

# **Service user engagement and health service reconfiguration: a rapid evidence synthesis**

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## **Abstract**

### **Background**

UK NHS organisations are required to consult patients and the public about proposals for major changes to services. The evidence base for current UK guidance is unclear.

### **Objectives**

To assess what is known about effective patient and public engagement in reconfiguration processes and to identify implications for further research.

### **Design**

Rapid evidence synthesis.

### **Setting**

Health services affected by reconfiguration proposals in the UK (particularly the English) NHS and similar health systems.

### **Participants**

Members of the public and their representatives, patients and patient groups.

### **Interventions**

Any intervention to encourage patients and the public and their representatives to be involved in discussions about proposals for major service change.

### **Main outcome measures**

Any measure of ‘successful’ engagement as reported by health service decision-makers, patients and public representatives. We were also interested in the outcome of controversial reconfiguration proposals.

## **Data sources**

We carried out separate searches for systematic reviews, primary research studies and grey literature. Database searches were limited to material published in English from 2000 to March 2014.

## **Review methods**

Final decisions on study inclusion were made by two reviewers independently. We used EPPI-Reviewer 4 to record decisions and for data extraction and quality assessment. We carried out a narrative synthesis using multiple frameworks (including pre-specified research questions and current guidance). In synthesising the case studies, we selected a number of ‘exemplars’ based on quality of reporting and some evaluation of the process of engagement.

## **Results**

Eight systematic reviews, seven empirical research studies and 24 case studies (six exemplars) were included. Methods of engagement varied in nature and intensity, and generally involved a mixed methods approach. There was no evidence on the isolated impact of any particular engagement method or collection of methods. In general, engagement was most likely to be successful when the process started at an early stage, offered opportunities for genuine interaction and was led and supported by clinicians involved in delivering the relevant services. The impact of engagement was variably measured and demonstrated. Impact was more frequently defined in terms of process measures rather than success or failure of reconfiguration. Little was reported on the potential negative impact of service user engagement.

## **Conclusions**

Patients and the public could be engaged through a wide variety of methods. In selecting which methods to employ locally, decision-makers should take into account the nature of the local population and of the proposed service changes. Problems often arose because decision-makers paid insufficient attention to issues considered important by the public. NHS England guidance could be a helpful practical framework for future engagement activity.

## **Future work**

Clearly reported evaluations of interventions are needed including those that test the sustainability of methods of engagement and their impact over time. The NHS England guidance on planning and delivering service change may provide a foundation for the design of future research.

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## List of Abbreviations

CCG	Clinical Commissioning Group
EBD	Experience Based Design
GP	General practitioner
HS & DR	Health Service and Delivery Research
IRP	Independent Reconfiguration Panel
LINK	Local Involvement Network
MP	Member of Parliament
NIHR	National Institute of Health Research

## Scientific summary

### Background

The need to fully engage staff, patients and public in discussions and decisions about changes to the way health services are delivered has been recognised for many years. In England, local authority health overview and scrutiny committees must be consulted by local NHS bodies about proposals for substantial changes to services. Committees can refer proposals to the Secretary of State for Health if they are not satisfied with the consultation process or consider that the proposals are not in the interests of the health service in their area. The Independent Reconfiguration Panel (IRP) provides independent advice to the Secretary of State in such cases. More recently, the Health and Social Care Act 2012 established a new mechanism (Healthwatch) to drive patient involvement locally and nationally across the NHS. Best practice guidance is available from several sources, for example NHS England's *Planning and delivering service changes for patients* and *Transforming participation in health and care*. Proposals for service changes by commissioners and other bodies are required to pass four tests, the first of which is to be able to demonstrate evidence of strong public and patient engagement.

While much of the guidance reflects common sense, there is a need to establish the strength of the evidence base around different approaches to public engagement and involvement and in terms of impact. Proposed changes to health service delivery are often controversial locally and sometimes nationally. Effective public engagement may help resolve controversy and result in a broad consensus on the way forward. In contrast, inadequate consultation may result in lack of agreement, leading to proposals being delayed or referred to the IRP or ultimately the courts.

A wide variety of approaches to public engagement and involvement are available. Examples include surveys, face-to-face and telephone interviews, public meetings, focus groups, online consultations (including use of social media), local referenda and citizen juries (also known as citizen panels or stakeholder dialogues). The available literature describing and evaluating how these approaches have operated in practice appears to be disparate and widely scattered.

Any evidence that can clarify factors associated with positive public engagement will be of value both to NHS decision-makers and society as a whole.

## **Objectives**

To assess what is known about effective patient and public engagement in reconfiguration processes and to identify implications for further research. The specific research questions were as follows:

1. How have patients and the public been engaged in decisions about health service reconfiguration in the past?
2. How has patient and public involvement affected decisions about health service reconfiguration?
3. Which types of patient and public involvement have had the greatest impact on these decisions?
4. Which methods of patient and public involvement are likely to be sustainable/repeatable?
5. How have differing opinions about reconfiguration between patients, public, and clinical experts and other senior decision makers been negotiated and resolved?

## **Methods**

### *Scope and definitions*

The project was resourced as a rapid evidence synthesis. There is no generally accepted definition of this term and a number of other terms have been used to describe rapid reviews incorporating systematic review methodology modified to various degrees. Our intention was to carry out a review using systematic and transparent methods to identify and appraise relevant evidence and produce a synthesis that goes beyond identifying the main areas of research and listing their findings. However, we anticipated that the process would be less exhaustive and the outputs somewhat less detailed than might be expected from a full systematic review. Added to this, we expected to find limited evidence on the subject in the peer-reviewed primary literature.

The focus of the review was reconfiguration of health service provision in the NHS. Reconfiguration includes large-scale system change, such as relocation of hospitals, (re)location of specialist care, and changes in provision of urgent/emergency/out-of-hours care. We did not consider small-scale change, for example, at hospital ward-level or within a GP practice.

We defined patient/public/user/carer engagement or democratic involvement as including any means of seeking and responding to the views of patients and the wider public at any stage of the process of reconfiguration (including identifying possible options for change). We have not attempted to standardise the varied terminology used to indicate service user engagement across the included studies. In our search strategy, terms included “user” and “carer” engagement and involvement. The scope included existing patients, carers and their representative groups, and the general public and their representatives (for example, local councillors and MPs).

#### *Data sources*

We carried out separate searches for systematic reviews, primary research studies and grey literature. Searches were limited to material published in English from 2000 to March 2014. We looked for relevant evidence in three main areas:

- Systematic reviews of methods of/approaches to patient/public engagement. We only included reviews that are relevant to patient/public involvement in decisions about health service reconfiguration. Reviews of patient/public involvement in research were excluded.
- Empirical studies of any design evaluating methods of/approaches to patient/public engagement. Studies that focus on involvement in research were excluded;
- Case studies that have examined how patient/public involvement has worked in specific examples of system change in the recent past.

The following databases were searched for systematic reviews: The Cochrane Database of Systematic Reviews (CDSR), the Campbell Library, Database of Abstracts of Reviews of Effects (DARE), Database of Promoting Health Effectiveness Reviews (DoPHER), the EPPI

Centre Evidence Library, and Health Systems Evidence

(<http://www.mcmasterhealthforum.org/hse/>). For primary research we searched MEDLINE & MEDLINE in process, ASSIA, Health Management Information Consortium, PsycINFO, Social Care Online, and the Social Science Citation Index. In addition to the database searches, a wide range of websites relevant to UK health policy, health service delivery and organisation and user engagement were searched to identify any policy documents, reports, case studies or grey literature.

The following were excluded:

- ‘Emergency’ reconfigurations triggered by failure of a service provider, such as a NHS Trust;
- Consultation/involvement of NHS staff, except as part of a broader consultation where staff and patient/public involvement could not be separated;
- Patient/public representation on bodies where reconfiguration is part of the remit but is not the main focus;
- Patient/public engagement methods where complaints management is the focus (such as Patient Advice and Liaison Service, Healthwatch independent advocacy arm).

### *Review methods*

Records were managed within an EndNote library (EndNote version X6). Final decisions on study inclusion were made by two reviewers independently. We used EPPI-Reviewer 4 to record decisions and for data extraction and quality assessment. We carried out a narrative synthesis using multiple frameworks (including pre-specified research questions and current guidance). In synthesising the case studies, we selected a number of ‘exemplars’ based on quality of reporting and some evaluation of the process of engagement.

### **Results**

The searches identified 2322 potentially relevant references, of which 1896 were excluded based on title and abstract and 15 were unobtainable. Following screening of full texts and websites, eight systematic reviews, seven empirical research studies and 24 case studies (six exemplars) were included. The evidence contributed to answering research questions about methods of engagement and effects on decision-making. Evidence was less substantial in

relation to research questions about the differential effects of methods, their sustainability, and means of negotiating differences between stakeholders. Methods of engagement were varied in nature and intensity, and generally involved a mixed methods approach. Engagement programmes were conducted across a range of health services with diverse audiences. There was no evidence on the isolated impact of any particular engagement method or collection of methods. There was little detail about their sustainability.

The impact of engagement was variably measured and demonstrated. Impact was more frequently defined in terms of process measures rather than success or failure of reconfiguration. Key process factors identified were organisation readiness and commitment to service user engagement, clarity of aims, and adequate resources. Although the overall quality of evidence was mixed, key factors specifically associated with positive service user engagement were identified from the exemplar case studies. Indeed, the exemplars identified may indeed represent what good evidence looks like. Clearly reported objectives, methods, contextual detail, and reflective reporting are key elements to achieving good quality evidence in the future. Little was reported on the potential negative impact of service user engagement, but the variable effect of media coverage (which may encourage polarised views) was highlighted; lessons from past referrals to the Independent Reconfiguration Panel appeared potentially helpful.

## **Conclusions**

This review has identified that meaningful engagement is hard to achieve, and research to evaluate its impact is difficult to conduct.

Nevertheless, our review demonstrated that it was possible to address these difficulties. Great advances have been made to set out frameworks for engaging users in discussions and decisions about service re-configurations. We found a number of exemplar case studies which showed meaningful engagement could be achieved. Our review also demonstrated that present NHS England guidance goes some way to providing a helpful working framework for future engagement activity. Moreover, although the evidence base was not large, we found studies that provided insight into the value of user engagement and its impact on shaping service reconfiguration. In particular, this review has succeeded in clarifying some of the factors associated with positive service user engagement.



Patients and the public could be engaged through a wide variety of methods ranging from public meetings and distribution of information to the use of modern social media. People could be engaged as individuals, in small groups and in larger groups. In selecting which methods to employ locally, decision-makers will need to take into account the nature of the local population and of the proposed service changes. In general, engagement was most likely to be successful when the process started at an early stage of planning service change, offered opportunities for genuine interaction, and was led and supported by clinicians involved in delivering the relevant services. Interactive methods involving small groups, such as citizens' juries, could be very successful, although there may be difficulties in recruiting genuinely representative samples.

Our review also highlighted the importance of engaging with public representatives (in England primarily in the form of local authority scrutiny committees). The committees were important because of their power to refer disputed reconfiguration proposals to the Independent Reconfiguration Panel (IRP), an outcome that NHS decision-makers should seek to avoid. The IRP's summary of lessons from its reviews is an important resource, as is the availability of informal advice from the IRP.

The IRP report noted that problems often arose because NHS decision-makers paid insufficient attention to issues considered important to the public. There was evidence from case studies and public opinion research that many people were unwilling to accept longer journey times in return for the promise of better quality care at specialised centres. Since reconfiguration often involves centralisation of services, tackling these issues should be a priority for the leadership of the NHS at the national and local levels. There were potentially divergent issues to consider across other challenges to the NHS, such as decentralisation of services across several locations, or moving services from one location to another.

Given that service reconfiguration dominates the health policy agenda in almost all countries, it is essential to build upon the practical and research foundations that have already been laid.

### *Implications for healthcare*

The NHS England stages of reconfiguration may provide a helpful framework on which to base plans for future service user engagement programmes. However, this framework should not necessarily be considered as a linear process or a set of distinct elements. The ‘ladder of engagement and participation’ (based on the work of Sherry Arnstein) seemed to offer less practical value. The four-dimensional framework developed by Gibson et al may be worth further evaluation.

Within the NHS England framework, some key factors contributing to successful engagement and/or service reconfiguration appeared to be:

- Ensuring a clear understanding of the local context.
- Early engagement; consulting widely.
- Demonstrating clinical-led case for change, with focus on service improvement rather than cost savings.
- Demonstrating openness and developing shared understanding of change through local partnership working.
- Promoting ownership of the change model and feedback results of engagement.
- Implementing strong managerial leadership
- Using mixed approaches, particularly deliberative methods of engagement, targeted where necessary for different population groups.
- Considering access and transport issues as part of service change.
- Evaluation and follow-up.
- Expecting the unexpected.

Of these key factors, the one aspect that seemed most pressing was the striking need for robust evaluation and follow-up in user engagement programmes. Where evaluation had taken place – and particularly in relation to some potentially valuable case studies – it was largely poorly reported and therefore difficult to appraise from a research viewpoint. Limiting factors are time constraints in healthcare practice and naturally less concern for academic rigour. However, present reporting made it difficult to learn and move forward. Evaluation of user engagement in future health service reconfiguration is vital if we are to avoid reinventing the wheel each time public interaction is required. Ideally, evaluation should be conducted

independently of those directing the engagement programme, and should be embedded throughout the entire process from planning to implementation. Specific attention should be paid to explicitly and consistently describing the contextual characteristics of the situation, the methods of engagement, outcomes measured, overall impact (including positive and negative impact, and differential effects of engagement methods), the sustainability of efforts (through appropriate follow-up), and lessons to be learned. The need to publish evidence on methods and impact of patient and public voice activity was touched upon in NHS England's Transforming Participation in Healthcare.

### *Implications for research*

The NHS England guidance on stages of reconfiguration may be of value in providing a generalisable approach and basis for user engagement in practice. The guidance may also provide foundation for the design of future research on the evaluation of user engagement in service reconfiguration. These aspects were recommended areas of future research, together with an exploration of how the guidance might apply beyond the NHS setting.

In addition, further longer-term evaluations are needed to test the sustainability of methods of engagement and their impact over time. More research may also be warranted on the specific impact of interventions in negotiating and resolving differing opinions between patients, public, and clinical experts. Cost-effectiveness evaluation of engagement methods would be beneficial.

Word count: 2352

## Plain English summary

The need to fully engage patients and public in discussions and decisions about changes to the way health services are delivered (reconfiguration) is generally recognised. Proposed changes (such as moving services from one place to another) are often unpopular. Effective public engagement may help to overcome people's objections (sometimes by changing the original proposals). In contrast, inadequate consultation may lead to proposals being delayed or challenged in the courts.

The purpose of this research was to assess what is known about effective patient and public engagement in reconfiguration processes. We did this by searching for and summarising relevant information from published research and relevant websites. We were particularly interested in overviews of research and examples of good practice relevant to the NHS.

We found that patients and the public have been engaged in a wide variety of ways ranging from public meetings and distribution of information to the use of social media. In general, engagement was most likely to be successful when the process started at an early stage of planning service change, offered opportunities for genuine interaction and was led and supported by health professionals. Problems were most likely if NHS organisations did not pay enough attention to issues considered important by the public. NHS organisations should report on how they have involved patients and the public in decisions about changes to services. They should also evaluate the results of the consultations (for example, how satisfied were people with the process and what was actually done as a result).

Word count: 250

# 1 Background

The need to fully engage staff, patients and public in discussions and decisions about changes to the way health services are delivered has been recognised for many years. In England, local authority health overview and scrutiny committees must be consulted by local NHS bodies about proposals for substantial changes to services. Committees can refer proposals to the Secretary of State for Health if they are not satisfied with the consultation process or consider that the proposals are not in the interests of the health service in their area. The Independent Reconfiguration Panel (IRP) provides independent advice to the Secretary of State in such cases.<sup>1</sup> More recently, the Health and Social Care Act 2012 established a new mechanism (Healthwatch) to drive patient involvement locally and nationally across the NHS. Best practice guidance is available from several sources, such as NHS England's *Planning and delivering service changes for patients*<sup>2</sup> and *Transforming participation in health and care*.<sup>3</sup> Proposals for service changes by commissioners and other bodies are required to pass four tests, the first of which is to be able to demonstrate evidence of strong public and patient engagement. The remaining tests seek to demonstrate: consistency with current and prospective need for patient choice; a clear clinical evidence base; and support for proposals from clinical commissioners.

While much of the guidance reflects common sense, there is a need to establish the strength of the evidence base around different approaches to public engagement and involvement and in terms of impact. Proposed changes to health service delivery are often controversial locally and sometimes nationally. Effective public engagement may help resolve controversy and result in a broad consensus on the way forward. Successful implementation of this process may, in turn, bring about greater satisfaction that services adequately reflect public preferences; and may ultimately improve clinical outcomes or better access to services. In contrast, inadequate consultation may result in lack of agreement, leading to proposals being delayed or referred to the IRP or ultimately the courts. Any evidence that can clarify factors associated with positive public engagement will be of value both to NHS decision-makers and society as a whole.

A wide variety of approaches to public engagement and involvement are available. Examples include surveys, face-to-face and telephone interviews, public meetings, focus groups, online

consultations (including use of social media), local referenda and citizen juries (also known as citizen panels or stakeholder dialogues). The available literature describing and evaluating how these approaches have operated in practice appears to be disparate and widely scattered. Recent systematic reviews have looked at the impact of patient and public involvement on UK health care in general<sup>4</sup> and at strategies for interactive public engagement in development of healthcare policies and programmes;<sup>5</sup> in the primary literature examples include: an academic study of a ‘decision conference’ including patients and caregivers to consider eating disorders services;<sup>6</sup> a general discussion of the issues in a journal aimed at health service managers;<sup>7</sup> and a number of case studies published by the NHS Confederation.<sup>8-12</sup>

The objective of this project was to bring together evidence from published and grey literature sources, to assess what is known about effective patient and public engagement in reconfiguration processes, and to identify implications for further healthcare practice and research.

## **2 Methods**

### **2.1 General approach**

The project was resourced as a rapid evidence synthesis. There is no generally accepted definition of this term and a number of other terms have been used to describe rapid reviews incorporating systematic review methodology modified to various degrees. Our intention was to carry out a review using systematic and transparent methods to identify and appraise relevant evidence and produce a synthesis that goes beyond identifying the main areas of research and listing their findings. However, we anticipated that the process would be less exhaustive and the outputs somewhat less detailed than might be expected from a full systematic review. Added to this, we expected to find limited evidence on the subject in the peer-reviewed primary literature.

### **2.2 Research questions**

We sought to address the following five questions:

1. How have patients and the public been engaged in decisions about health service reconfiguration in the past?
2. How has patient and public involvement affected decisions about health service reconfiguration?
3. Which types of patient and public involvement have had the greatest impact on these decisions?
4. Which methods of patient and public involvement are likely to be sustainable/repeatable?
5. How have differing opinions about reconfiguration between patients, public, and clinical experts and other senior decision makers been negotiated and resolved?

### **2.3 Scope and definitions**

The focus of the review is reconfiguration of health service provision in the NHS. We also considered evidence on health services delivered by non-NHS providers (for example,

voluntary sector/private sector) and the joint provision of health and social care where this impacts directly on NHS provision. Where relevant, we considered international evidence from other health systems which are comparable and relevant to the NHS. In addition to England/UK, the included systematic reviews covered studies conducted worldwide; other research and case studies additionally covered Scotland and Canada.

Reconfiguration includes large-scale system change, such as relocation of hospitals; (re)location of specialist care; and changes in provision of urgent/emergency/out-of-hours care. We did not consider small-scale change, for example, at hospital ward-level, within a GP practice. Reconfiguration has been defined in the literature as “*a deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialities that are available in each hospital or other secondary or tertiary acute care unit in locality, region or healthcare administrative area*”.<sup>13</sup>

In the literature, the terms engagement and involvement are often used interchangeably. For the purposes of public involvement in research, INVOLVE ([www.invo.org.uk](http://www.invo.org.uk)) distinguishes between active *involvement* of patients or members of the public in research projects and *engagement*, which provides information and knowledge about research in an accessible way (for example, through science festivals or open days). This distinction is difficult to sustain in the context of proposals for service reconfiguration where provision of information may (or may not) lead to active involvement. Events such as public meetings or citizens’ juries have elements of both information provision and active contribution of patients or public members to developing or modifying (or rejecting) proposals for change. In this review we define patient/public engagement or democratic involvement as including any means of seeking and responding to the views of patients and the wider public at any stage of the process of reconfiguration (including identifying possible options for change). We have not attempted to standardise the various terminology used to indicate service user engagement across the included studies. In our search strategy, other terms included “user” and “carer” engagement and involvement (see Appendix 1). The scope included existing patients, carers and their representative groups; and the general public and their representatives (for example, local councillors and MPs).



## 2.4 Inclusion and exclusion criteria

We looked for relevant evidence in three main areas:

- Systematic reviews of methods of/approaches to patient/public engagement. We only included reviews that were relevant to patient/public involvement in decisions about health service reconfiguration. Reviews of patient/public involvement in research were excluded;
- Empirical studies of any design evaluating methods of/approaches to patient/public engagement. Studies that focussed on involvement in research were excluded;
- Case studies examining how patient/public involvement worked in specific examples of system change in the recent past. We anticipated that these were more likely to be found in the grey literature than in peer-reviewed publications. Case studies of this kind were likely to provide a biased sample of ‘successful’ rather than typical patient/public involvement but were more likely to provide useful data to inform future practice. We also searched for case studies where public involvement failed to produce an agreed way forward or resulted in unintended consequences, using the web site of the IRP as a starting point.

The following were excluded:

- ‘Emergency’ reconfigurations triggered by failure of a service provider, such as a NHS Trust;
- Consultation/involvement of NHS staff, except as part of a broader consultation where staff and patient/public involvement could not be separated;
- Patient/public representation on bodies where reconfiguration was part of the remit but was not the main focus;
- Patient/public engagement methods where complaints management was the focus (for example, Patient Advice and Liaison Service, Healthwatch independent advocacy arm).

## **2.5 Literature search**

### **2.5.1 Search strategy for reviews**

A search strategy was developed on the Cochrane Database of Systematic Reviews (Wiley) to identify any systematic reviews or overviews of systematic reviews of user engagement. As user engagement is described in a variety of ways in the literature a wide range of text words, synonyms and subject headings were included in the search strategy. Key terms for user engagement were identified by scanning key papers, discussion with the review team and use of database thesauri. Searches were restricted to reviews published from 2000 onwards. No language restrictions were applied to the searches. The search strategy was adapted for use in each of the review databases searched. Text word searches were limited to searching in the title field only for databases where this was possible. The following databases were searched in March/April 2014: The Cochrane Database of Systematic Reviews (CDSR), the Campbell Library, Database of Abstracts of Reviews of Effects (DARE), Database of Promoting Health Effectiveness Reviews (DoPHER), the EPPI Centre Evidence Library and Health Systems Evidence (<http://www.mcmasterhealthforum.org/hse/>).

### **2.5.2 Search strategy for primary studies**

A search strategy for primary studies was developed using MEDLINE (Ovid SP). The existing strategy for reviews described above (containing terms for user engagement) was combined using the Boolean operator AND with a second set of terms for reconfiguration. As this was a rapid review, a number of limits were used to focus the strategy: focussing of subject headings, a date limit of 2000 onwards, and restriction to English language studies. The range of databases searched was more limited than would be usual for a full systematic review. In particular, no specific databases of conference proceedings, theses or foreign language studies were searched. Relevant databases covering literature from health, health management and social science were searched in March/April 2014: MEDLINE & MEDLINE in process, ASSIA, Health Management Information Consortium, PsycINFO, Social Care Online and the Social Science Citation Index. The MEDLINE strategy was adapted for use in each database.

### **2.5.3 Search strategy to locate grey literature**

In addition to the database searches, a wide range of websites relevant to UK health policy, health service delivery and organisation, and user engagement were searched to identify any policy documents, reports, case studies or grey literature. Websites were selected on the basis of expert knowledge and judgement. A list of relevant websites was drawn up by the review team and further additions to the list were suggested by our collaborators and external contacts. Each website was browsed manually and/or searched using the website search function where available, depending on the size of literature contained on the website. Searches were carried out in April/May 2014. Relevant documents hosted on the websites relating to user engagement in the reconfiguration of services published since 2000 in English were retrieved and downloaded. Further links within each website to documents on other websites were not explored. To supplement the website searches, a focussed search of Google was carried out to locate UK reports on service reconfiguration. Using the Google advanced search facility, the search was limited to UK pdfs published in English from 2000 onwards with the term “reconfiguration” in the title of the webpage. The first 100 results were scanned for relevance. Further case studies were identified through contact with local hospitals and other experts and researchers working in the field of user engagement.

Records were managed within an EndNote library (EndNote version X6). After de-duplication, 2322 records in total were identified.

Further details of the search strategies and results can be found in Appendix 1.

### **2.6 Study selection, data extraction and quality assessment**

Search results were initially screened by a single reviewer to eliminate obviously irrelevant items. Full-text copies were ordered or downloaded for potentially relevant records. Final study selection was carried out by two reviewers independently, with disagreements resolved by discussion or involvement of a third reviewer if necessary.

We used EPPI-Reviewer 4 (EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, UK) to record decisions about study selection and for data

extraction and quality assessment. We developed separate data extraction forms to record key information for different evidence sources (systematic reviews, case studies and other research). For case studies, data extraction was done in two stages: basic details were extracted for all included case studies; then a number of ‘exemplars’ were selected for more detailed data extraction and analysis. Exemplars were those case studies that provided most detailed and current information about the methods used for patient/public engagement and involvement and/or assessed the impact of engagement/involvement in reconfiguration decisions. Data extraction was performed by one reviewer and checked by a second.

We assessed systematic reviews for methodological quality and reliability using the approach of the Database of Abstracts of Reviews of Effects (DARE). We planned to assess published primary research studies using appropriate design-specific tools described in CRD’s guidance for undertaking systematic reviews in health care (2009).<sup>14</sup> Unpublished case studies and non-peer-reviewed reports were not formally assessed for quality (risk of bias) but we sought to identify any instances of more rigorously conducted and fully reported case studies. Issues considered were:

- The extent to which an appropriate diversity of perspectives (for example, across service user and NHS) were considered in assessing the impact of patient/public engagement;
- The extent to which the case study was conducted and reported with transparency.
- Reflexivity on any specifically adopted perspective, together with adequacy and clarity of reporting on intervention context, methods, and impact.

## 2.7 Synthesis

We carried out a narrative synthesis using multiple frameworks to guide our analysis. In addition to the five research questions specified in the study protocol, we considered chronological aspects of reconfiguration decisions in terms of the seven stages specified in the NHS England guidance on planning and delivering service changes (see Box 1).<sup>2</sup> Levels of engagement/involvement were assessed where possible using the version of Arnstein’s ‘ladder of engagement and participation’ presented in the NHS England guidance on transforming participation in health and care (see Box 2).<sup>3</sup> We used the available literature to

determine the extent to which evidence supported or disagreed with the recent guidance and to highlight areas where the evidence was conflicting or insufficient.

In synthesising the case studies, we focussed on those case studies identified as exemplars (those case studies that provided more detail, see above). We were particularly interested in identifying case studies with an element of independent evaluation by an organisation not involved in the reconfiguration being examined.

Given the resources available for the project, we planned to focus on only a small number of exemplars. For other case studies, we extracted basic details only and used these studies to supplement the analysis of themes emerging from the exemplar case studies.

**Box 1: NHS England stages** (Taken from ‘Planning and delivering service changes for patients’,<sup>2</sup> pp 14–15)

- |  |
|--|
| <p>NHS England stages:</p> <ol style="list-style-type: none"><li>1. Setting the strategic context</li><li>2. Proposal</li><li>3. Discussion</li><li>4. Assurance</li><li>5. Consultation</li><li>6. Decision</li><li>7. Implementation</li></ol> |
|--|

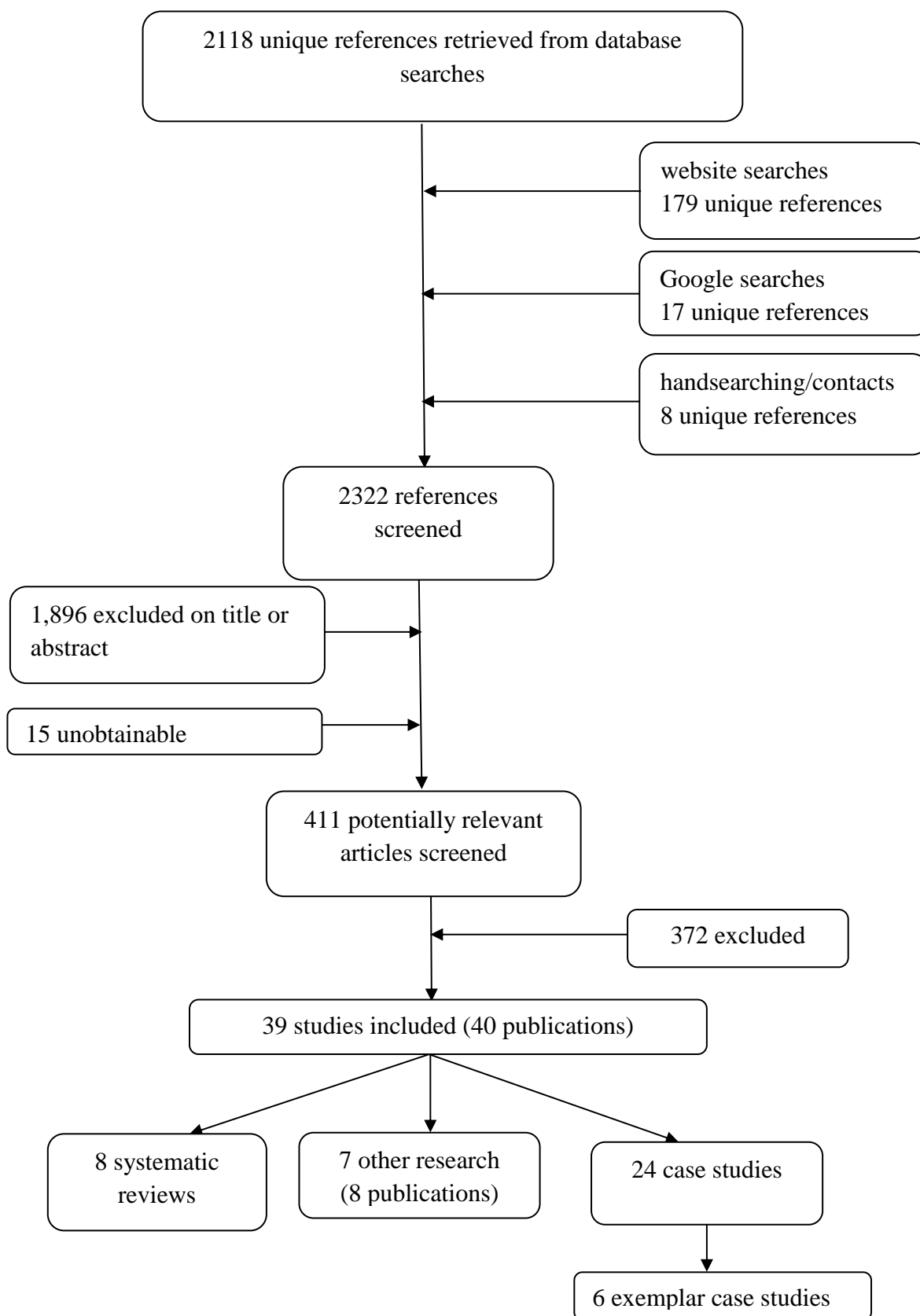
**Box 2: The ladder of engagement and participation presented in the NHS England guidance on transforming participation in health and care<sup>3</sup>**

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

### 3 Nature of the evidence

We included eight systematic reviews;<sup>4, 5, 15-20</sup> eight papers (describing seven distinct pieces of work) that were classified as other healthcare-related research<sup>1, 21-27</sup> and 24 case studies.<sup>6-12, 28-44</sup> See Figure 1 for details.

Full data extraction tables for the systematic reviews, other research, case studies and case study exemplars are available in the Appendices, along with details of the systematic reviews quality assessments (see Appendices 2-6).



**Figure 1: PRISMA flow chart**

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## 3.1 Systematic reviews

### 3.1.1 Overview

We identified eight systematic reviews conducted between 2002 and 2012 (see Appendix 2). The number of included studies in these reviews ranged from eight to 344. Study locations included various European countries, the USA, Canada, Australia, New Zealand, Israel, and Japan. All reviews included some proportion of UK studies. Four reviews contained a majority of studies located in the UK<sup>15-17, 20</sup> and two reviews<sup>4, 18</sup> had a complete focus on the UK setting (see Table 1). Reading across the reviews, there was some overlap of studies. Due to resource limitations, further examination of the nature and extent of this overlap was not carried out.

**Table 1: Selected characteristics of systematic reviews where emphasis is on UK studies**

Study reference	Type(s) of reconfiguration	Who was engaged/involved?	Method(s) of engagement/involvement
Conklin et al (2012) <sup>15</sup>	Relevant studies (where reconfiguration was the goal): Examples: resource allocation relating to local health integration networks; shaping policies and decisions about primary care provision and delivery; health-care priority setting; health policy decisions about the delivery of women's health services; decision making about local health services.	Special interest groups; public; patients; staff; NHS lay board members. More specific definitions of "the public" varied and were generally unclear across the studies. Terms used by the study authors: representatives of patient organisations; ordinary citizens; individuals with no particular axe to grind; those whose voices might not otherwise be heard.	Surveys; conference and website; community health councils; public meetings; local patient groups; citizen panels/juries; group simulation using roulette wheel; collaboration between agencies/groups/individuals.
Crawford et al (2002) <sup>16</sup>	Various services, including primary care, mental health, learning and physical disability, general healthcare, community services, inpatient and outpatient, social care, maternity, neurology, HIV. Most studies looked at smaller-scale change. Approximately one quarter of studies focused on larger-scale change, including changes to organisation of care and/or services. Of these studies, two involved a plan for hospital closure.	Most studies described participants as patients. Others reported involvement of carers, service users, staff, Health and Welfare Council, Community Health Council, citizens, lay board of directors, or mixed populations.	Patient groups, consultation meetings, committees and forums; interviews; citizen's juries; survey; focus groups; representation on planning boards and panels; mixed methods.
Crawford et al (2003) <sup>17</sup>	Specific reconfiguration not described. Reconfiguration contexts described as various within health, social and community care; non-health public sector (including postal services, social security, education, housing); private sector (including consumer goods,	Current, past and potential service users and their representatives. Providers.	Various, covering time limited methods (to elicit user perceptions/preferences); and long term approaches (building relationships with service users). Some initiated by provider; others initiated by service users. Public sector tended to use more deliberative approaches. Examples: surveys, focus

	travel, entertainment); and voluntary sector (disability/neurological services).		groups; deliberative approaches (such as citizen's juries, public conferences); user/community groups; formal bodies (such as Community Health Councils, patient groups, advocates and link workers).
Daykin et al (2007) <sup>18</sup>	General/strategic development; cancer services; mental health; older people's services.	Staff, members of the public, patients.	Employment of an individual to work with community groups; inter-professional cancer education programme; user groups; forums for service users and officials; community based exercise facility for people with mental health problems; citizen's juries; community initiative to elicit and respond to the views of older people; regional-level action research programme with staff.
Mockford 2012 <sup>4</sup>	General	Patients/carers; public	Lay membership of boards, panels and working groups; user groups.
Rose et al (2003) <sup>20</sup>	Promoting democracy and representation and/or cultural change (over 50% of included studies). Strategic planning, restructuring of services (very few studies), and policy initiatives. New service provision and the employment of service users in organisations.	Most studies focused on service users and professional staff. A quarter of studies involved carers. Others involved: user groups, carer groups, public, Community Health Councils.	Most studies focused on collective consumerism, involving consultation, representation, partnership, evaluation, involvement in staff recruitment. Methods not explicitly stated.

### **3.1.2 Quality of the reviews**

The quality of the eight systematic reviews varied. Seven reported an adequate search and provided study details, and all presented implications for research and/or practice. However, the extent to which review conclusions were reliably supported by the evidence presented (in the traditional sense of critically appraising systematic reviews) was limited by the fact that only two reviews formally assessed the quality of included studies. Seven of the reviews involved mixed evidence sources such as reviews, qualitative and quantitative (largely observational) studies; grey literature, and discussion papers.

### **3.1.3 Types of reconfiguration**

Although all eight reviews were related to service reconfiguration, not all framed their objective in these terms. Where reconfiguration was described beyond general terms, review authors referred to priority setting, local planning and policy development, and decisions about health service resource allocation. Service user engagement was explored across a range of specialist services and generic service or policy development. Examples of specific clinical service changes included those which were cancer-related,<sup>5, 18</sup> mental health,<sup>16</sup> women's health and maternity,<sup>15, 16</sup> and older peoples' services.<sup>18</sup> Other reviews examined system-wide change, such as the shaping of primary care and community services;<sup>16, 17</sup> one review included two studies concentrating on plans for hospital closure.<sup>16</sup> Some reviews adopted a wider remit, capturing more than merely health implications. These particular reviews focused (in addition to healthcare services) on proposals for change in areas such as environmental planning, education, and housing.<sup>17, 19</sup>

### **3.1.4 Engagement methods and who was involved**

There was no consistent definition of service-user engagement or involvement. Where this was reported, engagement was specified in the review authors' terms and did not appear substantially linked to any wider conceptual or theoretical framework.

A range of methods was employed in the engagement process. The extent to which methods were explicitly specified varied. Those that were primarily informative in nature included, for

example, communication via traditional publicity, and the provision of website materials.<sup>15, 19</sup> Other methods indicated more active involvement of service users in eliciting feedback by opinion polls and surveys.<sup>16, 17, 19</sup> Consultation and deliberative methods featured in all reviews, being largely operationalised as collaborative partnerships, citizens' juries, working groups, consensus conferences, and other mechanisms. Where public meetings and community forums were described, without further detail it was often difficult to determine their positioning on the ladder of engagement and participation (see Box 2 above). Across many reviews, a mixture of methods was used to capture the service user voice. Four reviews discussed the potential sustainability of methods.<sup>5, 15, 17, 19</sup>

Across the reviews, service-users were frequently described as "the public", although this term tended to be defined loosely and variably. Others engaged in the process were patients, carers, staff, local residents, councillors, members of parliament, and stakeholders (invariably not defined). The engagement of multiple audiences was referred to in many cases.

### **3.1.5 Impact**

Most reviews were broadly agreed on the paucity of evidence of impact in relation to service user engagement and reconfiguration. More robust evaluative research was generally recommended. Many review authors cited the critical influence of contextual variables on successful engagement; one referred in particular to geographic variability.<sup>15</sup> The absence of measureable outcomes was problematic;<sup>4, 15, 20</sup> the lack of independent research was reported to be a considerable limiting factor.<sup>17</sup>

Successful engagement was defined variably across the included studies, with many describing impact on processes rather than service reconfiguration *per se*. For example, changes in service user views about services, organisational culture change with regard to commitment to user engagement, or shifts in learning about future processes represented outcomes in two reviews.<sup>15, 16</sup>

There was some evidence of impact on service delivery outcomes in terms of changes to service provision,<sup>4, 16</sup> and in particular for location and access issues,<sup>4</sup> priorities integrated into a regional programme, and new resources found for services resulting from the activities

of citizens juries and other community collaborations.<sup>15</sup> One review included two studies that reported a successful challenge to hospital closure, resulting in the proposal being modified or abandoned.<sup>16</sup>

Negative consequences of engagement were rarely reported. However, two reviews referred to service users interpreting the engagement process as tokenism,<sup>16</sup> and community stakeholders were reported to experience unintended consequences (feeling ostracised) when challenging statutory sector partners.<sup>15</sup>

Whilst there was little evidence to support the isolated success of any particular engagement method,<sup>18, 19</sup> there were positive indications for those characterised as more deliberative in nature and involving face-to-face interactions,<sup>5, 15, 18, 19</sup> and for engagement efforts comprising multiple methods.<sup>18</sup> There was mixed support for partnership working, being seen as central to success in one review,<sup>5</sup> and having no systematic relationship with any form of organisational change in another.<sup>20</sup>

Tentative success factors in service user engagement appeared to be organisational support for the process; a willingness of users to engage; clarity surrounding the aims of engagement; and adequate resourcing of evaluations.<sup>5, 17, 18, 20</sup>

There was little discussion about the potential sustainability of methods. In one review, the institutionalisation of partnerships was seen as a key driver,<sup>5</sup> whilst regional meetings were seen as potentially repeatable in another.<sup>15</sup>

### **3.1.6 Systematic reviews in summary**

Reviews were conducted with a reasonable level of attention to methodological rigour. Due to the diversity and nature of the study designs, the quality of the studies included in the reviews was difficult to determine. A variety of health services were studied, and a range of engagement methods (described by various terminologies) adopted. Not all systematic reviews focused completely on health service reconfiguration. Where this was the case, review objectives seemed closely aligned to reconfiguration (for example, the focus was on priority setting, or decisions about resource allocation for future services).

The isolated impact of service user engagement (as distinct from the engagement of staff and other stakeholders) was sometimes difficult to distinguish. Reviews focused largely on the impact of service user engagement on outcomes related to process (for example, shifts in organisational views about engagement) rather than those related to the impact of engagement on reconfiguration success.

Positive indications were noted from engagement methods that were more deliberative; those involving face-to-face interactions, and those comprising multiple methods. Tentative factors leading to successful service user engagement were organisational support, willingness of users to engage, clarity about the aims of engagement, and adequate resourcing of evaluations.

## **3.2 Other research**

### **3.2.1 Overview**

We identified eight publications that described seven other research projects in the area (see Figure 1). All were located in the UK (four in England, two in Scotland, and one UK-wide). The papers were selected based on relevance to this review. They were not evaluated for methodological quality. Although diverse in methodology, it was possible to identify three broad categories of discussion papers about service user engagement and reconfiguration.

### **3.2.2 Influencing factors, trade-offs, and options appraisal**

Three papers focused in part on engagement in proposed changes in accident and emergency services.<sup>21-23</sup> Changes to community hospital provision were additionally explored in the Scottish-based paper; in this paper, discussion of services involving day-long deliberative panels, surveys and interviews with the public and NHS stakeholders resulted in the identification of several key drivers underpinning successful service-user engagement.<sup>23</sup> These were reported primarily as the need for common understanding on the case for change, careful selection of methods of public engagement, focus on location and access, and a strong clinical case for change.

In-depth interviews and flash cards were used to elicit information about preferences and trade-offs amongst patients and members of the public in two English localities.<sup>21, 22</sup>

Discussion revealed that most participants were unwilling to accept trade-offs (particularly for longer journey times to access higher quality care). A key message for commissioners and policy makers was to not assume that presenting the clinical case for change, together with very visible clinical leadership of the proposals, would result in associated community support. Whilst this could be viewed as a negative or unexpected consequence of engagement, hostility to the proposal identified in this research demonstrated an important step in the process of arriving at a democratically-derived solution.

### **3.2.3 Mechanisms for independent scrutiny and lessons from failures**

A review of Independent Reconfiguration Panel (IRP) reviews sought to highlight common themes arising from various cases of service reconfiguration referred to the organisation between 2003 and 2010.<sup>1</sup> The report illustrated the following precursors to referral: inadequate community and stakeholder engagement in the early stages of planning and change; inadequate promotion of the clinical case for change; the broad vision of integration was overlooked; benefits of change were underplayed; content and methods of conveying information was limited; lack of preparedness to respond on key issues such as money, transport, and emergency care; and inadequate attention to responses throughout and beyond the consultation.

The issue of independent scrutiny was further discussed in an expert opinion paper exploring the robustness of local and national scrutiny mechanisms (local overview and scrutiny committees, judicial scrutiny, and the role of the IRP) relating to a range of NHS service reconfigurations.<sup>24</sup> The report concluded that local overview and scrutiny committees were assertive in questioning and challenging proposals. Uncertainties were uncovered relating to decisions about exactly when consultation was required and the definition of “substantial” change. Costs and benefits of local authority scrutiny were also discussed.

Recommendations for local leaders of service reconfiguration from a further expert opinion paper placed strong emphasis on involving patients in the coproduction of services (where patients and organisations were engaged from the start as equals in shaping the case for



redesigning services to meet their needs and preferences), and less reliance on formal consultation.<sup>27</sup>

### **3.2.4 The nature of communication and role of the media**

The first of two papers focused on how primary care trusts could most effectively communicate proposals for service reconfiguration to the general public.<sup>25</sup> Using focus groups and case studies, the authors discussed the use of language. Results showed that certain words and phrases (such as “budget”, “value for money”, and “competitive tendering”) were not fully understood and sometimes misunderstood by service users. Consequently, the potential tension between organisational transparency and communicating in a way that successfully engaged people was exposed. In Scotland, media coverage of changes to rural maternity services was observed in another report.<sup>26</sup> This report documented variations in reporting across a number of newspapers and BBC coverage, with positive and negative accounts of the service change.

### **3.2.5 Other healthcare-related research in summary**

Other healthcare-related research comprised discussion papers and debates, with some examination of public views about engagement and/or service reconfiguration. The research highlighted the existence of key steps in the reconfiguration process that could result in referral to the IRP if not followed correctly (see above).<sup>1</sup> The research also indicated where service user engagement could be construed negatively; the importance of effective use of language in communicating with multiple audiences; variations in media opinion about service change; and consequent potential to influence service users in their decision making.

## **3.3 Case studies**

### **3.3.1 Overview of case studies not examined in depth**

We identified 24 case studies, but for 18 of these detailed data extraction was not carried out due to variability in the consistency and depth of reporting. The basic details of these case studies are summarised as follows.

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Most case studies highlighted potential indicators of success but failed to provide enough detail about methods of engagement and/or report the association of these methods with specific impact.<sup>7, 9, 10, 12, 28-37</sup> Most studies were located in England and in the NHS setting. Specific types of reconfiguration included hospital mergers, integration of health and social care; changes linked to primary care, maternity, emergency services, acute care, pain services. Other types of reconfiguration were less well specified, such as the centralisation of services, or unspecified large-scale reconfiguration. A wide range of participants was involved in the engagement process, including patients and public, NHS staff, Foundation Trust members and governors, voluntary sector organisations, members of parliament, and others.

Two reports focused on the history and development of specific models of patient and public engagement. These included a detailed account of activities from the Somerset Health Panels,<sup>38</sup> and a description of how a Public Involvement Network model was developed in Dorset, England.<sup>39</sup> Another report which looked at the planning of regional supportive cancer services in Ontario, Canada, focused generally on barriers to effective patient involvement.<sup>40</sup>

The final case study reference was a web link to 24 reports produced between 2005 and 2012 by the Scottish Health Council on behalf of the Scottish Government.<sup>41</sup> As with the English NHS, Scottish Health Boards are required to involve patients and local communities adequately in relation to significant NHS service change. Across these reports, types of reconfiguration varied. Details centred on aspects of the consultation process and on learning points to improve future public consultations.

### **3.3.2 Case study exemplars**

Six case studies were identified as being exemplars of good practice on the basis of one or more of the following: completeness and quality of reporting (particularly on methods and impact); diversity of perspectives employed; reflexivity in reporting; and demonstrable impact resulting from a specified engagement process.<sup>6, 8, 11, 42-44</sup> See Table 2, Box 3, and Appendix 6.

**Table 2: Selected characteristics of case studies identified as exemplars**

Study reference	Setting	Type(s) of reconfiguration	Who was engaged/involved?	Methods
Airoldi et al 2013 <sup>6</sup>	PCT eating disorders service.	Priority setting in eating disorder services, with emphasis on improving services in a climate of decreasing resources.	Patients, caregivers, clinicians, health care managers. There were 5 patients/carers out of 24 in the group. Follow-up was conducted with a wider set of stakeholders (not specified) in the local health economy.	Decision conferences: working meetings attended by key stakeholders, led by an impartial facilitator. Participants assessed the value of services based on (1) cost; and (2) population health benefit. Additionally: semi-structured and unstructured interviews; email correspondence; direct observation of workshops; use of flipchart notes and minutes of board meetings; follow-up events and interviews at one and two years post consultation. A steering group and an independent evaluator oversaw the process, in addition to input from the case study author.
Gamble & Sloss 2011 <sup>42</sup>	Urgent Care/Emergency Department	Re-design of minors care within the Emergency Department. To include integration of a walk-in centre (separately located at the time; engagement work on the walk-in centre does not form part of the present study); improved integration with the out-of-hours GP service; and to consider a	Patients, carers, staff, hospital governors	Observation sessions in ED; focus group; real-time feedback (patient experience questionnaire via standpoint machine); inpatient national survey results specific to York ED. Other engagement work was proposed (no details in this report) as part of the Trust's wider communications strategy on proposals to create an urgent care centre. The proposed work included

		potential GP triage service.		attendance at local events, presentations to specialist interest groups, information-giving at the Hospital Open Day.
NHS Confederation 2013 <sup>11</sup>	Acute and Emergency care.	"Better Healthcare in Bucks": Centralisation of emergency care. Providing care closer to home for most patients. Establishment of clinical centres of excellence.	Patients, public, primary care and hospital-based clinicians, other health service staff, MPs, local health overview and scrutiny committee, voluntary organisations.	Public meetings, clinical summits, online surveys, website, video showing interviews with lead clinicians, printed materials, local media campaign, presentations and site visits. A wide-reaching communications programme (internal and external) was implemented to support the service change.
NHS Confederation 2013 <sup>8</sup>	Acute hospital (maternity services)	Redesign of maternity services	Patients and their representatives: Women and their families, GPs, Local councillors and MPs, including the Joint Health Overview Scrutiny Group. Parent groups, Sure Start. Others engaged in the process: Community midwives, Hospital-based clinicians.	On-line responses, public meetings, face-to-face meetings with key stakeholders, letters, articles in relevant local and national media, website updates, "Ground-breaking events", posters and postcards, employment of a redesign lead at the Trust. Public engagement ran alongside a comprehensive staff training programme.
Sainsbury Centre for Mental Health 2010 <sup>43</sup>	Mental health day and vocational services.	Service re-design as part of a wider review of modernising day and vocational services for people with mental health problems.	Service users, commissioners, external consultants.	A working group (comprising 8 service users) was established to take part in the review of services, in response to invitation leaflets and posters distributed to local day centres. Three members of the working group joined a separate

				project steering group, which also included representatives from commissioners and external consultants. The group's remit included: design of the review of services; research with service users to gather views about services; contributing to decisions about service re-design; contributing to the development of service specifications and tender documents; helping to select future providers in the tendering process.
NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Primary care	Urgent care services.	Patients, public, clinicians, partner organisations (representatives from primary care, secondary care, local authority, voluntary sector), local and regional scrutiny committees, local media.	Distribution of consultation document and video; interactive workshop for clinicians and partner organisations; presentations to local and regional health scrutiny committees; surveys; public meetings; focus groups; Facebook posts.

### **3.3.2.1 Overview**

Consultations took place between 2007 and 2014. All were conducted in the UK. Four case studies were commissioned by NHS organisations (foundation or acute care trusts, primary care trust, clinical commissioning group). One case study was carried out by the Sainsbury Centre for Mental Health, and the other was commissioned by The Health Foundation.

### **3.3.2.2 Quality of the case studies**

Based on our three assessment criteria, the overall quality of these case studies was good (defined as adequate and clear reporting; evidence of reflexivity; and diverse perspectives considered). Report authors had generally considered diverse perspectives in the conduct of their case studies. There was evidence of reflexivity in the reporting (authors had reflected on findings and discussed the implications for practice in many cases), and reporting depth and clarity was considered largely good to excellent.

### **3.3.2.3 Types of reconfiguration**

Proposed changes to services covered urgent and emergency care,<sup>42, 44</sup> centralisation of emergency care, providing services closer to home, and developing clinical centres of excellence,<sup>11</sup> acute hospital maternity services,<sup>8</sup> mental health services,<sup>43</sup> and priority setting for eating disorder services.<sup>6</sup>

### **3.3.2.4 Populations engaged**

Multiple audiences were involved in all except one case study where the consultation focused more narrowly on patients and members of the public (although this piece of work was part of a wider engagement and communication strategy).<sup>42</sup> Across the case studies, other people engaged in the process included patient representatives, NHS staff and clinicians, overview and scrutiny committees, carers, local councillors and members of parliament, partner organisations (including the voluntary sector), specific statutory bodies (for example, Surestart), media, commissioners, and external consultants.

### Box 3: Key themes from the exemplar case studies

<b>Key factors of successful engagement/reconfiguration from case study exemplars</b>	
<u>Study and reference</u>	<u>Key themes</u>
NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	<ul style="list-style-type: none"> <li>• Wide consultation.</li> <li>• Extensive range of methods, including targeting for hard-to-reach groups.</li> <li>• Reflections on local context.</li> </ul>
York Teaching Hospital NHS Foundation Trust (Gamble & Sloss 2011 <sup>42</sup> )	<ul style="list-style-type: none"> <li>• Use of Experience Based Design theory.</li> <li>• Actions linked to micro- and macro-level change.</li> <li>• Link between engagement work and wider communications strategy.</li> </ul>
Buckinghamshire & Oxfordshire PCT/Buckinghamshire Healthcare NHS Trust (NHS Confederation 2013 <sup>11</sup> )	<ul style="list-style-type: none"> <li>• Clinician-led case for change; shared understanding through local partnership working.</li> <li>• Focus on service improvement rather than cost savings.</li> <li>• Start engagement early.</li> <li>• Consult widely; including face-to face discussions with politicians and local stakeholders.</li> <li>• Discussions about one aspect of care can provide forum for wider debate.</li> <li>• Consider access to services/transport issues.</li> </ul>
NHS Sandwell & West Birmingham NHS Trust (NHS Confederation 2013 <sup>8</sup> )	<ul style="list-style-type: none"> <li>• Set out clear clinical case for change; clinician-led.</li> <li>• Openness/refrain from unworkable options.</li> <li>• Feedback the consultation results.</li> <li>• Expect the unexpected, eg, cultural influences.</li> </ul>
Sainsbury Centre for Mental Health 2010 <sup>43</sup>	<ul style="list-style-type: none"> <li>• Suitable practical arrangements and inclusivity for engagement activity.</li> <li>• Genuine partnership in decision-making.</li> <li>• Promotion of service user wellbeing.</li> <li>• Learning for the future.</li> </ul>
NHS Sheffield PCT (Airoldi et al 2013 <sup>6</sup> )	<ul style="list-style-type: none"> <li>• The collective character of deliberations.</li> <li>• Ownership of the model and its results.</li> <li>• Analysis of the whole pathway.</li> <li>• Identifying opportunity cost of budget allocations.</li> <li>• Presence of patients to identify patient benefit.</li> <li>• Models based on cost-effectiveness principles.</li> <li>• Managerial leadership.</li> </ul>

### 3.3.2.5 Case study exemplars in focus: engagement methods and impact

#### *NHS Scarborough and Ryedale Clinical Commissioning Group*

A three month consultation was commissioned by Scarborough and Ryedale Clinical Commissioning Group (CCG) in relation to urgent care services.<sup>44</sup> The consultation was intense and wide-reaching (an estimated 200,000 people were contacted), and this involved gathering the views of service users and the general public about their experiences of current provision, together with their thoughts about a proposed new model of urgent care.

Clinicians, partner organisations (representatives from primary care, secondary care, local authority, voluntary sector organisations) and local media were also consulted.

Multiple engagement methods were employed, including the distribution of a consultation document and accompanying video; an interactive workshop for clinicians and partner organisations; presentations to local and regional health scrutiny committees; questionnaires (paper and online); a series of public meetings and focus groups; and use of social media. The demonstrable impact of this consultation was a number of key considerations being taken forward to inform a service tender specification for urgent care services. Important issues identified by service users were the need for appropriate location of services with attention to parking, transport, and security (a significant finding was that people would not be willing to travel further for an improved service, echoing findings from other research).<sup>21-23</sup> Service users also called for the appropriate design of services for a range of potential users; appropriate access to medical records and liaison with NHS 111 (where necessary); and adequate information to aid decision-making about how and when to access urgent care. It was strongly felt that patient experience should form part of on-going performance and quality measures for urgent care services. In November 2014, the successful provider of these services was announced with effect from April 2015. From the CCG's press release, it was evident that issues raised in the public consultation (such as access and car parking) had been taken on board in the reconfigured service.

This case study highlights the potential effectiveness of wide-reaching stakeholder consultation, including those opposing change. Use of an extensive range of engagement methods (including those to access hard-to-reach populations and others most likely to access



urgent care services) and intensive reflection on local context appeared to be significant drivers. The direct impact of this engagement on successful service reconfiguration will require further evaluation.

### ***York Teaching Hospital NHS Foundation Trust***

The Trust conducted a three-month consultation focusing on public and patients/patient representatives in relation to re-designing the minors care pathway with a view to developing an integrated urgent care service within their Emergency Department.<sup>42</sup> This piece of work formed part of a wider consultation on urgent care services including the integration of a walk-in centre (separately located at the time); improved integration with the out-of hours GP service, and consideration of a potential GP triage service. The project was set in the broader strategic context of helping to maximise effective future streaming of patients across minor and major's care within the Emergency Department.

Uniquely in this series of exemplars, the methodology underpinning the particular engagement exercise was Experience Based Design (EBD)<sup>45</sup>. This methodology focuses on capturing and understanding patients', carers' and staff experience of services, with a view to using them to inform actions for the physical re-design of systems and processes.

Three key engagement methods were used: observation sessions in the Emergency Department by Hospital Governors and members of the Local Involvement Network (LINK); focus groups with service users who had attended the Emergency Department in the preceding year; and real-time feedback (a questionnaire on a standpoint machine located in the Emergency Department waiting area).

A number of key issues arising from this engagement exercise were fed into an action plan for the Emergency Department redesign at micro- and macro-level. Various aspects relating to physical redesign were linked directly to the Trust's Capital Works Programme (for example, major alterations to the reception area, and the provision of a designated quiet area for people with particular clinical needs such as those suffering from dementia). Indeed, in identifying the needs of patients with dementia as a priority, the Emergency Department

consultation proposed a review of wider activity around the referral and service access for these patients.

This case study highlighted the potential effectiveness of consultations that were more narrowly-focused, time-limited, and based on a specific methodological framework.

### ***Buckinghamshire and Oxfordshire PCT Cluster/Buckinghamshire Healthcare NHS Trust***

The redesign of emergency care featured again in the next case study reported by the NHS Confederation and carried out across NHS hospital sites in Buckinghamshire.<sup>11</sup> This study focused on the proposed centralisation of emergency care, alongside other objectives to provide care closer to home, and to establish a number of clinical centres of excellence. Similar to York (above), this was a short-term consultation, but with wider reach involving patients, public, primary care and hospital-based clinicians and other NHS staff, members of parliament, local overview and scrutiny committees, and voluntary sector organisations.

A range of engagement methods was used, including public meetings, clinical summits, online surveys, website access, video recordings showing interviews with lead clinicians, printed materials, local media campaign, presentations and site visits. Public meetings were seen as opportunities to provide assurance on fears about service closure.

Results of the engagement programme led to direct action in response to patient concerns about transport and access to services. Concerns were considered in more depth by a multi-disciplinary task group comprising council members, hospital and ambulance service representatives. A direct outcome of this partnership work was the subsequent provision of free travel on local bus networks, and the establishment of a county-wide community transport hub.

For service redesign, implementation began six months after the consultation had ended. An emergency medical centre at one site was replaced with a new minor injuries unit, together with the transfer of some inpatient medical wards, a new day unit, and a step-down ward. The engagement process was reported to continue beyond the implementation stage.

Key messages from this case study were: the importance of reaching a shared understanding of the case for change at local level (involving partnerships with primary and secondary care) and possibly by focusing on one aspect of care to encourage wider debate about services; starting public engagement early and listen to/accommodate the views of all interest groups where possible; encouraging clinicians to make the case for change, focusing on the potential to improve services rather than cost savings; and engaging face-to-face with local politicians and stakeholders. This case study also demonstrated the direct impact of engagement in bringing together a multidisciplinary team to address a specific issue of patient and public concern (transport and service access), and how positive action could result from collaboration with agencies outside the healthcare system.

### ***NHS Sandwell and West Birmingham NHS Trust***

Maternity service redesign was the focus of an engagement exercise spanning four years at Sandwell and West Birmingham NHS Trust, reported by the NHS Confederation.<sup>8</sup> The proposed redesign arose from a pre-consultation exercise that resulted in three options for the delivery of maternity care across the region. On these three options a range of participants were consulted over a three-month period. Participants included patients and their representatives, GPs, local councillors and MPs, community midwives, and hospital-based clinicians.

Methods of engagement include online activities, public meetings, face-to-face meetings with key stakeholders, use of local and national media, “ground-breaking events”, posters and post cards, and the employment of a redesign lead at the Hospital Trust.

Response to the consultation was reported to be overwhelmingly in favour of the option to establish a community birth centre, with specialist care taking place at an inner-city hospital location. It was proposed that women and their families would contribute to the design of the new facilities. The option was approved and its implementation ran in parallel with an intensive communications and engagement programme and a staff training programme.

The nexus between engagement, service reconfiguration, and health outcomes was tentatively demonstrated in this case study. The maternity services at Sandwell and West Birmingham

NHS Trust resulted in the highest normal birth rate in the country in 2011/2012, a national award from the Royal College of Midwives for promoting natural birth was received in 2013, and in the same year the Trust's maternity services were upgraded to level 2 of the Clinical Negligence Scheme in recognition of safety standards. The unforeseen consequence of this reconfiguration (and one which will reportedly be taken forward as a lesson for future consultations) was that some women preferred to give birth in the Black Country, rather than in the specialist unit in Birmingham. It was unclear from the report whether this was potentially related to socio-economic status or broader cultural influences.

Many of the key messages for future service user engagement mentioned earlier were illustrated in this case study. Additionally, this study provided novel insight to cultural factors that can exert a strong influence on patient choice of service location, and thus potentially affect the success of reconfiguration.

### ***Sainsbury Centre for Mental Health***

A case study carried out over two years by the Sainsbury Centre for Mental Health focused on engagement as part of a wider review of modernising day and vocational services for people with mental health problems.<sup>43</sup> Participants included in the process comprised service users, commissioners, and external consultants.

A working group (consisting of eight service users) was established to take part in the review of services. Three members of the group joined a separate project steering group, which also included representatives from commissioners and external consultants. The group's remit was to design the review of services, gather service user views, and contribute to decisions about service redesign (for example, the development of service specifications and tender documents, and helping to select future service providers).

This case study focused heavily on a process evaluation of the consultation, and several key considerations were highlighted relating to the need for clarity of purpose; attention to detail (for example, the provision of background contextual information to aid the process of service re-design); openness between commissioners and staff about the implications of service change; and the need for effective management and resolution of conflict and hostility. A list of specific issues was presented in terms of what worked well and what

worked less well. Key indicators of successful engagement were reported to be suitable practical arrangements (inclusivity, minimal use of jargon, and an agreed working agreement); decision-making based on genuine and valued partnerships with service users; consideration of service user wellbeing (in terms of whether they felt their input was worthwhile); and commitment to on-going development of the engagement process.

Outcomes directly relating to service redesign were less well documented. Many service users were reported to feel positively about their involvement in the process, in terms of personal lives and services offered. Three new models were proposed in relation to the provision of future day and vocational services.

## ***NHS Sheffield PCT***

The final case study in this section focused on a 6-month engagement programme relating to the redesign of eating disorder services in Sheffield (delivered by the primary care trust at that time), reported by The Health Foundation.<sup>6</sup> Participants in the process included patients, caregivers, clinicians, and health care managers. Follow-up was conducted with a wider set of stakeholders (unspecified) in the local health economy.

Methods of engagement included: decision conferences attended by key stakeholders and led by an impartial facilitator; interviews; email correspondence; direct observation of workshops, use of flipchart notes and minutes of board meetings; and post-consultation follow-up events.

Results of the decision conferences directly impacted on the development of a business case. The objective the business case being to reallocate resources by expanding capacity in primary care and increasing community or outpatient services, with a view to reducing the number of referrals of patients to residential care. The case was approved, spending for the eating disorder service was reduced by more than 15%, and reductions were sustained in subsequent years.

Key messages for overcoming resistance to service change were: the collective character of deliberations and encouraging ownership of the model and its results; analysis of the whole pathway and helping to identify opportunity costs of alternative budgetary choices; strong patient presence; development of a model based on cost-effectiveness analysis principles; and strong managerial leadership.

### **3.3.2.6 Exemplars in summary**

The series of case studies chosen as exemplars of good practice were conducted across a range of healthcare services and implementation contexts, with diverse audiences, and using multiple engagement methods. Key messages focused mainly on the potential mechanisms for successful engagement, and less so on possible negative outcomes. Attempts were clearly

made in two cases studies to link engagement efforts with impact on service reconfiguration and (further) on health,<sup>8</sup> and financial outcomes.<sup>6</sup>

## 4 Synthesis

This section focuses on evidence emerging from the review (but particularly the case study exemplars). We first summarise the evidence in relation to the ‘ladder of engagement and participation’<sup>3</sup>, secondly, we consider the NHS England guidance,<sup>2</sup> and finally we draw together the material to answer our five research questions.

### 4.1 Ladder of engagement and participation

The NHS England guidance on transforming participation in health and care uses a ‘ladder of engagement and participation’ (based on the work of Sherry Arnstein) to classify different ways in which patients and the public can participate in health (see Box 2).<sup>3</sup> The ladder has five levels: informing, consulting, involving, collaborating and devolving. It is argued that participation becomes more meaningful towards the top of the ladder (devolving). Although there is academic debate about the limitations of this model, in terms of its narrow focus on transfer of power between providers and services<sup>46</sup> it has been widely used in studies of engagement and participation in health.

For the included case studies, we only assessed the levels of engagement reported in those selected as exemplars. Among the six exemplars, the highest level was devolving in one case,<sup>6</sup> collaborating in four,<sup>11, 42-44</sup> and involving in one.<sup>8</sup> Thus, these generally well-reported case studies were characterised by relatively high levels of engagement, which would be expected to allow meaningful interaction between participants and NHS decision-makers. This sample of case studies was too small to allow any assessment of whether levels of engagement had increased over time.

Levels of engagement in studies reported in included systematic reviews were also high. The highest level reported was ‘collaborating’ (which involved working in partnership with communities and patients on all aspects of a decision) for all except one review. The broad review of user involvement in change management by Crawford et al. was judged to include

examples of ‘devolving’ (placing decision-making in the hands of the community or individuals).<sup>17</sup> The high levels of engagement may partly reflect the broad coverage of the included systematic reviews.

Levels of engagement reported or discussed in studies in the ‘other research’ category were generally lower than in the case studies or reviews. Two reports related to the ‘collaborating’ level.<sup>23, 27</sup> The Scottish Health Council report sought input from public panels and NHS stakeholders on how to enhance public involvement in NHS service change.<sup>41</sup> The other report was an expert opinion report on how NHS managers should seek to frame debates around reconfiguration.<sup>27</sup> As with the systematic reviews, both reports were broad in scope, though much more specifically focused on service change.

Overall, the ‘ladder of engagement’ was of some help in differentiating among studies but its use was based on the assumption that the methods reported provide genuine opportunities for engagement and were not just offered to meet legal or bureaucratic requirements. The extent to which this was true may depend on contextual factors that were difficult to assess from paper reports.

## **4.2 NHS England Stages of Reconfiguration**

The NHS England guidance covers seven stages (see Box 1), ranging from ‘setting the strategic context’ through to ‘implementation’, although the boundaries between these are not always clear-cut. Some themes and issues arose at multiple stages of the process. It should be noted at the outset that most of the evidence appeared to adopt the perspective of health system decision-makers responsible for the process of service change and comments about ‘successful’ engagement or service change should be seen in those terms.

We did not systematically attempt to assess the extent to which stages of the NHS guidance were addressed in the case studies not selected as exemplars. When considering the stages of the NHS guidance addressed in the other research studies, the extent to which attention to specific stages influenced the overall success of the engagement process and other outcomes was unclear.



Table 3 summarises which of the stages were covered by the literature, with a focus on the relevant exemplar case studies.

**Table 3: NHS England Stages of Reconfiguration: summary of findings from relevant exemplars**

<b>NHS England stage</b>	<b>Guidance/recommendations</b>	<b>Relevant exemplars</b>	<b>Findings/comments</b>
1 Setting the strategic context	Continuous dialogue with communities on local health priorities and needs	Airoldi et al 2013 <sup>6</sup> ; Sainsbury Centre for Mental Health 2010 <sup>43</sup> ; NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Limited evidence of this from reports
2 Proposal	Identify range of possible service changes. Statutory duty to involve service users. Good practice to involve patients, the public and wider stakeholders in the early stages of building a case for change.	Airoldi et al 2013 <sup>6</sup> ; Sainsbury Centre for Mental Health 2010 <sup>43</sup> ; NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Difficult to identify as a discrete stage; often mixed with wider public consultation
3 Discussion	Formal discussion with local stakeholders, including relevant health and wellbeing boards and local authority health scrutiny bodies	Airoldi et al 2013 <sup>6</sup> ; Gamble & Sloss 2011 <sup>42</sup> ; NHS Confederation 2013 <sup>11</sup> ; NHS Confederation 2013 <sup>8</sup> ; Sainsbury Centre for Mental Health 2010 <sup>43</sup> ; NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Also difficult to identify as a discrete stage. Limited research.
4 Assurance	Demonstrate clinical case for change, the robustness of the reconfiguration programme, workforce and financial plans, and the alignment between the proposal and commissioning plans (where relevant)	Airoldi et al 2013 <sup>6</sup> ; Gamble & Sloss 2011 <sup>42</sup> ; NHS Confederation 2013 <sup>11</sup> ; NHS Confederation 2013 <sup>8</sup> ; NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Limited evidence to demonstrate explicit attention to the assurance stage of the guidance, other than three exemplar case studies reporting that clinical case for change was proposed.
5 Consultation	Continuous engagement with service users throughout the period of reconfiguration, with options to focus on specific reconfiguration and allow for a range of approaches for appropriate tailoring.	Airoldi et al 2013 <sup>6</sup> ; Gamble & Sloss 2011 <sup>42</sup> ; NHS Confederation 2013 <sup>11</sup> ; NHS Confederation 2013 <sup>8</sup> ; Sainsbury Centre for Mental Health 2010 <sup>43</sup> ; NHS Scarborough and Ryedale Clinical Commissioning Group 2014 <sup>44</sup>	Continuous engagement with service users throughout the period of consultation featured heavily across the evidence base. Many engagement activities were designed with specific populations in mind.

6 Decision	The need for commissioners to determine which (if any) of the configuration options are to be pursued; at the same time notifying all relevant stakeholders.	Airoldi et al 2013 <sup>6</sup> ; NHS Confederation 2013 <sup>11</sup> ; NHS Confederation 2013 <sup>8</sup>	Some evidence that decisions had been made and communicated to service users and stakeholders in respect of reconfiguration. The particular influence of Overview and Scrutiny Committees in this process was highlighted.
7 Implementation	The need for clarity about implementation plans, and maintenance of an on-going dialogue with service users in relation to the bedding down of service reconfiguration.	Airoldi et al 2013 <sup>6</sup> ; NHS Confederation 2013 <sup>11</sup> ; NHS Confederation 2013 <sup>8</sup>	Some attention to the implementation stage was evident in a limited number of articles, mainly in the exemplar case studies in terms of follow-up with service users or communication at this stage.

## 4.2.1 Stage 1: Setting the strategic context

### 4.2.1.1 Exemplar case studies

Three of our exemplar case studies covered this phase of reconfiguration.<sup>6, 43, 44</sup> The extensive literature on public involvement in commissioning and other decision-making bodies was excluded as we only looked at examples that were explicitly focusing on service change and reconfiguration. The main issue emphasised by the guidance was continuous dialogue with local communities and representative bodies on local health priorities and needs.

Of the three case studies, only the Scarborough and Ryedale urgent care redesign involved a broad public consultation.<sup>44</sup> The other case studies involved setting the strategic context with small groups of service users/carers.<sup>6, 43</sup> The Scarborough and Ryedale report noted the involvement of CCG governing body members, local clinicians, voluntary/third sector organisations and local authority scrutiny committees prior to the wider public consultation. However, the extent to which the urgent care consultation was influenced by a process of continuous dialogue with local communities and stakeholders was unclear from the report of the consultation.<sup>44</sup>

We did not systematically attempt to assess the stage(s) of engagement covered by case studies not selected as exemplars. However, a number of case studies reported attempts by UK health authorities to engage the public and patients in discussion of broad strategic issues prior to developing proposals for service change. An example is the ‘Big Health Debate’ organised by Liverpool PCT in 2006 and involving structured discussion and voting on different options to inform redesign of primary care and community services.<sup>33</sup> Another case study, referring to work done in Cornwall and the Isles of Scilly, stressed the importance of engaging with the public to gain information and establish trust in a situation where there had been a history of conflict over proposals for service change.<sup>34</sup> In a case study in Surrey and Sussex, where some hospitals faced a potential loss of acute services, extensive ‘pre-consultation’ in the absence of firm proposals was reported to have increased public concern.<sup>36</sup> These examples reinforced the importance of local contextual factors in influencing how proposals for service change are received and discussed; the Surrey and Sussex example, in particular, may reflect a lack of success in engaging with the public to

discuss the strategic context and drivers of change before introducing potentially unpopular proposals.

#### **4.2.1.2 Systematic reviews**

Among the included systematic reviews, a 2009 scoping review by Mitton et al looked at public participation in healthcare priority setting.<sup>19</sup> The review included a wide variety of empirical studies, mainly focusing on macro-level priority setting. Despite a lack of rigorous evaluations, two-thirds of included studies reported that participation processes were successful (as defined by the original study authors). Use of deliberative methods (often as part of an ongoing process rather than one-off events) and face-to-face contact were associated with higher levels of perceived successful participation. In studies where affecting an actual decision was the intention of the engagement process, this was reported to be achieved in 60% of cases, not achieved in 10%, and unclear or not reported in 30% (actual numbers of studies unclear). Other systematic reviews provided limited information about this stage of the service change process.

#### **4.2.1.3 Other research**

Three pieces of ‘other research’ were judged to address this stage of the service change process.<sup>1, 26, 27</sup> The Independent Reconfiguration Panel report on lessons from reviews identified inadequate community and stakeholder engagement in the early stages of planning change as a key factor in proposals referred to the Panel for formal review.<sup>1</sup> In Scotland, the study of media coverage of reconfiguration of maternity services at Caithness General Hospital reported that the issue was framed as a conflict between Highland Health Board management and local people, with a lack of information about issues underpinning the proposed changes.<sup>26</sup> Issues around how proposals for service change were framed were also central to an expert opinion report published by the NHS Confederation.<sup>27</sup> This report stressed the need to focus on drivers of change and potential benefits of new models of service without over-using the term ‘reconfiguration’.

#### **4.2.1.4 Summary**

Overall, the limited available evidence suggested that early strategic engagement with patients and the public along with other stakeholders could contribute to the process of developing and implementing proposals for service change. Although there was a lack of

rigorous evaluations, opportunities for ongoing face-to-face interaction appeared to be viewed positively.<sup>19</sup> One-off deliberative approaches allowing groups of patient or public representatives to express views on possible service changes in a structured way have also been reported as successful.<sup>6, 33</sup> This early stage of discussing service change is important because it can influence how the issue is framed and perceived by the patients and public with whom decision-makers are trying to engage. Case studies emphasised the importance of local contextual factors which those responsible for service change may or may not be able to influence. The Surrey and Sussex case study cited above,<sup>36</sup> involved a phased roll-out of engagement to different groups which could have had a negative impact on those who entered the process later.

## **4.2.2 Stage 2: Proposal**

### **4.2.2.1 Exemplar case studies**

At the proposal stage, the NHS England guidance stresses the importance of identifying a range of potentially viable options for change and involving patients, the public and other stakeholders at an early stage in building a case for change. Three of our exemplar case studies assessed methods and impact of public and patient involvement at this stage;<sup>6, 43, 44</sup> these were the same three exemplars as for the previous stage, emphasising the difficulty of separating the two stages. In addition, a further case study from the NHS Confederation reported in some detail the methods of public engagement at the proposal stage in Greater Manchester but without evidence of impact.<sup>10</sup>

As with the previous stage, the Sheffield eating disorders<sup>6</sup> and Sainsbury Centre for Mental Health<sup>43</sup> case studies involved small groups of service users/carers rather than the general public. Key themes of the eating disorder case study included: collective deliberation encouraging ownership of the process and its results; analysis of the pathway as a whole; and framing the problem in terms of patient benefit, seen as a result of the presence of patients as part of the group developing the proposal. In this case study, the group was able to identify the opportunity cost of alternative budget allocations and develop a model based on theoretical principles which provided a credible rationale for difficult decisions.<sup>6</sup> Some similar themes of service users and commissioners working together to identify potential new

models of service emerged from the Sainsbury Centre for Mental Health case study, although this did not involve a cost-effectiveness analysis.<sup>43</sup>

The Scarborough and Ryedale case study<sup>44</sup> reported on a broad public consultation that primarily included elements of stages 2, 3 and 5 of the NHS England guidance (proposal, discussion and consultation). It appeared that patients and the public were involved from an early stage, although the exact details of how the Clinical Commissioning Group (CCG) had developed its 'vision' for urgent care services were not clear. The CCG did use a wide variety of methods to involve patients and the public in the process. The consultation had an impact in identifying issues that needed to be considered in the specification and tendering process for a new urgent care service. Overall, this case study did not fit closely to the NHS England model, as a broad public consultation appeared to have begun at an earlier stage than envisaged in the NHS England guidance. This may reflect the context of reconfiguring the service by means of a service specification and tendering process. However, although not included as an 'exemplar' case study, the 'Healthier Together' consultation in Greater Manchester also involved early engagement of wider groups of patients and the public in discussing the need for change and broad principles involved rather than commenting on specific proposals for service change.<sup>10</sup>

#### **4.2.2.2 Systematic reviews**

Of the eight systematic reviews considered, the only review to address this stage of service change was the broad overview of interactive methods of public engagement by Abelson et al.<sup>5</sup> Two other systematic reviews contained potentially relevant evidence but their broad scope made it difficult to fit them with the stages mentioned in the NHS England guidance.<sup>4</sup>

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Findings from the empirical literature synthesis by Abelson et al indicated that interactive public engagement can be implemented successfully in various situations.<sup>5</sup> Success appeared to depend on contextual factors, including organisational commitment and the topic under discussion. The authors noted that participant satisfaction and topic-specific learning appeared higher when the engagement process was well designed but process satisfaction was not necessarily linked to perceived impact on policy decision-making. Group debate was



identified as an important contributor to participant satisfaction. This finding fitted with the reports of case studies involving small groups of service users contributing to service change proposals in eating disorders and mental health services.<sup>6, 43</sup>

A systematic review of the impact of patient and public involvement on the UK NHS did not report any examples that could be specifically linked to this stage of service change.<sup>4</sup> The same was true of a broad (but written from a UK perspective) systematic review of user involvement in change management.<sup>17</sup>

#### **4.2.2.3 Other research**

Other research studies considered relevant to this stage were the same as those for the previous stage,<sup>1, 26, 27</sup> plus a report from the Scottish Health Council.<sup>23</sup> The IRP review identified specific issues resulting in referrals that imply insufficient attention to involving patients and the public at the ‘proposal’ stage, specifically ‘important content missing from reconfiguration plans and limited methods of conveying information’.<sup>1</sup> The NHS Confederation report emphasises the possibility of ‘co-production’ of improved services by patients/public and NHS managers and warns against over-reliance on formal consultation.<sup>27</sup> This picks up on a theme also mentioned by Abelson<sup>5</sup> and the Sheffield and Sainsbury Centre case studies.<sup>6, 43</sup> Finally, although Thomson et al’s study focused primarily on media coverage, their background explanation implied that proposals for reconfiguration of maternity services in Caithness were developed with little or no patient or public input, and this could have been a contributory factor to the subsequent controversy.<sup>26</sup>

The Scottish Health Council research involved public participants recruited via a citizens’ panel in day-long deliberative events to obtain their views on how to improve public involvement in NHS major service change. NHS stakeholders were involved through interviews and a national online survey. In the proposal stage, both the public panels and NHS stakeholders offered views on factors that should be taken into account when developing options for change. While both groups felt that improving the quality of current services was the most important factor, the report author identified a major difference between the public and NHS stakeholder views, summed up as “the public felt strongly that local accessibility was more important than access to specialist capacity even when the

services were of a lesser quality”.<sup>23</sup> This finding agreed with research in England discussed below.<sup>21, 22</sup> The report also noted the importance of trying to reach a resolution of conflicting views before applying a scoring system to different options, “otherwise many or some of those taking part could weight options to support particular points of view”.<sup>23</sup>

#### **4.2.2.4 Summary**

Studies of patient and public involvement at this stage divided into those that involved relatively small groups of service users/public members and those that involved broader public engagement to inform the development of more specific proposals for service change. The latter type of engagement was used in Scarborough and Ryedale,<sup>44</sup> but it was unclear how this fitted in with the NHS England guidance which appeared to reserve widespread public engagement to later stages.

Case studies<sup>6, 43</sup> and one systematic review<sup>5</sup> suggested that positive results (for both participant satisfaction and potential influence on decisions) could be achieved when patient/public members and commissioners worked together and were able to form a common view of how service change could bring benefits to patients. However, evidence from public opinion surveys suggested that the public and NHS commissioners may have different priorities which, if not resolved, could cause problems for the later stages of the service change process.<sup>23</sup>

#### **4.2.3 Stage 3: Discussion**

The discussion stage of the NHS England guidance involves discussion with local representative bodies such as health and wellbeing boards and local authority health scrutiny committees.<sup>2</sup>

##### **4.2.3.1 Exemplar case studies**

Most of the exemplar case studies included some reference to engagement with health scrutiny committees, councillors, MPs or other public representatives.<sup>6, 8, 11, 42-44</sup> However, this was not the main focus in any of the exemplars and meetings, discussions or

‘engagement’ were generally referred to without any further details. The role of scrutiny committees in particular was addressed in more detail in studies included in the ‘other research’ category as discussed below.

One case study, not suitable for use as an exemplar, referred to the situation in Wyre Forest, where local opposition to loss of services at Kidderminster Hospital was expressed through the political process.<sup>35</sup> Opponents of the proposed reconfiguration formed a political group and elected representatives to Parliament and the local District Council. However, while this was a famous case in the history of NHS reconfiguration, the outcome also appeared to reflect local contextual factors that had not been replicated elsewhere.

#### **4.2.3.2 Systematic reviews**

Three systematic reviews included some evidence on the discussion phase of service change,<sup>5, 15, 16</sup> the relevance of three others was unclear.<sup>4, 17, 18</sup> Overall, the information presented in these reviews was too general to be helpful in analysing public involvement through discussion with representatives or representative bodies in the context of service change in the UK NHS. Two UK-specific systematic reviews did not contain any relevant evidence.<sup>4, 18</sup>

#### **4.2.3.3 Other research**

Five studies in this category were judged relevant to the discussion phase.<sup>1, 23, 24, 26, 27</sup> The most important was the 2007 Nuffield Trust report on the ‘politics of reconfiguration’ which included a discussion and case studies of the operation of local authority scrutiny committees.<sup>24</sup> The case studies illustrated how scrutiny committees worked with patient groups, clinicians and other stakeholders. The role of scrutiny committees in referring reconfiguration proposals to the IRP was also discussed, a theme also raised in the IRP overview of lessons learned from reviews.<sup>1</sup> The authors of the Nuffield Trust report considered scrutiny committees to be assertive in questioning and challenging proposals but basing their challenge on evidence rather than being opposed in principle to any change.<sup>24</sup> This conclusion was supported by the case studies (although as with all case studies their

representativeness/generalisability was uncertain) and to some extent by the report's status as an independent academic evaluation.

The NHS Confederation report on reframing the debate around reconfiguration also considered the role of public representatives. Taking a broadly NHS managerial perspective, the report advocated the need for local and national leaders to work with patient groups and clinicians to support service changes where these are supported by evidence of improved clinical outcomes.<sup>27</sup>

In the Scottish context, the Scottish Health Council report on enhancing public involvement in major NHS service change reported the views of a small sample of the public on proposals for independent scrutiny of reconfiguration plans prior to public consultation.<sup>23</sup> Public panels expressed some support for independent review but were less clear about the stage in the process at which this should take place. In Thomson et al's study of media coverage of reconfiguration of maternity services at Caithness General Hospital, the role of councillors and MSPs was mentioned. In this case study, the representatives appeared as supporting a public campaign against the reconfiguration proposals rather than being involved in a formal consultation process.<sup>26</sup>

#### **4.2.3.4 Summary**

Discussion of service change proposals with public representative bodies is an important statutory part of the process. Although this was treated as a separate stage from wider public consultation in the NHS England guidance, case studies suggested that the two stages often took place simultaneously or overlap with one another.<sup>8, 11, 44</sup> Local authority scrutiny committees were important because of their role in referring contested proposals to the Independent Reconfiguration Panel. An independent academic review in 2007 gave a generally positive assessment of how these committees were operating, based on a small number of case studies.<sup>24</sup>

#### **4.2.4 Stage 4: Assurance**

The main issues emphasised by this stage of the guidance is to demonstrate the clinical case for change, the robustness of the reconfiguration programme, workforce and financial plans, and the alignment between the proposal and commissioning plans (where relevant).

##### **4.2.4.1 Exemplar case studies**

Five of our exemplar case studies indicated some attention to this phase of reconfiguration<sup>6, 8, 11, 42, 44</sup>, although explicit detail was lacking and it was not possible to conclude definitively. Three studies referred to the need to set out the case for clinical change prior to service re-design.<sup>8, 11, 44</sup> One case study reported the discussion of costs and alternative budget allocations, and the framing of intent for patient benefit.<sup>6</sup> In a further study, coverage of this stage was implied but lacking in detail.<sup>42</sup>

##### **4.2.4.2 Systematic reviews**

Some of the included systematic reviews loosely referred to a form of assurance being part of the engagement process. For example, those focusing on priority setting, resource allocation, health service and policy planning, local goal setting, and (amongst the engagement methods) the provision of information about options for change.<sup>5, 15, 16, 18</sup> Firm demonstration of assurance was not evident in any of the reviews.

##### **4.2.4.3 Other research**

In pieces of work classed as other research, only the review of referrals to the Independent Reconfiguration Panel demonstrated clearly that the assurance stage of reconfiguration had been addressed, along with consideration of all other stages.<sup>1</sup> In the remainder of papers it was implied, with reference in the text to evidence for change not persuading communities to accept change,<sup>21, 22</sup> high levels of financial disclosure being given to participants.<sup>25</sup> the need for clinically-driven case for change and making the case for value,<sup>27</sup> and a hindering factor to successful engagement being lack of issues underpinning change.<sup>26</sup>

#### **4.2.4.4 Summary**

There was limited reporting to demonstrate attention paid to the assurance stage of the guidance. Explicit attempts were reported in three exemplar case studies in demonstrating the clinical case for change prior to service redesign.<sup>8, 11, 44</sup> Firm demonstration of attention to assurance was not evident in any of the systematic reviews, although indirectly it may have been present where reference was made to priority setting, resource allocation, health service and policy planning, and local goal setting.

#### **4.2.5 Stage 5: Consultation**

The main issues emphasised by this stage of the guidance is continuous engagement with service users throughout the period of reconfiguration, with emphasis on methods that focus on specific reconfiguration options and allow for a range of approaches for appropriate tailoring.

##### **4.2.5.1 Exemplar case studies**

All of our exemplar case studies demonstrated efforts to achieve adequate consultation at various stages of service reconfiguration according to the guidance.<sup>6, 8, 11, 42-44</sup> All studies employed multiple engagement methods. Many justified the choice of a specific method in terms of intent to target a specific population, for example, using social media to capture the voice of younger people,<sup>44</sup> and focus groups to gather the views of a mental health patient attending the Emergency Department.<sup>42</sup>

##### **4.2.5.2 Systematic reviews**

Five systematic reviews were selected here to demonstrate compliance with the guidance on consultation.<sup>5, 15, 16, 18, 20</sup> Multiple engagement methods featured heavily, with a notable frequency of community-based initiatives such as citizens' juries,<sup>5, 15, 16, 18</sup> emphasis on partnerships and collaborations,<sup>15</sup> and collective consumerism.<sup>20</sup> Targeting attempts were illustrated across the reviews, for example, in a specific community initiative to elicit and respond to the views of older people.<sup>18</sup>

### **4.2.5.3 Other research**

All pieces of other healthcare-related research reported some attention to the consultation stage, and this was illustrated by use of multiple methods.<sup>1, 21-27</sup> An attempt to tailor future consultations for specific populations was demonstrated in an exercise to test public understanding of frequently-used NHS terminology.<sup>25</sup> The paper focusing on a Scottish Health Board debate had prime focus on different messages emanating from media coverage of proposed changes to maternity services.<sup>26</sup> The paper demonstrated that media coverage (as a method of consultation) could be manipulative, in contrast to other reported consultation attempts in this review that have sought to demonstrate transparency and rigour.

### **4.2.5.4 Summary**

Continuous engagement with service users throughout the period of consultation featured heavily across the case study exemplars, systematic reviews, and other research. Multiple engagement methods were reported, many of which aimed to target specific populations.<sup>18, 25, 26, 42, 44</sup> The nature of the evidence made it difficult to identify any specific methods as better or worse than others, but emphasised the need to use methods appropriate to the local setting and the population groups most affected by proposed service changes. Consultation methods involving direct interaction with small groups of service users were often considered successful but raised issues around the representativeness of those involved.

## **4.2.6 Stage 6: Decision**

The main issue emphasised by this stage of the guidance is the need for commissioners to determine which (if any) of the configuration options are to be pursued; at the same time notifying all relevant stakeholders.

### **4.2.6.1 Exemplar case studies**

Three exemplar case studies<sup>6, 8, 11</sup> provided evidence that decisions had been reached on issues concerning service redesign following engagement programmes. The implication was, additionally, that stakeholders had been notified of such decisions but methods of

communication were not explicit. In particular, there was evidence that decision conferences had played an important part leading to the approval of a business case to reallocate resources for services.<sup>6</sup> Multiple engagement methods were followed by a decision to replace an emergency medical centre with a new minor injury unit and other wards.<sup>11</sup> The creation of new maternity services appeared to result from another successful multi-method engagement programme.<sup>8</sup>

#### **4.2.6.2 Systematic reviews**

Two systematic reviews showed that engagement using multiple methods, (and particularly the use of citizens' juries) were successful in influencing decisions about the commissioning of new services.<sup>15, 16</sup> Proposals for hospital closures were modified or abandoned as reported in Crawford et al,<sup>16</sup> demonstrating further the impact of potential for engagement to influence the process of decision-making.

#### **4.2.6.3 Other research**

Decisions about service reconfiguration were referred to in other healthcare-related research.<sup>1, 23-26</sup> The particular influence of Overview and Scrutiny Committees was highlighted in relation to details on various proposals accepted and rejected.<sup>24</sup> Decision uncertainty was reflected in the paper focussing on media portrayal of maternity services in Scotland.<sup>26</sup>

#### **4.2.6.4 Summary**

There was some evidence that decisions had been made and communicated to service users and stakeholders in respect of reconfiguration.<sup>6, 8, 11</sup> The particular influence of Overview and Scrutiny Committees in the process was highlighted.<sup>24</sup>



## **4.2.7 Stage 7: Implementation**

The main issue emphasised by this stage in the guidance is the need for clarity about implementation plans, and maintenance of an on-going dialogue with service users on the bedding down of service reconfiguration.

### **4.2.7.1 Exemplar case studies**

Three exemplar case studies referred to some measure of follow-up with service users or communications strategies to support the implementation process.<sup>6, 8, 11</sup>

### **4.2.7.2 Systematic reviews and other research**

Efforts to maintain dialogue with service users was implied in the results of a systematic review in repeatability of regional meetings.<sup>15</sup> The implementation stage was covered, along with other stages, in the Independent Reconfiguration Panel review of referrals.<sup>1</sup>

### **4.2.7.3 Summary**

Some attention to the implementation stage was evident in a limited number of articles, mainly in the exemplar case studies in terms of follow-up with service users or communication at this stage. None of the included systematic reviews or other research addressed the implementation stage.

### 4.3 Research questions addressed

We did not attempt to assess systematically the extent to which our research questions were addressed in the case studies not selected as exemplars. Engagement methods were often not described in sufficient detail to provide meaningful reporting. Where reported, the range of methods did not appear materially different to those identified in the other types of research above. Similarly, the lack of details about methods precluded meaningful analysis with respect to demonstrable impact on service reconfiguration. The measure of impact on decisions about health service reconfiguration, sustainability of engagement methods, and resolving and negotiating differing opinions about reconfiguration were also not sufficiently reported in these studies.

Tables 4, 5, and 6 summarise the evidence (by type of research) on the extent to which the five research questions were addressed.

**Table 4: Research questions addressed by systematic reviews**

Research Question	Systematic Reviews							
	<i>Abelson et al (2010)</i> <sup>5</sup>	Conklin et al (2012) <sup>15</sup>	Crawford et al (2002) <sup>16</sup>	Crawford et al (2003) <sup>17</sup>	Daykin et al (2007) <sup>18</sup>	Mitton et al (2009) <sup>19</sup>	Mockford et al (2012) <sup>4</sup>	Rose et al (2003) <sup>20</sup>
1. How have patients and the public been engaged in decisions about health service reconfiguration in the past?	x	x	x	x	x	x	x	x
2. How has patient and public involvement affected decisions about health service reconfiguration?		x	x	x	x	x	x	
3. Which types of patient and public involvement have had the greatest impact on these decisions?		x		x		x		
4. Which methods of patient and public involvement are likely to be sustainable/repeatable?	x	x	x	x		x		
5. How have differing opinions about reconfiguration between patients, public, and clinical experts and other senior decision makers been negotiated and resolved?								

x = evidence available

**Table 5: Research questions addressed by other research**

Research Question	Other Research						
	<i>Barratt et al. 2014<sup>21, 22</sup></i>	<i>Boyes 2008<sup>23</sup></i>	<i>Day and Klein 2007<sup>24</sup></i>	<i>IRP 2010<sup>1</sup></i>	<i>NHS Confed 2010<sup>25</sup></i>	<i>NHS Confed 2013<sup>27</sup></i>	<i>Thomson et al. 2008<sup>26</sup></i>
1. How have patients and the public been engaged in decisions about health service reconfiguration in the past?	x	x	x		x	x	x
2. How has patient and public involvement affected decisions about health service reconfiguration?			x			x	x
3. Which types of patient and public involvement have had the greatest impact on these decisions?			x				x
4. Which methods of patient and public involvement are likely to be sustainable/repeatable?	x	x			x	x	
5. How have differing opinions about reconfiguration between patients, public, and clinical experts and other senior decision makers been negotiated and resolved?	x	x	x	x		x	x

x = evidence available

**Table 6: Research questions addressed by exemplar case studies**

Research Question	Exemplar Case Studies					
	<i>Airoldi et al 2013<sup>6</sup></i>	<i>Gamble &amp; Sloss 2011<sup>42</sup></i>	<i>NHS Confed 2013<sup>11</sup></i>	<i>NHS Confed 2013<sup>8</sup></i>	<i>Sainsbury Centre for Mental Health 2010<sup>43</sup></i>	<i>NHS Scarborough and Ryedale Clinical Commissioning Group 2014<sup>44</sup></i>
1. How have patients and the public been engaged in decisions about health service reconfiguration in the past?	x	x	x	x	x	x
2. How has patient and public involvement affected decisions about health service reconfiguration?	x	x	x	x		x
3. Which types of patient and public involvement have had the greatest impact on these decisions?			x	x		
4. Which methods of patient and public involvement are likely to be sustainable/repeatable?	x		x			
5. How have differing opinions about reconfiguration between patients, public, and clinical experts and other senior decision makers been negotiated and resolved?	x		x			x

x = evidence available

#### **4.3.1 Q1: How have patients and the public been engaged in decisions about health service reconfiguration in the past?**

All of our exemplar case studies,<sup>6, 8, 11, 42-44</sup> systematic reviews,<sup>4, 5, 15-20</sup> and all except one piece of work classed as other healthcare-related research<sup>21-27</sup> adequately answered this question.

Methods of engagement varied in nature and intensity (from informative to deliberative), and use of mixed methods to capture service user voice seemed to be the general approach. The engagement process ranged from being a one-off event, to deliberations spanning several months or years. Details on the sustainability of methods were lacking.

#### **4.3.2 Q2: How has patient and public involvement affected decisions about health service reconfiguration?**

Five exemplar case studies,<sup>6, 8, 11, 42, 44</sup> all six systematic reviews,<sup>4, 15-19</sup> and three pieces of other healthcare-related research<sup>24, 26, 27</sup> contributed to answering this question, demonstrating some element of impact from service user engagement. As mentioned earlier in this review, impact was variably defined across the included papers, and more frequently in terms of process measures rather than outcomes related to the success or failure of service reconfiguration.

Of particular note was the impact reported in one exemplar. In this case study, multiple engagement methods resulted in service user preference for a particular maternity service configuration in Sandwell and West Birmingham.<sup>8</sup> Not only did the consultation appear to achieve broad consensus about future service provision, the resulting reconfiguration was associated with improvements in wider outcomes relating to patient health and safety, for example percentage of ‘normal’ births. Various other levels of impact were demonstrated in our exemplars, for example: from wide-reaching consultations that added robustness to a service tender specification for urgent care services (with specific issues raised by the public, in terms of access and car parking, subsequently helping to inform the agreed service model),<sup>44</sup> to the direct impact of engagement on securing initiatives to improve transport and access to healthcare services.<sup>11</sup>

Systematic reviews focused largely on process outcomes, with key factors to successful engagement (with potential to influence successful reconfiguration) being organisational readiness and commitment to service user engagement; clarity about the aims of engagement; and adequate resources of the process and evaluation of engagement.<sup>17, 18</sup> In examining discussion papers and debates about service user engagement and/or service reconfiguration, other healthcare-related research was helpful in identifying some of the negative outcomes on service reconfiguration, such as the variable impact of media coverage.<sup>26</sup>

#### **4.3.3 Q3: Which types of patient and public involvement have had the greatest impact on these decisions?**

Two exemplar case studies,<sup>8, 11</sup> three systematic reviews,<sup>15, 17, 19</sup> and two pieces of other healthcare-related research<sup>24, 26</sup> contributed to answering this question.

Information was sparse in general, but exemplars indicated differential success in regular face-to-face meetings, discussions with politicians and local stakeholders, and initiatives to ensure that all interested parties were listened to.<sup>11</sup> Social media was highlighted as a particularly effective method for engaging young people in decisions about reconfiguration.<sup>8</sup>

Systematic reviews highlighted the influential effect of a range of methods, including small group meetings and plenary sessions, surveys, and citizens' juries,<sup>15</sup> and deliberative methods.<sup>19</sup> One systematic review concluded that there was no best method for involving users in the NHS.<sup>17</sup>

Other healthcare-related research focused on the particular influence of overview and scrutiny committees,<sup>24</sup> and the potential to encourage polarised views in the decision-making process through different angles of media coverage.<sup>26</sup>

#### **4.3.4 Q4: Which methods of patient and public involvement are likely to be sustainable/repeatable?**

Two exemplar case studies,<sup>6, 11</sup> five systematic reviews,<sup>5, 15, 16 17, 19</sup> and five pieces of other healthcare research<sup>21-23, 25, 27</sup> provided insight to answering this question, although details on the sustainability of methods were lacking.

Sustainability of multiple methods was implied in one exemplar case study which reported continuous dialogue with service users at the end of the implementation period.<sup>11</sup> Two systematic reviews emphasised the sustainability of methods that encouraged partnership working and collaboration;<sup>5, 15</sup> and a further review cited the on-going application of multiple engagement methods over a mean duration of four years.<sup>19</sup> In other healthcare-related research, the repeatability of focus groups was implied as these were continued post-consultation.<sup>25</sup>

#### **4.3.5 Q5: How have differing opinions about reconfiguration between patients, public and clinical experts and other senior decision makers been negotiated and resolved?**

Three exemplar case studies<sup>6, 11, 44</sup> and seven pieces of other healthcare-related research<sup>1, 21-24, 26, 27</sup> contributed some evidence to answering this question. There was no evidence from systematic reviews.

The exemplars highlighted potential mechanisms for negotiating and resolving differing opinions between various stakeholders. These included decision conferences, public meetings, and the overview and scrutiny committee function. Other healthcare-related research implied the possible success of in-depth interview techniques to elicit trade-offs between service alternatives.<sup>21, 22</sup> Public deliberative panels,<sup>23</sup> co-production of services,<sup>47</sup> and public campaigns<sup>26</sup> were other possible mechanisms, as was referral to the Independent Reconfiguration Panel.<sup>1</sup>



## 5 Discussion

The objective of this rapid evidence synthesis was to bring together evidence from published and grey literature sources, to assess what is known about effective patient and public engagement in reconfiguration processes, and to identify implications for further research. The review was guided by five research questions, existing NHS guidance on seven stages of reconfiguration<sup>2</sup> and a theoretical framework outlining five incremental intensities of service user involvement.<sup>3</sup>

Evidence was gathered from three main areas: systematic reviews of methods of/approaches to patient/public engagement; empirical studies of any design evaluating methods of/approaches to patient/public engagement; and case studies where public/patient engagement appears to have worked or not worked well. The review successfully identified a number of case study exemplars of good practice.

### 5.1 Summary of the evidence

Methods of engagement identified in this rapid evidence synthesis were varied in nature and intensity, and generally involved a mixed methods approach. Engagement programmes were conducted across a range of health services with diverse audiences. There was no evidence on the isolated impact of any particular engagement method or collection of methods, and there was little detail about their sustainability.

The impact of engagement was variably measured and demonstrated. Impact was more frequently defined in terms of process measures rather than success or failure of reconfiguration. Key process factors identified were organisation readiness and commitment to service user engagement, clarity of aims, and adequate resources. Little was reported on the potential negative impact of service user engagement, but the variable effect of media coverage (which may encourage polarised views) was highlighted, and lessons from past referrals to the Independent Reconfiguration Panel may be helpful.

Early engagement can help to contextualise and influence the perceptions of service users. Ongoing face-to-face interaction may be beneficial, and deliberative methods may provide

further help to ensure a wide representation of service user voice. Social media may be useful, particularly to engage with young people. It is helpful to form common views between public and commissioners, but different priorities may present difficulties.

This was a difficult area to research, the evidence was limited, and rigorous evaluations were lacking. Much of the evidence was from single case studies, which may have limited generalizability in other settings. The evidence to support methods of service user engagement in health service reconfiguration was inconclusive; we were unable to recommend a particular method to effect a specific outcome. The lack of independent research was noted (case studies identified were likely to be biased towards successful reconfiguration from the perspective of NHS Managers), as was the absence of measurable outcomes and clear definitions of successful reconfiguration.

## **5.2 Reflections on the evidence**

Much of the evidence presented in this review related to the UK NHS setting. For those embarking on future service user engagement programmes, the exemplars identified may indeed represent what good evidence looks like. Clearly reported objectives, methods, and contextual detail, and reflective reporting are key elements to achieve this.

The review uncovered a broad range of engagement methods, from those simple and informative in nature, to more deliberative methods involving the development of shared understanding with service users, and identifying solutions through partnership and collaborative working. No single specific method of engagement appeared to be more effective than another; the use of mixed methods of engagement was frequently reported. Whilst there may be an argument for evaluating the collective effect of multiple methods (on the basis that this is reflective of practice), the relative effects of different engagement methods from a cost-effectiveness viewpoint may be a topic warranting further research.

Service user engagement was rarely evaluated in terms of its direct impact on the success or failure of service reconfiguration. Interim and process outcomes were frequently reported (such as changes in service user views about services, organisational culture change with regard to commitment to user engagement, or shifts in learning about future processes). This

poses a question for future research about what is really meant by impact in evaluations of service user engagement and health service reconfiguration. Until more clarity is reached about objectives and outcomes, the evidence is likely to remain inconclusive. Future evaluation of interventions is vital.

Although not explicitly stated, impact appeared to be context specific, the relative success of this was set against a backdrop of local dynamics, historical issues, and baseline service user expectations. Furthermore, the impact of interventions to involve patients and the public in reconfiguration decisions was likely to be mediated by contextual factors which could vary widely across settings as well as over time. Some of these factors were at least in part predictable and could be used to select appropriate engagement methods. Examples are the nature of the area (such as urban or rural), age structure and socio-economic characteristics of the local population, and the types of services affected by reconfiguration proposals.

Additionally, local responses to configuration proposals can be inherently unpredictable, making it difficult or impossible to discuss alternatives and seek ways to resolve different opinions. Many community groups have opposed loss or downgrading of services in their local hospital; only in one setting (Wyre Forest) did they succeed in getting a representative elected to Parliament and gain control of the local council.<sup>35</sup> This example dates from the early 2000s and the fact that it has not been repeated since suggested the existence of some highly unusual local factors. In another example, a campaign against changes to hospital services in Surrey and Sussex was strengthened by the support of well-known local residents, a factor unlikely to be reproduced in less affluent areas.<sup>36</sup>

The exemplars and other case studies included in our review cover a range of different services and geographical settings. One obvious distinction is between services for the general population (e.g. primary and urgent care); for specific sections of the population (e.g. maternity services); and for people with specific conditions (e.g. specialist mental health services). The balance between engaging with the general public and with patients, patient groups and carers, and hence the methods used, tends to reflect the type of service. The type of setting (e.g. urban, suburban or rural) may also influence the process of engaging with patients and the public, although it is likely that the increasing use of online and social media-based methods will reduce the importance of geographical factors over time. It is also likely

that other, more subtle factors influence the appropriateness of using different methods of engagement in different circumstances. A fuller analysis of this type of issue would require a larger sample of well-reported exemplars than we were able to obtain for this review, but this could be a topic for future primary research. A robust conceptual model of the rationale and goals of patient and public involvement in reconfiguration decisions would be helpful for this type of research.

In the synthesis, a pragmatic decision was taken to map the evidence against existing policy and guidance. We turned to potential triangulation between the evidence, the NHS stages of reconfiguration, and Arnstein's 'ladder of engagement and participation'; the extent to which the different sources correlate with each other and offer a consolidated framework to those considering service user engagement in health service reconfiguration. Generally, convergence of concepts from the different sources was difficult to determine, as it was not possible to distinguish with confidence the seven stages and the five levels of engagement in the included evidence. It was clear though that the 'ladder of engagement and participation' (based on the work of Sherry Arnstein) provided less theoretical contribution than the NHS England stages. In respect of the ladder, examples of devolved decisions to the community were not well represented in our evidence. One might propose that devolvement might more appropriately apply to smaller-scale service change than the various larger-scale reconfigurations considered in this review.

Given the nature of the review questions, it was clear that evidence was unlikely to be generalisable in the traditional sense of identifying elements which frame the research questions (Populations, Interventions, Comparators, and Outcomes). We suggest that generalisability of the evidence to future service reconfigurations may lie in the *approach* (for example, using the seven NHS England Stages) to guide the engagement process, rather than attempting to generalise based on the *mechanics* or the *context* underpinning that approach.

We focused our search for evidence on studies of direct relevance to patient and public involvement in service reconfiguration. Resource constraints meant that we have not systematically reviewed the theoretical and empirical literature on patient and public involvement in healthcare generally (although this was covered to some extent in the

systematic reviews we have included). For theoretical frameworks we concentrated on those that have informed current NHS guidance (NHS England's stages of service change and the 'ladder of engagement and participation'). Arnstein's ladder dates back to the 1960s and other theoretical frameworks have been developed more recently. For example, Gibson et al<sup>48</sup> suggested that earlier models of patient and public involvement were unable to respond effectively to the current context of declining faith in traditional political structures and processes and diversity of values, ideologies and social groups trying to make their voices heard. They proposed a four-dimensional framework for analysing the nature of patient and public involvement. This framework encourages knowledge accumulation from multiple sources, with emphasis on the development of reasoned, interactive, and equitable discussions between lay and professional people. The framework, they argued, could assist the development of new structures and processes that may allow professionals and lay people to work together more productively than most current structures permit.<sup>48</sup>

Another critique of current practice in patient and public involvement generally related to the issue of power imbalance between patients and members of the public and NHS managers and clinicians. This was the original purpose of Arnstein's 'ladder of involvement and participation', to suggest that most involvement activity was more tokenistic than genuine participation.<sup>49</sup> Harrison and Mort coined the phrase 'technology of legitimation', arguing that patient and public involvement "can be seen as a means by which managerial legitimacy is maintained in the context of an increasingly pluralistic policy arena".<sup>50</sup> Similar issues were raised by Martin in a study of service user involvement in the establishment of cancer genetics services in England.<sup>51</sup>

In view of resource constraints and the service-focused nature of this review, we were unable to address these issues in any depth, but we recognise that it is important for NHS decision-makers to be aware of and reflect on these critiques. However, these issues relate to all types of patient and public involvement in health care (and in policy- and decision-making generally) and are not specific to service reconfiguration, which was the main focus of this review.

### 5.3 Reflections on the review process

The topic area had parallels with the evaluation of complex interventions and public health research; engagement was often part of a multicomponent intervention from which it was difficult to isolate individual effects, and the long term impact was difficult to measure. Reconfiguration was defined for this review as large-scale system change (for example, relocation of hospitals; (re)location of specialist care; changes in provision of urgent/emergency/out-of-hours care) as opposed to small-scale change (for example, at hospital ward-level, within a GP practice). It became evident during the study selection process that the distinction between large-scale and small-scale change was not always straightforward, and this was not helped by variable use of terminology to describe service change. Judgements had to be made, and discussions took place between reviewers to reach agreement on inclusion, particularly where articles reported on a mixture of different levels of change, and often as part of an overarching strategy.

Given the rapid nature and limited resources available, limitations were placed on the review process. For example, strict criteria were applied on the reporting aspects of articles to tighten the focus to those most likely to provide useful information. Studies contained within reviews were not extensively followed up, and the overlap of studies across reviews was not examined. For case studies, a number of websites provided external links to other case studies, for example the Scottish Health Council;<sup>41</sup> external links were not followed, instead a signpost was provided, together with a summary of characteristics of those studies.

Of interest for future search strategies in service facing reviews, two of the exemplar case studies were retrieved through contacts, and not by the review search strategy. Contact with experts routinely forms part of traditional searching, and this aspect represented a particularly important contribution to the present review.

The variable quality of evidence across the included systematic reviews may be a consequence of the composite nature of that evidence. Mixed methods evidence appeared to be a defining feature of the topic area selected for this review. Assessing the quality of a review based on mixed methods and/or multiple sources presented difficulties in applying traditional assessment criteria based on individual study design. Currently, there is no robust reliability assessment tool for mixed methods reviews.

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Early specification of criteria for evaluating the quality of case studies in this review (based on clarity and transparency of reporting) enabled the successful identification of evaluations that might serve as exemplars of good practice. This was a relatively straightforward aspect of the review. Based on our three assessment criteria, the overall quality of these case studies was good (defined as adequate and clear reporting; evidence of reflexivity; and diverse perspectives considered). However, given that good reporting was part of the inclusion criteria for case studies, selection bias was a possibility in this review.

## 6 Conclusions

### 6.1 Key conclusions from the project

The overall quality of evidence in our review is mixed. The included systematic reviews comprised multiple types of evidence and study designs, and most reviews did not report any quality assessment of included studies. A number of potentially helpful case studies were found, but the quality of reporting was generally poor. Six case studies were selected as exemplars on the basis of clearly reported evaluations, and these provided focus for our analysis. One of the key findings from this review is that meaningful engagement is hard to achieve, and research to evaluate its impact is difficult to conduct.

Nevertheless, our review demonstrated that it was possible to address these difficulties. Great advances have been made to set out frameworks for engaging users in discussions and decisions about service re-configurations. We have found a number of exemplar case studies which show meaningful engagement can be achieved. Moreover, although the evidence base was not large, we have found studies that were able to provide insight into the value of user engagement and its impact on shaping service reconfiguration. In particular, this review succeeded in clarifying some of the factors associated with positive service user engagement.

Patients and the public can be engaged through a wide variety of methods ranging from public meetings and distribution of information to the use of social media. People can be engaged as individuals, in small groups and in larger groups. In selecting which methods to employ locally, decision-makers will need to take into account the nature of the local population and of the proposed service changes. In general, engagement was most likely to be successful when the process started at an early stage of planning service change, offered opportunities for genuine interaction and was led and supported by clinicians involved in delivering the relevant services. Interactive methods involving small groups, such as citizens' juries, could be very successful, although there may be difficulties in recruiting genuinely representative samples.

Our review also highlighted the importance of engaging with public representatives; in England primarily in the form of local authority scrutiny committees. The committees are



important because of their power to refer disputed reconfiguration proposals to the Independent Reconfiguration Panel (IRP), an outcome that NHS decision-makers should seek to avoid. The IRP's summary of lessons from its reviews<sup>1</sup> was an important resource, as was the availability of informal advice from the IRP.

The IRP report noted that problems often arose because NHS decision-makers paid insufficient attention to issues considered important to the public. There was evidence from case studies<sup>44</sup> and public opinion research<sup>21-23</sup> that many people were unwilling to accept longer journey times in return for the promise of better quality care at specialised centres. Since reconfiguration often involved centralisation of services, tackling such issues should be a priority for the leadership of the NHS at the national and local levels. There were potentially divergent issues to consider across other challenges to the NHS, such as decentralisation of services across several locations, or moving services from one location to another.

Drawing on the included systematic reviews and exemplar case studies, our review broadly addressed the first two research questions seeking to identify methods and impact of service user engagement in health service reconfiguration. Evidence on differential impact of methods, the sustainability of methods and outcomes, and methods of resolving differences between interested parties was less well documented. We noted some difficulty in distinguishing the stages of reconfiguration presently recommended by NHS England, but we uncovered some congruence with this guidance and what appears to be happening in practice, particularly in relation to the concentration of activity noted at stages 3 (discussion) and 5 (consultation). There is also some accord between these specific NHS England stages and the theoretical basis provided by Arnstein's ladder of participation. Across all evidence types, engagement activity appeared to move beyond basic information-giving towards the consultation and collaboration steps in the Arnstein's ladder. It appears that future activity might usefully engage more readily with earlier and later stages in the process.

Given that service reconfiguration dominates the health policy agenda in almost all countries, it is essential to build upon the practical and research foundations that have already been laid.

### **6.1.1 Strengths of this review**

The rapid nature of this review provides a timely, service-facing response to identify methods and impact of service user engagement in health service reconfiguration. This will be particularly valuable as the UK National Health Service navigates a way through arguably the biggest financial and operational challenge since its inception in 1948. The needs of service users are positioned at the heart of all service reconfigurations.

Whilst providing a rapid response, the review also maintained the highest quality standards through the adoption of a systematic and explicit review process, featuring:

- A thorough and comprehensive search to identify both published and unpublished studies.
- A strong pragmatic focus, with less emphasis on academic deliberation, and more on knowledge translation to a service-based audience.
- Input of external advisors to corroborate the findings.

### **6.1.2 Weaknesses of this review**

Despite its strengths, there were potential weaknesses arising from this review. These related to the fact that inconsistent terminology featured frequently, and inadequate descriptions of reconfiguration were encountered, which made it difficult on occasion to decide on the eligibility of studies for inclusion. To mitigate this, such cases were discussed fully to ensure consistent judgements were made. If there was doubt about the value of a study, it was not included. The rapid timeframe for the review also meant that the detail of some studies was not followed up (for example, studies contained within web links), although appropriate summaries and signposts were provided. All of this meant that relevant studies may have been overlooked.

The nature of the evidence also presented potential problems. Most of the recommendations emanated from a small sample of case studies. These were potentially biased as they documented successful engagement in reconfiguration, largely from an NHS commissioner

or provider perspective. Whilst many practical examples of engagement are available, they are generally poorly-reported in terms of methods, context, impact and sustainability over time.

## 6.2 Implications for health care

The NHS England stages of reconfiguration<sup>2</sup> may provide a helpful framework on which to base plans for future service user engagement programmes. However, this framework should not necessarily be considered as a linear process or a set of distinct elements. Arnstein's 'ladder of engagement and participation'<sup>3</sup> (based on the work of Sherry Arnstein) seems to offer less practical value. The four-dimensional framework developed by Gibson et al<sup>48</sup> may be worth further evaluation.

Within the NHS England framework, some key factors contributing to successful engagement and/or service reconfiguration appear to be:

- Ensuring a clear understanding of the local context.
- Early engagement, consulting widely.
- Demonstrating clinical-led case for change, with focus on service improvement rather than cost savings.
- Demonstrating openness and developing shared understanding of change through local partnership working.
- Promoting ownership of the change model and feedback results of engagement.
- Implementing strong managerial leadership
- Using mixed approaches, particularly deliberative methods of engagement, targeted where necessary for different population groups.
- Considering access and transport issues as part of service change.
- Evaluation; follow-up.
- Expecting the unexpected.

Of these key factors, one aspect that seemed the most pressing was the striking need for robust evaluation and follow-up in user engagement programmes. Where evaluation has taken place - particularly in some potentially valuable case studies - it was largely poorly reported and difficult to appraise from a research viewpoint. Potential limiting factors are

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time constraints in healthcare practice and naturally less concern for academic rigour. However, present reporting made it difficult to learn and move forward. Evaluation of user engagement in future health service reconfiguration is vital if we are to avoid reinventing the wheel each time public interaction is required. Ideally, evaluation should be conducted independently of those directing the engagement programme, and should be embedded throughout the entire process from planning to implementation. The reporting system in Scotland may provide some helpful pointers.<sup>41</sup> Specific attention should be paid to explicitly and consistently describing: the contextual characteristics of the situation; the methods of engagement, outcomes measured, and overall impact (including positive and negative impact, and differential effects of engagement methods); the sustainability of efforts (through appropriate follow-up); and the lessons to be learned. The need to publish evidence on methods and impact of patient and public voice activity is touched upon in NHS England's Transforming Participation in Healthcare.<sup>3</sup>

### **6.3 Implications for research**

One of the difficulties of the review was that much of the research was context-specific, which made generalisation difficult. Reconfiguration of services might be considered for the general population (such as primary care) for people with diagnosed conditions (such as mental health problems) for people seeking specific services (such as maternity services; or across geographical areas. Although the contexts are diverse, many challenges will be common.

The NHS England guidance on stages of reconfiguration may be of value in providing a generalisable approach and basis for user engagement in practice. The guidance may also provide a foundation for the design of future research on the evaluation of user engagement in service reconfiguration. These aspects are recommended areas of future research, together with an exploration of how the guidance might apply beyond the NHS setting.

In addition, further longer-term evaluations are needed to test the sustainability of methods of engagement and their impact over time. Prospective evaluations with contemporaneous data collection including use of observational methods may be the most suitable methods to achieve this. More research may also be warranted on the specific impact of interventions in

negotiating and resolving differing opinions between patients, public and clinical experts.  
Cost-effectiveness evaluation of engagement methods would be beneficial.

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### Contributions of authors

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### External advice

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Lucy Brown, Head of Communications, York Teaching Hospital NHS Foundation Trust.

Kay Gamble, Lead for Patient Experience, York Teaching Hospital NHS Foundation Trust.

Representatives of York Teaching Hospital NHS Foundation Trust were engaged with this review via Dr Jane Dalton (in her role as a publicly-elected Governor at the Trust). This process was helpful in providing local context to the research, and to enable discussion on potential exemplars for the review.

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# Appendices

## Appendix 1. Search strategies

### 1. Search strategies for reviews

The Cochrane Database of Systematic Reviews via the Cochrane Library, Wiley

<http://onlinelibrary.wiley.com/>

Issue 3 of 12, March 2014

Search date: 27<sup>th</sup> March 2014

Records retrieved: 30

- #1 MeSH descriptor: [Consumer Participation] explode all trees 993
- #2 MeSH descriptor: [Public Opinion] this term only 54
- #3 MeSH descriptor: [Consumer Organizations] this term only 9
- #4 MeSH descriptor: [Consumer Advocacy] this term only 10
- #5 MeSH descriptor: [Patient Advocacy] this term only 59
- #6 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\*) near/2 (particip\* or engage\* or involve\* or consult\* or opinion\* or voice\* or dialogue or view\* or input\* or partner\* or represent\* or collaborat\* or advoc\*)):ti 777
- #7 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\*) near/2 (jury\* or juries or panel\* or forum\*)):ti 10
- #8 community next health next council\*:ti 0
- #9 local next involvement next network\*:ti 0
- #10 healthwatch:ti 0
- #11 national next voices:ti 0
- #12 foundation next trust next governor\*:ti 0
- #13 FT next governor\*:ti 0
- #14 co-produc\* or coproduc\*:ti 13
- #15 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 in Cochrane Reviews (Reviews and Protocols) 30

#### Key:

MeSH descriptor = indexing term (MeSH heading)

\* = truncation

:ti = terms in title field

near/2 = terms within two words of each other (any order)

next = terms are next to each other

## The Campbell Library

<http://www.campbellcollaboration.org/lib/>

2003-2014

Search date: 25<sup>th</sup> March 2014

Records retrieved: 32

ID	Search	Hits
1	title is particip* or title is engage* or title is involve* or title is consult* or title is opinion* or title is voice* or title is dialogue or title is view* or title is input* or title is partner* or title is represent* or title is collaborat* or title is advoc*	15
2	<a href="#">title is "citizen jury" or title is "citizen juries" or title is forum* or title is panel*</a>	0
3	keywords is "citizen jury" or keywords is "citizen juries" or keywords is forum* or keywords is panel*	0
5	keywords is particip* or keywords is engage* or keywords is involve* or keywords is consult* or keywords is opinion* or keywords is voice* or keywords is dialogue or keywords is view* or keywords is input* or keywords is partner* or keywords is represent* or keywords is collaborat* or keywords is advoc*	17
8	title is "community health council" or title is "community health council*" or title is "local involvement network" or title is "local involvement networks" or title is Healthwatch or title is "national voices" or title is co-produc* or title is coproduc* or title is "foundation trust governor" or title is "foundation trust governors" or title is "FT governor" or title is "FT governors"	0
9	keywords is "community health council" or keywords is "community health council*" or keywords is "local involvement network" or keywords is "local involvement networks" or keywords is healthwatch or keywords is "national voices" or keywords is co-produc* or keywords is coproduc* or keywords is "foundation trust governor" or keywords is "foundation trust governors" or keywords is "ft governor" or keywords is "ft governors"	0

Key:

\* = truncation

“ ” = phrase search

## Database of Abstracts of Reviews of Effects (DARE)

CRD Internal Content Management System (includes those records published in DARE on the CRD website and records retrieved for possible inclusion in DARE but rejected)

Search date: 25<sup>th</sup> March 2014

Records retrieved: 356

- 1 MeSH DESCRIPTOR consumer participation
- 2 MeSH DESCRIPTOR patient participation
- 3 MeSH DESCRIPTOR public opinion
- 4 MeSH DESCRIPTOR patient advocacy
- 5 MeSH DESCRIPTOR consumer advocacy
- 6 MeSH DESCRIPTOR consumer organizations
- 7 #1 OR #2 OR #3 OR #4 OR #5 OR #6
- 8 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 particip\*):ti
- 9 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 particip\*):ti
- 10 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 involve\*):ti
- 11 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 consult\*):ti
- 12 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 opinion\*):ti
- 13 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 voice\*):ti
- 14 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 dialogue):ti
- 15 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 view\*):ti
- 16 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 input\*):ti
- 17 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 partner\*):ti
- 18 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 represent\*):ti
- 19 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 collaborat\*):ti
- 20 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 advoc\*):ti
- 21 ((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\* or care giver or care givers) adj2 (jury\* or juries or panel\* or forum\*)):ti
- 22 ("community health council" or "community health councils"):ti
- 23 ("local involvement network" or "local involvement networks"):ti
- 24 healthwatch:ti
- 25 "national voices":ti
- 26 ("foundation trust governor" or "foundation trust governors" or "FT governor" or "FT governors"):ti
- 27 (co-produc\* or coproduc\*):ti
- 28 #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19

OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27  
29 #7 OR #28  
30 FROM 2000 TO 2014  
31 #29 AND #30

Key:

MeSH descriptor = indexing term (MeSH heading)

\* = truncation

:ti = terms in title field

adj/2 = terms within two words of each other (any order)

“ ” = phrase search

## Database of Promoting Health Effectiveness Reviews (DoPHER)

<http://eppi.ioe.ac.uk/webdatabases/Search.aspx>

Search date: 27<sup>th</sup> March 2014

Records retrieved: 40

121	Freetext: "Patient* engage*"	0
123	Freetext: "user* engage*"	1
125	Freetext: "client* engage*"	0
127	Freetext: "consumer* engage*"	0
129	Freetext: "citizen* engage*"	0
131	Freetext: "citizen* engage*"	0
133	Freetext: "public engage*"	0
135	Freetext: "communit* engage*"	7
137	Freetext: "stakeholder* engage*"	0
139	Freetext: "Patient* particip*"	4
141	Freetext: "user* particip*"	1
143	Freetext: "client* particip*"	0
145	Freetext: "consumer* particip*"	1
147	Freetext: "citizen* particip*"	0
149	Freetext: "public particip*"	0
151	Freetext: "communit* particip*"	6
153	Freetext: "stakeholder* particip*"	1
155	Freetext: "Patient* involve*"	5
157	Freetext: "user* involve*"	0
159	Freetext: "client* involve*"	0
161	Freetext: "consumer* involve*"	0
163	Freetext: "citizen* involve*"	0
165	Freetext: "public involve*"	0
167	Freetext: "communit* involve*"	16
169	Freetext: "stakeholder* involve*"	0
171	121 OR 123 OR 125 OR 127 OR 129 OR 131 OR 133 OR 135 OR 137 OR 139 OR 141 OR 143 OR 145 OR 147 OR 149 OR 151 OR 153 OR 155 OR 157 OR 159 OR 161 OR 163 OR 165 OR 167 OR 169	40

Key:

\* = truncation

“ ” = phrase search

## **EPPI Centre Evidence Library**

<http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=62>

Search date: 27<sup>th</sup> March 2014

Records retrieved: 1

The list of Eppi Centre reviews was browsed for relevance. 1 relevant record was retrieved.

## **Health Systems Evidence**

<http://www.mcmasterhealthforum.org/healthsystemsevidence-en>

Search date: 1<sup>st</sup> April 2014

Records retrieved: 95

The search was carried out using the pre-defined database topic search of consumer and stakeholder involvement. 95 records in total were retrieved.

## ***2. Search strategies for primary studies***

### **MEDLINE In-Process & Other Non-Indexed Citations and MEDLINE via OvidSP**

<http://ovidsp.ovid.com/>

1946 to 20<sup>th</sup> March 2014

Searched on: 24<sup>th</sup> March 2014

Records retrieved: 467

- 1 exp \*Consumer Participation/ (16670)
- 2 \*Public Opinion/ (7243)
- 3 \*Patient Advocacy/ (11992)
- 4 \*Consumer Advocacy/ (1551)
- 5 \*Consumer Organizations/ (661)
- 6 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 particip\$).ti,ab. (31113)
- 7 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 engage\$).ti,ab. (4448)
- 8 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 involve\$).ti,ab. (22446)
- 9 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 consult\$).ti,ab. (6340)



- 10 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 opinion\$).ti,ab. (4103)
- 11 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 voice\$).ti,ab. (1435)
- 12 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 dialogue).ti,ab. (515)
- 13 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 view\$).ti,ab. (7186)
- 14 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 input\$).ti,ab. (1662)
- 15 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 partner\$).ti,ab. (5922)
- 16 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 represent\$).ti,ab. (11498)
- 17 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 collaborat\$).ti,ab. (2831)
- 18 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 advoc\$).ti,ab. (3722)
- 19 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 (jury\$ or juries or panel\$ or forum\$)).ti,ab. (1668)
- 20 community health council\$.ti,ab. (95)
- 21 local involvement network\$.ti,ab. (8)
- 22 healthwatch.ti,ab. (32)
- 23 national voices.ti,ab. (0)
- 24 (foundation trust governor\$ or FT governor\$).ti,ab. (3)
- 25 (co-produc\$ or coproduc\$).ti,ab. (2003)
- 26 or/1-25 (131571)
- 27 (reconfigur\$ or re-configur\$).ti. (686)
- 28 ((reconfigur\$ or re-configur\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ab. (327)
- 29 ((redesign\$ or re-design\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (1609)
- 30 ((reorganis\$ or re-organis\$ or reorganiz\$ or re-organiz\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (2498)
- 31 (brain or cortical or cortex).ti,ab. (887140)
- 32 30 not 31 (2202)

- 33 ((restructur\$ or re-structur\$) adj5 (service\$ or system\$ or care or healthcare or NHS or hospital\$)).ti,ab. (1848)
- 34 ((major or large-scale or substantial\$ or extensive\$) adj5 (chang\$ or reform\$ or modif\$ or transform\$ or shap\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (1727)
- 35 27 or 28 or 29 or 32 or 33 or 34 (8160)
- 36 26 and 35 (388)
- 37 Health Facility Merger/ (4446)
- 38 Health Facility Moving/ (250)
- 39 Health Facility Closure/ (2151)
- 40 Hospital Restructuring/ (4532)
- 41 ((hospital\$ or service\$ or care or healthcare or NHS) adj3 (closure\$ or closing or close\$ or merg\$ or relocat\$ or re-locat\$ or transfer\$ or decommission\$ or de-commission\$ or disinvest\$ or disinvest\$)).ti,ab. (9594)
- 42 or/37-41 (19523)
- 43 26 and 42 (447)
- 44 36 or 43 (810)
- 45 exp animals/ not humans/ (3903063)
- 46 44 not 45 (810)
- 47 letter.pt. (830574)
- 48 editorial.pt. (349409)
- 49 47 or 48 (1179918)
- 50 46 not 49 (797)
- 51 limit 50 to yr="2000 -Current" (492)
- 52 limit 51 to english language (467)

**Key:**

/ = indexing term (MeSH heading)

exp = exploded MeSH heading

\* = focussed MeSH heading

\$ = truncation

.ti,ab. = terms in either title or abstract fields

adj2 = terms within two words of each other (any order)

**ASSIA** via ProQuest

<http://www.proquest.com/>

Search date: 26<sup>th</sup> March 2014

Records retrieved: 234

(((SU.EXACT("Participation") OR SU.EXACT("Community participation") OR SU.EXACT("Citizen participation") OR SU.EXACT("Patient participation") OR SU.EXACT("Consumer participation") OR SU.EXACT("Client participation")) OR SU.EXACT("Engagement") OR SU.EXACT("User involvement") OR SU.EXACT("Consumer representation") OR SU.EXACT("Advocacy") OR SU.EXACT("Citizens' juries") OR SU.EXACT("Community health councils") OR SU.EXACT("Public opinion")) AND la.exact("English") AND pd(2000-2014)) OR (TI,AB((Patient\* OR user\* OR client\* OR consumer\* OR citizen\* OR public OR communit\* OR stakeholder\* OR carer\* OR caregiver\* OR care-giver\* OR "care giver" OR "care givers") NEAR/2 (particip\* OR engage\* OR involve\* OR consult\* OR opinion\* OR voice\* OR dialogue OR view\* OR input\* OR partner\* OR represent\* OR collaborat\* OR advoc\*)) AND la.exact("English") AND pd(2000-2014)) OR (TI,AB((Patient\* OR user\* OR client\* OR consumer\* OR citizen\* OR public OR communit\* OR stakeholder\* OR carer\* OR caregiver\* OR care-giver\* OR "care giver" OR "care givers") NEAR/2 (jury\* OR juries OR panel\* OR forum\*)) AND la.exact("English") AND pd(2000-2014)) OR (TI,AB("community health council" OR "community health councils" OR "local involvement network" OR "local involvement networks" OR Healthwatch OR "national voices" OR co-produc\* OR coproduc\* OR "foundation trust governor" OR "foundation trust governors" OR "FT governor" OR "FT governors") AND la.exact("English") AND pd(2000-2014))) AND (((TI(reconfigur\* OR re-configur\*) OR AB((reconfigur\* OR re-configur\*) NEAR/5 (service\* OR system\* OR care OR healthcare OR hospital\* OR NHS)) OR TI,AB((redesign\* OR re-design\*) NEAR/5 (service\* OR system\* OR care OR healthcare OR hospital\* OR NHS)) OR TI,AB((reorganis\* OR re-organis\* OR reorganiz\* OR re-organiz\*) NEAR/5 (service\* OR system\* OR care OR healthcare OR hospital\* OR NHS)) OR TI,AB((restructur\* OR re-structur\*) NEAR/5 (service\* OR system\* OR care OR healthcare OR NHS OR hospital\*)) OR TI,AB((major OR large-scale OR substantial\* OR extensive\*) NEAR/5 (chang\* OR reform\* OR modif\* OR transform\* OR shap\*) NEAR/5 (service\* OR system\* OR care OR healthcare OR hospital\* OR NHS))) OR (SU.EXACT("Organizational change") OR SU.EXACT("Reorganization") OR SU.EXACT("Structural change") OR SU.EXACT("Restructuring"))) AND la.exact("English") AND pd(2000-2014)) OR ((SU.EXACT("Closure") OR SU.EXACT("Mergers") OR SU.EXACT("Relocation") OR TI,AB((hospital\* OR service\* OR care OR healthcare OR NHS) NEAR/3 (closure\* OR closing OR close\* OR merg\* OR relocat\* OR re-locat\* OR transfer\* OR decommission\* OR de-commission\* OR disinvest\* OR dis-invest\*))) AND la.exact("English") AND pd(2000-2014)))

**Key:**

SU.EXACT = subject heading

TI,AB = terms in the title or abstract fields

NEAR/2 = terms within two words of each other (any order)

\* = truncation

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“ ” = phrase search  
la.exact = language limit  
pd = publication date limit

## Health Management Information Consortium via OvidSP

<http://ovidsp.ovid.com/>

1979 to January 2014

Searched on: 25<sup>th</sup> March 2014

Records retrieved: 574

- 1 exp Participation/ (7731)
- 2 exp opinions/ (10525)
- 3 exp consumer representation/ (829)
- 4 exp advocates/ (96)
- 5 exp patient & public involvement services/ (126)
- 6 commission for patient & public involvement in health/ (4)
- 7 local representative committees/ (11)
- 8 citizens juries/ (84)
- 9 patient partnership strategy/ (16)
- 10 community health councils/ (366)
- 11 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 particip\$).ti,ab. (2004)
- 12 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 engage\$).ti,ab. (595)
- 13 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 involve\$).ti,ab. (3277)
- 14 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 consult\$).ti,ab. (1437)
- 15 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 opinion\$).ti,ab. (645)
- 16 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 voice\$).ti,ab. (196)
- 17 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 dialogue).ti,ab. (43)
- 18 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 view\$).ti,ab. (2158)

- 19 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 input\$.ti,ab. (164)
- 20 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 partner\$.ti,ab. (868)
- 21 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 represent\$.ti,ab. (645)
- 22 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 collaborat\$.ti,ab. (300)
- 23 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 advoc\$.ti,ab. (469)
- 24 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 (jury\$ or juries or panel\$ or forum\$)).ti,ab. (357)
- 25 community health council\$.ti,ab. (554)
- 26 local involvement network\$.ti,ab. (78)
- 27 healthwatch.ti,ab. (53)
- 28 national voices.ti,ab. (8)
- 29 (foundation trust governor\$ or FT governor\$.ti,ab. (18)
- 30 (co-produc\$ or coproduc\$.ti,ab. (87)
- 31 or/1-30 (26280)
- 32 exp organisational change/ (3458)
- 33 Structural change/ (140)
- 34 change management/ (1926)
- 35 (reconfigur\$ or re-configur\$.ti. (106)
- 36 ((reconfigur\$ or re-configur\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ab. (199)
- 37 ((redesign\$ or re-design\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (483)
- 38 ((reorganis\$ or re-organis\$ or reorganiz\$ or re-organiz\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (670)
- 39 ((restructur\$ or re-structur\$) adj5 (service\$ or system\$ or care or healthcare or NHS or hospital\$)).ti,ab. (463)
- 40 ((major or large-scale or substantial\$ or extensive\$) adj5 (chang\$ or reform\$ or modif\$ or transform\$ or shap\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (412)
- 41 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 (6932)
- 42 31 and 41 (671)
- 43 exp "contraction of services"/ (668)

- 44 exp service relocation/ (208)
- 45 site relocation/ (57)
- 46 ((hospital\$ or service\$ or care or healthcare or NHS) adj3 (closure\$ or closing or close\$ or merg\$ or relocat\$ or re-locat\$ or transfer\$ or decommission\$ or de-commission\$ or disinvest\$ or disinvest\$)).ti,ab. (1910)
- 47 43 or 44 or 45 or 46 (2586)
- 48 31 and 47 (249)
- 49 42 or 48 (879)
- 50 limit 49 to yr="2000 -Current" (574)
- 51 limit 50 to english (574)

**Key:**

/ = indexing term (MeSH heading)

exp = exploded MeSH heading

\$ = truncation

.ti,ab. = terms in either title or abstract fields

adj2 = terms within two words of each other (any order)

**PsycINFO via OvidSP**

<http://ovidsp.ovid.com/>

1806 to March week 4, 2014

Searched on: 28<sup>th</sup> March 2014

Records retrieved: 390

- 1 \*Participation/ (4167)
- 2 client participation/ (1323)
- 3 \*Public Opinion/ (5012)
- 4 advocacy/ (3187)
- 5 \*Involvement/ (3321)
- 6 community involvement/ (2575)
- 7 collaboration/ (5449)
- 8 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 particip\$).ti,ab. (14125)
- 9 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 engage\$).ti,ab. (4401)
- 10 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 involve\$).ti,ab. (7873)
- 11 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 consult\$).ti,ab. (2157)

- 12 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 opinion\$).ti,ab. (4010)
- 13 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 voice\$).ti,ab. (775)
- 14 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 dialogue).ti,ab. (455)
- 15 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 view\$).ti,ab. (4369)
- 16 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 input\$).ti,ab. (664)
- 17 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 partner\$).ti,ab. (3358)
- 18 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 represent\$).ti,ab. (3527)
- 19 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 collaborat\$).ti,ab. (2313)
- 20 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 advoc\$).ti,ab. (1823)
- 21 ((Patient\$ or user\$ or client\$ or consumer\$ or citizen\$ or public or communit\$ or stakeholder\$ or carer\$ or caregiver\$ or care-giver\$) adj2 (jury\$ or juries or panel\$ or forum\$)).ti,ab. (850)
- 22 community health council\$.ti,ab. (12)
- 23 local involvement network\$.ti,ab. (6)
- 24 healthwatch.ti,ab. (6)
- 25 national voices.ti,ab. (0)
- 26 (foundation trust governor\$ or FT governor\$).ti,ab. (0)
- 27 (co-produc\$ or coproduc\$).ti,ab. (438)
- 28 or/1-27 (66071)
- 29 exp organizational change/ (8947)
- 30 ((reconfigur\$ or re-configur\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (146)
- 31 ((redesign\$ or re-design\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (438)
- 32 ((reorganis\$ or re-organis\$ or reorganiz\$ or re-organiz\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (733)
- 33 ((restructur\$ or re-structur\$) adj5 (service\$ or system\$ or care or healthcare or NHS or hospital\$)).ti,ab. (659)

- 34 ((major or large-scale or substantial\$ or extensive\$) adj5 (chang\$ or reform\$ or modif\$ or transform\$ or shap\$) adj5 (service\$ or system\$ or care or healthcare or hospital\$ or NHS)).ti,ab. (526)
- 35 ((hospital\$ or service\$ or care or healthcare or NHS) adj3 (closure\$ or closing or close\$ or merg\$ or relocat\$ or re-locat\$ or transfer\$ or decommission\$ or de-commission\$ or disinvest\$ or disinvest\$)).ti,ab. (1858)
- 36 or/29-35 (13057)
- 37 28 and 36 (509)
- 38 limit 37 to yr="2000 - 2014" (400)
- 39 limit 38 to english language (390)

Key:

/ = indexing term (MeSH heading)

exp = exploded MeSH heading

\* = focussed MeSH heading

\$ = truncation

.ti,ab. = terms in either title or abstract fields

adj2 = terms within two words of each other (any order)

## Social Care Online

<http://www.scie-socialcareonline.org.uk/>

Search date: 7<sup>th</sup> April 2014

Records retrieved: 171

- [ - PublicationYear:'2000 2014']

**AND**

- [ - SubjectTerms:"participation" including **narrower terms**
  - OR SubjectTerms:"public opinion" including **this term only**
  - OR SubjectTerms:"advocacy" including **this term only**
  - OR SubjectTerms:"interest groups" including **this term only**
  - OR SubjectTerms:"consultation" including **this term only**
  - OR SubjectTerms:"user views" including **this term only**
  - OR SubjectTerms:"collaboration" including **this term only**
  - OR SubjectTerms:"co-production" including **this term only**

**AND**

- [ - SubjectTerms:"change management" including **this term only**
  - OR SubjectTerms:"service closure" including **this term only**

**OR**



- [ - AllFields:'reconfigur\*'  
 - OR AllFields:"re-configur\*"  
 - OR AllFields:'redesign\*'  
 - OR AllFields:"re-design\*"  
 - OR AllFields:'reorganis\*'  
 - OR AllFields:"re-organis\*"  
 - OR AllFields:'reorganiz\*'  
 - OR AllFields:"re-organiz\*"  
 - OR AllFields:'restructur\*'  
 - OR AllFields:"re-structur\*" ]

Key:

SubjectTerms = subject heading search

AllFields = terms in any field

\* = truncation

“ ” = phrase search

**Social Science Citation Index** via Web of Science, Thomson Reuters

<http://thomsonreuters.com/thomson-reuters-web-of-science/>

1956 – 26<sup>th</sup> March 2014

Search date: 28<sup>th</sup> March 2014

Records retrieved: 437

- |      |              |  |
|------|--------------|--|
| # 17 | <b>437</b>   | (#16 AND #9) <b>AND LANGUAGE:</b> ( <i>English</i> )<br>Indexes=SSCI Timespan=2000-2014  |
| # 16 | <b>5,505</b> | #15 OR #14 OR #13 OR #12 OR #11 OR #10<br>Indexes=SSCI Timespan=2000-2014  |
| # 15 | <b>2,633</b> | (TS=((hospital* or service* or care or healthcare or NHS) NEAR/3 (closure* or closing or close* or merg* or relocat* or re-locat* or transfer* or decommission* or de-commission* or disinvest* or dis-invest*))) <b>AND LANGUAGE:</b> ( <i>English</i> )<br>Indexes=SSCI Timespan=2000-2014 |
| # 14 | <b>701</b>   | (TS=((major or large-scale or substantial* or extensive*) NEAR/5 (chang* or reform* or modif* or transform* or shap*) NEAR/5 (service* or system* or care or healthcare or hospital* or NHS))) <b>AND LANGUAGE:</b> ( <i>English</i> )<br>Indexes=SSCI Timespan=2000-2014                    |

- # 13    **855**            (TS=((restructur\* or re-structur\*) NEAR/5 (service\* or system\* or care or healthcare or NHS or hospital\*))) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 12    **516**            (TS=((reorganis\* or re-organis\* or reorganiz\* or re-organiz\*) NEAR/5 (service\* or system\* or care or healthcare or hospital\* or NHS))) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 11    **727**            (TS=((redesign\* or re-design\*) NEAR/5 (service\* or system\* or care or healthcare or hospital\* or NHS))) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 10    **220**            (TS=((reconfigur\* or re-configur\*) NEAR/5 (service\* or system\* or care or healthcare or hospital\* or NHS))) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 9      **61,671**          #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1  
Indexes=SSCI Timespan=2000-2014
- # 8      **909**            (TS=(co-produc\* or coproduc\*)) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 7      **2**                (TS=(“foundation trust governor\*” or “FT governor\*)) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 6      **0**                (TS=“national voices”) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 5      **6**                (TS=healthwatch) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 4      **6**                (TS=“local involvement network”) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 3      **12**              (TS=“community health council”) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014
- # 2      **1,509**          (TS=((Patient\* or user\* or client\* or consumer\* or citizen\* or public or communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\*) NEAR/2 (jury\* or juries or panel\* or forum\*))) **AND LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014

# 1      **59,787**      (TS=((Patient\* or user\* or client\* or consumer\* or citizen\* or public or  
communit\* or stakeholder\* or carer\* or caregiver\* or care-giver\*) NEAR/2  
(particip\* or engage\* or involve\* or consult\* or opinion\* or voice\* or dialogue  
or view\* or input\* or partner\* or represent\* or collaborat\* or advoc\*))) AND  
**LANGUAGE:** (*English*)  
Indexes=SSCI Timespan=2000-2014

Key

TS= topic tag; searches terms in title, abstract, author keywords and keywords plus fields

\* = truncation

“ ” = phrase search

NEAR/2 = terms within 2 words of each other (any order)

### 3. Search strategies to locate grey literature

The following websites were either browsed manually and/or searched using the website search function where available, depending on the size of literature contained on the website. The searches were carried out during the period 11<sup>th</sup> April 2014 – 2<sup>nd</sup> May 2014. The search was limited to documents published in English from 2000 onwards. 187 relevant documents were identified.

Website	Results
Center for Studying Health System Change <a href="http://www.hschange.org/">http://www.hschange.org/</a>	0
Department of Health <a href="https://www.gov.uk/government/publications">https://www.gov.uk/government/publications</a>	15
Foundation Trust Governors Association <a href="http://www.ftga.org.uk/">http://www.ftga.org.uk/</a>	0
Health Services and Delivery Research (HS&DR) Programme <a href="http://www.nets.nihr.ac.uk/programmes/hsdr">http://www.nets.nihr.ac.uk/programmes/hsdr</a>	11
Health Services Management Centre, University of Birmingham <a href="http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/index.aspx">http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/index.aspx</a>	8
Healthcare Improvement Scotland <a href="http://www.healthcareimprovementscotland.org/">http://www.healthcareimprovementscotland.org/</a>	0
Healthwatch England <a href="http://www.healthwatch.co.uk/">http://www.healthwatch.co.uk/</a>	0
Independent Reconfiguration Panel <a href="http://www.irpanel.org.uk/view.asp?id=0">http://www.irpanel.org.uk/view.asp?id=0</a>	52
Joseph Rowntree Foundation <a href="http://www.jrf.org.uk/">http://www.jrf.org.uk/</a>	5
National Voices <a href="http://www.nationalvoices.org.uk/">http://www.nationalvoices.org.uk/</a>	2
NHS Confederation <a href="http://www.nhsconfed.org/Pages/home.aspx">http://www.nhsconfed.org/Pages/home.aspx</a>	20
NHS England <a href="http://www.england.nhs.uk/">http://www.england.nhs.uk/</a>	4
NHS Improving Quality <a href="http://www.nhsiq.nhs.uk/">http://www.nhsiq.nhs.uk/</a>	3
NHS Institute for Innovation and Improvement <a href="http://www.institute.nhs.uk/">http://www.institute.nhs.uk/</a>	5
NHS Scotland <a href="http://www.show.scot.nhs.uk/">http://www.show.scot.nhs.uk/</a>	7
NHS Wales <a href="http://www.wales.nhs.uk/">http://www.wales.nhs.uk/</a>	2
NICE	3

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<a href="http://www.nice.org.uk/">http://www.nice.org.uk/</a>	
RAND corporation <a href="http://www.rand.org/">http://www.rand.org/</a>	0
Scottish Health Council <a href="http://www.scottishhealthcouncil.org/patient_public_participation/patient_public_participation.aspx">http://www.scottishhealthcouncil.org/patient_public_participation/patient_public_participation.aspx</a>	16
Social Care Institute for Excellence (SCIE) <a href="http://www.scie.org.uk/">http://www.scie.org.uk/</a>	12
The Health Foundation <a href="http://www.health.org.uk/publications/">http://www.health.org.uk/publications/</a>	6
The Kings Fund <a href="http://www.kingsfund.org.uk/">http://www.kingsfund.org.uk/</a>	9
The Nuffield trust <a href="http://www.nuffieldtrust.org.uk/">http://www.nuffieldtrust.org.uk/</a>	4
The Picker Institute Europe <a href="http://www.pickereurope.org/">http://www.pickereurope.org/</a>	3
total	187

A focussed search of Google, using the advanced search, was carried out to locate reports on service reconfiguration. The search was limited to UK pdfs published in English from 2000 onwards with the term “reconfiguration” in the title of the webpage. The first 100 results were scanned for relevance. The search was carried out on 2<sup>nd</sup> May 2014 and identified 18 reports.

## Appendix 2. Systematic reviews data extraction

<p><b>Study:</b> <i>Abelson et al (2010)</i><sup>5</sup></p> <p><b>Authors' objectives:</b> <i>To evaluate the effectiveness of interactive strategies for engaging the public in the development of healthcare policies and programmes at provincial/regional level. Particular attention is given to public engagement of rural populations (and to the New Brunswick context in Canada), in both official languages (English and French), and regarding the determinants of health.</i></p> <p><b>Inclusion criteria:</b> <i>Original and review articles of empirical studies of public engagement methods, practices, and evaluations in the development of healthcare policy and programmes. Theoretical and conceptual work that helps inform the evaluation of public engagement. Key background papers of methodological and theoretical issues relating to public engagement. Languages restricted to English and French.</i></p> <p><b>Exclusion criteria:</b> <i>Not stated.</i></p> <p><b>Search dates:</b> <i>2000 to 2009</i></p>
<p><b>Number of included studies:</b> <i>34</i></p> <p><b>Included study designs:</b> <i>Cochrane review (1); systematic review (1); scoping review (1); narrative reviews (2); empirical studies evaluating a public engagement intervention in healthcare (12) (including 3 comparative evaluations; where reported, comparisons were different intensities not different interventions); non-empirical papers of evaluation approaches and methods (8); Canadian grey literature documents containing empirical and non-empirical studies (9).</i></p> <p><b>Countries of included studies:</b> <i>12 published empirical studies include: Canada (7); UK (3); USA (1); Australia (1).</i></p>
<p><b>Types of reconfiguration:</b> <i>Published empirical studies: Priority setting, planning and policy development in a number of areas including local health goal-setting; health promotion and healthy public policy; cancer-specific and general health service planning and delivery; and policy development related to new health technologies.</i></p> <p><b>Definitions of engagement/involvement:</b> <i>Review authors' definition: A category of methods for involving citizens in healthcare decision-making that incorporates at least 3 elements: (1) the provision of information to participants about the topic/issue being discussed; (2) the opportunity for interactive discussion among participants and potentially between participants the public engagement sponsors; (3) an explicit process for collecting individual or collective input. Definitions also provided for included reviews.</i></p> <p><b>Who was engaged/involved:</b> <i>Urban/rural/Francophone/Aboriginal populations. Participants recruited from community-based organisations; local residents/citizens/stakeholders/hard-to-reach groups.</i></p> <p><b>Methods of engagement/involvement:</b> <i>Ad hoc deliberative meetings (eg, citizen's panels/juries held over 1-3 days; long-term collaborative partnerships over several months or years. Three studies looked at partnerships as models of, or inputs to, effective and sustainable public engagement.</i></p>
<p><b>Method of synthesis:</b> <i>Critical interpretive synthesis (Dixon-Woods et al 2006): conceptual translation of quantitative/qualitative/non-empirical studies.</i></p> <p><b>Conceptual/theoretical framework or logic model used:</b> <i>There is a contextual framework mentioned (fig 1, p6) but not explicitly stated that this was used. Many of the included studies employed a conceptual framework in their evaluation.</i></p>

**Research questions addressed:** 1,4.

**Stages of involvement:** 1,2,3,4?,5.

**Levels of involvement:** *Informing; Consulting; Involving; Collaborating.*

**Results:** *Results from the review of reviews indicated that greater conceptual clarity is needed about the meaning of effective public engagement, common evaluative criteria, and more rigorous evaluation of the effects of public engagement on a range of outcomes of interest. Key messages from the 12 published empirical studies: Interactive public engagement can be implemented successfully in various situations, and success is dependent on contextual variables. Organisational commitment and topic-related characteristics appear to be key contextual variables. Public engagement mechanisms need to be adapted to the wider context of policy development around the issue, including topic, the group(s) to be engaged, the history of the issue, and the perceived power dynamics. Skills required to conduct interactive processes can be learned in a supportive organisational environment. Participant satisfaction and increased topic-specific learning is higher when the engagement process is well designed, although process satisfaction does not necessarily lead to perceived impact of participation on policy decision-making. Group debate features as an important contributor to satisfaction. Partnerships are central to the effectiveness of community-based public engagement strategies. Institutionalisation of partnerships beyond the active phase can enable sustainable change. Interactive public engagement can influence participant views, but is less likely to change more dominant views. Results from the Canadian grey literature highlighted the need for open processes of engagement, with the involvement of policy-makers and participants in setting indicators, benchmarks, and goals in evaluating public engagement activity. Further results are reported in the paper from the published non-empirical literature (focusing on theoretical and conceptual work in public engagement evaluation) Further results are also reported on engaging the public about the determinants of health; engaging rural populations; public engagement in different languages; and combining theory and practice.*

**Authors' conclusions:** *Current interest in public engagement among Canadian health system managers and policy-makers needs to be matched by clear thinking from all interested parties (researchers, managers, and policy-makers) about the terminology, goals, theoretical properties, and benefits of public engagement.*

**Comments:** *Not all focused on reconfiguration. Related to this review are those focusing on priority setting and resource allocation. Not clear if any study overlap with Mitton et al (2009)<sup>19</sup> as Mitton did not present study details. Crawford et al (2002) also included in the Abelson review.*

**Study:** *Conklin et al (2012)*<sup>15</sup>

**Authors' objectives:** *To evaluate the outcomes of public involvement in health care decision-making, priority-setting, resource allocation, and health service planning at the macro- and meso-level.*

**Inclusion criteria:** *Focus on evaluation studies. For this review, involvement was conceptualised as taking a broader societal perspective on public involvement where the public were: (1) lay citizens/community members; (2) representatives of organised social interest groups, such as coalitions, partnerships; (3) organisations of staff members and/or patients/customers/clients, and input was from a broad group (not individual) perspective. Any outcome or impact was eligible, as defined by the study authors.*

**Exclusion criteria:** *Surveys of beliefs/attitudes about participation. Studies that examined involvement in service development, shared decision making of individual treatment, clinical decisions, participatory action research, therapeutic and service delivery decisions, and clinical guidelines. Studies of preferences for participation among health care professionals or users. Reviews, editorials, commentaries. Studies in languages other than English, German, or French.*

**Search dates:** *Published articles from November 2000 to April 2010 were sought.*

**Number of included studies:** *19*

**Included study designs:** *Nine descriptive case studies; 10 empirical studies (cross-sectional; comparative pre-post design; qualitative; mixed methods). Follow-up (where reported) ranged from one year to seven years.*

**Countries of included studies:** *Majority in England, Canada, USA, Northern Ireland. Others included France, the Netherlands, Italy, and Israel.*

**Types of reconfiguration:** *Relevant studies (where reconfiguration was the goal): Examples: resource allocation relating to local health integration networks. Shaping policies and decisions about primary care provision and delivery. Health-care priority setting. Health policy decisions about the delivery of women's health services. Decision making about local health services.*

**Definitions of engagement/involvement:** *The review authors defined six levels of involvement (consultation, participation, engagement, partnership, community development, representation), but stated that these were often used interchangeably, even within included studies.*

**Who was engaged/involved:** *Special interest groups; public; patients; staff; NHS lay board members. More specific definitions of "the public" varied and were generally unclear across the studies. Terms used: representatives of patient organisations; ordinary citizens; individuals with no particular axe to grind; those whose voices might not otherwise be heard.*

**Methods of engagement/involvement:** *Surveys; conference and website; community health councils; public meetings; local patient groups; citizen panels/juries; group simulation using roulette wheel; collaboration between agencies/groups/individuals.*

**Method of synthesis:** *Narrative.*

**Conceptual/theoretical framework or logic model used:** *Not stated.*

**Research questions addressed:** *1,2,3,4.*

**Stages of involvement:** *3,4,5,6,7.*

**Levels of involvement:** *Informing; consulting; involving; collaborating.*

**Results:** *Where reported, details of specific and measurable data on outcomes were generally lacking. Studies demonstrated how public involvement had influenced decision making and led to*



*acceptance and implementation (1 study involving small group meetings/plenary sessions); practical changes/improvement were achieved (3 studies involving surveys and group meetings), priorities (identified through the involvement activity) were integrated to a regional programme (1 study); and resources had been found for new services (3 studies involving citizen's juries, community group representations/collaborations). One study demonstrated repeatability of regional meetings (a deliberative consultation activity) in two other organisations. Other studies suggested that the impact or influence of public involvement on shaping strategic decisions was found to be minimal (3 studies), geographically variable (2 studies), or mixed (1 study). Common outcome measures were participant views or "change" as a measure of influence of public engagement on decisions, policy and practice. Some studies reported improved learning or knowledge of processes involved in consultation and priority setting, and benefits for deliberative procedures. Negative consequences of public involvement were reported as costs, and unintended outcomes for participating stakeholders when challenged by members of the public.*

**Authors' conclusions:** *Evidence of impact on public involvement in health care policy remains scarce, despite the growing body of work. Firm conclusions about effective and appropriate involvement activities are difficult to draw. Focus on outcomes risks missing the normative argument that involving the public in the health-care policy process may be seen to be of intrinsic value.*

**Comments:** *This review was designed as a scoping review.*

**Study:** *Crawford et al (2002)<sup>16</sup>*

**Authors' objectives:** *To examine the effects of involving patients in the planning and development of health care.*

**Inclusion criteria:** *Studies of patient involvement (defined as the active participation in the planning, monitoring, and development of health services of patients, patient representatives, and wider public as potential patients) in the planning and development of health care.*

**Exclusion criteria:** *Studies of patient involvement in research, community development, health promotion, self management and self help, and the role of doctors and patients in determining individual treatment choices. Studies measuring patient satisfaction or patient preferences without describing how information was used to help develop a service.*

**Search dates:** *1966 to 2000*

**Number of included studies:** *42*

**Included study designs:** *Case reports (31); surveys (5); review of minutes of meetings (3); action research (3). Four of the included studies used qualitative research methods.*

**Countries of included studies:** *UK (28); Sweden; USA; Australia; Canada.*

**Types of reconfiguration:** *Various services, including primary care, mental health, learning and physical disability, general healthcare, community services, inpatient and outpatient, social care, maternity, neurology, HIV. Most studies looked at smaller-scale change. Approximately one quarter of studies focused on larger-scale change, including changes to organisation of care and/or services. Of these studies, two involved a plan for hospital closure.*

**Definitions of engagement/involvement:** *Review author's definition: Active patient participation in the planning, monitoring, and development of health services of patients, patient representatives, and wider public as potential patients.*

**Who was engaged/involved:** *Most studies described participants as patients. Others reported involvement of carers, service users, staff, Health and Welfare Council, Community Health Council, citizens, lay board of directors, or mixed populations.*

**Methods of engagement/involvement:** *Patient groups, consultation meetings, committees and forums; interviews; citizen's juries; survey; focus groups; representation on planning boards and panels; mixed methods.*

**Method of synthesis:** *Narrative*

**Conceptual/theoretical framework or logic model used:** *No.*

**Research questions addressed:** *1,2,4.*

**Stages of involvement:** *3?,4?,5,6.*

**Levels of involvement:** *Informing; Consulting; Involving; Collaborating.*

**Results:** *Most frequently cited effects of patient involvement were the production of new or improved sources of information for patients; and making services more accessible (smaller scale changes). Seven reports described new services being commissioned, and two reports described hospital closure proposals being modified or abandoned as a result of patient involvement. Mixed response from patients in terms of satisfaction with the process of involvement. Organisational attitudes to involving patients became more favourable (4 reports), resulted in culture change to being more open to involving patients (2 reports), and resulted in further involvement projects (2 reports). Other reports (6) discussed less favourable consequences, such as involvement being used to legitimise decisions*

*already made, or a slower decision-making process.*

**Authors' conclusions:** *Involving patients has contributed to changes in the provision of services across a range of different settings. The evidence base for the effects on use of services, quality of care, satisfaction, or health of patients does not exist.*

**Comments:** *This review appears to be a subset (based on healthcare context only) of Crawford et al (2003)<sup>17</sup> (which contains a wider scope of sectors). The wider review has a different objective - to look at transferability of user involvement from other sectors to healthcare. Therefore, it appears appropriate to treat these as two separate reviews.*

**Study:** *Crawford et al (2003)*<sup>17</sup>

**Authors' objectives:** *To evaluate user involvement in change management across a range of sectors (health, other public services, voluntary, and private sectors). To identify factors that promote successful user engagement, and identify relevance to the NHS.*

**Inclusion criteria:** *Any study design focusing on the aims, processes, and outcomes of service user involvement in change management at local organisational level.*

**Exclusion criteria:** *Studies not directly related to change management (such as campaigns for change in policy at national level).*

**Search dates:** *Databases: Published after 1980 to 2002. Other searches (where reported) to 2002.*

**Number of included studies:** *344 (of those reporting outcomes, 55 related to public sector health, social care, and community care; 19 related to public sector non-health; and 23 related to the private sector). See Appendix 3.*

**Included study designs:** *Most were qualitative process evaluations or discussion papers on case studies.*

**Countries of included studies:** *Largely UK. Others: Australia, Sweden, Denmark, USA, Canada, Austria, Japan. See Appendix 3.*

**Types of reconfiguration:** *Specific reconfiguration not described. Reconfiguration contexts described as various within health, social and community care; non-health public sector (including postal services, social security, education, housing); private sector (including consumer goods, travel, entertainment); and voluntary sector (disability/neurological services).*

**Definitions of engagement/involvement:** *Review authors' definition: taking an active part in change management at the organisational level.*

**Who was engaged/involved:** *Current, ex. and potential service users and their representatives. Providers.*

**Methods of engagement/involvement:** *Various, covering time limited methods (to elicit user perceptions/preferences); and long term approaches (building relationships with service users). Some initiated by provider; others initiated by service users. Public sector tended to use more deliberative approaches. Examples: surveys, focus groups; deliberative approaches (such as citizen's juries, public conferences); user/community groups; formal bodies (such as Community Health Councils, patient groups, advocates and link workers).*

**Method of synthesis:** *Thematic (using qualitative methods)*

**Conceptual/theoretical framework or logic model used:** *Not stated.*

**Research questions addressed:** *1,2,3,4.*

**Stages of involvement:** *Not clear. Difficult to apply to such a general review.*

**Levels of involvement:** *Informing, consulting, involving, collaborating; devolving.*

**Results:** *User involvement in healthcare (represents the majority of evidence in this review): Small numbers of reports attributed changes in services to user involvement. The impact of changes on service quality has not been evaluated. User involvement in other public sector services: Similar issues to healthcare, but greater emphasis on involving local residents who are not service users. Emphasis on complaints procedure in social services. User involvement in the voluntary sector: Very limited number of reports. Emphasis on user-led services. User involvement in the private sector: User engagement more frequently applied to shaping products and services (not structural or*

*organisational policy change). Less emphasis on methods of involvement than other sectors. Quality of evidence reported to be poor (reported for private sector only). See pp 10 and 11.*

**Authors' conclusions:** *There is little evidence of independent research in any of the sectors examined. No best method for involving users within the NHS. Methods need to be selected on the basis of aims of involvement, capacity of local users and providers, and financial/other constraints. Facilitators of successful user involvement appear to be: increase clarity of aims of involvement to service users; increase willingness of users to engage; reduce organisational resistance to user involvement; increase appropriately-resourced evaluation on where user involvement has made a difference.*

**Comments:** *NB: There is overlap in the first 55 studies (on public sector health, social care, and community care) in this review with Crawford et al 2002<sup>16</sup> (their review of 42 studies focusing on health care).*

**Study:** *Daykin et al (2007)*<sup>18</sup>

**Authors' objectives:** *To evaluate the impact of strategies, including the Patient Advice and Liaison Service (PALS), for patient and public involvement in healthcare.*

**Inclusion criteria:** *Initial inclusion criteria: Quantitative studies (with measurable outcomes) or qualitative research focusing on defined patient and public engagement (PPI)/user involvement interventions in an identified healthcare population. English language and published between 2000 and 2005. Second stage inclusion criteria: RCT/experimental studies. Quantitative studies measuring outcomes against an identified baseline. Qualitative and mixed-methods studies focusing on successful or unsuccessful elements of the strategy under investigation.*

**Exclusion criteria:** *Second stage exclusion criteria: Studies focusing on individual treatment and care. Anecdotal reporting only, no recognisable research process.*

**Search dates:** *2000 to 2005.*

**Number of included studies:** *Eight evaluations.*

**Included study designs:** *Four case studies; two independent evaluations using qualitative methods; one project evaluation using mixed-methods; one action research study.*

**Countries of included studies:** *UK*

**Types of reconfiguration:** *General/strategic development; cancer services; mental health; older people's services.*

**Definitions of engagement/involvement:** *Definition not stated.*

**Who was engaged/involved:** *Staff, members of the public, patients.*

**Methods of engagement/involvement:** *Employment of an individual to work with community groups; interprofessional cancer education programme; user groups; forums for service users and officials; community based exercise facility for people with mental health problems; citizen's juries; community initiative to elicit and respond to the views of older people; regional-level action research programme with staff.*

**Method of synthesis:** *Narrative.*

**Conceptual/theoretical framework or logic model used:** *Realist Framework: identifying contexts and mechanisms that lead to favourable or unfavourable outcomes.*

**Research questions addressed:** *1,2.*

**Stages of involvement:** *Not clear. Possibly 3,4?,5.*

**Levels of involvement:** *Informing, consulting, collaborating.*

**Results:** *Difficulties were reported in documenting impacts from PPI. Problems were due to time lag between intervention and outcomes, and difficulty isolating the direct impact of PPI from other potential contributory factors. Social benefits (2 studies): Engagement with community groups and activists can assist in shifting service provision towards a social model of care. New services provided as a result of PPI intervention. PPI can help to de-stigmatise mental illness and offer a means of re-integration to the community. Other outcomes were reported, but they did not correspond with the review inclusion criteria (eg, focused on improvements to individual care, and in relation to community health improvement). Pre-requisites for effective PPI identified as follows: Structure and resources: organisational structures that support partnership working; community capacity for change; programme-level structures to support staff and safeguard users' well-being; and mechanisms to identify impact of user involvement on decisions. Politics and discourse: commitment*

*to deliberative process involving discursive democracy and community development. Attitudes and culture: adaptations and change by staff needed to enable successful participation of users in service development. Specific results in relation to PALS are reported in the paper.*

**Authors' conclusions:** *Authors' conclusion appeared to focus on limitations of the evidence, in terms of relevance to the evaluation of PPI and quality criteria.*

**Comments:** *The review authors excluded a number of reviews on the basis they didn't meet the review criteria. NB. Some reviews, for example, Crawford et al 2003/4 were discussed in Abelson (2010).*

**Study:** *Mitton et al (2009)*<sup>19</sup>

**Authors' objectives:** *To examine methods and impact of public engagement in health care priority setting decision-making.*

**Inclusion criteria:** *Study design: English language studies in peer-reviewed journals. Population: ordinary or lay citizens/community members; representatives of organised social interest groups (including coalitions, partnerships); organisation staff members/employees and/or patients/customers/clients. Intervention: Public engagement or involvement in decision-making.*

**Setting/Context:** *Decisions at macro- (high level funding) and meso- (specific services and programmes) level; decisions about treatment eligibility at group or typical patient level; monitoring and evaluation relating to priority setting or resource allocation. Perspective: societal.*

**Exclusion criteria:** *Study design: News items, letters, editorials, book reviews, non peer-reviewed journal articles. Population: Exclusively professionals or experts. Context/Setting: Studies of wider policy frameworks and choices, (such as clinical rationing) unless they focused directly on how public engagement was used to develop such frameworks. Perspective: individual.*

**Search dates:** *1981-2006*

**Number of included studies:** *175 articles (190 distinct cases of public engagement)*

**Included study designs:** *Observational*

**Countries of included studies:** *USA (40%), UK (26%), rest of Europe (8%), Canada (9%), Australia/New Zealand (7%), and elsewhere (10%).*

**Types of reconfiguration:** *Largely macro-level decision making. General assessments of public priorities for government spending or development of broad vision statements in health care (97 cases). Non-health care (largely environmental science; urban planning) (77 cases). Most health care reconfiguration focused on public health and health promotion. Others on general policy and spending, regional health authorities and integrated systems, mental health, acute care, pharmaceuticals or health technology assessment, and long term care. 16 cases included health and non-health care sectors.*

**Definitions of engagement/involvement:** *Three levels: Communication; Consultation; Participation.*

**Who was engaged/involved:** *Where defined (167/190 cases): Public as individuals (speaking on their own behalf) (42). Public as organised interest groups (speaking on behalf of a membership) (20). Public as patients or consumers of services (speaking on issues outside their personal experience) (14). Most of the 190 cases reported engagement with multiple public audiences. 38% of cases reported particular attention to disadvantaged populations or groups with special needs.*

**Methods of engagement/involvement:** *Communication: Traditional publicity; public meeting/hearing; drop-in centre; internet information; telephone hotline. Consultation: Opinion poll/survey; referendum; consultation document with select population; electronic consultation/interactive website; focus group; study circle or open space; standing citizens' advisory panel. Participation: Citizens' jury or consensus conference; negotiated rule making or task force; deliberative poll or planning cell; town meeting with voting. Most cases (93 of 183 codable) used multiple methods. 405 techniques employed in total. 58% consultation; 24% communication; 18% participation. From the codable data, 49% one-off events; 45% on-going over a period of time (mean duration approx. 4 years). 40% of cases involved face-to-face interaction, and this was more likely to occur within deliberative engagement processes.*



**Method of synthesis:** *Narrative*

**Conceptual/theoretical framework or logic model used:** *Lomas (1997): three level scale to assess the scope of public engagement (with added 4th category of monitoring and evaluation). Rowe & Frewer (2005): coding framework for intensity and methods of public engagement.*

**Research questions addressed:** *1,2,3,4.*

**Stages of involvement:** *1 (largely macro-level priority setting).*

**Levels of involvement:** *Informing, Consulting, Involving, Collaborating.*

**Results:** *Evaluation of effectiveness carried out in only 32% of included cases; and most of this was process evaluation. No direct experimental comparison of different methods. Despite the lack of evaluation, two thirds of included articles concluded that participation processes were successful (as defined by the study authors). 6% of cases were deemed to be unsuccessful, and 14% inconclusive. Cases using deliberative methods were more successful than those employing lower levels of engagement (eg, communication or consultation). Cases where face-to-face contact were perceived to be more successful than those without direct interaction. In studies where the intention of engagement was making a difference (or leading to a decision other than what would have been arrived at in the absence of engagement), 60% of cases stated an impact; 10% stated this had not been achieved; and in 30% of cases the impact was unclear or unspecified.*

**Authors' conclusions:** *Some practices for public engagement in priority setting are promising; for example, use of multiple methods and balancing broad consultations with in-depth engagement using new deliberative techniques. Lack of evaluation limits the ability to suggest supportive evidence for any particular approach to public engagement in priority setting.*

<p><b>Study:</b> <i>Mockford 2012<sup>4</sup></i></p>
<p><b>Authors' objectives:</b> <i>To identify the impact of PPI on UK NHS healthcare services and to identify the economic cost of PPI. Secondary objectives were to examine how PPI has been defined, theorised and conceptualised, and how the impact of PPI is captured or measured.</i></p>
<p><b>Inclusion criteria:</b> <i>Studies of user/patient activity which involved patients, carers or the public working (a) in a collaborative way with health professionals or management or (b) in a user-led way. All types of study designs were eligible except those specifically excluded.</i></p>
<p><b>Exclusion criteria:</b> <i>Studies of children's services; health research; NHS research and development; voluntary sector; independent healthcare services; and educational services. Studies of involvement as part of an individual's health care. Discussion papers, 'think pieces' and editorials.</i></p>
<p>Search dates: <i>1997 to 2009</i></p>
<p><b>Number of included studies:</b> <i>28 (42 publications)</i></p>
<p><b>Included study designs:</b> <i>Case studies (20); 'evaluations' (5); secondary data analyses (2); survey (1)</i></p>
<p><b>Countries of included studies:</b> <i>UK</i></p>
<p><b>Types of reconfiguration:</b> <i>General</i></p>
<p><b>Definitions of engagement/involvement:</b> <i>Not reported. Authors stated that included studies rarely provided an explicit definition of PPI, engagement or similar terms.</i></p>
<p><b>Who was engaged/involved:</b> <i>Patients/carers; public</i></p>
<p><b>Methods of engagement/involvement:</b> <i>Lay membership of boards, panels and working groups; user groups.</i></p>
<p><b>Method of synthesis:</b> <i>Narrative</i></p>
<p><b>Conceptual/theoretical framework or logic model used:</b> <i>No</i></p>
<p><b>Research questions addressed:</b> <i>1; 2</i></p>
<p><b>Stages of involvement:</b> <i>Unclear</i></p>
<p><b>Levels of involvement:</b> <i>Consulting; Involving; Collaborating</i></p>
<p><b>Results:</b> <i>Results indicated that PPI took many forms and had a range of impacts on healthcare services, including design, location of and access to services; provision of additional services; re-organisation of existing services; and changes in organisation of acute trusts. Reporting quality was poor and there was little evidence on costs.</i></p>
<p><b>Authors' conclusions:</b> <i>There is a need for significant strengthening of the evidence base around the impact of PPI on NHS healthcare services. Development of clear concepts and robust forms of measurement is required.</i></p>
<p><b>Comments:</b> <i>Focused on small-scale (such as ward level) change as well as larger scale change.</i></p>

**Study:** *Rose et al (2003)*<sup>20</sup>

**Authors' objectives:** *To evaluate user and carer involvement in organisational change management in a mental health context.*

**Inclusion criteria:** *English language articles published between 1987 and 2002. Studies of user and carer involvement in organisational change in a mental health context.*

**Exclusion criteria:** *Participants aged under 18 and over 65 years. User/carers involvement in auditing and evaluation of services, where changes resulting from involvement are not described.*

**Search dates:** *1987-2002*

**Number of included studies:** *112*

**Included study designs:** *Most included studies were discussion papers (61 discussing practice; 43 discussing concept; some discussed both). There were 34 qualitative papers; 16 quantitative papers (including 4 trials); 7 organisational reports; 2 unpublished dissertations.*

**Countries of included studies:** *UK (71); USA (42); Europe (1); Australia/New Zealand (3); more than one country (9).*

**Types of reconfiguration:** *Promoting democracy and representation and/or cultural change (over 50% of included studies). Strategic planning, restructuring of services (very few studies), and policy initiatives. New service provision and the employment of service users in organisations.*

**Definitions of engagement/involvement:** *Review authors' definition: Consumerism (individual), including day-to-day personal care planning. Consumerism (collective), group involvement in the planning, delivery, implementation and monitoring of services. Citizenship.*

**Who was engaged/involved:** *Majority of studies focused on service users and professional staff. A quarter of studies involved carers. Others involved: user groups, carer groups, public, Community Health Councils.*

**Methods of engagement/involvement:** *Majority of studies focused on collective consumerism, involving consultation, representation, partnership, evaluation, involvement in staff recruitment. Methods not explicitly stated.*

**Method of synthesis:** *Narrative. Use of coding frame to elicit most frequently occurring aspects of user involvement activity.*

**Conceptual/theoretical framework or logic model used:** *Review authors' definition could also be classed as a conceptual framework for the review: Consumerism (individual), including day-to-day personal care planning. Consumerism (collective), group involvement in the planning, delivery, implementation and monitoring of services. Citizenship. Adapted version of Arnstein's ladder of participation was also used.*

**Research questions addressed:** *1*

**Stages of involvement:** *5*

**Levels of involvement:** *Consulting, involving, collaborating.*

**Results:** *Outcomes were rarely measurable (and based on subjective judgement of the study author). 58 papers reported unknown or unclear outcomes; 52 papers reported positive outcomes; 14 reported negative outcomes of user involvement. The included trials did not focus on reconfiguration. Amongst the other studies, various relationships were proposed between the type of user involvement and type of change. For example, collective consumerism was associated with restructuring and strategic planning, but could equally be conceptualised as tokenism. Partnership working showed no*

*systematic relationship with any form of organisational change (small number of reports). Citizenship and campaigning were associated with change of mission. User control was associated with new service provision. Drivers for successful user involvement included a facilitating organisational culture, information provision, funding, and service user training.*

**Authors' conclusions:** *The review shows a complex picture of user and carer involvement in change management. The evidence is diverse and of variable quality.*

### Appendix 3. Systematic reviews quality assessment

Study reference	Adequate search?	Quality assessed?	Quality assessment used in analysis?	Study details reported?	Research/practice implications identified?	Conclusions supported by evidence?
Abelson et al (2010) <sup>5</sup>	Yes.	No.	N/A	Yes.	Yes.	Reliability unclear. No quality assessment of empirical studies, including comparative studies.
Conklin et al (2012) <sup>15</sup>	No. Limited to two databases. Published studies only. 3 languages.	No.	N/A	Yes.	Yes.	Not clear. Restrictions in search, and absence of quality assessment.
Crawford et al (2002) <sup>16</sup>	Yes	No. (authors justified on the basis of no available criteria for case reports).	N/A	Yes.	Yes.	Yes.
Crawford et al (2003) <sup>17</sup>	Yes.	No formal quality assessment. Assessment based on relevance to review question.	N/A	Yes (for studies reporting outcomes).	Yes.	Yes.
Daykin et al (2007) <sup>18</sup>	Yes.	Yes. CASP.	Yes, although not explicitly used. Full results not reported.	Yes.	Yes.	Yes.
Mitton et al (2009) <sup>19</sup>	Yes	No	No	No	Yes	Unclear. No study details to verify the authors conclusions about methods and impact. No quality assessment of included studies (although all observational).
Mockford 2012 <sup>4</sup>	Yes	Yes	Yes	Yes	Yes	Yes
Rose et al (2003) <sup>20</sup>	Yes.	No.	N/A	No.	Yes.	Unclear. No study details to verify results which are essentially based on vote-counting. Not possible to verify authors conclusion in relation to variable quality.

#### Appendix 4. Other research data extraction

Author and Country	Focus/design, Setting and Date	Type(s) of reconfiguration and Who was engaged/involved	Stages <sup>a</sup> and levels <sup>b</sup> of involvement and Method(s) of engagement/involvement	Results of engagement/involvement	Key themes and Comments
Barratt et al. 2014 <sup>21, 22</sup> England	Interview study to examine factors that influence patient and public response to proposals for major service change, including willingness to accept the trade-offs inherent in decisions about reorganising care. Analysis 'combined inductive and deductive approaches, drawing on sociocultural perspectives of risk as an analytic focus'. Two urban areas, one where service changes were being considered ('Greenville') and one where no changes were proposed ('Hilltown'). Not reported	Proposed reconfiguration involving closure of local Emergency Department Participants (n = 28) were classified as Greenville parents (5); Greenville older people (6); Greenville activists/patient reps (9); and Hilltown NHS patients (8). It was not reported how participants were recruited.	Stages: 4?; 5 Levels: Informing; Consulting In-depth interviews. Participants were invited to use flash cards to select their priorities for emergency care, including aspects they might be prepared to have less of (e.g. rapid access) in return for more of another (e.g. consultant-delivered care).	Main findings of the study were: most participants were unwilling to accept the trade-offs involved in consolidating services. There was a widespread belief that timely access is associated with better outcomes. As a result, participants were not prepared to accept a longer journey to hospital. Participants did not consider anticipated improvements in care as a result of centralising services to be gains worth having. They believed care quality would be negatively affected because greater patient numbers would mean more pressure on staff. Participants in both areas held similar views. The authors also stated that in the area where service changes were being considered, presentation of evidence by clinicians was not effective but instead fuelled hostility to the proposals.	Timely access to services; emergency care; clinical leadership insufficient; clinical evidence not accepted; public perceptions; centralisation of services; quality of care; safety concerns Implications as stated by authors: Commissioners and policy makers should not assume that evidence will persuade communities to accept service change. Commissioners should instead make explicit plans for changes in patient flows and should clarify the roles of key staff groups. No quantitative data were reported.
Boyes 2008 <sup>23</sup> Scotland	To identify potentially effective methods for involving the public in the option generation and	Focus was any type of major service change. Public panels considered an actual case from their	Stages: 2; 3; 5; 6 Levels: Informing; Consulting;	The public panels made a number of recommendations under the broad headings: reach a common understanding on the need for change;	Demonstrate need for change; different types/methods of involvement; access to

	<p>appraisal and decision-making stages of NHS major service change. Methods included a literature review; deliberative panels; interviews with NHS stakeholders; an online survey; and a 'Service Change Dialogue'. NHS services in Scotland 2007 (public panels and other events)</p>	<p>area (Accident &amp; Emergency service change in Monklands and closure of community hospitals in Coldstream and Jedburgh) and a vignette setting out a hypothetical option Public participants recruited from Scottish Council Foundations Citizens' Panel; none had actively taken part in public involvement relating to major NHS service change in their local area (Borders or Stages Lanarkshire). NHS stakeholders were involved through interviews and a national online survey.</p>	<p>Involving; Collaborating Public engagement/involvement in this research was through participation in day-long deliberative panels</p>	<p>carefully select methods and tools for engaging the public; location matters most to the public; consult on a range of feasible options; the public need compelling evidence that proposed changes will lead to better health outcomes; strengthen accountability; improve quality of feedback; independent review; and learn, adapt and improve. Full details in the report</p>	<p>services; provide range of options; demonstrate benefits of reconfiguration; feedback; external scrutiny Report commissioned by the Scottish Health Council</p>
<p>Day and Klein 2007<sup>24</sup> England</p>	<p>Expert opinion review of the 'machinery for independent scrutiny of organisational and service change in the NHS'. Main focus is local authority scrutiny, covering overview and scrutiny committees (OSCs); judicial scrutiny; the role of the Secretary of State; and the Independent Reconfiguration Panel (IRP). NHS services affected by</p>	<p>Closure of small local hospital (Keynsham); major reconfiguration involving redistribution of services among three acute hospitals (Tees) Keynsham: Joint OSC involving Bath &amp; North East Somerset Council, Bristol City Council and South Gloucestershire Council; also local organisations, patient groups and GPs Tees: Joint OSC involving six local</p>	<p>Stages: 3; 5; 6 Levels: Informing; Consulting; Involving Keynsham: Five OSC meetings; consultation with local organisations, patient groups and GPs; visit to facilities that would provide care once</p>	<p>Keynsham: Joint OSC accepted proposal to close Keynsham Hospital subject to 21 recommendations in line with IRP advice. NHS Trusts involved accepted most of the Joint OSC recommendations. Tees: Joint OSC was satisfied with consultation although public response rate was only 10%. OSC report drew heavily on evidence from local clinicians. Five proposals were accepted and four rejected. Proposals for reconfiguration of maternity and paediatric services were referred to the IRP, which in January 2007</p>	<p>Different types/methods of involvement; external scrutiny; clinician opposition to reconfiguration; political influence Report also highlighted the importance in the Tees example of opposition from clinicians likely to be affected by change. Overall, the authors considered OSCs to be assertive in questioning and challenging proposals but basing their</p>

	<i>reconfiguration proposals 2003-2007 (for example reconfigurations discussed in text)</i>	<i>authorities; also public and 'stakeholders'</i>	<i>Keynsham Hospital closed; advice from IRP on consultative process and reconfiguration plans. Tees: Consultation on external review by Prof. Ara Darzi, including 150 public meetings, 350 meetings with stakeholders and distribution of a consultation document to 377,000 properties.</i>	<i>recommended accepting them in a modified form.</i>	<i>challenge on evidence rather than being opposed in principle to any change. The report also discussed uncertainty over when consultation is required and the definition of 'substantial' change; and the possibility of judicial review when disagreements cannot be resolved locally. The authors suggested that reconfiguration proposals should include a risk assessment of what might go wrong in the process of implementation. Elements required to assess costs and benefits of local authority scrutiny were also discussed.</i>
<i>Independent Reconfiguration Panel (2010)<sup>1</sup> UK</i>	<i>Review of 17 reviews carried out by the IRP since 2003. Common themes arising. Includes: Maternity services Children's services Accident &amp; Emergency Impatient emergency trauma Surgery Medical care General care for older people Services for older people with mental health problems Microbiology services</i>	<i>Various (details provided). NHS leaders, local councillors, community representatives.</i>	<i>Stages: 1-7 (as necessary). Levels: Informing; consulting; involving. The role of the IRP is to advise the Secretary of State for Health on contested NHS reconfigurations in England, and specifically to</i>	<i>N/A</i>	<i>Clinical, managerial, procedural issue deemed to be significant in referrals that have been subject to formal review: Inadequate community and stakeholder engagement in the early stages of planning change. The clinical case has not been convincingly described or promoted. Clinical integration across sites and a broader vision of integration into the whole</i>



	<i>Oesophago-gastric cancer surgery services Reviews took place from 2003 to 2010.</i>		<i>give advice about proposals formally referred to the Secretary of State for decision.</i>		<i>health community has been weak. Proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services. Important content missing from reconfiguration plans and limited methods of conveying information. Health agencies caught on the back foot about three issues most likely to excite local opinion: money, transport, and emergency care. Inadequate attention to responses during and after the consultation.</i>
<i>NHS Confederation 2010<sup>25</sup> England</i>	<i>Report focuses on how PCTs can best communicate with the public about decisions on local service change. Based on two pieces of research carried out by Ipsos MORI on behalf of the PCT Network: focus group research with the general public (testing common words and phrases used by the NHS in describing service change) and case studies of local PCT service changes (interviews with</i>	<i>Any: report focuses on general principles of communication and language use. General public via focus groups (no further details reported). In the only case study discussed separately (South Gloucestershire), members of campaign groups were engaged.</i>	<i>Stages: 4?; 5; 6 Levels: Informing; Consulting; Involving Focus groups to assess public reaction to various statements on the roles of PCTs as well as phrases used to explain policy issues such as commissioning and local decision-making.</i>	<i>Based on the PCT case studies and the IRP report on lessons from reviews, the following themes were identified: consult early; target the right stakeholders; develop proposals in partnership with healthcare professionals; communicate a strong narrative; be open to the evidence, demonstrate genuine involvement; make personal leadership a priority; be prepared for further dialogue with a hostile audience; and continue discussions post-consultation. Findings from focus groups suggested that words/phrases that created confusion for the public included 'budget', 'clinicians', 'competitive</i>	<i>Communication; language use; public perceptions; focus groups; clinical leadership; managerial leadership Also includes 'Key points for communicators</i>

	<p>senior leaders at NHS South Gloucestershire, NHS West Sussex, South East London PCTs and NHS East and North Hertfordshire) NHS services affected by reconfiguration proposals. Report takes a commissioner's (PCT) perspective. Dates of focus groups and case studies were not reported.</p>		<p>In the South Gloucestershire case study, engagement methods included personal involvement of the chief executive; re-visiting evidence for the proposed solution; membership for campaign groups in the PCT's reference group; and high levels of disclosure of financial and other information to reference group members.</p>	<p>tendering', 'engagement', 'postcode lottery', 'safety' and 'value for money'. The public disliked phrases that suggested the PCT was abdicating responsibility; unrealistic or exaggerated examples; and comparisons between different services. The authors suggested that the findings show there is sometimes a tension between being transparent about the need for change and communicating in a way the public can relate to.</p>	
<p>NHS Confederation 2013<sup>27</sup> England (authors state also relevant to UK as a whole)</p>	<p>Expert opinion report examining why reconfiguration proposals have failed in the past and how clinicians, managers and patients can work together to reframe the debate by stressing the benefits of developing new models of care. Report based on over 50 structured interviews and a series of workshops and</p>	<p>Report addresses issues around reconfiguration in general, illustrated by a range of case studies providing brief details of successful and unsuccessful approaches from practice. Three types of reconfiguration featured prominently: moving care out of hospitals; centralising specialist services; and reacting to</p>	<p>Stages: 1; 2; 3; 4?; 5 Levels: Informing; Consulting; Involving; Collaborating Methods in case studies include: a dedicated transport group to consider access; Patient</p>	<p>The authors identified six key principles to serve as a foundation for most reconfiguration plans: healthcare is constantly changing; there are significant benefits to delivering new models of care; reconfiguration is a catch-all term and drivers of change need to be understood to consider potential benefits; patients can co-produce better services; a 'whole-system' approach is essential; and change requires consistency of leadership.</p>	<p>Demonstrate need for change; clinical leadership; managerial leadership; political leadership; access to services; different types/methods of involvement; patient groups; co-production; communication; language use</p>

	<p>meetings, with input from the Academy of Medical Royal Colleges, the NHS Confederation and National Voices (coalition of health and social care charities in England). NHS services affected by reconfiguration proposals. Dates of interviews and workshops not reported. Report published 2013.</p>	<p>hospital trusts that are unsustainable. People involved in contributing to the report included members of patient groups and charities and public representatives (MPs). Case studies give examples of involving patients/patient groups, clinicians, managers and NHS staff generally.</p>	<p>and Client Council (Northern Ireland); Marie Curie programme to redesign services for palliative care patients. Other methods and examples discussed in the text.</p>	<p>Recommendations for local leaders were: co-produce any change with patients - don't rely on formal consultation; create a clinically-driven case for change; make the case for value; provide a forum to consider access; and develop plans openly with staff. Recommendations for national leaders were also presented. The report also identified primary concerns in the following areas and suggested possible ways of addressing them: access; resources; 'the system'; leadership; communication; and collaboration</p>	
<p>Thomson et al. 2008<sup>26</sup> Scotland</p>	<p>Content and qualitative analysis of media coverage of reconfiguration of maternity services in Caithness (Scotland) and its impact on public participation in policy decision-making. Rural maternity unit (Caithness General Hospital, Wick) September 2003 to December 2004</p>	<p>Change from consultant-led to midwife-led obstetric unit. Public, including campaign group; public representatives (MSPs, councillors and church leaders). Limited details in paper as focus was on media coverage.</p>	<p>Stages: 1; 2; 3; 4?; 5; 6 Levels: Informing; Consulting Debate between proponents (Highland Health Board) and opponents of reconfiguration as portrayed by local and national media.</p>	<p>The authors' thematic analysis ('qualitative document analysis' based on 'ethnographic content analysis') covered 4 newspapers and the BBC Scotland website. There were 145 articles covering issues around the Caithness reconfiguration, containing 173 positive and 435 negative (anti-change) comments. Only the BBC news website had more positive than negative quotes (27 vs. 19). There was a general framing of the issue in terms of polarised opposition between Highland Health Board management (based in Inverness) and local people. There was a lack of information about issues underpinning change. In response to the public campaign, Highland Health Board offered several service options to the public,</p>	<p>Media coverage; Polarisation; Public perception; Conflict; Maternity services; Rural health services</p>

				<i>but they continued to demand a consultant-led service. Eventually, three consultant posts were advertised and filled but uncertainty about the future of the service remained at the end of the study.</i>	
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Key:

<sup>a</sup> Stages of involvement: 1. Setting the strategic context; 2. Proposal; 3. Discussion; 4. Assurance; 5. Consultation; 6. Decision; 7. Implementation.

<sup>b</sup> Levels of involvement:

## Appendix 5: Case studies data extraction

Author Country	Setting Date Organisation commissioning report	Type(s) of reconfiguration Who was engaged/involved	Comments
Airoldi et al 2013 <sup>6</sup>  England  (used as an exemplar)	Sheffield PCT eating disorders service. June to December 2009. N/A The Health Foundation provided financial support to the author.	Priority setting in eating disorder services, with emphasis on improving services in a climate of decreasing resources. Patients, caregivers, clinicians, health care managers. There were 5 patients/carers out of 24 in the group. Follow-up was conducted with a wider set of stakeholders (not specified) in the local health economy.	
Brown 2012 <sup>28</sup>  England	NHS Foundation Trust October 2010 to February 2012 York Teaching Hospital NHS Foundation Trust (report to Monitor)	Merger of York and Scarborough Hospital Trusts Foundation Trust members and governors; general public; PCTs/CCGs; neighbouring NHS Trusts; Local Involvement Networks; MPs; Overview and Scrutiny Committees; media; community groups/forums; hospital Leagues of Friends	Focus on methods of communication with stakeholders, no information on impact. Links engagement with communications strategy.
Bruce et al. 2011 <sup>29</sup>  England	Health and social care services in Hartlepool; Bolton; Warrington (two sites); Basildon; Brandon (Suffolk); Hammersmith and Fulham; Burnley; and Clacton and Jaywick (Essex) 2004 to 2010 N/A (authors were members of Turning Point which developed the Connected Care model for integrated care)	Redesign of services to promote integration of health and social care General public (including community researchers) and community groups	Article focuses on barriers to implementing integrated care and partnership working, with limited details of methods/impact of community engagement
Carver et al. 2011 <sup>30</sup>  England	NHS services across Hertfordshire 2007 to 2008 N/A (article written by NHS managers involved in reconfiguration and other stakeholders)	Centralisation of inpatient and emergency services; commissioning of two local general hospitals; establishment of a county-wide network of urgent care centres Patients; general public; community groups and other stakeholders; NHS staff; MPs, council leaders and other local politicians; local media; health overview and scrutiny committee	Focus on methods and indicators of successful engagement. Highlights links between engagement and communication strategies.

Caseley 2010 <sup>31</sup> England	London boroughs of Bexley, Bromley, Greenwich and Lewisham Not reported N/A	Large-scale reconfiguration involving four hospital sites and community services for more than a million people Stakeholder groups (including organisations working with under-represented groups); general public (via meetings and consultation documents distributed to households, businesses, NHS and community organisations; NHS staff; other NHS organisations (neighbouring PCTs and London Ambulance Service); local authority scrutiny committees; stakeholder reference group	Focus on methods and indicators of successful engagement. Highlights link between engagement and communication strategy
Clarke and Rozansky 2013 <sup>7</sup> England	NHS services in south-west and north-west London Not reported N/A (authors worked for OPM, an independent research organisation and consultancy involved in the reconfigurations discussed)	Major reconfiguration proposals covering five hospitals in south-west London (Better Services, Better Value); limited details of plans in north west London (Shaping a Healthier Future) General public; community groups; others (not specified)	Article mentions how plans for surgery and palliative care were modified as a result of public feedback. In north-west London additional travel analysis was undertaken to address public concerns. Authors stated that reconfiguration depends on people being prepared to travel further for better quality and safer care. People believe their own experience rather than published data, especially when complicated formulae have been used to calculate average travel times.
Coe 2012 <sup>38</sup> England	NHS services in Somerset 1994 to 2003 N/A (Author was research lead for Somerset health panels between 1999 and 2003)	Panels discussed various issues related to reconfiguration, e.g provision of 24-hour GP cover; confidential drug services for young people; services for elderly people; local outpatient services vs. centralised General public: members were recruited for three rounds only by independent recruiters trained by the core research team. Recruiters visited homes at different times of the	Not a case study of specific reconfiguration but includes background on history of PPI in the NHS and compares health panels with other similar methods

		<i>day/week to reach a wider range of potential participants.</i>	
<i>Cohen et al. 2011<sup>32</sup></i>	<i>Community health services in Ontario, Canada Summer 2009 to July 2010</i>	<i>Merger of two organisations providing community health services</i>	<i>Limited information on methods used (surveys and focus groups), emphasis on need for ongoing engagement</i>
<i>Canada</i>	<i>N/A (authors were from organisations involved in the reconfiguration)</i>	<i>Clients and community members of the two organisations; corporate members; funders; Provincial Association of Ontario Health Centres and Community Health Centre network; management team and staff team; union representing staff; partner organisations; local politicians</i>	
<i>Davies 2006<sup>33</sup></i>	<i>NHS services in Liverpool November 2006</i>	<i>Redesign of primary care and community-based services</i>	<i>Article focuses mainly on an event (the Big Health Debate) organised by Liverpool PCT and involving structured discussion and voting on different options</i>
<i>England</i>	<i>N/A</i>	<i>Public, health professionals and representatives of voluntary organisations and other stakeholders</i>	
<i>Gamble &amp; Sloss 2011<sup>42</sup></i>	<i>Urgent Care/Emergency Department Consultation took place between September and November 2011.</i>	<i>Re-design of minors care within the Emergency Department. To include integration of a walk-in centre (separately located at the time; engagement work on the walk-in centre does not form part of the present study); improved integration with the out-of-hours GP service; and to consider a potential GP triage service.</i>	<i>The approach to patient and public engagement was based on the methodology of Experience Based Design (EBD). EBD focuses on capturing and understanding experiences of services as part of service re-design. The report formed part of a paper to be presented to the local Health Overview and Scrutiny Committee.</i>
<i>England</i>	<i>York Teaching Hospital NHS Foundation Trust/NHS North Yorkshire and York.</i>	<i>Patients, carers, staff, hospital governors.</i>	
<i>(used as an exemplar)</i>			
<i>Gold et al. 2005<sup>40</sup></i>	<i>Cancer services in Ontario 1999 to 2003</i>	<i>Planning of regional supportive cancer care networks</i>	<i>Main focus is barriers that hindered effective patient involvement</i>
<i>Canada</i>	<i>N/A</i>	<i>Patients, defined as people currently receiving cancer care or cancer survivors; representatives of patient support groups</i>	
<i>Greenwood 2007<sup>34</sup></i>	<i>NHS services in Cornwall &amp; Isles of Scilly; Calderdale &amp; Huddersfield; and Sandwell &amp; Birmingham</i>	<i>Cornwall: Pre-consultation to gain information and establish trust with local communities; Calderdale: reconfiguration of maternity services; Sandwell: large-</i>	<i>Focus on methods and indicators of successful engagement. Highlights</i>
<i>England</i>			

	<i>Not reported N/A</i>	<i>scale reconfiguration involving new acute hospital supported by five community hospitals and 95% of GP practices new or refurbished Public; NHS staff (including primary care managers in Calderdale &amp; Huddersfield); local authority scrutiny committee; stakeholder and community groups (including hospital League of Friends)</i>	<i>link between engagement and communication strategies.</i>
<i>Scottish Health Council<sup>41</sup> Scotland</i>	<i>NHS services affected by proposals for major service change 2005 to 2012 Reports produced by the Scottish Health Council on behalf of the Scottish Government</i>	<i>Any reconfiguration deemed by the Scottish Government to involve a major service change. Latest reports (2012) involve maternity services in Grampian and service changes at Dumfries and Galloway Royal Infirmary. Scottish NHS Boards are required to involve patients and local communities. Details vary among reports on the website.</i>	<i>Reports outline proposed service changes, details of the consultation process, whether it was considered adequate and any learning points to improve future public consultations.</i>
<i>Mason 2002<sup>35</sup> England</i>	<i>Acute hospital (Kidderminster Hospital) June 2002 (refers to elections in May 2002) N/A</i>	<i>Restoration of emergency and acute surgery services General public; local MP and councillors elected to represent campaign group (Health Concern)</i>	<i>Emphasis on role of campaigning groups and use of electoral process to challenge or reverse decisions to downgrade local hospital services.</i>
<i>Moore 2006<sup>36</sup> England</i>	<i>NHS services in Surrey and Sussex 2006 to 2007 N/A</i>	<i>Potential loss of acute services at two major district general hospitals and downgrading of three others Public (through extensive pre-consultation); clinicians and other NHS staff; local authority scrutiny committees</i>	<i>Focuses on methods, including possible negative consequences of a lengthy pre-consultation in the absence of firm proposals and a staged approach to engaging different groups.</i>
<i>NHS Confederation 2013<sup>10</sup> England</i>	<i>Health services across Greater Manchester area February 2012 to March 2013 NHS Confederation/NHS Greater Manchester</i>	<i>Area-wide service review to inform future reconfiguration focusing on integrated care; emergency surgery; acute emergency and urgent medicine; and women's and children's services Public; local media; voluntary organisations; patients/patient groups; MPs; local government; staff</i>	<i>Consultation Institute engaged to provide advice and produce a report into recent reconfiguration consultations (not publicly available)</i>
<i>NHS Confederation</i>	<i>Acute and Emergency care. Consultation started in January 2012 for 3</i>	<i>"Better Healthcare in Bucks": Centralisation of emergency care. Providing care closer to home for most patients.</i>	<i>The engagement process was carried out by the</i>



2013 <sup>11</sup> England (used as an exemplar)	months, building on earlier work done in the recent past. Final proposals published in May 2012. NHS Confederation report published March 2013. NHS Confederation/Buckinghamshire and Oxfordshire PCT Cluster/Buckinghamshire Healthcare NHS Trust.	Establishment of clinical centres of excellence. Patients, public, primary care and hospital-based clinicians, other health service staff, MPs, local health overview and scrutiny committee, voluntary organisations.	programme team attached to those commissioning the piece of work. However, independent companies were employed to facilitate engagement workshops, collate and analyse the data, and produce an independent report leading to preparation of a business case. "Better Health in Bucks" was given an Association of Healthcare Communications and Marketing award for its consultation and engagement programme.
NHS Confederation 2013 <sup>12</sup> England	Emergency services provided by Northumbria NHS Foundation Trust Unclear: report states that the process involved 3 months of engagement followed by 3 months of consultation but other statements refer to a much longer timescale. Building of the new hospital started in November 2012. NHS Confederation/Northumbria NHS Foundation Trust	Centralisation of emergency services and construction of a new Specialist Emergency Care Hospital Public (including specifically residents close to proposed new hospital site); local GPs; MPs; Overview and Scrutiny committees; clinical teams	Limited information on methods. Distinction between engagement and consultation unclear. Staged approach to engaging different groups appeared to work well (contrast with Moore 2006 <sup>36</sup> ).
NHS England 2013 <sup>37</sup> England	Community pain services in Dorset Not reported; new service commenced June 2013 NHS England	Redesign of community pain service Patients recruited via a local patient group and the Dorset Pain Society; GPs, secondary care, public health and allied health professionals also involved	Very limited details reported
NHS Confederation <sup>8</sup> England	Acute hospital (maternity services) 2009-2013 NHS Confederation/Sandwell & West Birmingham NHS Trust.	Redesign of maternity services Patients and their representatives: Women and their families, GPs, Local councillors and MPs, including the Joint Health Overview Scrutiny Group. Parent groups,	

<i>(used as an exemplar)</i>		<i>Sure Start. Others engaged in the process: Community midwives, Hospital-based clinicians.</i>	
<i>NHS Confederation 2013<sup>9</sup></i> <i>England</i>	<i>NHS Foundation Trust Summer 2011 to November 2012 NHS Confederation/Southern Health NHS Foundation Trust</i>	<i>Merger of Ridgeway Partnership (Oxfordshire Learning Disabilities NHS Trust) into Southern Health Service users and carers; staff; board members; clinicians; media. Ridgeway Partnership membership engagement group became a primary focus for engagement.</i>	<i>Case study mainly focuses on methods. Highlights issues around people with learning disabilities and around 'takeover' of a small NHS Trust by a larger one.</i>
<i>Nicholson-Banks 2010<sup>39</sup></i> <i>England</i>	<i>NHS services in Dorset (NHS Bournemouth and Poole) May to August 2009 (launch of network) N/A (Author is Patient and Public Engagement Manager for NHS Bournemouth and Poole)</i>	<i>N/A (Paper describes Public Involvement Network model and process of setting up the network) Public: members were recruited through PCT Health Information Shop; Healthpoint (based in a large local library); distributing information at local events; online registration through PCT website; and a mailing campaign to 3000 local households</i>	<i>Not a case study of reconfiguration. Paper describes model, including choice of five different levels of involvement. Authors report that over 100 people signed up to join the network between May and July 2009.</i>
<i>Sainsbury Centre for Mental Health 2010<sup>43</sup></i> <i>England</i> <i>(used as an exemplar)</i>	<i>Mental health day and vocational services. 2007 to 2009 Sainsbury Centre for Mental Health</i>	<i>Service re-design as part of a wider review of modernising day and vocational services for people with mental health problems. Service users, commissioners, external consultants.</i>	<i>This report is essentially a process evaluation of service user engagement. There was no direct evaluation of impact of service user engagement on service provision.</i>
<i>NHS Scarborough and Ryedale Clinical Commissioning Group 2014<sup>44</sup></i> <i>England</i>	<i>Primary Care Consultation took place from 6th January 2014 to 30th March 2014. NHS Scarborough and Ryedale Clinical Commissioning Group</i>	<i>Urgent care services. Patients, public, clinicians, partner organisations (representatives from primary care, secondary care, local authority, voluntary sector), local and regional scrutiny committees, local media.</i>	

<i>(used as an exemplar)</i>			
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## Appendix 6: Exemplar case studies data extraction

Author Stages and levels of involvement <sup>a</sup> Critical appraisal (perspectives, reflexivity and reporting) <sup>b</sup>	Methods	Results	Key themes
<p><i>Airoldi et al 2013</i><sup>6</sup></p> <p>Stages: 1.2.3.4.5.6.7. Mainly 2.</p> <p>Levels: Informing, consulting, involving, collaborating, devolving</p> <p>Perspectives: Yes.</p> <p>Reflexivity: Yes. (see Discussion)</p> <p>Reporting: Very good.</p>	<p><i>Decision conferences: working meetings attended by key stakeholders, led by an impartial facilitator. Participants assessed the value of services based on (1) cost; and (2) population health benefit. Additionally: semi-structured and unstructured interviews; email correspondence; direct observation of workshops; use of flipchart notes and minutes of board meetings; follow-up events and interviews at one and two years post consultation. A steering group and an independent evaluator oversaw the process, in addition to input from the case study author.</i></p>	<p><i>A business case was developed to re-allocate resources based on the results of the decision conferences. The objective of the business case was to reduce the number of referrals to residential care by expanding capacity in primary care and increasing community services or outpatient services at the local hospital. The business case was approved, and authority was given to expand local and community services to provide capability to treat borderline cases without referral to residential care. The financial net effect of this change was a reduction in spending for the eating disorder service by more than 15%. Two years later, the new care model had been implemented and savings were achieved. The author cites several success factors in overcoming resistance to change (see also key themes).</i></p>	<p><i>Key factors to successfully overcoming resistance to service change: (1) the collective character of deliberations, encouraging ownership of the model and its results; (2) the analysis of the whole pathway, helping to identify the opportunity cost of alternative budget allocations; (3) the presence of patients, reinforcing the need to frame the problem in terms of patient benefit; (4) the development of a model based on a theoretical framework (ie, cost-effectiveness analysis principles), which provided a credible rationale for difficult decisions; (5) managerial leadership.</i></p>
<p><i>Gamble &amp; Sloss 2011</i><sup>42</sup></p> <p>Stages: 3,4?, 5.</p> <p>Levels: Informing, consulting, involving, collaborating.</p>	<p><i>Observation sessions in ED; focus group; real-time feedback (patient experience questionnaire via standpoint machine); inpatient national survey results specific to York ED. Other engagement work was proposed (no details in this report) as part</i></p>	<p><i>Based on the results of the engagement work, an action plan was compiled for specific low-level changes to be made in a number of areas (including car park, reception and waiting area, information and communication aspects, treatment areas,</i></p>	<p><i>Use of experience based design as a framework to facilitate public and patient engagement. Action points and linkages to micro- and macro-level change. Link between engagement work and Trust's</i></p>

<p><i>Perspectives: Main focus of this report is on the patient/service user perspective.</i></p> <p><i>Reflexivity: No.</i></p> <p><i>Reporting: Good.</i></p>	<p><i>of the Trust's wider communications strategy on proposals to create an urgent care centre. The proposed work included attendance at local events, presentations to specialist interest groups, and information-giving at the Hospital Open Day.</i></p>	<p><i>and toilets). Higher level change was indicated (where appropriate) in the action plan between the engagement work and the wider ED re-design programme.</i></p>	<p><i>wider communications strategy.</i></p>
<p><i>NHS Confederation 2013<sup>11</sup></i></p> <p><i>Stages: 3,4,5,6,7.</i></p> <p><i>Levels: Informing, consulting, involving, collaborating.</i></p> <p><i>Perspectives: Yes.</i></p> <p><i>Reflexivity: Yes.</i></p> <p><i>Reporting: Very good.</i></p>	<p><i>Public meetings, clinical summits, online surveys, website, video showing interviews with lead clinicians, printed materials, local media campaign, presentations and site visits. A wide-reaching communications programme (internal and external) was implemented to support the service change.</i></p>	<p><i>Patient concerns about transport and access to services were addressed by a group (comprising council, hospital and ambulance service representatives) set up to consider issues in more depth and conduct further engagement work. Free travel on local bus networks became available, and a county-wide community transport hub was established. A core element of the engagement work was to address confusion about where patients would access treatment for particular conditions. Public meetings provided the forum for response from the programme team to help allay fears about service closure. Implementation commenced in November 2012, with the replacement of an emergency medical centre at one site with a new minor injuries unit together with the transfer of some inpatient medical wards and a new day unit and step downward. Continued dialogue with stakeholders was ongoing at the completion of the implementation stage.</i></p>	<p><i>(1) Reach a shared understanding of the case for change across the local health economy (involving partnership between primary and secondary care); (2) start public engagement as early as possible; (3) encourage clinicians to make the case for change, focusing on improvement of services rather than cost savings; (4) hold regular face-to-face discussions with politicians and local stakeholders; (5) listen to all interest groups and accommodate their views where possible; (6) discussions about one aspect of care can provide a useful forum for a wider debate about the shape of services; (7) importance of access to services; transport issues. NB. Report claims public understanding of increased travel times, but content doesn't appear to support this.</i></p>
<p><i>NHS Confederation 2013<sup>8</sup></i></p> <p><i>Stages: 3,4,5,6,7.</i></p>	<p><i>On-line responses, public meetings, face-to-face meetings with key stakeholders, letters, articles in relevant local and national media, website updates, "Ground-breaking</i></p>	<p><i>Agreement achieved on one of three options offered, ie, creation of a new midwife-led unit in Oldbury, to work alongside the newly-opened co-located (with specialist</i></p>	<p><i>Before developing options for service redesign, set out clearly the clinical case for change. Support clinicians in leading change and in</i></p>

<p><i>Levels: Informing, consulting, involving.</i></p> <p><i>Perspectives: Yes</i></p> <p><i>Reflexivity: Yes RE: negative consequence, cultural preference for place of birth. Will be taken into account for future public consultations.</i></p> <p><i>Reporting: Good</i></p>	<p><i>events", posters and postcards, employment of a redesign lead at the Trust. Public engagement ran alongside a comprehensive staff training programme.</i></p>	<p><i>care) midwifery-led unit at City Hospital. Positive impact on maternity care. Trust since achieved highest normal birth rate in the country; awards for safety and promotion of natural birth. Negative impact: Unforeseen consequence of reconfiguration was that some patients preferred to give birth in the Black Country, rather than in the area where the new facilities were located.</i></p>	<p><i>leading discussions with the public. Be open about what you intend to do, why you intend to do it, and what will happen in the interim. Don't include options you won't consider. To keep people informed, ensure that that the consultation results are fed back. Expect the unexpected - alongside high-quality care and facilities, cultural factors can also exert a strong influence on choice of service location. Use new and social media to engage with younger audiences.</i></p>
<p><i>Sainsbury Centre for Mental Health 2010<sup>43</sup></i></p> <p><i>Stages: 1.2.3.5.</i></p> <p><i>Levels: Informing, consulting, involving, collaborating.</i></p> <p><i>Perspectives: Yes.</i></p> <p><i>Reflexivity: Yes. What worked well, what worked less well, future suggestions.</i></p> <p><i>Reporting: Largely good. However, it was unclear whether the three new service models were the result of the engagement/reconfiguration process, or whether they</i></p>	<p><i>A working group (comprising 8 service users) was established to take part in the review of services, in response to invitation leaflets and posters distributed to local day centres. Three members of the working group joined a separate project steering group, which also included representatives from commissioners and external consultants. The group's remit included: design of the review of services; research with service users to gather views about services; contributing to decisions about service re-design; contributing to the development of service specifications and tender documents; helping to select future providers in the tendering process.</i></p>	<p><i>The process evaluation (involving interviews and focus groups with service user members of the working group) identified key factors for successful user involvement in future service re-commissioning: (1) Clarity of purpose: including roles and skills needed from service users; potential conflicts; expectations about support, supervision, and training; arrangements for reimbursements and rewards. (2) Attention to detail: provision of background contextual information (eg, government policy guidance) to help service users and staff in the process of service transformation. (3) Openness: between commissioners and staff about the potential implications of change and their future roles. (4) Conflict management and resolution: commissioners need to consider</i></p>	<p><i>Mental health; service user involvement.</i></p>

<p><i>represented the initial proposals under consideration.</i></p>		<p><i>the impact on service users involved in the process, so that conflicts do not become a focus for hostility. The authors provided a list of specific issues leading to what worked well and what worked less well. Many service users felt positively about their involvement, in terms of impact on their personal lives and services offered. Three new service models were proposed as the basis of future day and vocational services provision, with service points available across the locality.</i></p>	
<p><i>NHS Scarborough and Ryedale Clinical Commissioning Group 2014<sup>44</sup></i></p> <p><i>Stages: 1,2,3,4,5.</i></p> <p><i>Levels: Informing, consulting, involving, collaborating.</i></p> <p><i>Perspectives: Yes. Wide consultation; multi-stakeholder. Recognition of public concerns, eg, petitions.</i></p> <p><i>Reflexivity: Yes. Several references/cross references to contextual reflections, eg rural vs urban differences in response; contextual sensitivities re: Castle Health Centre.</i></p> <p><i>Reporting: Excellent. NB. Not</i></p>	<p><i>Distribution of consultation document and video; interactive workshop for clinicians and partner organisations; presentations to local and regional health scrutiny committees; surveys; public meetings; focus groups; Facebook posts.</i></p>	<p><i>Estimated consultation reach 200,000 people. 724 primary contacts made. Based directly on the findings of the public consultation, a number of key considerations (below) are to be taken forward to inform a service tender specification for urgent care services (to be awarded at the end of August 2014). (1) Appropriate location of services; parking and transport considerations; security; and appropriate design for a range of potential service users. (2) Inclusion of particular services; access to patient medical records, liaison with NHS 111. (3) Education: appropriate publication of information to enable decision-making about accessing urgent care. (4) Quality: patient experience to form part of urgent care service performance and quality measures; new service should maintain or build upon current quality. (5) Interim walk-in service: needed to bridge the end of the current contract to the start of the new one. Results</i></p>	<p><i>Wide stakeholder consultation (including consideration of methods to reach hard-to-reach populations and/or those most likely to access urgent care services, eg, young people; parents of younger children; and the elderly); ability to achieve wide reach; use of extensive range of methods; importance of reflections on local context; precursor to service tender; access to services; engagement with opponents of reconfiguration.</i></p>

<i>independent. This is a CCG report.</i>		<i>also found that people would not be prepared to travel further for an improved service (supports Barratt's work).</i>	
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<sup>a</sup> Stages of involvement, levels of involvement

<sup>b</sup> Critical appraisal criteria: Diverse perspectives considered? Evidence of reflexivity? Adequacy/clarity of reporting .