Engaging patients and the public in the commissioning and provision of services is recognised as best practice and is also a statutory requirement under the Health and Social Care Act (2012). However, the multiplicity of models and definitions for patient and public engagement (PPE) can make decisions about ‘how’ and ‘when’ to engage appear difficult. This review was commissioned by the engagement health and wellbeing board learning set, part of the National Learning Network for health and wellbeing boards.

PPE decisions are most appropriately taken and implemented when there is clarity about who needs to be engaged and for what purpose. The term PPE includes members of the public, carers and the range of people using services.

The following list of documents provides different ideas of ‘how’, ‘when’ and ‘why’ to do patient and public engagement; it is not an exhaustive list. Two over-arching principles emerge for health and wellbeing boards from this body of information and guidance.

**Key points**

- The multiplicity of models and definitions for patient and public engagement (PPE) can make decisions about ‘how’ and ‘when’ to engage appear difficult.
- PPE decisions are most appropriately taken and implemented when there is clarity about who needs to be engaged and for what purpose.
- People’s needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done.
- Engagement is needed most while HWBs are developing, new key cultures are being established and priorities are being set.

**At a glance**

**Audience:** This review is aimed at health and wellbeing board (HWB) members.

**Purpose:** To give HWB members an overview of the policy context in relation to public and patient engagement and to signpost to resources.

**Background:** This review was developed by a HWB learning set, which is part of the National Learning Network (see back cover) and is supported by the Department of Health, NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.
• Engagement should take place from the start of the life of the board and be woven into the DNA of the board throughout its work. The board’s start-up phase will be a demanding time and PPE could feel like an additional task, however it is while new strategies are being formed, new cultures are developing and priorities are being decided that engagement is needed most. It will be difficult to ‘hardwire’ engagement into the board at a later stage.

• There will be different types and levels of appropriate engagement depending on the situation. It is important that the board has a consistent and rigorous mechanism by which it can assess what form of engagement should take place at each new turn and evaluate its success.

Patient and public engagement (PPE): policy context and theory

National Council for Voluntary Organisations (September 2011), Pathways through Participation: What creates and sustains active citizenship?
www.ncvo-vol.org.uk/policy-research-analysis/research/pathways-through-participation

This project aimed to improve our understanding of how and why people participate, how their involvement changes over time, and what pathways, if any, exist between different activities. The findings conclude that there is a spectrum along which policymakers can have an effect, specifically, that they can:

- acknowledge an individual's motivations but are unlikely to change them
- influence an individual's resources (practical, social, learnt) which may act to facilitate participation
- shape opportunities for participation, such as the presence and effectiveness of organisations, events and public spaces. Good opportunities may trigger participation whereas poor opportunities or experiences will deter.

This work emphasises the importance of getting to know those you would like to engage with so that the engagement can be intelligent and productive for both parties.

Department of Health (September 2009), Putting people at the heart of care.

This document sets out the vision for patient and public engagement and experience in the NHS. It explains what it means and the role it can play in driving up the efficiency, quality and productivity of services.

National Institute for Health and Clinical Excellence (February 2008), Community engagement to improve health.

This document provides public health guidance on community engagement and community development approaches to health improvement, including the use of collaborative methodology and community champions. The guidance is for those working in the NHS and other sectors who have a direct or indirect role in – and responsibility for – community engagement. This includes those working in local authorities and the community, voluntary and private sectors.
NESTA and nef (July 2010), *Right here, right now: taking co-production to the mainstream.*

www.nesta.org.uk/publications/reports/assets/features/coproduction_right_here_right_now

People’s needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done. This is the underlying principle of co-production. However, the authors of this report suggest that, to date, public services have a tendency to disempower people who are supposed to benefit from services, to create waste by failing to recognise service users’ own strengths and assets, and to engender a culture of dependency that stimulates demand.

The report makes recommendations in three areas.

- Change the way services are managed and delivered: the report explores how to make it everybody’s business by building the key features of co-production into services. What are the necessary systems, structures, incentives and workforce skills to mainstream co-production?

- Change the way services are commissioned: build co-production into the commissioning framework, give priority to prevention, encourage flexibility and collaborative working and, finally, measure what matters.

- Open up new opportunities for co-production: launch prototypes in new sectors to test how co-production could be mainstreamed. Introduce a ‘co-production guarantee’ to facilitate wider adoption and scaling.

**People Powered Health**

People Powered Health is a programme from NESTA, working with the Innovation Unit, to support the design and delivery of innovative co-produced services for people that are living with long-term health conditions. There are six teams around the country and learning will be translated into a series of tools and products throughout 2012.

www.nesta.org.uk/areas_of_work/public_services_lab/people_powered_health

**Patient and Public Involvement Solutions (June 2008), RADAR Community engagement toolkit.**

www.patientpublicinvolvement.com/RADARfinal.pdf

This toolkit has been developed to assist organisations and groups to engage with and involve the full diversity of their local communities. It explores creating an ongoing conversation with communities “in their ways, in their time, and on their issues” and is based around five key processes: reflection, assessment, development, action and review.

The toolkit guides its audience through an assessment of the appropriate level of involvement and type of involvement an organisation needs to consider.
Healthwatch

Department of Health (March 2012), Local Healthwatch: A strong voice for people – the policy explained.

healthandcare.dh.gov.uk/files/2012/03/Local-Healthwatch-policy.pdf

Healthwatch is a new consumer champion set up to ensure the NHS is “genuinely centred on patients and carers” and aims to “give citizens a greater say in how the NHS is run”. To be established in April 2012, in its local form it will influence Joint Strategic Needs Assessments and joint health and wellbeing strategies through its statutory seat on every health and wellbeing board. At a national level, as Healthwatch England, it will be a statutory committee of the Care Quality Commission (CQC).

It is proposed that local Healthwatch will:

- provide information and advice to the public about accessing health and social care services and choice in relation to aspects of those services
- make the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion, including recommendations to advise the CQC to carry out special reviews or investigations into areas of concern
- promote and support the involvement of people in the monitoring, commissioning and provision of local care services
- obtain the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services
- make reports and recommendations on how those services could or should be improved.

“Healthwatch will strengthen the collective voice of local people across both health and social care, influencing Joint Strategic Needs Assessments and joint health and wellbeing strategies.”

Department of Health (2012), Local Healthwatch: A strong voice for people.

Local Government Association (April 2012), Building successful Healthwatch organisations

www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3506130/PUBLICATION-TEMPLATE

Local authorities are responsible for commissioning local Healthwatch organisations and this publication aims to help local authority commissioners to plan and implement robust Healthwatch organisations by April 2013. The 15 case studies in this report highlight some of the innovative work already taking place across the country as well as common threads and critical success factors.

Further learning on the development of Healthwatch will be available from the Local Government Association’s knowledge hub website:

https://knowledgehub.local.gov.uk/signin?saveLastPath=0
Patient and Public Involvement Solutions (January 2012), Shaping local Healthwatch – The actions and findings of 9 local authorities.

www.patientpublicinvolvement.com

A large number of diverse people across nine local authorities were asked for views on their desired shape for a local Healthwatch. Five key themes emerged together with the words most commonly used by all involved to express what they wanted with regard to each theme. Healthwatch should have:

- leadership which is professional and accountable
- management and operations which are professional, intelligent, a coordinated ‘hub’
- profile as being independent, genuinely representative, and evidence based
- representative, inclusive and diverse partnerships, existing networks and multiple access routes
- influence and independence that comes from being transparent, non-political and credible.

Centre for Public Scrutiny (September 2011), Smoothing the way – Developing Healthwatch through lessons from Local Involvement Networks (LINks).

www.cfps.org.uk/?id=484

The experience of Local Involvement Networks (LINks), the predecessor to local Healthwatch, has been very mixed. Centre for Public Scrutiny (CfPS) has reviewed their successes and their failures to develop lessons for Healthwatch. These lessons include:

- support with branding will help establish awareness of local Healthwatch so that people want to engage with local Healthwatch
- thinking about demography and geography when developing a patient and public engagement strategy is key, for example dispersed or transient populations may need extra help to engage
- local data and intelligence is needed alongside evidence about the experience of people who use services to ‘make a case’ for seldom heard voices
- a focus on current services risks missing opportunities to influence wider health and wellbeing and strategic commissioning
- ‘enter and view’ powers are an important tool for local Healthwatch to consider, as are lessons from complaints.

Public and patient engagement in commissioning and provision

Department of Health (August 2011), Better health, better experience, better engagement.

http://healthandcare.dh.gov.uk/better-health

This is a practical framework to help emerging clinical commissioning groups think through how they build engagement and insights into the care experience and commissioning from the outset. It provides practical advice, suggestions for action, signposting to examples of good practice and a summary of evidence of what works. It draws together the learning on good engagement and experience from emerging clinical commissioning groups across the country.
NHS Kent and Medway, Surrey and Sussex (September 2011), Supporting clinical commissioning groups in establishing meaningful engagement with patients, carers and their communities.

This pack was developed for clinical commissioning groups (CCGs) in three counties to ensure that adequate preparation for authorisation was taking place on the key requirement of meaningful engagement with patients, carers and their communities. The pack would be of use to any CCG thinking about the engagement requirements, and includes:

- a 'stocktake tool' to allow CCGs to assess their progress in all the areas of engagement in the authorisation process
- a guide to creating an action plan towards authorisation, including thinking through what support is needed and from where
- an outline of the statutory requirements on CCGs regarding engagement and key policies
- a detailed look at the core elements of engagement for use in the development of the engagement strategy
- in-depth working examples of engagement development with CCGs
- in-depth working examples of engagement processes in PCTs.

Local Government Association (March 2010), A glass half full – how an asset based approach can improve health and wellbeing.

www.local.gov.uk/c/document_library/get_file?uuid=fc927d14-e25d-4be7-920c-1add80bb1d4e&groupId=10171

This publication provides an introduction to the asset based approach, which focuses on assessing and building on the strengths and resources of a community rather than its needs and deficits. The document outlines a number of different ways to engage communities, including appreciative enquiry, participatory appraisal and open space technology.

A new publication on appreciative enquiry is due to be published by the LGA in June, 2012.

Centre for Public Scrutiny (May 2011), Peeling the onion: Learning, tips and tools from the Health Inequalities Scrutiny Programme.

http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

This document provides insight into how Overview and Scrutiny Committees have engaged with local people in the improvement of health services. It provides a series of tips on what works, in areas including:

- good facilitation, management and leadership
- giving time to the process of relationships
- valuing involvement and feedback results
- the way you feed back to stakeholders
- getting the right approach.

The King’s Fund (2011), Making shared decision-making a reality: no decision about me without me.

Shared decision-making is the process by which clinicians and patients work together to select tests, treatments, management or support packages, based
on clinical evidence and the patient’s informed preferences. There is compelling evidence that patients who are active participants in managing their health and healthcare have better outcomes than patients who are passive recipients of services. Shared decision-making is also important for commissioners because it reduces unwarranted variation in clinical practice. However, effective shared decision-making is not yet the norm. To make it a meaningful reality we need:

- greater national provision of decision-aids and the development of common and consistent approaches
- the identification of decision points in care pathways and the monitoring of the quality of shared decision-making
- better provision, recording of, and support for, shared decision-making by providers
- inclusion of the subject in training and appropriate incentivisation
- the inclusion of shared decision-making in commissioning standards and contracts.

NHS Confederation (October 2011), Patient and public engagement in the new commissioning system.
www.nhsconfed.org/Publications/discussion-paper/Pages/PPE.aspx

Effective public and patient engagement can lead to more patient-centred care, a greater sense of ownership among patients and moderated demand for healthcare resources. However, the evidence for the effectiveness of engagement in commissioning is less clear. The authors urge CCGs to look beyond practice lists in order to reflect the needs of geographical populations which may encompass many different characteristics. They remind commissioners that the quality of engagement will affect the reputation of the organisation and the trust of the local community. This paper provides a useful view on what ‘good engagement’ looks like: focused on culture rather than structures or techniques; integral to all activity; strategic, clear and coordinated; open and transparent; well resourced and supported; inclusive and representative; flexible; collaborative; sustained and focused on improvement. The paper also lists common techniques used in engagement work in the NHS, detailing their advantages, disadvantages and characteristics.

NHS Confederation (March 2012) Putting people first through shared decision-making (SDM) and collective involvement.
http://conference.nhsconfed.org/SiteCollectionDocuments/Putting_people_first_200312.pdf

This paper explores what it really means to put people first when commissioning and providing services, and sets out what we know about the benefits. Collective involvement is the engagement of people, patients and communities in the design, commissioning and delivery of services.

Individual shared decision-making (SDM) comes into its own in clinical situations that are not clear cut and where there is no clinical evidence in favour of one single best option, the authors suggest that it is relevant in the majority of cases. This paper signposts to some SDM tools.

As regards collective decision-making, the way the current health reforms bring the local democratic process together with setting priorities for health commissioning represents a significant opportunity. However, collective involvement is about involving all groups within communities, including those that do not hold a vote such as children, and the onus must be on ensuring those rarely heard voices are not lost.

There are two prevailing principles that inform user involvement in the strategic commissioning cycle, which is set out in diagrammatic form in this paper:

- that service users could and should be involved in each stage
- that there is discussion and agreement at each stage of the commissioning cycle of the purpose, role and boundaries of authority of both service users and commissioners.

Having involvement processes that are integral (rather than add-on) to monitor, evaluate and review change is crucial, according to this report. It is also crucial that any learning is shared.

This document was developed as part of the National Learning Network for health and wellbeing boards, a programme funded by the Department of Health and supported by the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement. Each health and wellbeing board learning set has focused on a theme that early implementers have said is of most interest and importance.

It aims to provide health and wellbeing board members with an accessible and helpful resource and does not necessarily showcase best practice but represents key learning on the issues. For further information, or to comment, please email hwb@nhsconfed.org.

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