the direction of the arrow) than the data point.

Healthwatch and patient group stakeholders: 2017 (798); 2016 (799); 2015 (693).

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6 NHS providers

Summary

- **The majority of NHS providers feel that they have been engaged by their CCG (79%) and two in three (66%) are satisfied with the way this engagement has taken place. However, NHS providers remain one of the least positive stakeholder groups in general. For example, while three in four (74%) report that the working relationship they have with their CCG is good, they are more likely than any other stakeholder group to report that it is poor (10% compared to 8% overall).**
- **While the majority of NHS providers remain positive about the way their CCG commissions services, they tend to be less positive than other stakeholder groups. Three in five agree that their CCG involves and engages the right individuals when making commissioning decisions (60%) and that they understand the reasons for their CCG's commissioning decisions (59%), and just over half (55%) have confidence in their CCG's ability to commission high quality services for the local population.**
- **Turning to leadership, NHS providers continue to be among the least positive stakeholder groups. Around half agree that the leadership of their CCG has the necessary blend of skills and experience (59%), will deliver its plans and priorities (54%), will deliver improved outcomes for patients (51%) and will deliver continued quality improvements (48%). NHS providers are slightly more likely to agree that the leadership of their CCG is clear and visible (67%) however.**
- **NHS providers are slightly more positive about their CCG's ability to monitor and review services. Two in three NHS providers (66%) agree that their CCGs effectively monitor the quality of services, two in three (68%) agree that they have confidence in their CCG to act on feedback it receives about services and five in six (85%) agree that they would feel able to raise concerns with their CCG. In each of these cases, the proportion that agree is higher, or in line with, the average across all stakeholder groups.**
- **The majority of NHS providers are positive about quality assurance within their CCGs. Just over two in three NHS providers (67%) feel that the amount of monitoring their CCG carries out on the quality of services is about right, with one in five (20%) saying there is too much monitoring.**
- **The proportion of NHS providers who report that their CCG understands the challenges they face has increased since 2016. Two in three NHS providers (66%) think their CCG understands the challenges facing their provider organisation, compared with 57% in 2016.**

CCGs mainly commission services for their local areas from NHS trusts, and therefore it is vital that CCGs and NHS providers work well together to ensure quality of provision and to develop a coherent long-term strategy. This survey looked at the working relationships between CCGs and NHS providers, and their views on ensuring the quality of services for their local communities.

A range of NHS providers – acute trusts, mental health trusts and community health trusts – were invited to take part in the survey, and each CCG was asked to provide details for up to two contacts from each of their main NHS providers.

The response rate among NHS providers was lower than the average across all stakeholder groups, with 48% of NHS providers taking part (compared with 62% overall). In addition to this being below the overall response rate, it is 7 percentage points lower than this stakeholder groups response rate in 2016 (55%).

6.1 Overall engagement of NHS providers

Although NHS providers tend to be positive about their overall engagement with their CCG, they continue to be less positive than other stakeholder groups. Around four in five (79%) NHS providers feel that they have been engaged by their CCG over the last 12 months, however, a significant proportion disagree that they have been engaged (21%). While NHS providers also continue to be satisfied with the way in which their CCG has engaged them over the last 12 months (66%), this is below the average across all stakeholder groups (70%). A higher proportion of NHS providers however would rate their working relationship with their CCG as good (74%).

Regarding their CCG's ability to engage with patients and the public, NHS providers are less positive with just over half (52%) saying they are satisfied. This is six percentage points below the stakeholder overall average (58%) and they remain the least positive stakeholder group.

While the majority of NHS providers remain positive about the way their CCG commissions services, this majority remains small. Three in five agree that their CCG involves and engages the right individuals when making commissioning decisions (60%) and that they understand the reasons for their CCG's commissioning decisions (59%), and just over half (55%) have confidence in their CCG's ability to commission high quality services for the local population. However, a smaller proportion agree that their CCG's plans will deliver continuous improvement in quality within the available resources (45%). In general, these findings have remained consistent since 2015.

Turning to leadership, NHS providers continue to be among the least positive stakeholder groups. Around half agree that the leadership of their CCG has the necessary blend of skills and experience (59%), will deliver its plans and priorities (54%), will deliver improved outcomes for patients (51%) and will deliver continued quality improvements (48%). NHS providers are slightly more likely to agree that the leadership of their CCG is clear and visible (67%) however. These low levels of positivity among NHS providers have remained broadly consistent since 2015. Furthermore, NHS providers are the least likely stakeholder group to report that their CCG is effective as a local system leader (68% compared to 73% across all stakeholder groups).

In line with other stakeholder groups, a large proportion of NHS providers know a great deal or a fair amount about their CCG's plans and priorities (81%). However, NHS providers report that they are less able to understand and able to engage in their CCG's plans and priorities than most other stakeholder groups. On a number of other measures however, NHS providers tend to be less positive about their CCG's plans and priorities. Around half (50%) feel that their comments have been taken on board when they have commented on their CCG's plans and priorities, that they have been given the opportunity to influence their CCG's plans and priorities (55%) or that their CCG's plans and priorities are the right ones (54%).

NHS providers are slightly more positive about CCGs' abilities to monitor and review services. Two in three NHS providers (66%) agree that their CCG's effectively monitor the quality of services, two in three (68%) agree that they have confidence in their CCG to act on feedback it receives about services and five in six (85%) agree that they would feel

able to raise concerns with their CCG. In each of these cases, the proportion that agree is higher, or in line with, the average across all stakeholder groups.

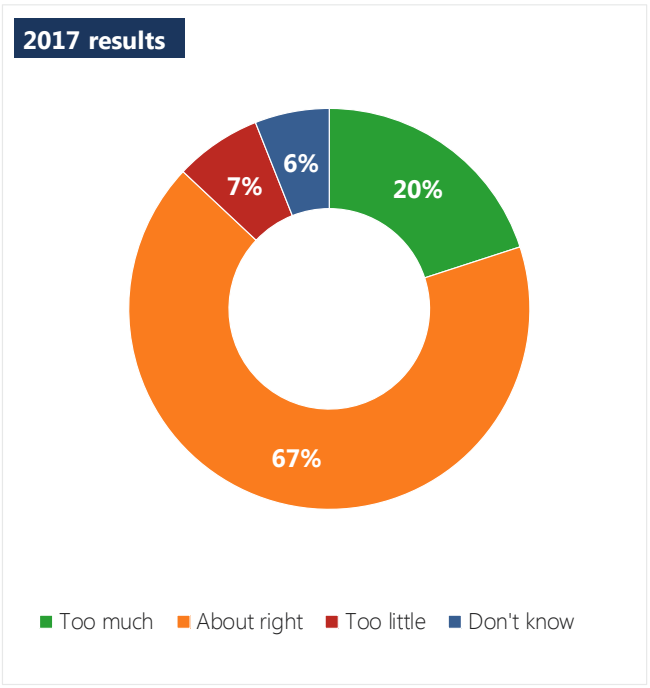
NHS providers are more positive about the extent to which their CCG has contributed to discussions in the wider health economy. Over two thirds (69%) feel that their CCG has contributed a great deal or a fair amount, broadly in line with the majority of other stakeholder groups. However, although the majority still feel that their CCG has contributed to wider discussions, the proportion decreased gradually since 2015, when 80% agreed that their CCG contributed to discussions.

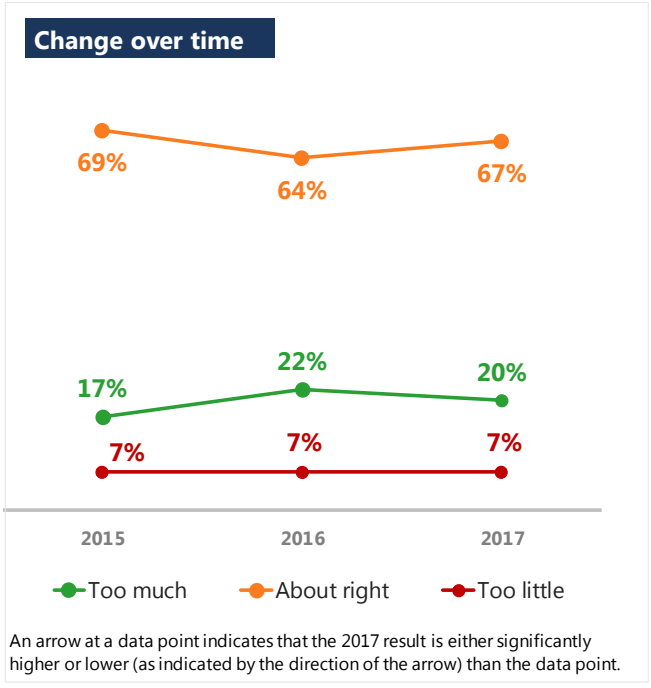
6.2 Quality assurance

One of the key roles for CCGs is to monitor the quality of the services they commission. The survey aims to allow NHS providers to comment on the quality assurance activities their CCG undertakes. Throughout, the results show the majority of NHS providers are positive about quality assurance within their CCGs.

Just over two in three NHS providers (67%) feel that the amount of monitoring their CCG carries out on the quality of their services is about right, with one in five (20%) saying there is too much monitoring. Only 7% think that an insufficient amount of monitoring is conducted.

Figure 6.1: Would you say that the amount of monitoring the CCG carries out on the quality of your services is too much, too little or about right?

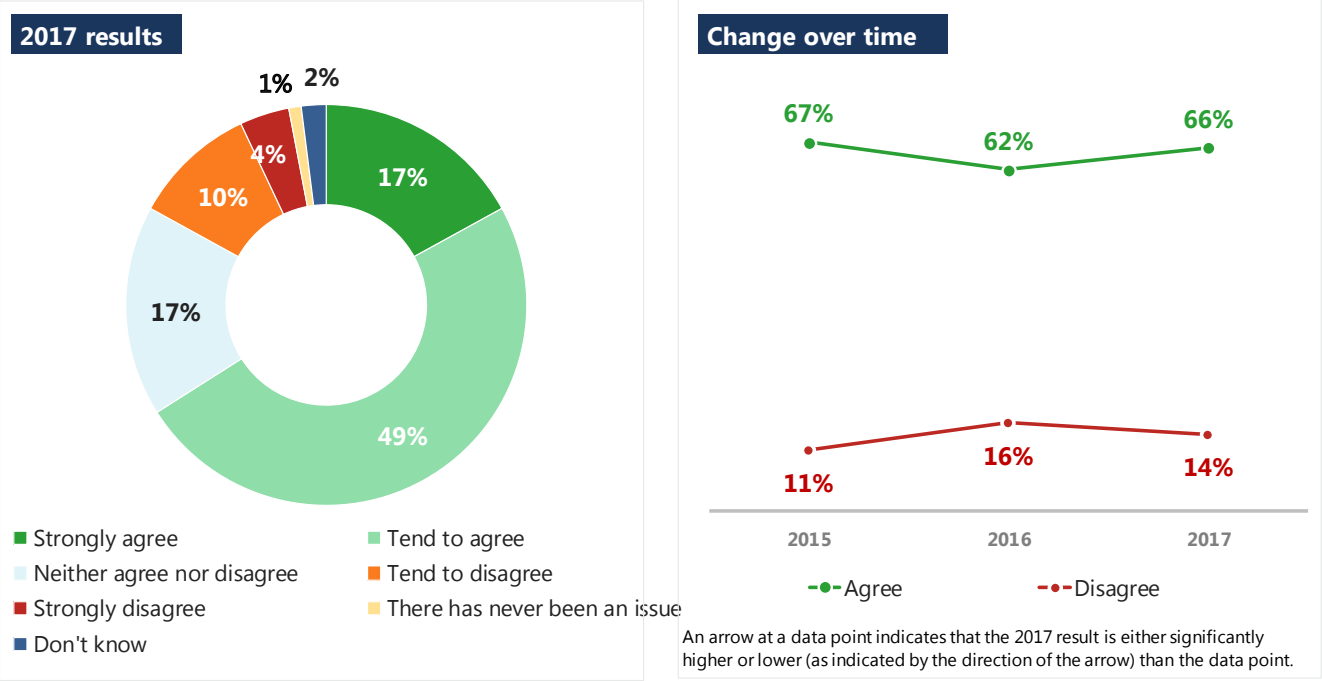




All NHS Providers: 2017 (653); 2016 (746); 2015 (827); 2014 (920).

In line with 2016, two in three NHS providers (66%) agree that when there is an issue with the quality of services, the response from their CCG is both proportionate and fair.

Figure 6.2: To what extent do you agree or disagree with the following statement? When there is an issue with the quality of services, the response of the CCG is proportionate and fair?



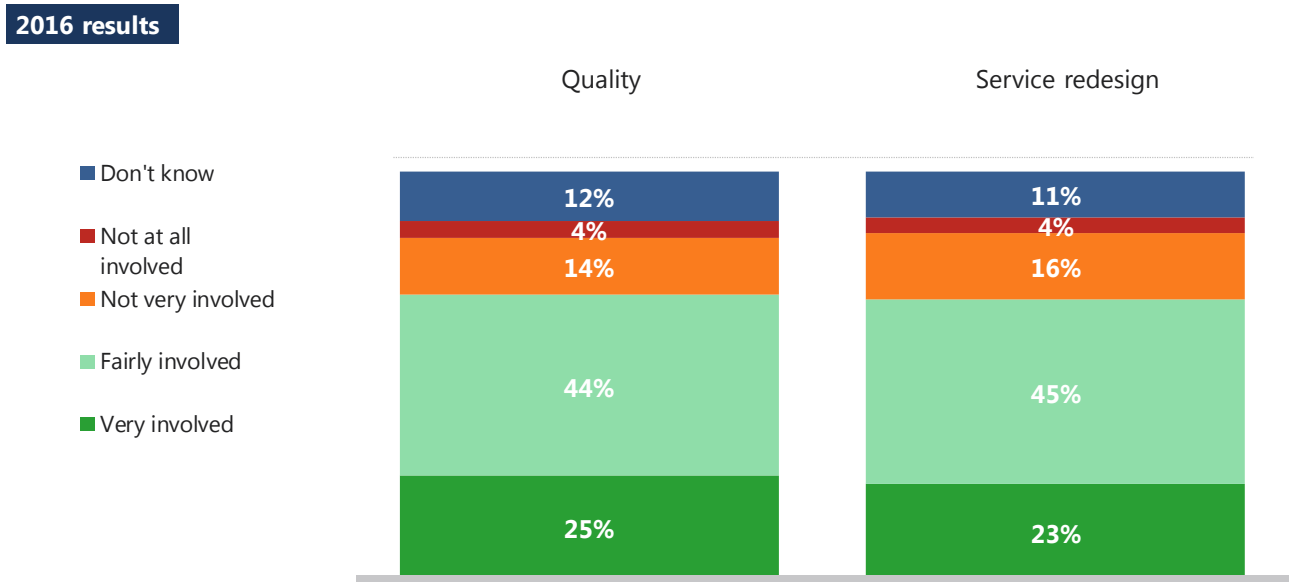
All NHS providers: 2017 (653); 2016 (746); 2015 (827).

6.3 Clinical involvement

CCGs are intended to be clinically-led organisations and therefore, the survey sought to find out the extent to which clinicians from their CCGs are involved in discussions with NHS providers about quality and service redesign.

A clear majority (72%) of NHS providers feel clinicians from their CCG are very or fairly involved in discussions about quality with only one in five (17%) reporting that clinicians are not very or not at all involved. A similar proportion (69%) report that clinicians from their CCG are involved in discussions about service design. These findings have remained fairly consistent since 2015.

Figure 6.3: How involved, if at all, would you say clinicians from the CCG are in discussions about...?

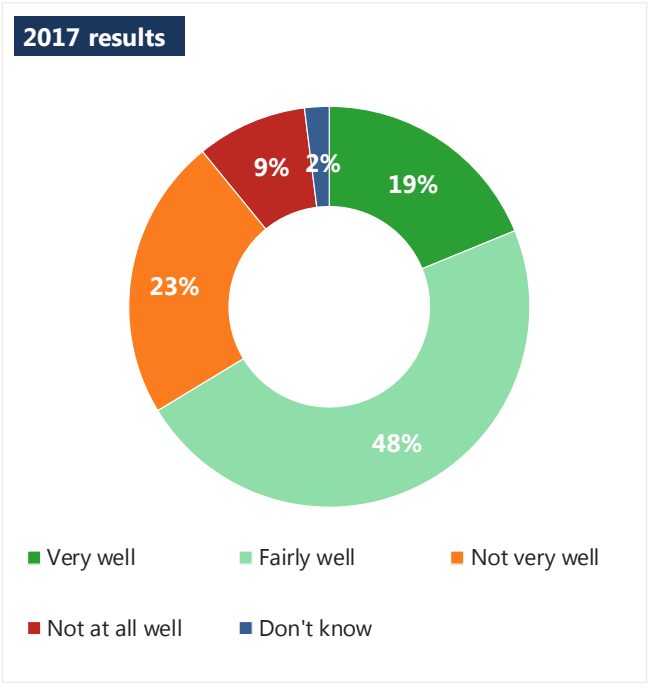


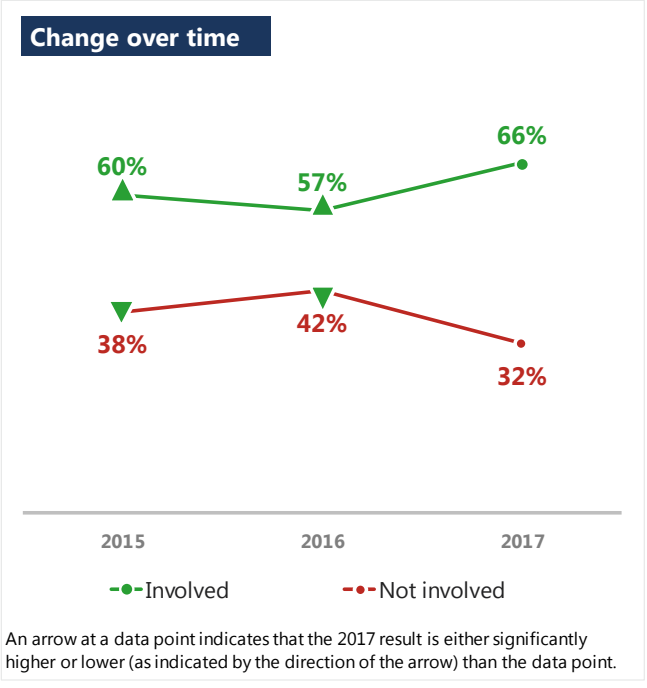
All NHS providers: 2016 (746).

6.4 Understanding of the challenges faced by NHS providers

The proportion of NHS providers who report that their CCG understands the challenges they face has increased since 2016. Two in three NHS providers (66%) think their CCG understands the challenges facing their provider organisation, compared with 57% in 2016. The proportion who disagree has also fallen this year; from two in five in 2016 (42%) to one in three (32%).

Figure 6.4: How well, if at all, would you say the CCG understands the challenges facing your provider organisation?





An arrow at a data point indicates that the 2017 result is either significantly higher or lower (as indicated by the direction of the arrow) than the data point.

All NHS providers: 2017 (653); 2016 (746); 2015 (827).

7 Upper tier and unitary local authorities

Summary

- **Upper tier and unitary local authority stakeholders continue to be one of the most positive stakeholder groups. The vast majority (88%) feel that they are engaged by their CCG a great deal or a fair amount and around four in five (78%) are satisfied with the way in which that engagement has taken place.**

- **Upper tier and unitary local authority stakeholders are particularly positive about their CCG's plans and priorities. The vast majority (88%) of upper tier and unitary local authority stakeholders feel they know a great deal or a fair amount about their CCG's plans and priorities – higher than any other stakeholder group. Upper tier and unitary local authority stakeholders are also particularly likely to agree that they have had the opportunity to influence their CCG's plans and priorities (71%) and that their comments about the plans and priorities are taken on board (62%).**

- **Upper tier and unitary local authority stakeholders are also very positive about the way in which their CCG commissions services; over two in three (69%) agree that their CCG involves and engages with the right individuals and organisations, that they have confidence in their CCG's ability to commission high quality services (70%) and that they understand the reasons for their CCG's commissioning decisions (69%). However upper tier and unitary local authority stakeholders tend to be less positive about their CCG's involvement of patients and the public.**

- **Upper tier and unitary local authority stakeholders tend to be positive about the leadership of their CCG. While the vast majority agree that there is clear and visible leadership of their CCG (79%) and that the leadership of their CCG has the necessary blend of skills and experience (72%), unitary and upper tier local authorities have less confidence that the leadership will deliver improved outcomes for patients or continued quality improvements.**

- **Upper tier and unitary local authority stakeholders have mixed opinions on the way in which CCGs monitor and review the quality of commissioned services. While just three in five (61%) agree that their CCG effectively monitors the quality of the services it commissions, unitary and upper tier local authorities are more likely to feel able to raise concerns with their CCG (92%) and that their CCG would act on feedback that it received (74%).**

Given the local focus of commissioning, effective relationships with local statutory bodies and local authorities are of the great importance to CCGs. The survey asked a range of questions to upper tier or unitary local authorities, to ascertain whether the positive relationships reported in previous years have been developed further.

There are also some specific areas in which CCGs and local authorities need to collaborate, including fulfilling statutory duties. The survey therefore asked upper tier and unitary local authority stakeholders about how well their CCG was working with them to refresh and deliver plans for integrated commissioning and about their effectiveness as part of the Safeguarding Adults and Safeguarding Children Boards.

All CCGs were asked to provide details for up to five stakeholders from each of the upper tier or unitary local authorities in their locality. Possible roles of these stakeholders included the Chief Executive, Director of Adult Services, Director of Children's Services, representatives from the Health Overview and Scrutiny Committee and elected members. At least one of the stakeholders was required to be able to comment on behalf of the local authority on the CCG's role in safeguarding children and safeguarding adults.

Around half (56%) of upper tier or unitary local authority stakeholders responded to the survey, this is roughly in line with the response rate from the 2016 study (57%).

7.1 Overall engagement of upper tier and unitary local authorities

As in 2016, upper tier and unitary local authority stakeholders continue to be one of the most positive stakeholder groups. The vast majority (88%) feel that they are engaged by their CCG a great deal or a fair amount and around four in five (78%) are satisfied with the way in which that engagement has taken place. The vast majority (83%) of upper tier and unitary local authority stakeholders would rate their working relationship with their CCG as good.

Again, when asked to give their views on their CCG's commissioning services, upper tier and unitary local authority stakeholders remained fairly positive. Over two in three (69%) agree that their CCG involves and engages with the right individuals and organisations when making commissioning decisions, that they have confidence in their CCG's ability to commission high quality services for the local population (70%) and that they understand the reasons for the decisions their CCG makes when commissioning services (69%). However, regarding how their CCG involves patients and the public in commissioning decisions, upper tier and unitary local authority stakeholders tend to be less positive. Just over half agree that their CCG acts on the views of patients and the public when making commissioning decisions (54%) and that their CCG effectively communicates about how it has acted on what it is told by patients and the public (52%). Upper tier and unitary local authority stakeholders were one of the least positive stakeholder groups in this respect.

Upper tier and unitary local authority stakeholders tend to be positive about the leadership of their CCG. The vast majority agree that there is clear and visible leadership of their CCG (79%) and that there is clear and visible *clinical* leadership of their CCG (76%). Around three in four are in agreement that the leadership of their CCG has the necessary blend of skills and experience (72%) and two in three have confidence in the leadership of their CCG to deliver its plans and priorities (68%). In each of these respects, unitary and upper tier local authority stakeholders are among the most positive stakeholder groups. However, unitary and upper tier local authorities have less confidence that the leadership will deliver; 62% have confidence in the leadership of their CCG to deliver improved outcomes for patients and 58% agree the leadership of their CCG is delivering continued quality improvements.

Upper tier and unitary local authority stakeholders have mixed opinions on the way in which CCGs monitor and review the quality of commissioned services. Just three in five (61%) agree that their CCG effectively monitors the quality of the services it commissions – one of the lowest levels of agreement across stakeholder groups, and a decrease in agreement since 2015 (68%). However, unitary and upper tier local authorities are more likely to feel able to raise concerns with their CCG (92%) and that their CCG would act on feedback that it received (74%).

Upper tier and unitary local authority stakeholders are particularly positive about their CCG's plans and priorities. The vast majority (88%) of upper tier and unitary local authority stakeholders feel they know a great deal or a fair amount about their CCG's plans and priorities – higher than any other stakeholder group. Upper tier and unitary local authority stakeholders are also particularly likely to agree that they have had the opportunity to influence their CCG's plans and

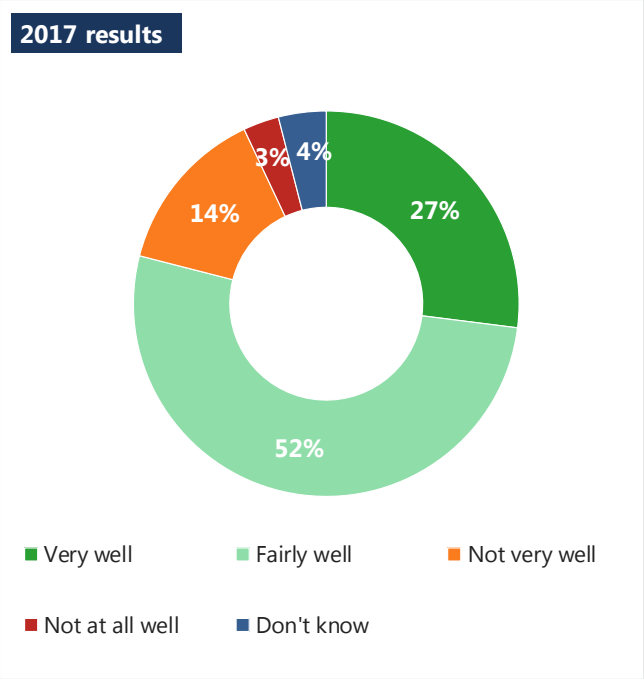
priorities (71%) and that their comments about the plans and priorities are taken on board (62%). In both these cases however, agreement has fallen since 2015, indicating that upper tier and unitary local authorities feel that their influence is declining.

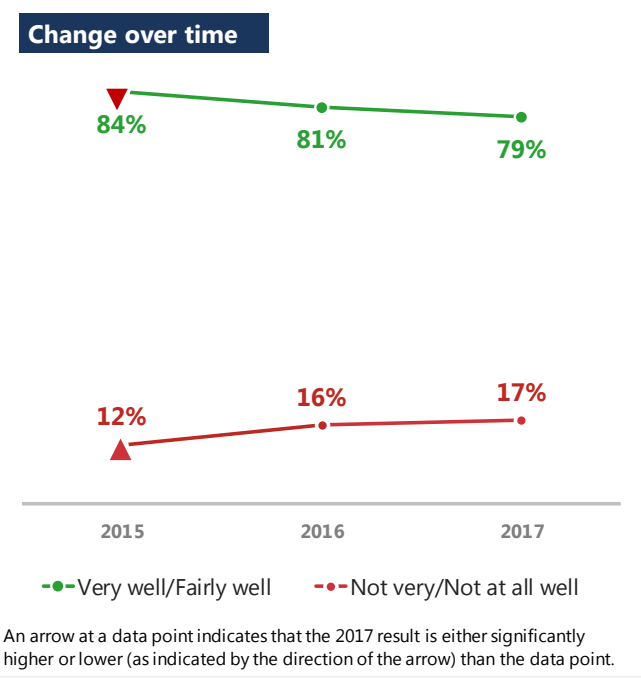
7.2 Integrated commissioning

Integrated commissioning between CCGs and local authorities has become increasingly important as the system moves towards better integration between NHS and social care services. Reflecting this, the survey asked upper tier and unitary local authority stakeholders questions on how their CCG is working with them to refresh and deliver shared plans for integrated commissioning.

Upper tier and unitary local authority stakeholders are positive, with over three quarters (79%) believing their CCG and their local authority work together well to deliver shared plans for integrated commissioning. However, since 2015, there has been a slight increase in the proportion who feel that the CCG and the local authority are not working well together (from 12% in 2015 to 17%).

Figure 7.1: How well, if at all, would you say the CCG and the local authority are working together to deliver shared plans for integrated commissioning?





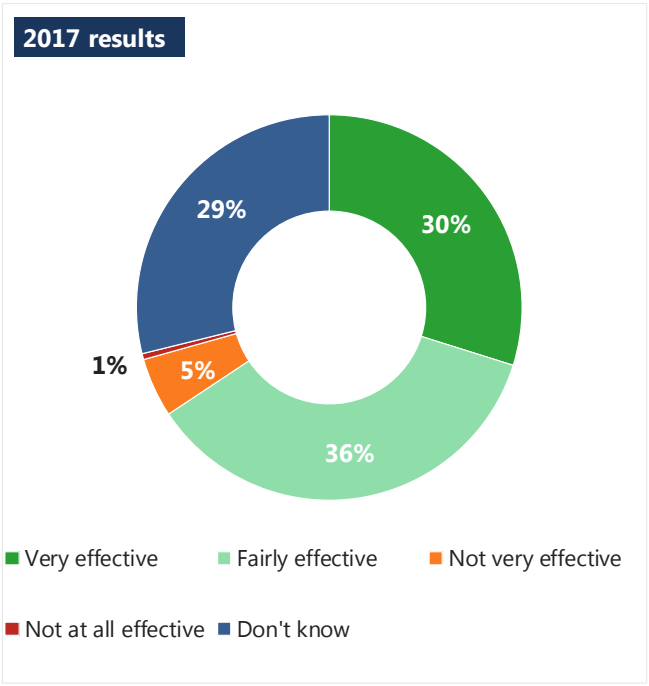
All upper tier/unitary local authority stakeholders: 2017 (602); 2016 (629); 2015 (672).

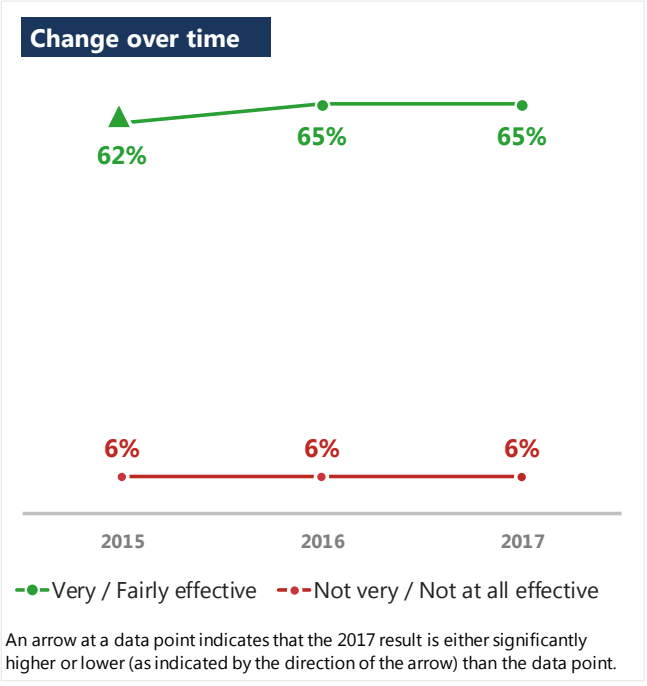
7.3 Safeguarding children and adults

CCGs and upper tier and unitary local authorities have a statutory duty to fulfil safeguarding responsibilities and are both members of Local Safeguarding Children Boards and Local Safeguarding Adults Boards. The survey therefore asked upper tier and unitary local authority representatives about how the CCG had been fulfilling its safeguarding responsibilities.

Two thirds (65%) of upper tier and unitary local authority stakeholders think that their CCG is an effective part of the Local Safeguarding Children Board which remains consistent with 2016. Only six per cent of upper tier and unitary local authority stakeholders think that their CCG is not effective.

Figure 7.2: How effective, if at all, has the CCG been as part of the Local Safeguarding Children Board?

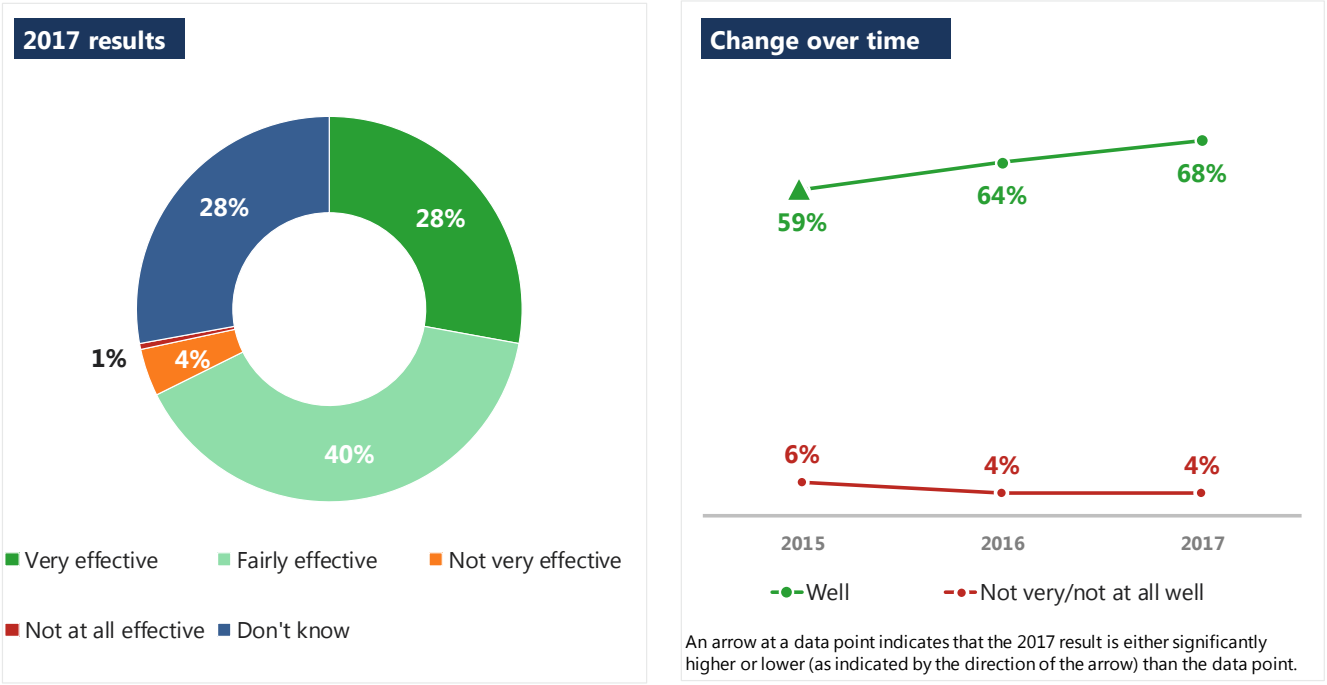




All upper tier/unitary local authority stakeholders: 2017 (602); 2016 (629); 2015 (672).

Positively, the proportion of upper tier and unitary local authority stakeholders who feel that their CCG has been an effective part of the Local Safeguarding Adults Board has increased since 2015; from 59% to 68% in 2017. Those who feel their CCG is not effective remains at four per cent.

Figure 7.3: How effective, if at all, has the CCG been as part of the Local Safeguarding Adults Board?



All upper tier/unitary local authority stakeholders: 2017 (602); 2016 (629); 2015 (672).

8 Health and wellbeing boards

Summary

- **The majority of health and wellbeing board (HWB) members (84%) have been engaged by their CCG and are satisfied with how this engagement has taken place (81%). These levels of positivity remain consistent with 2016.**
- **HWB representatives are generally positive about their CCG's commissioning decisions; particularly regarding the quality of these services that are commissioned. HWB representatives are less positive about the way in which their CCG makes decisions however; the proportions of HWB representatives who understand the reasons for the commissioning decisions their CCG makes (65%) and feel that their CCG engages with the right people when making decisions (63%) are broadly in line with the national average.**
- **Nearly all HWB members (96%) say that their CCG is an active member of the HWB, with three in five (61%) saying they are 'very active'. This proportion has increased since 2016 (90%).**
- **In comparison with other stakeholder groups, HWB members are particularly confident about the leadership of their CCG. Four in five HWB members (81%) agree that there is clear and visible leadership of their CCG, consistent with 2016 and 2015.**
- **HWB members are less likely to feel that their CCG's plans and priorities are the right ones (66%) than they were in previous years (74% in 2016 and 76% in 2015), or to feel as though plans and priorities have been effectively communicated (69% compared with 78% in 2016 and 82% in 2015).**
- **Roughly five in six HWB stakeholders (85%) say that their CCG and local authority are working well together to deliver shared plans for integrated commissioning. This is consistent with previous years.**

Health and wellbeing boards (HWBs) have a key role in bringing together CCGs and local authorities to develop a shared understanding of the health and wellbeing needs of the community and to tackle local inequalities in health. Together with the CCG, they undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed.

Each CCG was asked to provide details of two members of their HWB, one of which had to be the Chair. Where CCGs span more than one HWB, they provided details for each board of which they are members.

The survey response rate among HWBs was comparable to the overall response rate, with three in five of those invited to take part responding (61%, compared with 62% overall). This is slightly higher than HWB's response rate in 2016 (58%), however it is consistent with last year's response rates in that HWB fall one percentage point below the overall.

8.1 Overall engagement of health and wellbeing boards

As may be expected, given the requirement that each HWB must include a representative of their relevant CCG, the level of engagement between the two is high (84%) and satisfaction with the way in which HWBs have been engaged is also high (81%). However, while the proportion of HWBs who report a positive working relationship with their CCG remains higher than average (83% compared with 75% national average), this has decreased since 2015 (89%).

HWB members are generally positive about their CCG's commissioning decisions; particularly regarding the quality of these services, where they are among the most positive stakeholder groups. More than three in four (77%) have confidence in their CCG to commission high quality services and two in three (66%) believe their CCG's plans will deliver continuous improvements in quality (compared with 63% and 53% overall respectively). Linked to this, HWB members continue to express confidence that their CCG acts on feedback about the quality of services, with roughly four in five HWB representatives agreeing with this for the past three years (81% in 2015, 78% in 2016 and 80% in 2017). This is higher than nearly every other stakeholder group.

HWB representatives are less positive about the way in which their CCG makes decisions however; the proportion of HWB representatives that understand the reasons for the commissioning decisions their CCG makes (65%) and that feel their CCG engages with the right people when making decisions (63%) is broadly in line with the national average.

Turning to the leadership of their CCG, HWB members are particularly positive compared with other stakeholder groups. Four in five HWB members (79%) agree that there is clear and visible clinical leadership of their CCG and seven in ten HWB members (71%) have confidence in the leadership of their CCG to deliver plans and priorities. Since 2015, HWB members have also remained confident about the leadership of their CCG in terms of delivering improved outcomes for patients (73%).

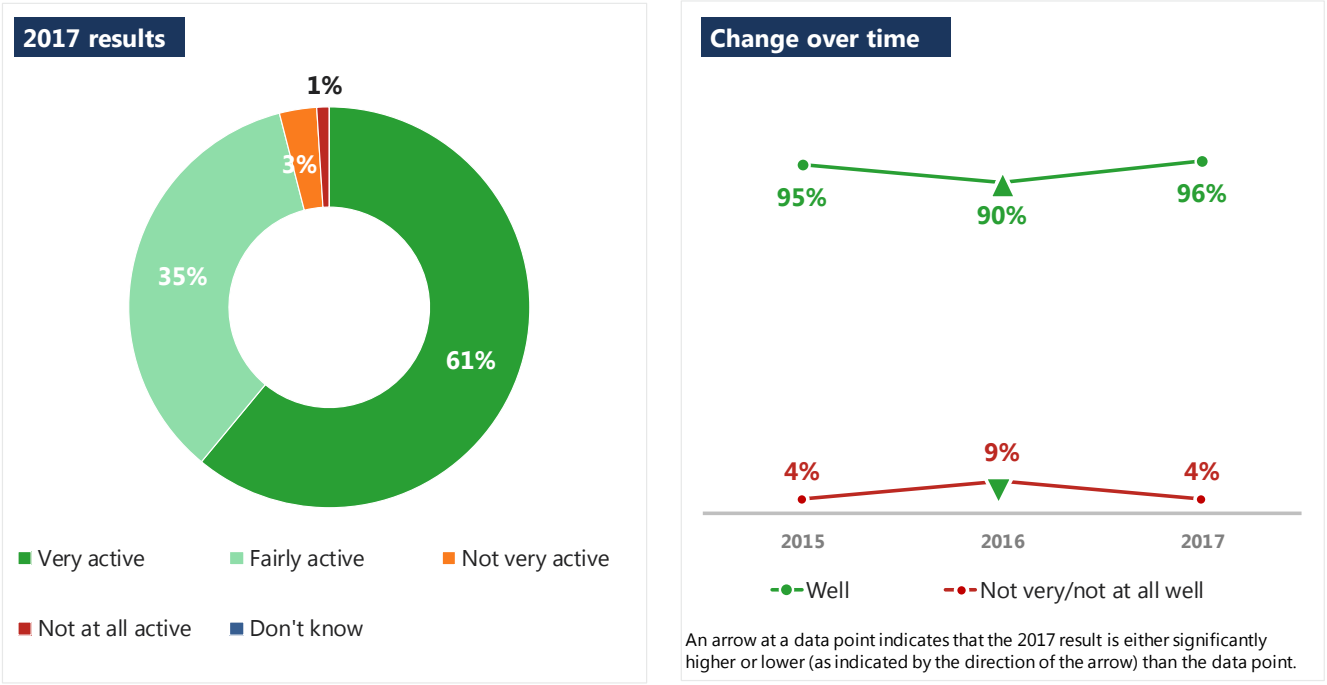
By several measures HWB members are less positive about the plans and priorities of their CCG in 2017 than they were in 2016 and 2015. This year, HWB representatives are less likely to feel as though their CCG's plans and priorities are the right ones (66% compared with 76% in 2015) and also less likely to feel as though they have had an opportunity to influence them (65% compared with 74% in 2016 and 78% in 2015). Additionally, HWB representatives say that their CCG's plans are less effectively communicated than in the past (69% compared with 78% in 2016 and 82% in 2015). Nonetheless, while HWB member's positivity about their CCG's plans and priorities has decreased in the past two years, it still remains well above average when compared with other stakeholder groups.

Two in three HWB representatives (64%) are satisfied with the steps taken by their CCG to engage with patients and the public. This is in line with the average and higher than both GP member practices and NHS providers. Close to three quarters of HWB members (72%) think that their CCG has contributed to wider discussions through local groups, such as urgent care working groups or strategic clinical networks. As in 2016 and 2015, this remains higher than average. Additionally, five out of six HWB representatives (85%) agree their CCG is an effective local system leader, in terms of working proactively and constructively with other partners in the local economy.

8.2 Engagement with the health and wellbeing board and its strategy

Nearly all HWB members (96%) say that their CCG is an active member of the HWB, with three in five (61%) saying they are *very* active.

Figure 8.1: How active, if at all, would you say the CCG is as a member of the health and wellbeing board?



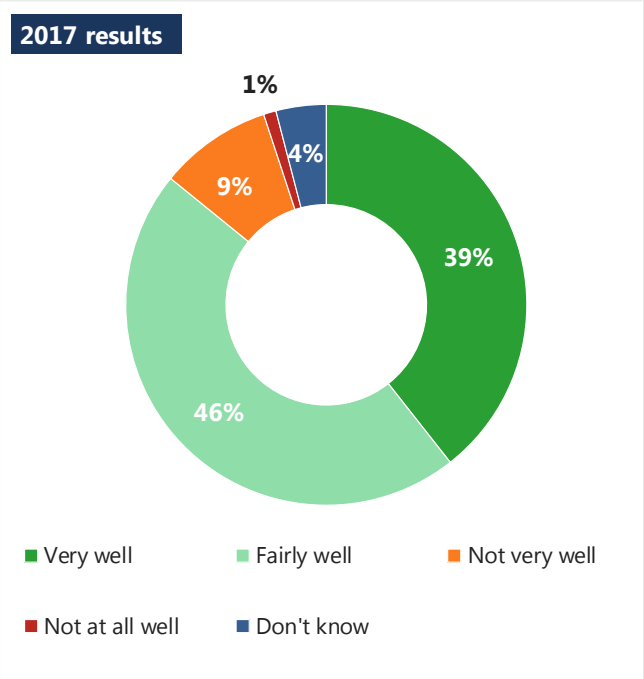
Health and Wellbeing Stakeholders: 2017 (235); 2016 (250); 2015 (274).

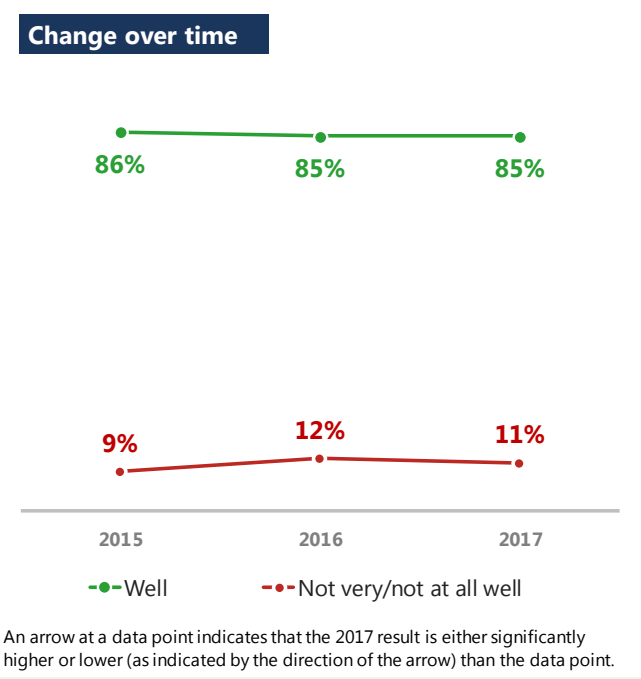
The proportion of HWB members who say that their CCG is an active member of the HWB (96%) has increased since 2016 (90%) and the proportion who say that it is not an active member has more than halved from nine to four per cent.

8.3 Integrated commissioning

Health and wellbeing boards are instrumental in the promotion of the integration of health and social care services. The survey therefore asked HWB stakeholders about how effective the relationships are between local authorities and CCGs in delivering shared plans for integrated commissioning.

Figure 8.2: How well, if at all, would you say the CCG and the local authority are working together to deliver shared plans for integrated commissioning?





Health and Wellbeing Stakeholders: 2017 (235); 2016 (250); 2015 (274).

Roughly five in six HWB stakeholders (85%) say that their CCG and local authority are working well together to deliver shared plans for integrated commissioning. This is consistent with previous years; having stayed consistent in 2016 (85%) and 2015 (86%).

Conversely, only one in ten of HWB members (11%) say that their CCG and local authority are not working very well, or at all well, together.

9 Other CCGs

Summary

- **Representatives from other CCGs are very positive about the level of engagement with the CCG, with four in five (80%) feeling engaged by the CCG in the last 12 months. The same proportion of representatives are satisfied with the way in which the CCG has engaged with them.**
- **This stakeholder group are also the most positive about the commissioning decisions made by the CCG and in terms of confidence in the quality of the services commissioned. Three quarters of representatives (73%) agree that they have confidence in the CCG to effectively monitor the quality of the services it commissions.**
- **The vast majority of representatives feel as though they would be able to raise concerns about the quality of local services within the CCG (90%) and also that they have confidence in the CCG to act on feedback it receives (80%).**
- **Representatives remain positive about the leadership of CCGs in comparison to other stakeholder groups however, on some measures, the level of positivity has decreased since 2016 and 2015.**
- **While members of this stakeholder group are relatively positive about the plans and priorities of CCGs, they rank among the lowest compared with the other stakeholder groups, falling below average on a number of measures.**
- **In terms of CCG engagement with local groups, representatives from other CCGs remain positive in comparison to other stakeholder groups. Representatives are most positive about the contribution that the CCG has made to wider discussions, with three in four (77%) feeling as though the CCG has contributed a 'great deal' or 'fair amount' to discussions with local groups such as urgent care working groups or strategic clinical networks.**

It is common for CCGs to have formal commissioning arrangements in place with other CCGs – particularly in areas of specialist care. As such, it is important to ask CCGs about their relationships with one another. As these are covered by the questions asked of all stakeholders, no additional questions were asked of this group.

CCGs were asked to provide contact details of up to five other CCGs with whom they collaborate. Response rates from other CCGs were the highest of all stakeholder groups; 74% compared with 62 % overall. This may be due to the high level of awareness of the survey among CCGs.

9.1 Overall engagement of other CCGs

Four in five representatives from other CCGs (80%) feel as though they have been engaged by the CCG in question in the last 12 months. The same proportion of representatives (80%) are satisfied with the way in which this engagement

has taken place. This stakeholder group ranks the highest (88%) in terms of perception of overall working relationship with CCGs.

Overall, representatives from other CCGs are very positive about the commissioning decisions made by the CCG. More than three in four representatives (77%) agree they have confidence in the CCG to commission high quality services. Three in four (72%) agree that the CCG engages with the right individuals and organisations when making commissioning decisions and roughly the same proportion (74%) agree that they understand the reasons for the commissioning decisions made by the CCG. In all these respects, this stakeholder group ranks most highly in comparison with other groups.

Members of this stakeholder group are also particularly positive about the quality of the CCG's commissioned services and the ability to provide feedback that will be acted on. Three in four representatives (73%) agree that they have confidence in their CCG to effectively monitor the quality of the services it commissions and two in three (68%) agree that the leadership of the CCG is delivering continued quality improvements. Additionally, the vast majority of representatives feel as though they would be able to raise concerns about the quality of local services within the CCG (90%) and that they have confidence it will act on the feedback it receives (80%). In this context, other CCGs are the most positive stakeholder group.

As was the case in previous years, representatives from other CCGs remain positive about the leadership of the CCG in question. Over four in five representatives agree that there is clear and visible leadership (85%) and also clinical leadership (83%) of the CCGs. Around three in four (73%) have confidence in the leadership of the CCG to deliver improved outcomes for patients. Interestingly, while this is a large proportion of other CCGs, and among the highest in comparison to other stakeholder groups, confidence in the CCG to deliver improved patient outcomes has decreased in the past two years (from 80% in 2016 and 79% in 2015).

While representatives of other CCGs are relatively positive about the plans and priorities of the CCG in question, they rank among the lowest compared with the other stakeholder groups, falling below average on a number of measures. Representatives are most positive about the CCG's actions and least positive about their engagement with the CCG's plans and priorities. The majority of representatives (63%) agree that the CCG's plans and priorities are the right ones and over three in four representatives (76%) have confidence in the leadership of the CCG to deliver them. Roughly the same proportion of representatives (77%) feel as though they know either a great deal or a fair amount about these plans and priorities and only 50% of representatives think that they have been given the opportunity to influence them. Despite this, representatives are more positive than they were in 2015.

In terms of CCG engagement with local groups, representatives from other CCGs remain fairly positive in comparison to other stakeholder groups. Around six in ten representatives (61%) agree that the CCG in question acts on the views of the patients and the public when making commissioning decisions and additionally, the same amount say they are satisfied with the steps taken by the CCG to engage with patients and the public. In these respects, other CCGs are in line with other stakeholder groups. Representatives are most positive about the contribution that the CCG has made to wider discussions, with over three in four (77%) feeling as though the CCG has contributed to discussions with local groups such as urgent care working groups or strategic clinical networks. This is higher than any other stakeholder group but has decreased since 2015 and 2016.

10 Wider stakeholders

Summary

- **Wider stakeholders are broadly positive about the level and form of engagement they have with their CCG. Close to nine in ten (84%) say that their CCG has engaged them a great deal or a fair amount over the past 12 months.**
- **Confidence in the overall and clinical leadership of their CCG is similarly high. Seven in ten (72%) agree that their CCG has clear and visible leadership and two thirds (68%) agree that their CCG has clear and visible clinical leadership.**
- **Views around CCG engagement with patients and the public tend to be slightly less positive. Fewer than six in ten (59%) report satisfaction with the steps taken by their CCG to engage with patients and the public.**

Previous chapters of this report give an overview of the survey results for each of the key stakeholder groups included in the research. For many CCGs, however, there are stakeholders who do not fall within these groups but whose feedback is nonetheless valuable. In order to allow the views of these stakeholders to be included in this research, each CCG was given the opportunity of including up to ten additional stakeholders from organisations not covered by the core stakeholder framework. This group is referred to as 'wider stakeholders' in this chapter and throughout the report.

This stakeholder group contains a broad range of roles and responsibilities from a variety of organisations, and its make-up within each individual CCG will depend on the relationships and structures that exist locally. As a result of this, no questions specific to this group were asked of these stakeholders - rather, they were asked only the general questions asked of all stakeholders, covering their working relationship with their CCG, the level of engagement their CCG has had with them, their confidence in the overall leadership and clinical leadership of their CCG and their thoughts on their CCG's plans and priorities.

Most CCGs took the opportunity to include these wider stakeholders in the survey, (190 of the 209 CCGs). The stakeholders listed within this group include (but are not limited to):

- clinicians, such as representatives of leadership networks or clinical service-based networks;
- Clinical support units (CSUs);
- Health Education England (local contact);
- lower tier local authorities;
- MPs;
- private providers;

- Public Health England (local contact);
- social care/community organisations;
- voluntary sector/third sector providers; and
- care homes.

For the first time in 2017, CCGs were also invited to include a representative from the Care Quality Commission (CQC). CQC representatives are also included as part of the wider stakeholder group.

When considering the survey results from this group it is important to take into account the diversity of these stakeholders. With this in mind, results from wider stakeholders will be more useful to CCGs at a local level than at the national level. Six in ten of those invited to participate in the survey responded (60%), which is comparable to the overall response rate of 62%.

10.1 Key wider stakeholder results in the overall findings

As in previous waves of the survey, wider stakeholders are generally positive about their CCG and the way in which their CCG engages with them. Wider stakeholders are more likely than average to report that their CCG has engaged with them a great deal or fair amount (84%, compared with 79% overall), and are also more likely than average to say that they are satisfied with this engagement (79%, compared with 70% overall). This positivity continues when looking at working relationships, and five in six (85%) report that their working relationship with their CCG is fairly or very good (compared with 75% among stakeholders overall).

Wider stakeholders also display broadly positive views around their CCG's commissioning decisions and the way in which these decisions are made, although perceptions here are not as positive as on overall engagement. For example, close to two in three (63%) wider stakeholders agree that their CCG involves and engages the right individuals when making commissioning decisions, and a similar proportion (68%) say that they have confidence in their CCG to commission high quality services for the local population. Across both of these measures, wider stakeholders are more positive than stakeholders overall (among whom 58% agree that their CCG involves and engages the right individuals and organisations when making commissioning decisions, and 63% report confidence in their CCG to commission high quality services for the local population).

Thinking about the leadership of their CCG, wider stakeholders remain broadly positive, although no more so than stakeholders overall. For example, two in three (66%) wider stakeholders agree that the leadership of their CCG has the necessary blend of skills and experience (compared with 65% overall). Similarly, seven in ten (72%) agree that their CCG has clear and visible leadership (compared with 71% overall). Looking at clinical leadership specifically, two in three wider stakeholders (68%) agree that their CCG has clear and visible clinical leadership, roughly in line with the 70% who agree among stakeholders overall.

There is confidence among wider stakeholders in the way in which their CCG monitors and reviews the quality of commissioned services. Around two in three wider stakeholders (64%) are confident that their CCG effectively monitors the quality of the services it commissions (roughly in line with 61% among stakeholders overall). Even more positively, close to nine in ten wider stakeholders (89%) say that, if they had concerns about the quality of local services, they would feel able to raise these concerns with their CCG. This figure is significantly higher than that for stakeholders overall,

among whom 84% would feel confident raising concerns. Thinking about the extent to which they feel their CCG would act on such concerns, three quarters of wider stakeholders (73%) say that they have confidence in their CCG to act on feedback it receives about the quality of services. Again, this is significantly higher than the figure for stakeholders overall (among whom 65% say that they are confident that their CCG would act on such feedback).

Wider stakeholders report good knowledge of their CCGs plans and priorities. Eight in ten (80%) say that they know a great deal or fair amount about their CCG's plans and priorities. This is roughly in line with the proportion across all stakeholders (77%). Wider stakeholders are also more likely than average to say that they have been given the opportunity to influence their CCG's plans and priorities (62%, compared with 54% average). Continuing this positive trend, more than half of wider stakeholders (55%) agree that their CCG's plans and priorities are the right ones (compared with 50% overall). Possibly linked to this, close to nine in ten wider stakeholders (85%) agree that improving patient outcomes is a core focus for their CCG, and eight in ten (78%) say that their CCG is an effective local system leader.

Wider stakeholders tend to be slightly less positive about CCG engagement with patients and the public. Fewer than six in ten (59%) report satisfaction with the steps taken by their CCG to engage with patients and the public. However, while slightly less positive here than on other measures, this does still represent a majority, and the figure for wider stakeholders is in line with that for stakeholders overall (among whom 58% report satisfaction).

11 Regional variation

Summary

- **As in previous years of the survey, there is little variation in survey results when broken down by region. However, in 2017 we do see a pattern emerge across those measures asked of all stakeholders and those measures asked of GP member practices. Looking at these measures, stakeholders in London and the North tend to be more positive than those in the South and the Midlands and East.**
- **Unlike in previous years, with the exception of GP member practices, variation by region is not generally seen on those measures asked only of specific stakeholder groups.**

Earlier sections of this report have focused on the results of this year's survey broken down by stakeholder group. This chapter explores how perceptions differ among the four NHS England commissioning regions (London, the Midlands and East, the North and the South). This serves to allow NHS England to identify potential areas of best practice across regions.

On those questions asked of all stakeholders, a pattern emerges whereby, across the majority of measures, stakeholders in London and the North are more positive than those in the South and the Midlands and East. Variation of five percentage points is seen in the extent to which stakeholders feel that they have been engaged by their CCG over the past 12 months, with 82% of stakeholders in London reporting that they have felt engaged to some or to a great extent, compared with just 77% of stakeholders the Midlands and East (81% feel engaged in the North and 78% feel engaged in the South). Similarly, stakeholders in London (72%) are more likely than those in the South (68%) or Midlands and East (69%) to say that they are satisfied with the way in which their CCG has engaged them.

This pattern is maintained across a number of other measures, such as those looking at the commissioning decisions made by their CCG. For example, stakeholders in London and the North are more likely than stakeholders in other regions to agree that their CCG engages with the right individuals and organisations when making commissioning decisions (63% in London and 60% in the North agree, compared with 56% in the South and in the Midlands and East). In terms of the extent to which stakeholders agree that their CCG's plans are delivering continuous improvements in quality within the available resources, stakeholders in London are more positive than those in any other region (59% agree in London, compared with 55% in the North, 51% in the Midlands and East and 49% in the South).

While stakeholders in London and, to a lesser extent, the North tend to be more positive overall than those from other regions, one exception to this pattern relates to the ability to raise concerns about the quality of local services. In London, 81% of stakeholders agree that they would feel able to raise concerns, compared with 85% in the South and 84% in both the Midlands and East and the North.

When looking at those questions asked only of GP member practices, we tend to see the same pattern continue. Across a range of measures, GP member practices in London and the North are slightly more positive than those in the South and the Midlands and East. For example, 62% of GP member practices in London and 61% in the North report that their CCG's arrangements for member participation in decision-making are effective, compared with 59% in the South and

55% in the Midlands and East. Conversely, member practices in the Midlands and East are significantly more likely than member practices in London, or the North to say that these arrangements are ineffective (38%, compared with 31% and 33% respectively). The same pattern is true of the confidence that member practices have in systems to sustain two-way accountability between CCGs and member practices (62% in London and 60% in the North say that they are confident in these systems, compared with just 55% in the South and 54% in the Midlands and East).

However, there are exceptions to this pattern among those questions asked only of GP member practices. GP member practices in London, for example, are significantly more likely than member practices in any other region to say that they are unfamiliar with the financial position of their CCG (42% say this, compared with 34% in the North, 33% in the South and 31% in the Midlands and East). In the South, where member practices tend to be more negative than in other regions, GPs are more likely than in any other region to agree that representatives from member practices are able to take a leadership role in their CCG if they want to (74% agree, compared with 69% in the North, 68% in London and 67% in the Midlands and East).

While this general pattern of stakeholders in London and the North being more positive covers those questions asked of all stakeholders and those asked of GP member practices only, the same pattern is not discernible among upper tier and unitary local authority stakeholders, health and wellbeing board members, or representatives from Healthwatch and other patient groups. In fact, among these groups, no discernible differences are seen by region. The same is also true among NHS providers, with the exception that NHS providers in the Midlands and East are significantly more likely than those in any other region to say that clinicians are either not very or not at all involved in discussions about service redesign (30% in the Midlands and East say this, compared with 18% in London, 17% in the South and 16% in the North).

The patterns seen here are clearer than they have been in previous years of the survey – however, while a pattern is discernible, the differences are subtle. Rather than suggesting that a particular region is performing better or worse overall than another, these results broken down by region should serve to aid identification of specific issues for improvement in each region, along with where best practice to be shared across regions might come from.

12 Technical information

12.1 Stakeholder lists

As in previous years, responsibility for identifying relevant stakeholders, collecting their contact details and providing these to Ipsos MORI fell to each of the 209 CCGs included in the survey.

Information packs, including information on how to collate stakeholder lists, were provided to the lead contact at each of the CCGs on 14th November 2016. CCG leads were asked to submit their completed lists, along with any additional local questions, by 12th December 2016.

The table below displays the framework that CCG leads are expected to follow when compiling their stakeholder lists. This framework is based on one devised following the engagement conducted in 2014 and agreed with NHS England. Each of the core organisations that CCGs are asked to include are listed, along with possible job roles. The job roles listed are suggestions, and it is up to CCG leads to decide whether these are the most appropriate individuals to be included in the stakeholder list. This is in contrast to the authorisation survey in 2013, when particular individuals from each organisation were specified, and is designed to take into account the flexibility of local relationships.

Table 12.1: Core stakeholder framework

Organisation type	Maximum numbers	Possible roles (exact contact will vary by CCG)
GP member practices	One from every member practice of the CCG	Designated GP lead
Other CCGs with whom the CCG collaborates on commissioning services (e.g. formal commissioning arrangements)	Up to five stakeholders in total (if the CCG collaborates with more than five CCGs, select the five with the closest relationship)	Clinical lead and/or Chair
Health and wellbeing boards	One or two stakeholders per Health and wellbeing board geographically linked with the CCG	For each health and wellbeing board, one of the nominated stakeholders must be the Chair. The other could be a board member
Upper tier or unitary local authorities	Between one and five stakeholders per upper tier or unitary local authority geographically linked with	Chief Executive Director of Adult Services

	the CCG. At least one of the stakeholders included must be able to comment on behalf of the local authority on the CCG's role in: Safeguarding of children Safeguarding of adults	Director of Children's Services Director of Public Health Representative from the Overview and Scrutiny Committee Elected members
Local Healthwatch	Between one and three stakeholders per local Healthwatch geographically linked with the CCG	Chair
Other patient groups, organisations or representatives	Between one and five stakeholders in total	Senior representatives from local or branches of national patient groups that represent different groups and patients nominated by the CCGs as appropriate
NHS providers – Acute trusts	One or two from each main acute provider(s) for the CCG	Chief Executive Medical Director (From each main acute provider)
NHS providers – Mental health trusts	One or two from CCG's main mental health provider in terms of contract value	Chief Executive Medical Director
NHS providers – Community health trusts	One or two from CCG's main community provider in terms of contract value	Chief Executive Medical Director
Additional stakeholders	Up to ten additional stakeholders of the CCG's choice. Please note that inclusion of additional stakeholders is optional.	For more information on possible additional organisations and roles that CCGs may wish to include, please see section 2.3.

CCG leads also had the option of including up to 10 additional stakeholders, not included in the framework above. Staff from NHS England or from within the CCG are not permitted to be included within these additional stakeholders. This year, for the first time, CCGs were invited to include one contact from the Care Quality Commission (CQC) within these additional stakeholders.

Variation in arrangements at the local level mean that the framework above is not a perfect fit for all CCGs. NHS England recognised that this variation would occur and therefore some additional guidance was provided on how to interpret the framework in accordance with local circumstances. Some of the most common issues identified by CCGs, along with their solutions, are listed below:

1. The community health, acute and mental health providers were the same organisation: CCGs were asked to only include the relevant details once.

2. One stakeholder performed two of the roles listed in the framework: Where this was the case (e.g. there was overlap between the Health and wellbeing board and Local Authority), CCGs were asked to nominate an alternative for one of the positions. If that was not possible, separate links to the survey were sent to the stakeholder for them to complete in respect of each role. The email containing the link and the introduction to the survey made it clear to which stakeholder group the survey was referring.

3. Stakeholders also being members of the CCG Governing body: As stakeholders are instructed to complete the survey from the perspective of their stakeholder organisation, rather than from any other role (e.g. their role on a CCG governing body), CCGs were advised that it was at their discretion whether to include these stakeholders in their list. Where CCGs opted to not include these stakeholders they were requested to provide alternative names.

4. CCGs working as a federation, where certain stakeholders will not be able to separately identify the individual CCGs within the federation: Due to the nature of the CCG improvement and assessment 2016/17 process, NHS England requires information at the CCG level even in cases where multiple CCGs are operating under a federation. However, this proves problematic for some CCGs and their stakeholders, who may not be able to distinguish between the relationships they have with the various CCGs that form the federation. To allow increased flexibility for CCGs working under these arrangements, a separate process for federated CCGs was introduced in 2017. This process allowed each federation to provide one 'federated' stakeholder list, including all those stakeholders who see the federation of CCGs as a single body. These stakeholders were asked to complete the survey only once, with reference to the federation as a whole.

A separate stakeholder list was then also provided by each of the CCGs within the federation, including those stakeholders whose relationship is with their individual CCG only. Stakeholders from these lists were asked to complete the survey as usual.

In order to provide NHS England with data at the CCG level, results from the federated stakeholders were duplicated for each CCG within the federation.

CCGs were asked to provide the following details for each stakeholder:

- Allocation to a stakeholder group
- Organisation

- Job title
- Full name
- Department (if applicable)
- Email address and telephone number of main contact
- Alternative email for main contact or email address for someone else (e.g. PA)

In order to ensure that all CCG stakeholder lists are provided in a consistent format, Ipsos MORI provides CCG leads with a stakeholder list template in Microsoft Excel, and this template also includes a separate tab for inclusion of CCG local statements. Once the Excel template has been completed, CCG leads are asked to submit this to Ipsos MORI via our secure CCG portal.

While, due to survey timings, it is not possible to fully check every stakeholder list, on receipt of the stakeholder lists, Ipsos MORI undertakes basic checks to ensure that the lists have been submitted in the required format.

A number of CCGs provided lists which were incomplete or inaccurate. Where there were a larger number of errors[4], Ipsos MORI worked with the CCG to make corrections. Where necessary, CCG leads are asked to make amendments and re-submit their lists. It was each CCG's responsibility to submit the list of stakeholders, act on any advice and, if necessary, re-submit an accurate list by the final deadline.

12.2 Questionnaire design

The 2017 questionnaire was largely based on that used in 2016, 2015 and 2014. This original questionnaire was developed by Ipsos MORI with input from CCGs and NHS England. Input into the questionnaire was sought via a co-design event for the survey in London, the aim of which was to ensure that the CCG 360 Stakeholder Survey was able to both support CCG's annual improvement and assessment conversations with NHS England and provide CCGs with a valuable tool for evaluating their progress and informing their organisational development.

It is important to both CCGs and NHS England that the survey remains comparable to previous versions, in order to allow for tracking of improvement and areas which have regressed. For this reason, the questionnaire for the 2017 survey followed a similar structure to the previous versions of the questionnaire, and only minimal changes were made to questionnaire wording. However, to account for the fact that the survey is now in its fourth year, and to help combat survey fatigue among respondents, a thorough questionnaire review was conducted prior to 2017 which resulted in a shortened questionnaire. A review was undertaken to ascertain which questions, if any, had seen only minimal changes in results across years. This list of questions was then discussed with NHS England and also the 360 survey CCG engagement group, and the decision was taken that some of these questions could be asked once every two waves, rather than every year.

[4] A list of common errors is included in Chapter 14.

As in previous years, the questionnaire was divided into a number of sections. The first section, on overall engagement, working relationships, plans and priorities and CCG leadership, was asked of all stakeholders taking part[5]. Additional sections were each aimed at a specific stakeholder group, allowing the survey to reflect the diverse areas of experience and knowledge that different stakeholder groups have with CCGs. All stakeholder groups were asked to answer one of these additional sections of specialised questions, apart from those stakeholders who were classed as either 'wider stakeholder group', 'other CCGs' or 'CQC'. The wording for GP member practices differed slightly to that for other stakeholders to reflect their status as a constituent member of CCGs rather than external stakeholders.

Finally, stakeholders were asked up to five local questions, specific to the CCG, where these were provided by the CCG. These were done in the form of a statement asking the stakeholder to rate CCGs. The statement or 'stem' of the question was standardised across all CCGs: 'How would you rate [CCG] on each of the following…'. CCGs were then able to identify up to five statements that fitted with this stem.

A standardised questionnaire was used across all CCGs. The name of the CCG was included within the question wording to make it clear to stakeholders which CCG they were answering about; this was especially important for those stakeholders who had been asked to complete surveys for multiple CCGs.

Questions were closely linked to each of the four domains set out in 'CCG improvement and assessment framework 2016/17'. This document outlines the criteria and evidence sources against which CCGs will be assessed during their assessment conversations. Questions were included in the survey for all components for which the CCG 360° Stakeholder Survey was intended to provide evidence.

The questionnaire predominantly comprised 'closed' questions which required stakeholders to select a response from a pre-specified scale or series of options. By using 'closed' questions the survey remained relatively short (taking an average of 20 minutes to complete by telephone), therefore reducing the burden on stakeholders. However, to ensure that CCGs gain more detailed insight into some of the reasons behind answers to closed questions and to allow stakeholders to feel they can respond more fully, stakeholders were also asked at least five free text questions during the survey.

12.3 Fieldwork

Fieldwork for the CCG 360° Stakeholder Survey was conducted using both an online and telephone methodology and was completed over a six-week period between 16th January and 28th February 2017. Fieldwork was extended this year based on feedback from CCGs, and in an effort to help boost response rates. In order that the end of fieldwork be timed to allow reporting back in advance of the scheduled annual improvement and assessment conversations between NHS England and CCGs, the fieldwork period began two weeks earlier than usual rather than ending two weeks later. As such, the timeframe allowed for surveys to be completed, the data to be analysed and disseminated to CCGs as closely as possible to these conversations.

[5] This is with the exception of CQC stakeholders, who were asked only four questions from the overall section. These questions were agreed in advance with NHS England, and took into account the difference in the nature of relationships between CCGs and the CQC and CCGs and their stakeholders.

Online fieldwork

At the launch of fieldwork, invitations to the online survey were emailed to every stakeholder for whom an email address was provided. Once the initial email invitation had been sent out to all stakeholders, CCG leads were informed that the survey was live and encouraged to send follow-up emails to further encourage participation.

To maximise response rates to the online survey, following the initial invitation, up to five reminder emails were sent out at weekly intervals to those who had not yet completed the survey.

The invitation and reminder emails all included details of the research and a link to the survey. To ensure that the survey was only completed once, the link was personalised and unique for each stakeholder. Using a unique link had a number of advantages:

- stakeholders were unable to complete the survey more than once;
- this removed the need for stakeholders to input a password to gain access to the survey;
- stakeholders were able to leave the survey at any time if necessary and return to the same point later; and
- reminders could be targeted specifically at non-responders and stakeholders who had started but not completed the survey, rather than all stakeholders.

Where email addresses for secondary contacts were provided, email invitations and reminders were sent to both the main email address and the secondary email address for each stakeholder. The email to the secondary contact made it clear that the survey had been sent to the main contact for completion, and asked for their assistance in bringing it to the main contact's attention.

A telephone and email helpline service was provided for the duration of fieldwork; contact details for the Ipsos MORI research team were included in the invitation and the survey itself in case respondents had any queries or encountered any difficulties completing the survey.

In the 2014 survey, a number of stakeholders experienced issues with accessing the survey via the link that was included in the email invitation. To avoid these issues, as in 2015 and 2016, the link was provided to stakeholders in plain text, which had to be copied and pasted into their browser. However, due to local security settings a minority of stakeholders had difficulty accessing the survey via the link that was included in the email invitation. Where the team at Ipsos MORI was alerted to this problem, the first response was for a member of the Ipsos MORI team to send the email again from their personal email account. In the vast majority of cases this ensured the stakeholder received their survey link, but where it did not, the stakeholder's details were taken and they were prioritised for a telephone interview. Appointments for the telephone interview were arranged at a time convenient for the stakeholder.

Telephone fieldwork

To assist in securing a high response rate, stakeholders were offered the option of completing the survey by telephone. Telephone interviews were available to all stakeholders from the start of fieldwork. For the first two weeks of fieldwork however, the telephone team only interviewed stakeholders who asked specifically for a telephone interview or those who were experiencing difficulty accessing the online survey.

After two weeks of fieldwork, details of those who had not yet responded to the online survey were sent to the Ipsos MORI telephone interviewing team for follow up. The purpose of these telephone calls was threefold:

- to obtain interviews over the telephone; or
- to remind stakeholders to take part online; or
- if the stakeholder refused to take part, to try and complete a short non-response survey.

Ideally, the telephone call would result in a telephone interview with the respondent or an appointment for a telephone interview at a later time. However, if the respondent did not want to complete the survey by telephone, the interviewer would encourage them to fill it out online. The telephone interviewer also had the option to email the online link to the respondent again if they wanted to complete the survey online but had missed or lost the original invitation. As a worst case scenario, if the respondent did not want to take part in the survey, they were asked to participate in a short non-response survey.

The content of the telephone questionnaire was exactly the same as the content of the online questionnaire. A total of 1287 stakeholders completed the survey by telephone, accounting for 15 % of the total responses. Many phone calls also resulted in stakeholders completing the survey online having been emailed their survey link again by the telephone interviewers.

12.4 Response rates

In total 8,516 completed surveys were achieved from a total sample of 13,691 stakeholders. This gave an overall response rate of 62.5%. When looking at the level of stakeholder groups, variation in response rates is apparent. In particular, NHS providers (48%), and upper tier/unitary local authority stakeholders (56%) have the lowest response rates. Other CCGs have the highest response rate at 74%.

This year's response rate of 62.5% compared with a response rate of 59% to the 2015 survey. This rise in response rate appears to be driven by some groups more favourably than others. The response rate among GP member practices, for example, has risen from 56% in 2016 to 63% in 2017, and among HWB board members the response rate has risen from 58% in 2016 to 61% this year. Other groups have seen a fall in their responses, such as NHS provides (whose response rate is 48% this year, in comparison with 55% in 2016). A full breakdown of response rate by stakeholder group, along with a comparison to 2016, is provided below.

Table 12.2: Response rate by stakeholder type

	2017	2016
GP member practice	63%	56%
Health and wellbeing board	61%	58%
Healthwatch/other patient groups	73%	75%

NHS provides	48%	55%
Other CCGs	74%	76%
Upper tier/unitary Local Authority	56%	57%
Wider stakeholders	60%	60%
Total	62.5%	59%

This year's response rate is discussed in detail in the 'project learnings' chapter of this report.

In 2017 a larger proportion of respondents completed the survey over the phone than in previous years (9% in 2016 and 10% in 2015). The proportion of surveys that were completed by telephone varies by stakeholder group and is highest among GP member practices (20% of GP member practices, accounting for 11% of all interviews). Among NHS providers, however, just 4% of the total completes were conducted via telephone interview.

12.5 Statistical reliability

Because a sample of stakeholders, rather than the entire population of stakeholders, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50 % of the stakeholders in a sample of 8,422 respond with a particular answer, the chances are 95 in 100 that this result would not vary more than one percentage point, plus or minus, from the result that would have been obtained from a census of the entire population of stakeholders (using the same procedures). An indication of appropriate sampling tolerances that may apply to the overall sample size and various stakeholder sup-groups in this survey are given in the following table.

Strictly speaking the tolerances shown here apply only to random samples, so these tolerances should be treated as indicative only. In addition, for this particular survey, the size of the population of stakeholders is unknown for the most part, so again the figures below should be treated as indicative only.

Table 12.3: Statistical reliability of the survey

Size of sample on which the survey results are based	Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)		
	10% or 90%	30% or 70%	50%
	±	±	±
100	5	8	9
400	3	5	5
900	2	3	3
5,000	1	1	1
8,516	1	1	1

When comparing an individual CCG's results from a question asked of all stakeholders to the overall average result across all CCGs, a difference must be of at least a certain size to be statistically significant. The following table is a guide to the required differences for CCGs with different numbers of stakeholders, bearing in mind the caveats mentioned above.

Table 12.4: Statistical reliability of the survey – comparing responses

Size of total sample on which the individual CCG's survey results are based	Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)		
	10% or 90% ±	30% or 70% ±	50% ±
119	5	7	9
70	7	11	12
50	8	13	14
30	11	17	18

The following table is a guide to the required differences for comparing a CCG's member practices with all member practices across all CCGs.

Table 12.5: Statistical reliability of the survey – comparing an individual CCG's GP member practices

Size of total sample on which the individual CCG's GP member practice results are based	Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)		
	10% or 90%	30% or 70%	50%
	±	±	±
88	6	10	11
68	7	11	12
56	8	12	13
20	14	21	23
10	20	30	33

The results for other stakeholder groups for individual CCGs should not be compared with the average for the same stakeholder group across all CCGs, because the number within each individual CCG will be very small.

13 Project learnings

This chapter of the report reviews the survey processes, discusses what worked and explores the lessons that can be learned for stakeholder surveys that are conducted in future years.

13.1 Incorporating feedback from CCG leads

In order to enable tracking of stakeholder engagement across years, the 2017 questionnaire and survey processes remained relatively similar to that of 2016. In order to identify any improvements that could be made without affecting comparability between years however, prior to the 2016 survey being commissioned, NHS England asked CCG leads to provide written feedback on potential improvements under the following headings:

- Initial communications
- Stakeholder lists
- Information materials
- Questionnaire
- Reporting

The CCG leads' feedback provided valuable insight into small ways in which the questionnaire could be updated to make it more relevant and the survey processes improved to make them more straightforward for CCG leads and stakeholders. The key themes that were apparent in the feedback were:

- The survey processes were seen to have been refined over the years and now run fairly smoothly. The consistency in the survey processes over the years makes the process of collating stakeholder lists and managing the survey processes within the CCG more efficient for CCG leads.
- The time of year at which the survey fieldwork is conducted – at the end of the financial year – makes it challenging for some stakeholders to participate, due to other work pressures. As such, changing the fieldwork timings has the potential to improve response rates.
- The questionnaire content was generally all felt to be useful however there was feedback on where improvements could be made. For example, the questionnaire was felt to be too long (particularly for GP member practices).
- Following changes made in 2016, the CCG level reports were found to be clear, concise and easy to use.

In order to take this feedback forward and incorporate it into the 2017 survey, an engagement meeting was held with CCG leads. This allowed the Ipsos MORI and NHS England teams to hear directly from end users of the survey data on how it could be improved. While the feedback from the meeting informed all aspects of the survey, there was a particular focus on updating the questionnaire to make it better meet the needs of CCGs.

13.2 Stakeholder lists

Feedback on the stakeholder list framework was generally positive and the efforts made in previous years to make the lists less prescriptive, continue to be welcomed. Allowing CCGs some freedom to tailor their stakeholder lists ensures that they can select the most appropriate stakeholders locally from each organisation to take part. It also allows for the variation between CCGs in terms of the organisations (and individuals within those organisations) they work closely with.

However, two further changes to the stakeholder lists were made following feedback this year:

- Arrangements for CCGs working as a federation: To allow increased flexibility for CCGs working as a federation, a separate process for federated CCGs was introduced in 2017. This process allowed each federation to provide one 'federated' stakeholder list, including all those stakeholders who see the federation of CCGs as a single body. These stakeholders were asked to complete the survey only once, with reference to the federation as a whole. A separate stakeholder list was then also provided by each of the CCGs within the federation, including those stakeholders whose relationship is with their individual CCG only. Stakeholders from these lists were asked to complete the survey as usual.

- The inclusion of CQC stakeholders: CCGs were invited to include a representative from the CQC on their stakeholder list. The inclusion of a CQC representative was optional, and in practice, only a small proportion of CCGs chose to include them.

To inform the stakeholder list in future years, it will be useful to gather feedback on how these changes were received by CCGs.

In previous years, a small number of CCGs have missed the deadline for stakeholder lists, meaning that the start of fieldwork was delayed for these CCGs. This year however, all 209 CCGs supplied their stakeholder lists by the deadline, ensuring that fieldwork started on time for all CCGs. There are a number of possible reasons for this:

- The timings for collating stakeholder lists changed this year; whereas previously CCG leads had been asked to collate the lists in January/February, this year, leads were asked to collate the lists in November/December.

- When asking for CCG lead nominations, NHS England provided CCGs with information about the survey timings. This may have allowed more appropriate leads – with the required availability – to be nominated.

- CCG leads report that, each year, improved processes and information materials (as well as increased familiarisation among CCG leads) mean that collating the list becomes more straightforward and efficient.

Another point that became apparent in previous years of the survey, and which continued to be an issue this year, is that many CCGs based their list on the pre-existing list from the 2016 survey. While this is a useful shortcut to take, in some cases it was clear that it resulted in stakeholder contact details being out of date. If CCGs are using lists from previous surveys as a basis for their list in the future, it must be emphasised that contact details must still be checked very carefully.

In general, the quality of stakeholder samples was high compared with previous years which is likely to reflect the increased length of time allowed to collate the lists, the simplification of the information materials, and increased familiarisation among CCG leads with the stakeholder list requirements.

13.3 Questionnaire

The format of the questionnaire remained in the same format since the original authorisation survey; an overall section upfront containing a series of general questions asked to all stakeholders followed by a short section of questions specific to each key stakeholder group. This approach ensures that all key elements, however specific, can be assessed using a single questionnaire without overburdening stakeholders or asking them to comment on topics that were outside their sphere of expertise.

However, feedback from CCG leads this year revealed a requirement for certain aspects of the questionnaire to be reviewed. CCGs' main concerns were:

- That the questionnaire is too long, particularly for GP member practice stakeholders who are asked a relatively large sub-set of the questions.
- That some of the questions are very similar to each other, or have ambiguous wording which could be confusing to stakeholders and make the interpretation of results challenging.
- That some questions ask about very specific aspects of the CCG's remit, and that, even when asked only of specific stakeholder groups, many stakeholders were unable to provide an accurate or informed response.

In response to these concerns, the questionnaire was reviewed with the aims of identifying:

- Questions that CCGs did not find helpful, or that were no longer relevant, and could be removed.
- Questions where the wording was ambiguous, or where the data was difficult to interpret, and which needed amending to aid understanding.
- Questions where the data showed little movement across years, and which could be asked every two years rather than annually.

Questions identified for potential removal were discussed with the engagement group before the questionnaire was finalised. In total, nine questions were removed; four from the overall section, one from the Healthwatch and other patient group section, two from the GP member practice section and two from the NHS providers section. The wording of four questions was amended, either to clarify the question or to include additional relevant information. Two new questions, about patient and public involvement, were added. Finally, two questions were removed this year but will be asked on a biennial basis going forward.

As in previous years, most questions in the questionnaire seemed to work well, with only small proportions for respondents saying they didn't know the answer to any one question. It will be useful to receive feedback from stakeholders or CCGs about the changes to the questionnaire – whether this has any impact on how the data is used or whether the shorter questionnaire length was noted by stakeholders.

As well as the core standard questionnaire, CCGs also had the opportunity to add up to five local questions that would only be asked of their stakeholders. In order to implement this across 209 CCGs it was necessary for some element of standardisation to be present. As such, the 'stem' of the question was standardised across all CCGs: 'How would you rate [CCG] on each of the following…'. CCGs were then able to identify up to five statements that fitted with this stem. In total, 77 of the 209 CCGs took up the opportunity and included at least one local statement (compared with 80 CCGs in

2016). Many CCGs chose to include the same statements that they had asked at the previous surveys to allow them to track changes in the responses over time.

This year, an error in the survey set-up process meant that for two CCGs, a sub-set of the local questions failed to be asked in the survey. In future years, an additional stage in the checking process will be added to ensure that this error does not occur

13.4 Methods

The methodology for the survey, which has been honed over the previous years, was kept relatively consistent for this year's survey. Overall, it continued to work well. The mixed methodology of an online survey in conjunction with a telephone follow-up meant that stakeholders had multiple opportunities to take part in the survey in a way and at a time convenient to them.

One large change that was made to this year's methods was to increase the length of fieldwork to six weeks. This follows a previous increase in 2016; from four to five weeks of fieldwork. This change was made as a result of feedback from CCGs and stakeholders that the time pressures on stakeholders during the fieldwork period led to non-response.

Related to this, another change was to move the survey fieldwork period. In all previous years of the survey, fieldwork has been conducted at the end of quarter 4, between March and April. As this is a very busy time of year for many stakeholders, and feedback data has indicated it is a key reason for non-response, fieldwork in 2017 was conducted from January to February.

13.5 Response rates

While the survey's response rate has always remained high, until this year the general trend had been that of a decline. This year however, the response rate saw a 3.5 percentage point increase, from 59 % to 62.5 %. As always, the response rates vary by stakeholder group and were lowest among NHS providers (48%), upper tier and unitary local authority stakeholders (56%), wider stakeholders (60%) and HWBs (62%). Much of this year's increase in response rates was driven by GP member practices who saw their response rate increase by seven percentage points, from 56 % to 63 %, since 2016 (see full breakdown in table in Chapter 12).

All respondents who were contacted by our telephone team were asked why they had chosen not to complete the survey online. The responses throw some light on the reasons that stakeholders do not complete the survey. As in previous years, the majority of stakeholders (62%) say that they were too busy. Smaller proportions cited technical problems (7%), did not think the survey was relevant to them (3%), or forgot about the survey (4%). GPs were particularly likely to say that they were too busy (66% compared with 55% of other stakeholder groups). As GPs are the largest stakeholder group in the sample, continuing to tackle the issue of GPs finding time to complete the survey seems key to increasing response rates further.

Finally, increasing the length of the fieldwork period may help to increase the response rate. However, given that the fieldwork period was increased by an additional week last year, and the response rate continued to fall, increasing the length of the fieldwork period may not have been a key reason behind the increase in response rates. Rather, the combination of moving the fieldwork period and increasing its length is likely to have been the key reason for the increase in response rates.

13.6 Reporting

The requirements for reporting were key considerations for the project as the lasting outputs that CCGs and NHS England local teams will use going forward.

Each CCG was provided with a PowerPoint report containing a slide for every question. The report contained comparisons of the CCG against the previous year, the average for all CCGs, the cluster[6] and Directors of Commissioning Operations (DCO) teams. It should be noted that there are significant caveats around comparisons of the results due to small stakeholder numbers and differences in stakeholder lists.

In addition to the PowerPoint report, CCGs were also provided with a PDF of the verbatim comments stakeholders gave to the open questions included in the survey. Feedback suggests this has been useful for CCGs as it provides them with additional information to help understand and interpret their results in a more meaningful way.

Prior to the 2016 survey, two engagement sessions were held with CCG leads in order to refine and clarify the PowerPoint reports. Substantial changes were made to the reports following these engagement groups, to reflect the needs of CCG leads. Feedback suggested that CCG leads found the reports improved; comments suggested that they were clear, concise and in a useful format. As such, relatively few changes were made to the report this year. The largest change was that, rather than being structured around assurance components – as it was in previous years – the report was re-structured by stakeholder type. This approach was taken to ensure that it remained easy to navigate in light of the changes to the 2016/17 improvement and assessment framework.

[6] Each CCG is compared to a cluster of the 20 other CCGs to which they are most similar in terms of Index of Multiple Deprivation averages (overall and health domain), age of population, ethnicity, population registered with practices, population density and ratio of registered population to overall population.

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