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Evidence Check

Client-centric commissioning

NSW GOVERNMENT

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It is not necessarily a comprehensive review of all literature relating to the topic area. It was current at the time of production (but not necessarily at the time of publication). It is reproduced for general information and third parties rely upon it at their own risk.

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Executive summary

Background

This Evidence Check rapid review was conducted for the NSW Department of Communities and Justice (DCJ). Its aims were (1) to contribute to an improved understanding of how to achieve authentic participation in the commissioning of human services and (2) to inform the revision and ongoing development of a commissioning participation framework and tools. The Evidence Check sought to identify and analyse recent evidence of effective ways of engaging with clients at various stages of the commissioning cycle. It examined approaches that have been tested within various phases of commissioning, particularly service needs analysis, design, procurement of providers, delivery and evaluation. This Evidence Check follows an earlier review, Outcomes-based commissioning and consumers.[3]

Evidence Check questions

This review aims to address the following question:

> What approaches have been effective in ensuring client participation in the commissioning of human services?

Summary of methods

The review team searched a range of academic databases for relevant literature published between December 2014 and December 2019. Ten papers met the inclusion criteria. Of these, three were of high quality, six of moderate quality and one of low quality.

The overall level of the quality of the evidence, based on this integrity assessment, was in the low range of moderate.

We conducted a desktop search for relevant grey literature published within the five years and found 10 results that offered detail about how to engage clients specifically within the commissioning process. These included guides, reports and case studies produced by the Association of Children's Welfare Agencies (Australia), Community Services Industry Alliance (Australia), Australian Government Department of Health (Australia), Participation Works Partnership (UK), Healthcare Quality Improvement Partnership (UK), Lancashire Children and Young People's Trust (UK), Local

Government Association and National Youth Agency (UK), Clinical Commissioners (UK) and the National Health Service (NHS).

Evidence grading

Given the qualitative nature of the included studies, an integrity assessment checklist[4], was used to assess the extent to which the peer-reviewed literature had addressed—and provided clear detail about—study design, participant selection, methods, ethics and limitations.

Key findings

The included papers used a variety of terms, such as participation, involvement and co-production, to describe client engagement and its different modes. Primary client groups (including clients, potential clients, families and carers) identified in the studies included users of cancer services, mental health services, sexual and reproductive health services and health services, as well as people who were Aboriginal or Torres Strait Islander, older, and unemployed single parents. Children and young people appeared as a client group in the grey literature in particular. The literature described various components of client participation:

- Clients were most commonly recruited through existing groups or networks of users and/or their families. Other means of recruitment were via services or the application process. Papers highlighted the importance of drawing on existing user-led and grassroots groups, as well as on existing local knowledge and experience.

- Gathering client views was considered important but again the literature provided limited detail about how this was done. One piece of literature described an event drawing on World Café group work methods[5] and another noted use of a values clarification exercise during a workshop. In other cases patients were trained to interview other patients and other work described committee structures. Again, the literature emphasised the importance of drawing on local relationships and groups in the process of gathering client views.

- Many papers mentioned incorporating client views, although they provided little information on the methods for doing so. There was little information about how client views were incorporated into decision making, an issue noted as a challenge by clients. Where information was available, papers noted mechanisms such as client views being expressed at meetings and drawing on information gathered at workshops that included clients.

- Reimbursement was not mentioned in most studies, although the grey literature noted the importance of valuing participants' contributions through means such as payment, vouchers, accreditation and celebration.

- The literature highlighted training as a crucial component of client engagement, for client representatives themselves and also for staff involved in client engagement activities. This was considered important for role clarification, understanding expectations and impacts, and

developing the skills and knowledge necessary to negotiate conflict and contribute meaningfully.

- The resources and commitments required to facilitate client engagement were generally not described in detail. However, the available data indicated the importance of having dedicated staff with the necessary time to facilitate engagement and build relationships. It was also perceived that dedicated funding should be allocated to client engagement in commissioning.

- Key challenges in implementing effective client engagement related predominantly to lack of clarification of the role of clients and challenges in engaging those people whose voices were least likely to be heard (the most marginalised people).

- Findings suggested there may be conflict between the types of commissioning approaches that are time-bound and competitive, and the long-term collaborative nature of community and client engagement.

The dearth of detailed information about how to effectively engage clients in commissioning points to the need for further research and evaluation in this area, a need explicitly identified in a number of the studies.

Gaps in the evidence

There was little empirical evidence as to the effectiveness of client participation in commissioning. Within the peer-reviewed literature much of the relevant work comprised commentaries from the perspectives of policy makers and practitioners and descriptions of proposed approaches to client participation. The grey literature predominantly comprised 'how to' guides and frameworks. Most of the available literature related to the commissioning of *health* rather than *human* services, although the boundaries between health and human services often overlap.

Discussion of key findings

While there was limited empirical evidence as to the impact and effectiveness of specific approaches to engaging clients in commissioning, a number of important lessons emerged that may be useful in guiding future efforts in client engagement. Overall, to be effective, client engagement in the commissioning of human services must be set out clearly and embedded at all steps of the commissioning process. It must also offer tailored and targeted approaches to engaging with people and communities that draw on existing local resources, groups and assets. Key lessons include:

1. Clarify, legitimise, reward and resource engagement
2. Focus time and resources on building relationships
3. An evidence base is important
4. There are opportunities for engagement throughout the commissioning cycle
5. Focus on the accessibility of the commissioning body, not the reachability of the clients

6. Leverage local talent, expertise and user groups

7. Engage in culturally safe and culturally relevant ways.

Conclusion

The limited body of literature does not offer conclusive evidence as to the most effective modes of client engagement in commissioning. However, it does offer important guidance in relation to the ways in which any mode of client engagement might be implemented in order to fulfil the expectations of those clients who take part and other stakeholders in the commissioning process.

A key message from the literature was to draw on existing groups led by or comprising people from the client group, or non-government organisations who already have relationships with the client group. People were found to be less likely to engage when they didn't feel clear about their role, its purpose or its impact on decision making and outcomes. Client engagement is most effective when the impact of participation is defined and made transparent to all involved. Clients must be able to see evidence that their engagement has influenced decision making, or be provided with transparent information about why their feedback has not been used in the ways envisaged.

Research and evaluation of the commissioning process is essential to build the empirical evidence base and address the substantial knowledge gaps that exist at present. This requires evaluation of the implementation of particular client engagement strategies in order to measure and identify impact and effectiveness.

In order for clients to have a meaningful influence on the decision making associated with commissioning and engage at all stages of the commissioning cycle, client engagement methods should draw heavily on community development models. This requires identifying and collaborating with local leaders, mapping out local assets and strengths and working within the community[6(p. 25)] to develop joint community and government human service supports and interventions.

Background

This Evidence Check rapid review was conducted for the NSW Department of Communities and Justice (DCJ). Its aims were to (1) contribute to an improved understanding of how to achieve authentic participation in the commissioning of human services and (2) inform the revision and ongoing development of a commissioning participation framework and tools. The Evidence Check sought to identify and analyse recent evidence of effective ways of engaging with clients at various stages of the commissioning cycle. It examined approaches that have been tested within various phases of commissioning, particularly service needs analysis, design, procurement of providers, delivery and evaluation, in order to answer the question:

> What approaches have been effective in ensuring client participation in the commissioning of human services?

In July 2019 the NSW Department of Justice and the Department of Family and Community Services were brought together into a single department (DCJ) to 'build stronger communities' with the aim of 'achieving safe, just, inclusive and resilient communities'. The DCJ works with individuals, children and families and, in particular, seeks to improve outcomes for:

- Children and young people

- Aboriginal people

- People with disability

- People from culturally and linguistically diverse backgrounds

- People experiencing domestic and family violence

- Victims of sexual assault

- Juvenile offenders

- People at high risk of reoffending

- People experiencing homelessness[7]

The NSW Government adopted its Commissioning and Contestability Policy in 2016, seeking to improve outcomes and value for money.[8] DCJ's specific approach to commissioning seeks to achieve the best possible outcomes for clients using a structured approach to the design and delivery of services that is efficient, effective and sustainable. Procurement of services is one part of a broader process that aims to ensure services are delivered by the organisation most likely to achieve successful outcomes. This means that commissioned services may be provided by DCJ directly, other

government departments, non-government organisations, private-sector organisations or via partnerships. DCJ has a responsibility to facilitate good outcomes for clients across the state of NSW and across diverse population groups. At times, this can mean that DCJ takes on a 'market-shaping' role—investing in, and working with, providers to build the capacity to address clients' needs where this capacity may not already exist.

In general, commissioning involves planning, purchasing and monitoring and evaluating services for particular population groups or individual clients[9] (see Figure 1). It involves a separation between the purchase and the provider of a service and bases service purchasing decisions on assessment of local needs and priorities, as well as the availability and quality of services.[10] In the UK, where health and social care services have a relatively long history of commissioning, NHS England, the health commissioning body, has a statutory obligation to involve patients and the public in the commissioning of health services.[1,11] While this obligation is not legislated in Australia, involvement of people and communities is generally recognised as an important principle of the emerging commissioning processes.[10]

Figure 1— Commissioning process, from the NSW Government Commissioning and Contestability Practice Guide[12]
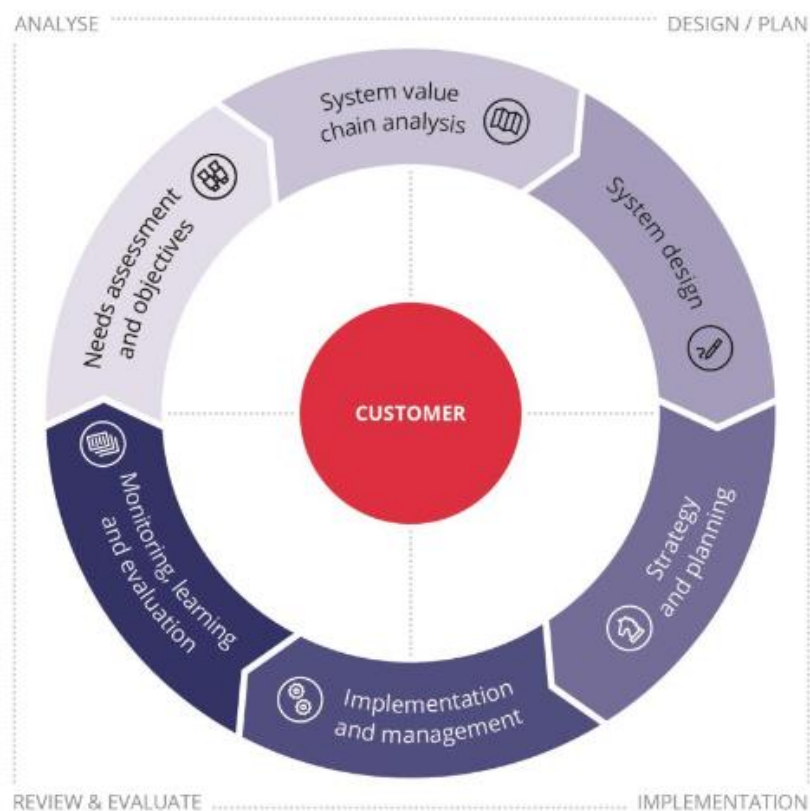
In 2017 the Department of Family and Community Services brokered an Evidence Check, Outcomes-based commissioning and consumers[3], which reviewed the evidence as to how consumers had been involved in commissioning and the effectiveness of such engagement (https://www.saxinstitute.org.au/wp-content/uploads/Outcomes-based-commissioning-and-consumers.pdf). In 2018 the DCJ developed the 'Client Voice and Engagement' resource, recognising

the importance of client involvement in the design of policy and the commissioning of effective services (see Figure 2). The resource sets out methods for client engagement including (but not limited to) surveys, submissions, interviews, focus groups, workshops and co-design. This Evidence Check seeks to offer evidence about particular strategies, tools and approaches that have contributed to effective client engagement in commissioning, in order to continue refining and adding detail to the DCJ's existing client engagement tools.

Figure 2— Benefits of capturing client voice at each stage of the commissioning cycle, based on the DCJ Commissioning Toolkit's Client Engagement tool

The language used to describe people who access or receive human services is contentious.[9,13,14] Particularly shaped by advocacy movements led by people living with disability and/or mental illness, language has tended to shift away from notions of passive service recipients and towards 'person-first' terminology. In this Evidence Check the term 'client' is generally used to describe people who are also often described in the literature as 'consumers', 'service users', 'participants', 'communities', 'patients' or 'people with lived experience'. Participatory approaches to service design and delivery may engage with many groups, including people who are direct clients of a service, their carers or family members, the broader public and people living in the area in which services are delivered[15] (see Figure 3).

Figure 3— From Farmer, Taylor, Stewart and Kenny 2017

Fig. 1.   Citizen participation in health service co-production.
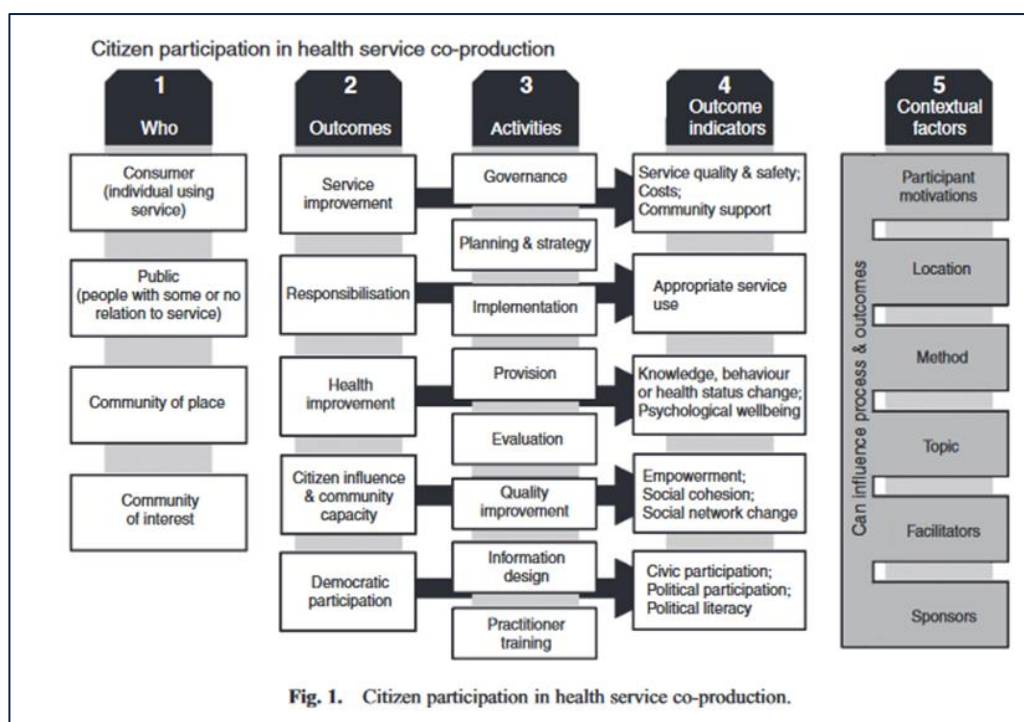
The language used to describe the 'participation' of people who use, or are affected by, services and policies is similarly contentious.[16,17] Arnstein's (1969) seminal 'ladder of citizen participation' sets out a framework for authentic participation. At the lowest rung sits 'manipulation', a form of non-participation.[18] In the mid-section sit various modes of 'tokenistic' participation, including informing and consultation. At the highest rungs sit modes of citizen power, including partnership, delegated power and citizen control. This model has been adapted more recently by Popay to frame the relationship between health improvement and community participation[19] (see Figure 4). Just who 'participants' are representing is also a key issue. Daya et al. argue authentic engagement and participation must draw on diverse experiences, views and voices and avoid expectations of a single client representing the views of a heterogeneous group of people.[20]

The articles included in this Evidence Check tend to use terms such as 'engagement', 'participation' and 'involvement' interchangeably. However, it is important to note that the various terms have subtly different connotations.[21] In the broader body of literature about client engagement in health and human services (not specifically related to commissioning) concepts such as collaboration and co-production have been posited as processes in which power shifts from conventional or regular producers and decision makers (policy makers and service providers) towards citizen producers or groups such as consumers, patients, clients and carers.[22,23] Authentic engagement and participation can suggest partnership and the potential for clients or participants to influence decision making[14], and has been associated with concepts of citizen rights and democracy.[21,24] In contrast, terms such as participation and involvement may be more passive—taking part in a consultation or an activity. Involvement is particularly pertinent within literature from the UK, where the concept of 'Patient and Public Involvement' (PPI) has gained prevalence within health policy and practice.[1,11] PPI refers to a broad spectrum of activities including consultation with patients and the public, representative roles on

forums and advisory groups and patient input into the assessment of proposals and evaluation of services.

In this Evidence Check we use the terms 'participation' and 'engagement', although this varies depending on the particular approaches described in the literature.

Figure 4— Pathways from community empowerment and engagement to health improvement (Popay 2010)
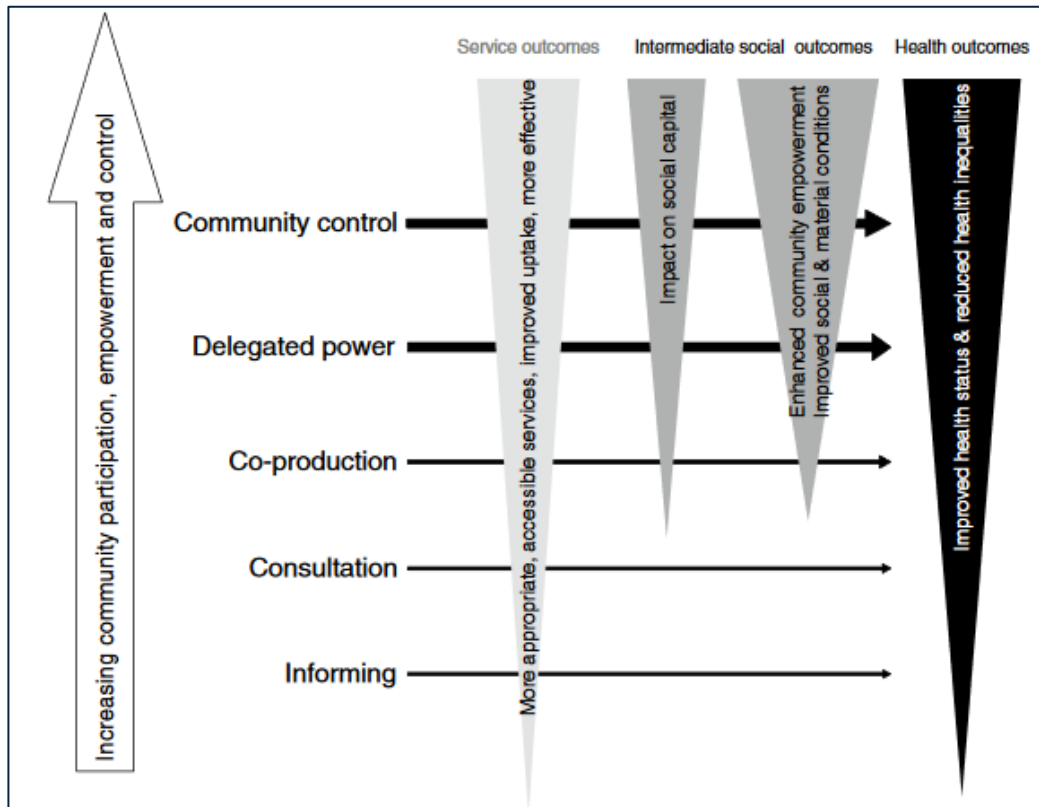
There is growing evidence that client and broader community engagement is important for the recognition of rights and citizenship and that, when done effectively, engagement can improve health and social outcomes, such as health program engagement for ethnic minority populations.[25] While evidence from the UK suggests it has limited impact on population health or service quality, effective community engagement has been associated with improvements in housing, crime, social capital and community empowerment.[26] Another review that included papers from countries comparable with Australia found some evidence of an association between community participation and engagement in service delivery and steps towards improved health outcomes in relation to service access and quality.[27] However, there is a limited body of rigorous evidence in this area, particularly due to challenges in measuring and attributing complex outcomes associated with engagement.[25,26] There is also a paucity of evidence demonstrating which specific engagement mechanisms and strategies are the most effective.[16] Bath and Wakerman[24] advocate that policy makers should strengthen support for participatory mechanisms in Australia and that one key way of achieving this is ongoing support for Aboriginal Controlled Health Services *"as exemplars of community participation in Australia"*.[(p. 5)] As examples of community-led and governed organisations, they outline a case where decision-making power sits with the community and offer already formalised approaches for community engagement and leadership.

Client engagement and participation are evolving concepts within the context of human services commissioning[10,28] but have long been key goals for community development practice.[6,29] Lindsay et al. suggest engagement of 'excluded groups' via co-production has become important as personalised approaches to service design and delivery have become more commonplace.[30] Particular groups and individuals may be excluded in a number of ways—socially, geographically, via stigma and discrimination, economically and in having limited access to opportunities such as education, housing, transport, healthcare and employment.[31] Bolzan and Gale suggest a market-based approach to the allocation of health and human services has positioned 'clients' as 'consumers', but marginalised groups have had to innovate in order to be actively involved in such an approach. They explored case studies of people with mental illness and older Australians who developed and took part in support groups as a step to building their power to be 'included'. In these examples, support groups became vehicles for collective action (e.g. advocacy and education), and one older persons' group even employed a project worker to maximise their opportunities for community participation. Bolzan and Gale[31] suggest that *"in recasting the relationship with professionals as a partnership rather than as a user/provider dichotomy these marginalised groups have contested the way in which power has been allocated and are claiming a position alongside professionals".*(p. 374)

Foremost among localised approaches to community engagement, devolution of power and collaborative decision making is the asset-based community development approach.[6,29] This model seeks to shift from needs or deficit models of policy making and program design to engagement with communities as partners, building on highly localised assets, strengths and resources.[29] Other recent approaches in Australia, such as the Justice Reinvestment model, have highlighted the potential for improvements in areas such as crime, education and economics, where highly localised and culturally specific community-controlled models of program design, development, delivery and evaluation are enacted.[32] The four domains of the Justice Reinvestment model, which is based on a Collective Impact framework[33], have offered early evidence of effectiveness. The domains of the model are: movement building activities (Aboriginal community leaders organise and plan change, the community is engaged); collaborative activities (work across service and justice systems, community rather than service leadership); programmatic activities (new inclusive service models, service hubs, alignment to community agenda); and procedural change activities (reforming ways of working and capabilities for justice agencies). A further Australian example of a community-based and empowerment-focused model of practice in this area is the Yawuru project, which sought to develop an understanding of, and indicators for wellbeing, 'from the ground up'.[34] This approach worked collaboratively with communities to gather their understanding of what makes a good life, and in doing so offered some useful insights into how 'outcomes' may be designed in a collaborative, community-led way.

In conducting this Evidence Check, we focused primarily on evidence-based approaches to client engagement in the commissioning cycle for human services. However, there is as yet a small body of literature in this area, and an acknowledged lack of research and evaluation of impact. Therefore, we also selectively accessed the broader body of literature on authentic and effective community participation and collaboration practices to inform our conclusions and recommendations.

Methods

Peer-reviewed literature

We searched the ProQuest, EBSCO, Scopus, Cochrane and Campbell Collaboration databases in December 2019 using the following terms:

Key term	Search terms
Commissioning cycle	"Needs analysis" OR "service needs" OR "service plan" OR "service needs" OR "service map*" OR "gap analysis" OR "service design" OR service-design OR service-develop* OR "service develop*" OR "service deliver*" OR implement* OR provide OR Evaluat* OR "performance measure*" OR "impact assess*" OR measure AND success OR monitor* OR Contract OR contest OR value-based OR "managed care" OR "group purchas*" OR incentive OR pay-for-performance OR "pay for performance" OR "pay for results" OR pay-for-results OR feedback OR "community development" OR asset-based OR "asset based" OR strengths-based OR "strengths based"
Commissioning	Commissioning
Client	Client OR consumer OR service-user OR "service user" OR customer OR participant OR user OR patient OR carer OR child* OR prison* OR out-of-home-care OR "out of home care" OR "foster care*" OR homeless* OR alcohol* OR drug OR youth OR juvenile OR indigenous OR aborigin* OR "culturally and linguistically diverse" OR CALD OR refugee OR minority OR offender
Participation	Participat* OR engage* OR inclusion OR voice OR advisor* OR consult* OR partner* OR involve* OR peak bod* OR collaborat* OR empower* OR co-design OR codesign OR inclusion OR client-centr* OR "client centr*" OR client-center* OR "client centr*"

The search terms were developed in consultation with the Department of Communities and Justice. Searches were limited to literature published since December 2014, published in the English language, and from countries with a comparable human services system, for example, New Zealand, the UK and Canada.

Inclusion criteria

The titles and abstracts of papers were initially screened for relevance. We included papers that incorporated aspects of the commissioning cycle and/or client participation or engagement or co-design, reported empirical data (quantitative and qualitative, mixed methods) and were related to human services or health and social care contexts. During second-round screening, we assessed the abstracts and full texts of papers. Two reviewers independently screened the first 50 results within the ProQuest database in order to establish a consistent approach to screening. After this point, one reviewer conducted the screening and a second reviewer provided input where there was uncertainty about a particular result. A second reviewer crosschecked 10% of the search results to ensure consistency.

Exclusion criteria

During the first screening cycle, we excluded papers if they were duplicates, did not report empirical data (for example, conference abstracts, editorials and reflective pieces, literature reviews), or were not related to human services or health or social care. During the second round of screening, papers were also excluded where they did not offer adequate evidence to inform consumer engagement in commissioning processes, which was the focus of this Evidence Check. For example, some papers focused on commissioning but had little content specific to consumer involvement, or referred to consumer involvement or co-design but lacked details about these processes. Other papers described client-centred services but did not illuminate whether or how clients had contributed to shaping these. Another paper described how views were sought regarding coping strategies and preferences for support; however, this involved a survey conducted for research purposes, with no identification of this as an 'engagement' activity and with no clear pathway for how results would or could be used to shape services. Papers describing commissioning within healthcare service contexts were also excluded where they were either very clinical in focus and/or did not offer any insights relevant to this Evidence Check.

A flow chart of the literature selection process is included as Appendix 1.

Evidence grading

The peer-reviewed evidence included in this Evidence Check was mainly qualitative (n=9), with one mixed-methods study (although only the qualitative component of this was relevant to the topic). Evidence grading tools, such as the NHMRC levels of evidence[35], were not applicable or relevant to the quality assessment of the largely exploratory qualitative articles included. As such, an integrity assessment checklist, a tool developed by Cheesmond et al.[4], based on Carroll et al.[36,37] was used to assess the extent to which the peer-reviewed literature had addressed, and provided clear detail about, the following elements:

- Question and study design
- Selection of participants
- Methods of data collection
- Ethics
- Limitations.

Each element was marked out of 2 where: 0=did not address, 1=partially addressed, 2=adequately addressed the element. As such, individual papers were scored out of 10 for integrity. A score less than 5 was considered low quality, 5–7 moderate quality and 8–10 high quality.

Included studies

Ten papers met the criteria for inclusion in the Evidence Check. Of these, three were high quality, six moderate quality and one was low quality.

The overall level of the evidence, based on this integrity assessment, was in the low range of moderate.

A summary table of the included studies is attached as Appendix 2.

We found four evidence reviews that did not meet the criteria of offering empirical findings relevant to the research question. However, they contained useful findings that reinforced the findings of this Evidence Check of peer-reviewed literature. A summary of these evidence reviews is attached as Appendix 3.

Grey literature

We conducted a desktop search, primarily using the Google search engine, for relevant grey literature published within the last five years, using various combinations of the search terms "*commissioning*", "*client*", "*engagement*", "*participation*" and/or "*involvement*". References within the reports and papers accessed were also checked and included, as relevant. We found 10 results that offered detail on how to engage clients specifically within the commissioning process. These included guides, reports and case studies produced by the Association of Children's Welfare Agencies (Australia), Community Services Industry Alliance (Australia), Australian Government Department of Health (Australia), Participation Works Partnership (UK), Healthcare Quality Improvement Partnership (UK), Lancashire Children and Young People's Trust (UK), Local Government Association and National Youth Agency (UK), Clinical Commissioners (UK) and the National Health Service (NHS). We did not assess the quality of evidence of the grey literature, as these were not articles written with the intention of presenting empirical or rigorous evidence.

The grey literature search also identified a range of resources offering guidance as to how to engage with clients, consumers or patients in broader health and human service development, delivery and evaluation (not specifically within the realm of commissioning). The body of work in this area is large and it was beyond the scope of this Evidence Check to synthesise all these resources. However, based on the existing knowledge of the research team and links within some of the included materials, we have provided a sample of resources at Appendix 4 that may be informative in designing client engagement in commissioning strategies and tools.

Relevant evidence reviews

As noted above, four papers that had synthesised other evidence were also reviewed as part of this Evidence Check process (Appendix 3).

Findings

Question: What approaches have been effective in ensuring client participation in the commissioning of human services?

The following findings summarise key content from the included literature to examine how studied attempts at client engagement in commissioning were designed, implemented and evaluated.

What is meant by 'engagement'?

The literature points to a broad range of conceptualisations of 'engagement' and 'participation' and the various terms are often used interchangeably. However, the following offers a brief guide to the different terms used to explore engagement, and their subtle differences:

- Participation[2,11,38 39]—taking part in predetermined activities

- Partnership[40,41]—a level of shared decision making and authority

- Involvement[1,2,40-45]—taking part in predetermined activities, having a voice in a predetermined process

- Patient and public involvement or patient and public engagement or patient and public participation[1,11,42,46,47]—legal duty of commissioners as per the NHS; can involve consultation, planning, public forums, advisory group participation

- Co-design and co-production[28,30,39,48]—identifying needs and designing responses to needs in a collaboration that may involve service users, non-government agencies and commissioning bodies, shifting power towards service users

- Community control[10]—community-led organisations and groups making decisions about needs and delivering services (possibly in partnership with other organisations)

- Engagement[2,28,39,49]—shared decision making, shared understandings, mechanisms for having voices heard

- Person-centred or child-centred[28,41,48]—outcomes are about the individual.

Lancashire Council[2], in its guide to involving young people in commissioning, uses terminology of 'participation' and 'involvement' but actually refers to quite collaborative and partnered approaches:

> "*Participation is a process by which someone is involved in and influences a decision about their life and this decision leads to change. Effective involvement of children and young people must be rooted in their right to influence the policy and services that affect them.*"[2]

Specific client groups

The 10 peer-reviewed papers related to a number of population groups. The primary groups identified were clients (including potential clients, families and carers) of cancer services[42,43], mental health services[47], sexual and reproductive health services[50] and general, primary or community-based healthcare[10,38,46,49], as well as people who were Aboriginal or Torres Strait Islander[10], older[38,40] and unemployed single parents.[30] Grey literature particularly noted children and young people as a client group.

The groups identified above are, of course, somewhat arbitrary; people accessing a specific service type are not homogeneous and will additionally belong to a diversity of other groups. For example, the Lorenc paper regarding sexual and reproductive health services noted a diversity of potential clientele in relation to ethnicity, youth, involvement in sex work, other health conditions and disability.[50] Further, while each paper focused on the needs or involvement of a particular group, the data presented in the papers were generally drawn from a wider stakeholder group. For example, commissioners and service providers were commonly included as study participants along with specific client group members.

Approaches to client participation

We searched papers for information pertinent to the planned engagement of clients in any step of the service commissioning cycle (i.e. service needs analysis, service design and planning, service delivery, service evaluation and procurement of providers). For each of these steps, we looked for information about recruitment, information provision, compiling and integrating client views, reimbursement, client experiences of participation, training/experience of staff and clients, and the resources required to facilitate engagement.

Recruitment processes

We searched for details of the process whereby clients became engaged, for example, whether people selectively sought to participate though existing networks or representative groups, or whether the opportunity to take part was advertised more widely.

The common route to involvement, identified in three papers, was through membership of an existing group or network.[42 47,49] For example, in a study of patient involvement in cancer service commissioning, Evans et al. found most of the clients involved in commissioning were initially recruited through their involvement in a cancer network partnership group. This was seen to be a 'natural progression'[42(p. 508)] from more general involvement to an active role in commissioning. In this example, people were informally invited to participate rather than formally applying for the role. Professionals acknowledged the tension between selectively inviting people they judged would be 'competent' and so able to contribute and a tendency to involve the 'usual suspects'.[42(p.508)] In another example, Frawley et al. described a five-day patient and public involvement (PPI) training event in Ireland attended by more than 40 clients of mental health services.[47] Participation in this training was

organised through existing local area mental health forums for people with direct experience of mental health services, although no details were provided on how participation in the training was promoted. In developing a 'patient experience' definition and strategy, Sanders et al. sought patient, carer and lay participants for an initial workshop from existing community sector networks and patient or service-user groups in North West London.[49] To further widen engagement, workshop participants were also asked to suggest additional groups with whom the researchers could meet and share draft documents. The research team also used existing consultation reports to provide a sense of the existing knowledge in that area.

Two papers described client involvement as arising from connection to services. Linsday et al. focused on the co-production of third-sector lead employability services for lone parents in five regions of Scotland.[30] In this paper, engagement occurred as an ongoing integral part of service operation and use. It appears engagement with clients to shape the services offered was not a single event but rather a rolling program of activities that built local social capital and relationships (e.g. through childcare centres), along with ongoing contact with existing clients and outreach to potential clients (e.g. doorknocking). The authors concluded that partnership with grassroots and consumer-led groups was an effective client engagement approach. To achieve such partnership, user- or consumer-led groups could be part of a consortium involved in the design and delivery of programs. Commissioners would need to factor lived experience, knowledge and relationships as criteria in the assessment of proposals and tenders. Schölvinck et al. focused on a patient advisory committee convened to contribute to the assessment of grant proposals to the Dutch Cancer Society.[43] Membership of this committee stemmed from previous experience as a cancer patient. The process of selection to the committee for current members was not described, although as this research took a participatory approach, a new process was co-designed during the project. This involved development of a recruitment profile and attendance at an information session (no further detail was provided about the new process).

One paper described public representation in commissioning processes occurring through an application process.[46] In this case, lay representatives were sought for two groups which supported local commissioning processes (i.e. a monthly public board meeting and a bi-monthly 'public patient engagement' (PPE) reference group). Recruitment involved advertising via a website, GP surgeries and the voluntary sector. The application process involved submission of a CV and interview. Although it was intended that there should be diversity among the lay representatives in terms of location of residence, age, ethnicity and health and wellbeing, in practice most of the lay representatives were white, middle-class and retired. Applicants were required to have the *"capacity to understand and represent the patient experience and to keep patients and the public informed of and involved in the work"*. [46(p.20)]

A further three papers had some content implying that a level of engagement had occurred, but they did not describe the mechanism by which people were recruited to provide their views.[38,40,50] Jun et al. described a participatory safer integrated medicine management project for which a series of three stakeholder workshops were held, each of which included at least one patient or carer among groups of professional stakeholders.[38] Interviewees in the Chadborn et al. study suggested third-sector health and social care providers for older people sought opinions and routine monitoring data from their clientele that were then fed forward to commissioners for future service planning and delivery.[40] Lorenc et al. described a steering group set up to guide a project developing PPE training for commissioners of sexual and reproductive health services.[50] The steering group included 'patient representatives' among a list of other stakeholders. However, none of these papers explained how

people had been identified or encouraged to engage, although Jun et al.[38] noted it was challenging to recruit patients/carers.

The remaining paper had no content relevant to how clients could be recruited to commissioning-related engagement activities.[10]

The literature consistently recognised the challenges of recruiting clients and communities into the commissioning process. Challenges were related to clients' limited time, experience, confidence, resources and the fact that their status as a 'client' meant they were likely to be navigating complex personal circumstances.[10,46] In light of this, representativeness was particularly challenging—ensuring the engagement of a diverse range of clients who represented the spectrum of actual clients in terms of age, gender, geography, socioeconomic status and lived experience.[42,46]

Of particular relevance to the work of DCJ, the NHS Framework for patient and public participation in Health and Justice commissioning[1] sets out a number of principles and recommended strategies (though not empirically tested) for engaging marginalised client groups, including involuntary users of government services. This framework sets out principles and strategies for the engagement of people in detention or diversion schemes (including adults, older people, young people and people from minority ethnic communities), emphasising the importance of:

- Participation approaches that recognise the restrictions placed upon people in detention, and their limited access to computers and information technology

- Potential limitations of literacy, requiring information in different modes and in accessible language

- Engaging with existing participation mechanisms such as prison councils

- Engaging with former prisoners to work with current prisoners

- Recognising that people may be experiencing significant crisis and that involvement activities must be timed accordingly

- Ensuring that at least two people with lived experience are invited to participate at any time and engaging with relevant community groups to support their participation

- Cultural awareness training for staff.

It also sets out principles and strategies for engaging with victims and survivors of rape and sexual assault, such as:

- Working in a trauma-informed way and recognising the potential to retrigger trauma responses

- Engaging with specialist support services and ensuring adequate support mechanisms are in place (noting that some participants will share detailed information about their experiences)

- Ensuring consultation work with survivors and offenders is kept separate

- Acknowledging and responding to the particular concerns that participants may have regarding confidentiality and maintaining boundaries.

A number of approaches were found to be useful in initiating and sustaining the engagement of specific target groups, as follows:

Engage locally

Henderson et al.[10] examined the ways in which patients and communities had been engaged in primary healthcare commissioning processes in Australia. They found local knowledge was important, and that its value was often under-recognised in the commissioning process. Involving local organisations—those with existing knowledge of, and relationships with, the community—in the commissioning and delivery of services was helpful. It was also recognised that awarding tenders to some local organisations could be challenging where they may have lacked skills or resources related to the service being commissioned.

Engaging with people and communities at local events and venues was found to be useful in gaining diverse perspectives within client engagement processes.[49]

Draw on existing user-led or grassroots groups

There was evidence that the 'third' or non-government sector could play an important role in the commissioning of health and social services for older people, and that they were well placed to "reach vulnerable populations and to provide intelligence about them" Chadborn et al.[40(p. 116)] This research, with commissioners, third-sector managers and representatives of older people's groups, found third-sector organisations were considered to be in positions of trust and that partnerships between commissioning bodies and well placed third-sector organisations were a better way of learning about community-level needs than standardised engagement and assessment tools. However, the research identified a risk that "*not all third sector organizations are robust business organizations*"[40(p. 122)], reiterating the finding from Henderson[6] that commissioning processes, particularly the awarding of tenders, need to consider how to build the capacity of, and relationships with, organisations that have strong relationships and connections with the community, but not necessarily service-specific skills.

The value of such partnership with local, user-led and grassroots groups was also consistently recognised in the grey literature. Mason[28], in a study that focused on children and families, found peak bodies and non-government organisations considered themselves well placed to facilitate engagement with clients. Non-government organisation representatives reported that they already had strong relationships with children and families but they needed adequate resourcing (in terms of staff and funding) to engage their clients in the commissioning process and to contribute to co-design processes with their government counterparts.

CASE STUDY: ENGAGING PEOPLE IN PRISONS

In the UK an ex-offender group called User Voice was commissioned by the South East Health and Justice Commissioning Team to undertake all patient and public voice activities across the region, including in 16 prisons. Peer researchers in each prison were recruited and provided with accredited training. Peer researchers undertook a paid role where they conducted surveys and focus groups to obtain feedback on health services. They were supported by User Voice staff members, who were former prisoners themselves. The process was considered successful because it was prisoner-led and supported by a user-led organisation independent of the prison. The information was given to the commissioners in order to inform different stages of the commissioning cycle. For example, peer researchers in Lewes Prison were involved in each stage of the procurement process for the new substance misuse service, including:

- *Assessing the current commissioned service*
- *Contributing to the service specifications*
- *Devising questions for tender*
- *Evaluating bidder responses*
- *Devising questions for bidder interviews*
- *Undertaking a service-user interview of shortlisted bidders*
- *Working with the successful provider to mobilise the new service.*

(From: NHS England, 2017, Framework for public patient involvement)[1(pp. 30–1)]

A recommended strategy for client engagement in commissioning includes partnering with, and involving existing groups that work with, or are led by, the client group.[1,2,39,44]

The Lancashire Children and Young People's Trust[2] suggested that to engage children and young people in commissioning it was useful to draw on existing youth participation mechanisms and groups. These can include young carers' groups and various youth advisory groups. They also urged commissioning bodies to consider diverse groups of young people and to try to include young people with relevant needs.

Information provision

To address this topic we searched for details as to how clients were provided with information, either about their role in the commissioning process, or about the commissioning decision itself (for example, the nature and level of need to be met, resources available, current service provision options and limitations).

Frawley et al. described a training program for patients and family members to develop the skills to participate in local mental health client engagement.[47] Although this training was not specific to any point of the commissioning cycle or single event, it included content relevant to any part of the cycle (for example, understanding how services work, identifying priorities, resolving conflict, committee effectiveness).

Three papers commented on the importance of role clarity for clients involved in commissioning.[42,43,46] For example, clients involved in cancer commissioning emphasised the need to be informed about the requirements and costs of the role.[42] Similarly, lay representatives to local healthcare commissioning processes were not clear about *"what they were expected to achieve, and who they were representing and informing".*[46(p. 489)] In this case, the representatives themselves requested training to better enable them to fulfil their role and found this useful. As the patient representatives in the Schölvinck et al.[43] paper were assessing research proposals, both the representatives themselves and other stakeholders felt it was important they should have a basic understanding of the scientific method, cancer mechanisms and current research directions (for which some had undertaken training). None of the papers provided specific suggestions for how information needs might be routinely identified, or appropriate training developed or delivered.

Feedback regarding the results and effects of client participation in commissioning processes is also an important element of information provision. The importance of this and the experience of participants when it is not provided is more fully addressed in Section 2.6, below.

Six papers did not directly address this aspect.[10,30,38,40,49,50]

Gathering client views

For this section we extracted details of the methods by which client views were sought and recorded, for example through client surveys or interviews. We focused on how views were sought for the purposes of commissioning or directly informing service design or improvement, rather than on data collection processes undertaken primarily for research purposes (which may or may not later be used to inform commissioning matters).

Few papers described in detail the process by which client views were gathered. An exception to this was Sanders et al.[49], who described the steps by which client views were sought regarding patient experience. First, a World Café event was held in which participants discussed three questions (e.g. 'what is patient experience?'), recording their thoughts and responses on tablecloths, with the comments then captured on flip charts. Then, a values clarification exercise was conducted in which five questions were posed (e.g. 'the ultimate purpose of capturing patient experience is…'). Individual responses were captured on sticky notes and then grouped thematically. Facilitators also took notes during events.

Two papers provided a generic description of how views were sought, but without sufficient detail for use as a 'how to' example.[42,46] For instance, Evans et al.[42] mentioned the use of a 'listening post' whereby cancer service client representatives were trained to interview other patients about their chemotherapy experiences. However, it was not clear what the training involved or how the views of the patients were then collated or used. O'Shea et al.[46] described the membership structure and frequency of local clinical commissioning board meetings and PPE reference group meetings, but did not fully explain what was discussed at these meetings, who decided this, or how views were elicited. They also noted that although members of the public could attend the board meetings, there was insufficient time for them to meaningfully contribute.

Three papers, while not giving detailed information about how to gather community views, commented on the importance of key relationships in involving communities and individuals.[10,30,40] For instance, in Chadborn et al.[40] both commissioners and third-sector key workers spoke of the importance of local community connections in engaging with citizens to build capacity for community-led action, although the paper provided no specific examples of this in action. Similarly, participants in Henderson et al.[10] highlighted the importance of local knowledge when engaging with Aboriginal and Torres Strait Islander communities, with one participant noting that organisations such as local Aboriginal medical services were well placed to undertake this role. Lindsay et al.[30] gave an example of how grassroots organisations can successfully reach out to lone unemployed parents in their own homes, with local key workers chatting with potential clients and taking 'wee notes'[(p. 580)] about what they wanted and what would help them get there.

Jun et al.[38] gave a detailed description of the process by which stakeholder workshops were conducted to identify priorities and solutions in relation to medication self-management. This included description of some of the materials used to record stakeholder suggestions. However, these were general tools and approaches rather than specific to client engagement, and there were very few client participants in the stakeholder workshops. It is of interest to note that a patient 'persona' was presented at the initial workshop to *"help participants stand in the shoes of users"*[(p. 51)] as they identified priorities and solutions. However, the persona was developed on the basis of previously conducted stakeholder interviews, which apparently did not include a client.

In one study, patient representative views about cancer research funding proposals were captured via a proposal assessment process[43] (see Section 2.4). The remaining two of the 10 peer-reviewed papers did not include information about how client views might be gathered[47,50], although Lorenc et al.[50] described the development of an online resource that promised to contain such content.

Compiling and integrating client views

To address this aspect we searched for text that described how client views (collected as per Section 2.3, above) were then handled and synthesised with other opinions and information to inform commissioning decisions.

On the whole, the papers did not explicitly describe how client views were incorporated into a decision-making process.[10,38,40,46,47,50] In some papers, though, it was clear that client views were at least aired in commissioning or decision-making processes, for example at meetings (Evans[40], O'Shea[44]).

Some papers described conflicting views between clients and others involved in the commissioning process. In one example, professionals felt they had implemented the suggestions of clients but the clients themselves disagreed because, though a service was provided, it did not look like what they had described. While providers and clients recognised that client involvement had been a priority, the actual extent to which clients were heard and able to influence outcomes was contested.[42] Related to this, it was suggested that the processes of decision making needed to be made clearer to client participants. At the same time, it was acknowledged that it can be difficult to demonstrate the specific impact of involvement on commissioning decisions, let alone eventual health outcomes.[42]

In some instances, it was suggested that information from clients was not taken into account by commissioners, perhaps due to lack of time and resources.[40] Similarly, patient representatives on a funding review panel *"repeatedly reminded their colleagues"* of the importance of taking their views into account in assessing proposals).[41(p. 257)] During this project, the assessment form was adjusted to clarify which aspects were to be assessed by the patients' representatives and how. Facilitation of proposal review meetings was also introduced.

Sanders et al.[49] provided a good description of how workshop participants' views shaped development of a patient experience strategy, which was intended to be useful to future commissioning exercises. This included typing up all client view information collected at relevant workshops and meetings and using these to develop a definition of patient experience and to identify common themes to underpin a patient experience strategy. This process was led by one of the researchers, who created an audit trail of her decision making for verification by her colleagues. The resultant documents were then circulated to workshop participants for member checking.

Lindsay et al.[30] described co-production between workers and service users as an individual process at the level of 'individual user journeys'

and as a representative process at the 'broader program' level[p. 580]. Here, opportunities for clients to share their views were initiated predominantly via key workers.

Reimbursement

We extracted information describing whether and how clients were reimbursed (financially or otherwise) for their involvement.

The need to inform clients about the potential costs of their involvement in cancer service commissioning was mentioned in Evans et al.[40], but it was not clear whether any reimbursement was actually offered. The clients interviewed for that study recognised that contributing to the commissioning process required substantial time and energy, and some felt that payment (in addition to reimbursement of costs) should be made.

Nine studies did not mention reimbursement of clients.[10,30,38,40,43,46,47,49,50] It may be that reimbursement was offered in some of these situations but not mentioned in the paper, although it was apparent in Jun et al.[38] that only GP attendees at a stakeholder workshop (which also included patients/carers) were reimbursed.

Grey literature, particularly about young people's involvement in commissioning, emphasised the importance of having formal recognition of participation. Payment was considered a good option, with a cautionary note that payments may have implications for tax and income, and that options such as gift vouchers, celebratory events and thank you cards could also be useful. At a minimum, covering out-of-pocket expenses was considered essential. Further, young people tended to feel their contribution had been valued where information about any changes to services that had resulted from their input was clearly communicated to them and/or where they had been able to attain accredited training.[2,45,51]

Clients' experiences of participation

We extracted information that considered how people who had been involved in commissioning decisions found the experience. In some papers, this information came directly from client interviews, while other papers reported on other stakeholder *perceptions* of client experiences.

Two papers specifically commented on involvement as a positive experience. Frawley et al.[47] assessed participant satisfaction with patient and public involvement (PPI) training using an exit survey incorporating both quantitative and qualitative questions. Training participants judged it to be a positive experience overall. Likewise, client participants in Lindsay et al.[30] reported feeling empowered, listened to and having choice.

Although other papers did not assess client satisfaction with engagement directly, several did offer specific suggestions as to how to support this or suggestions of things to avoid. For example, patient and public representatives who took part in a clinical commissioning group found it difficult to assess the impact of their participation to determine whether they had adequately represented their peers because they were not provided feedback about the outcomes of the processes they took part in.[46] Likewise, Evans et al.[42] found users who took part in commissioning groups and forums needed to have the 'feedback loop' closed. They wanted to know how their involvement had shaped commissioning decisions. Participants in the Evans et al. study also highlighted the need for peer

support in the role, including a larger pool of potential representatives to generate ideas and to attend meetings. Patient representatives assessing cancer research proposals acknowledged a dialogue had occurred with other reviewers, but questioned the extent of their influence on the eventual funding decisions.[43] This was confirmed by the authors, who also observed some challenges for patient reviewers in contributing to meetings and suggested more time was required to hear their viewpoints.

Henderson et al.[10] questioned whether typical time frames for commissioning were compatible with meaningful engagement, citing the example of Aboriginal and Torres Strait Islander Health Services where efforts have been made over many years to engage well with communities. The words of one participant alluded to the contrast between community engagement done 'quickly' and done 'properly'. (p. 85) Likewise, a client who participated in stakeholder workshops about safer medication management felt the three workshops held were *"not enough to discuss such an important topic"*.[35](p.58)

Three papers did not comment on clients' experiences of participation.[40, 49, 50]

Participants in the ACWA study[28] suggested that while there was much rhetoric about including children's voices in commissioning processes, few were able to identify formal processes for achieving this. In particular, there was no evidence of *"using client feedback systematically as the basis for system reform"*.[25](p. 23) NHS England[1], in its framework for patient and public participation, urged that feedback be provided about the impact of people's participation. In particular, it was important to explain whether, and how, their involvement influenced commissioning outcomes. It was one thing to gather clients' ideas and recommendations but another to demonstrate to those clients how this shaped reform and/or decision making.

Training/expertise of staff and clients

For this aspect of the Evidence Check, we extracted examples of staff (i.e. commissioners or service providers) undertaking training or possessing particular skills to better engage with clients. We also extracted evidence of training and support for clients to better enable their involvement.

Formal, relevant training as part of client engagement and co-production processes was seen as important. An evaluation of a five-day training program to enable patient and public involvement in mental health services in Ireland highlighted that training was as important for the professionals involved in commissioning as it was for the non-professionals.[47] Participants in the evaluation, including service users and family members, reported that it was important to 'blur' the boundaries

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CASE STUDY: LANCASHIRE CHILDREN'S RIGHTS SERVICE

Lancashire County Council in the UK undertook a commissioning process for the delivery of a Children's Rights and Advocacy Service. It designated funds to involve children in the process (covering costs such as food and travel). A questionnaire was distributed to all children for whom the Council had a 'responsibility of care', with a prize of an iPod offered. 10% of the target group (141 young people) completed the questionnaire. A group of young people, who were existing participants on a representative group, set up their own panel as part of the tender process. The tender was rated 70% on quality and 30% on cost. The young people's panel was allocated a portion of the decision-making power (a portion of the 70% on quality). They came up with their own panel questions, which they put to the providers, and also asked providers to do an activity with them explaining children's rights. After the interviews young people scored the providers, had a discussion and came up with a group score and feedback. They were also able to nominate providers they thought should not get the tender. Young people gave their feedback directly to the adult panel. After the successful tenderer had accepted the offer, the young people were informed of the outcome. The commissioners felt the young people's feedback was invaluable and it was noted that the provider who scored most highly from the young people was the one who was awarded the tender.

(From: Lancashire Children and Young People's Trust, n.d., 'How to effectively involve children and young people in commissioning'.[2](p.15)

between users, carers, families and professionals during training in order to mitigate against hierarchical decision making.

Service users were generally found to have been recruited to take part in commissioning activities for their experience in accessing relevant services, not because of particular skills and expertise in 'participation'. In fact, there was some scepticism reported about engaging with service users who had extensive experience in participation and engagement forums, where they may be perceived as 'professional users'.[40(p. 508)] Given the diverse experience, knowledge and skills that service users (and the professionals who facilitate and take part in engagement activities) may bring, it was viewed as essential to provide training at the early stages of client engagement in commissioning.[42] Further, having relevant skills and knowledge was identified as an important means for service-user representatives to have their roles legitimised.[46]

In the process of developing a PPE tool for commissioners of sexual and reproductive health services, Lorenc et al.[50] opted to build an online product rather than deliver face-to-face training. This was to provide an ongoing resource that people could tap into as needed. This tool was released in a series of 11 instalments and an update email list established. Thirty-three people subscribed to the tool but there was no information about how many had actually accessed or used it. O'Shea et al.[(46)] reported that lay members of clinical commissioning processes had requested training, for example, in the commissioning process, while Schölvinck et al.[43] alluded to training for patient reviewers of funding proposals; neither paper provided further detail, however.

Four papers did not include any relevant material.[10,38,40,49]

Based on feedback from community services industry representatives about effective client engagement in commissioning, it was recommended to *"build capability around innovative ways in which to co-design and co-produce outcomes with service users"*.[48(p. 24)] While there was little detail provided about the specific steps required to build capability, it was suggested that the community services industry had a responsibility to build its own capacities for engagement and to build the capacity of other stakeholders. Further, such capability building was seen to align with steps such as the development of community service guidelines and principles about how to engage clients throughout the commissioning cycle. There was a requirement to build the capacity of industry and non-government staff, government staff and service users themselves.

A case study of 'young commissioners' in the UK county of Devon stressed the importance of tailored training to enable young people to contribute to commissioning. This training was developed via a partnership between the Devon County Council and the young people's charity, Young Devon. Young Devon employed a Young Commissioning Ambassador to engage the most disadvantaged young people in the processes and training was accredited and tested over three years. Further, the training was modified for *"young people with special education needs"* in order to facilitate the engagement of young people who experienced the most significant disadvantage.[49(p. 8)]

Resource requirements

For this section we extracted any information provided about staffing needs and other costs of undertaking engagement activities and processes.

Four papers provided some limited information on the human resources used to develop and/or implement an engagement process.[38,47,49,50] The three three-hour stakeholder workshops described in

Jun et al.[38] were designed and run by a team of six people—three academics and three healthcare professionals. The mental health PPI training program described in Frawley et al.[47] was developed by the authors and delivery was co-facilitated by nursing academics, people with lived experience and a community facilitator. Lorenc et al.[50] described a series of conversations and meetings to support the development of a PPE tool that could be used by commissioners to design engagement processes. Similarly, Sanders et al.[49] indicated their work to develop a patient experience strategy was undertaken by a team of three with experience in community and practice development. However, in each of these cases no estimate of the overall cost of these resources was provided.

Six papers did not comment specifically on the resources required to undertake engagement[10,30,40,42,43,46], although some papers also commented more generally that commissioning processes can be a substantial pull on organisational resources[10] or that *"dedicated budgets and resources are needed…"*[50(p. 11)], while Lindsay et al.[30] noted the extensive and resource-intensive relationship building undertaken by staff in the local community.

Challenges/obstacles

From the data, we extracted examples of issues, concerns and barriers expressed by clients and users who had been engaged in commissioning, stakeholder organisations such as non-government agencies and peak groups, and commissioning bodies. A number of consistent themes emerged.

From the perspective of clients and service users, a lack of clarity regarding the purpose, expectations and potential outcomes of their engagement was a common concern. In a study of PPI in clinical commissioning, 'lay members' (users and carers, not professionals) of reference groups found the lack of clarity regarding the purpose of the groups and lack of clarity regarding their particular roles confusing.[46] This was exacerbated for those people who took part as individuals rather than representatives of a particular organisation, who expressed concerns about the lack of representativeness and democracy of the process, given that members were not elected. In contrast, those lay members who represented an organisation expressed feeling clear about their mandate to facilitate information flow between the reference group and their organisation's members.[46]

Evans et al.[42] found a lack of clarity about the role of service users in decision making in the commissioning process led to their disengagement, and that addressing the status gaps between service users and professionals was an important step in clarifying roles. In an evaluation of a participatory approach to health design, users of health services took part in workshops but did not take part in ongoing monitoring and implementation of recommendations. In contrast, professional stakeholders were involved in pre- and post-workshop activities.[38]

A study exploring the influence of patient representatives on commissioning review panels found patient representatives had very different perceptions of their roles and often felt unclear about their purpose and responsibilities. Some patient representatives felt the purpose of their participation was to offer informed and technical advice from a wide-ranging perspective, while others considered their role was to speak from a personal perspective.[43]

Issues of representativeness were also noted, in particular the challenges associated with engaging the most marginalised or stigmatised people.[28,42,46,50] In testing a tool to enable patient and public engagement (PPE) in commissioning, Lorenc et al.[50] found stigma and confidentiality concerns made

it particularly difficult to engage with people at risk of Sexual and Reproductive Health and HIV/AIDS (SRHH) concerns, noting that:

> "… people at risk of poor SRHH are least likely to have their voices heard, particularly those from ethnic minorities, young people, sex workers, and those with mental illness, substance misuse problems and disabilities."[50(p. 8)]

Client engagement was seen by participants, government and non-government stakeholders to be impeded where there were not sufficient resources in place. Two studies noted engagement was particularly difficult where there was not sufficient staff time to facilitate and support engagement, training and skill development, or funds to support travel and logistical requirements.[42,46]

Where commissioning processes were competitive, particularly in tendering, this was considered a barrier to engagement and relationship building; this will be discussed in further detail below.[10,40,49]

Commissioning-specific

We searched for data that related specifically to the commissioning cycle and its various processes. Much of this data overlapped with the findings previously discussed. However, the most notable finding was the recognised conflict between the time-limited competitive nature of some commissioning processes and the long-term collaborative nature of relationship building.[10,30,40,42,49] Client engagement was found to require a long process of building connections with groups such as community-led organisations, non-government organisations and user/client groups.[30] Building the relationships with such groups was only the first step in reaching out to their wider networks to connect with a more diverse, and potentially more marginalised, group of clients. In contrast, the commissioning process was perceived to happen at a quick pace. It was also reported that the competitive tendering processes involved in commissioning created tensions among the very groups and organisations that might best lead and facilitate community and client engagement, particularly where 'outside' organisations were contracted to deliver localised services.[10] There was concern, particularly expressed by stakeholders from the third-sector groups, that the administrative and bureaucratic systems of commissioning bodies were quite different from those in the non-government sector. They worried that organisations and groups with the strongest community and client connections may not be considered 'competitive' due to lack of capacity in areas such as organisational management.[10,40]

Evaluation

While evaluation is recognised as a core process within the overall commissioning cycle, the available evidence suggested that the evaluation, specifically, of client engagement has tended not to be integrated into this cycle.

The limited empirical evidence on the topic of client engagement in commissioning consistently highlighted the need for further research. Evans et al.[42(p.505)] noted that:

"Extensive research has been conducted into the impact of user involvement, but the general conclusion is that the evidence for its effectiveness is weak; not that there is strong evidence that it is ineffective; rather, the methodological challenges of evaluating it mean that conclusive evidence is rarely found."

Jun et al.[38] (p.49) evaluated a participatory approach to developing a framework for integrated medicine management. They recognised that the 'knowledge gap' in understanding participatory approaches to community-based healthcare systems was an important rationale for the study. They identified the usefulness of a range of templates and approaches and found an ongoing need for research into online mechanisms of participatory approaches.

Lindsay et al.[30] acknowledged their own qualitative research on third- and public-sector collaboration was relatively small scale, with limited generalisability. They suggested further research on co-production and collaboration was important to understand its applicability and the impact it might have on enhancing personalisation of social services. Lorenc et al.[50] noted that while their evaluation of the development of a client-engagement-in-commissioning resource was valuable, it would benefit from further research into the usefulness and application of the resource. They found that, consistent with other studies, their project *"identified the need for evidence of successful PPE, including effectiveness and costs"*.[50(p. 11)]

Discussion

There is limited empirical evidence available on the impact and effectiveness of specific approaches to engaging clients in commissioning. This restricts the ability to offer 'proven practice' guidance and recommendations about tools and approaches. However, a number of consistent and important lessons emerged from this Evidence Check that may be useful in guiding future efforts in client engagement. Effective engagement is that which facilitates the participation of diverse and often-disadvantaged groups and individuals, is able to demonstrate the impact of this participation on decision making, is perceived by participants as worthwhile, is valued by commissioners, maximises the use of existing and new resources and, ultimately, contributes to more relevant services and better outcomes for clients. Overall, to be effective, client engagement in the commissioning of human services must be set out clearly and embedded at all steps of the commissioning process. It must also offer tailored and targeted approaches to engaging with people and communities that draw on existing local resources, groups and assets. This discussion sets out key lessons for the effective engagement of clients in commissioning. Findings from the peer-reviewed and grey literature are synthesised to examine each lesson.

Lesson 1: Clarify, legitimise, reward and resource engagement

Service-user and client participants across the various studies reported that having their roles set out clearly and well understood was important to them. Further, it was important to participants to understand the impact of their engagement on commissioning outcomes.[28,42,46,50]

The grey literature reinforced the importance of role clarity. For example, in engaging young people in commissioning, the UK National Youth Agency and Local Government Association program[49] advised [(p. 13)]: *"Make clear young people's roles and ensure they understand the parameters of their involvement."*

Legitimising the role of user representatives was an ongoing theme, closely related to the issue of role clarification. Concerns and questions about the legitimacy, or perceived legitimacy, of engagement and participation strategies was noted frequently.[42,43] Recognition took various forms—financial, status, decision-making authority, accreditation and thanks.

In evaluating the engagement of patients in the assessment of proposals for cancer research, Schölvinck et al.[43] found formally embedding the role of the patient reviewers was important. Until there were formal positions allocated on the Dutch Cancer Society's scientific committee, patients felt the need to advocate for the value of their role in assessing proposals. However, the findings of the study indicated patients still tended to have to *"adjust to the scientific social norms"*[(p. 261)], rather than the conventional professional environment shifting or adapting to the patients' norms. While service users had delineated roles in the process, there was limited evidence of how this patient involvement affected decision making.

O'Shea et al.[(46)] noted that having specific allocated staff and governance representatives was crucial to effective patient and public involvement (PPI). *"The CCG [Clinical Commissioning Group] provided resources to support PPI: staff in the form of a PPI lead; manager and admin support; and a board member with a remit for PPI".*[46(p. 492)] Further, Evans et al.[42] found the active involvement of *senior* managers of commissioning bodies was a key factor in effective client engagement. Where senior managers were actively involved and took an interest in client engagement, users felt the partnership was genuine. It was also considered that the level of skill and experience brought to the engagement process by senior staff was important to its success.

This was also reflected in the grey literature, as exemplified by Participation Works Partnership's[45(p.12)] recommendation when working with children and young people, to:

> *"Involve adults from across the organisation—from senior executives, councillors and board members down. This is not just the business of specialist participation workers!"*

There was little evidence available to guide approaches to reimbursement of client participants, although Evans et al.[42] found users expected, at least, their costs to be covered and, at best, to receive payment. The grey literature highlighted the importance not only of monetary recognition but also public recognition, accreditation and professional development opportunities and the opportunity to celebrate resultant service changes.[41,44]

Lesson 2: Focus time and resources on building relationships

Lindsay et al.[30(p. 582)] highlighted the importance of relationship building as an explicit and resourced part of designing and delivering personalised support programs, finding two important elements in their study: first, that the funder specifically requested local partnerships and collaborative models that included local and service-user representative organisations; and, second, that time and resources were allocated to the relationship-building phase, recognising that this required the time of funding body staff, often resource-poor non-government and service-user groups and community representatives. The commissioning body must demonstrate that they value building relationships that facilitate community engagement.

Henderson et al.[10] considered the extensive time, expertise, resources and energy that had already led to models of community-led governance in Australia, such as Aboriginal Community Controlled Health Organisations. Research participants from Primary Health Networks noted that the competitive nature of commissioning "*has potential to undermine existing service relationships*".[10(p. 87)] They noted that not only was relationship building challenged by the environment of competition, but that building effective relationships across stakeholder groups, including communities, was often problematic due to the different responsibilities and levels of engagement at the various levels of government, particularly state and federal.

Non-government stakeholders considered that shifting the importance of, and power within, relationships between commissioning bodies, non-government organisations, children and families was important in working towards improved client engagement in commissioning.[28] They perceived that the active involvement of children, carers and parents in commissioning processes was a means to work towards more trusting relationships and shared accountability in out-of-home care services.

Lesson 3: An evidence base is important

The limited available evidence served to highlight the need for developing the evidence base to understand the processes and impact of client engagement in commissioning.

A project that brought together patient and carer representatives, consumer-body representatives and professionals to develop a patient experience strategy found that being evidence-based was an important fundamental value.[49] Client engagement and valuing lived experience does not exclude the valuing of other types of evidence.

In order for commissioning bodies to learn and reflect in ways that authentically recognise the needs of clients, it is important that data collected about client outcomes and needs are used to determine priorities—collected client data should shape service design and delivery. Chadborn et al.[40] found while third-sector agencies involved in contract delivery were collecting substantial information from clients about outcomes and needs, the commissioning bodies were not routinely using this information to inform their decision making. Client engagement offers opportunities for more than the collection of 'new' or external data; it also requires effective use of existing client data, which must be adequately factored into the design, procurement and evaluation of services.

Within the grey literature, there was a strong emphasis on the need not only to implement but also to evaluate client engagement in order to understand its impact and effectiveness. Petsoulas et al.[52], for example, argued that while there had been some evaluation and documenting of processes of PPI in UK health service commissioning there had been negligible assessment of the impact of that involvement. As a result, there was limited basis for confidence that newly mandated processes could address issues with previous approaches, nor that the former approaches were not effective. One issue that hampered assessment of evaluation was lack of definition of effective participation.

Evaluation of commissioning outcomes, as well as of the client engagement process, offers opportunities for clients to contribute as evaluators and researchers. The UK Healthcare Quality Improvement Partnership (HQIP)[44] reported that a research project led by Service User Researchers offered valuable insights into 'lay public' perspectives on commissioning. Participation Works Partnership[(45)] noted the importance of evaluating commissioning outcomes as well as the participation processes, suggesting that:

> *"Outcomes must be measured and information and good practice shared with commissioners, providers and the local community. Children and young people can be involved using similar tools to the monitoring stage. For example, you could publish stories, case studies, photos and information leaflets. It is also important to remember to evaluate young people's experience of being part of the commissioning process. Using participatory techniques, storytelling and creative workshops are a good way of learning about their experiences."*[45]

Lesson 4: There are opportunities for engagement throughout the commissioning cycle

Participation and engagement should be ongoing throughout the phases of the commissioning cycle, requiring strategies to ensure the sustainability of client engagement mechanisms. This involves consideration of funding, time (of staff and participants), logistics of participation and the burden of participation on clients. Evans et al.[42(p. 509)] found users considered their engagement was more effective where they were involved in commissioning from the earliest stages and that they needed a

role in setting the agenda (see also Hare[53]). An evaluation of a participatory approach to healthcare planning for older people illustrated the potential for client engagement to lose traction over time.[38] In this model, patients and carers were acknowledged as an important stakeholder group. They participated in a series of collaborative workshops, but were not included in pre-workshop interviews to shape the methods, or in the post-workshop steering committee. Similarly, the Community Services Industry Alliance[48] report noted the potential for service users to make important contributions in co-design, co-production, developmental evaluation and insights (understanding needs). To maximise the value of engagement required multiple options and opportunities. The Lancashire Children and Young People's Trust[2] considered that young people should participate at all stages of the commissioning cycle. Similarly, the Australian Government Department of Health[39] indicated that Primary Health Networks (key health commissioning bodies) should: "*embed consumer and carer co-design throughout the commissioning cycle, including in needs assessment; policy development; strategic planning; prioritisation; procurement of services; and monitoring and evaluation*".[(p. 1)] Evidence from one review suggested structures for participation should reflect the nature of the lives of people participating and account for their likely changes in circumstances over time. For example, people with dementia were likely to be able to participate actively for a period of time, but as the disease progressed, the nature of their involvement would need to look different.[53]

Figure 5 sets out examples of the types of client engagement activities identified by NHS England[1] that may be effective at different stages of the commissioning cycle.

Figure 5— Patient and public participation in the health and justice commissioning cycle (NHS England, 2017[(p. 17)])
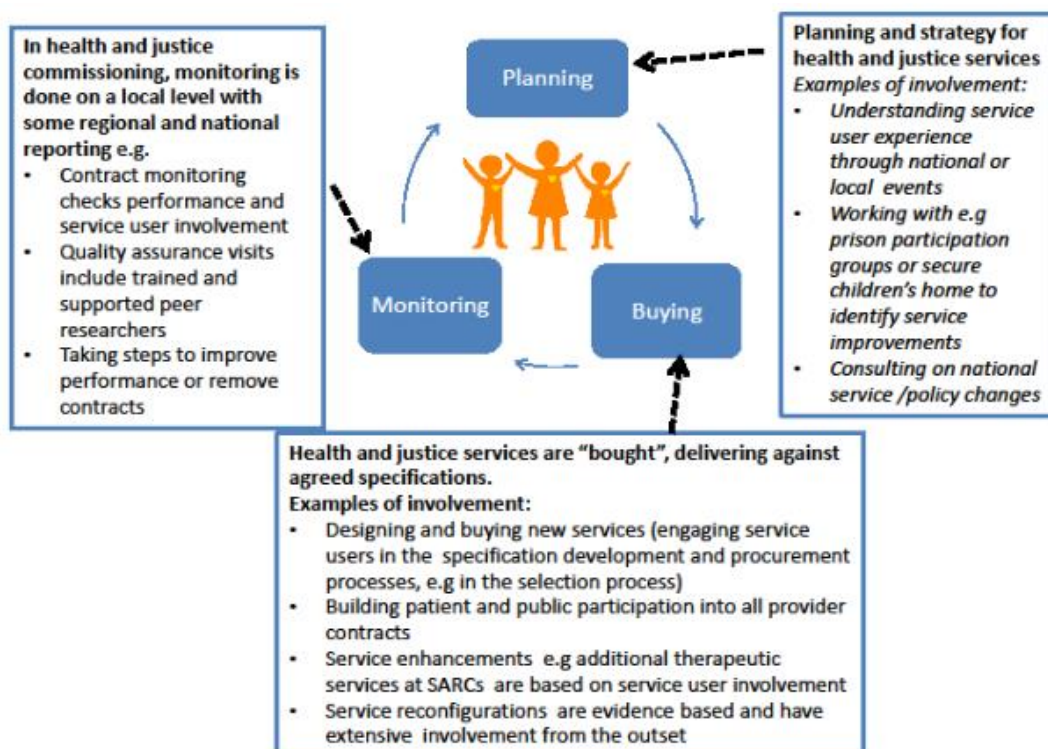
Lesson 5: Focus on the accessibility of the commissioning body, not the reachability of the clients

Clients within human services may often be the most marginalised and vulnerable people. In particular, people who are engaged with human services agencies on an involuntary basis may be among the least likely to have the capacity or will to take part in commissioning processes. However, these are also the people whose voices are least frequently heard in policy making, program design and service delivery.[50] Lindsay et al.[30] suggested a fundamental step to building engagement and working towards genuine co-design was to reframe the challenge. Rather than perceiving clients as 'hard to reach' the impetus needed to be on the service providers and policy makers ensuring their engagement opportunities were 'easy to access'. Practically, this was achieved by ensuring the proximal and user-friendly components of accessibility (i.e. commissioned services were signposted and physically accessible as well as welcoming). Within the co-production model they described, local partnerships that included grassroots organisations with existing connections to the target clients were essential, as was the allocation of time, funding and staff to focus on engagement and relationship building at the outset of the program.

Participants in the study conducted by Schölvinck et al.[43](p. 257) identified the need for a 'cultural shift' in order to effectively include patients in commissioning activities. Effective approaches to client engagement require commissioning bodies to consider their own strengths and weaknesses and make changes at an organisational level to become more accessible to a wider range of clients. Such approaches require recognition of the unique positions of particular client groups (such as families in crisis and people in detention), via use of specialist support networks, considered timing of engagement activities and multimodal methods that recognise factors such as limited access to technology and varying levels of literacy.[1]

Lesson 6: Leverage local talent, expertise and user groups

Sanders et al.[49] described an assets-based approach to engagement that recognised the particular skills and expertise of patients, staff, users and carers, and tapped into their skills in facilitating *"conversations with their peers"*.(p. 15) As part of this assets-based approach they recognised the importance of language—using first-person statements and the words of people and communities rather than interpreting and translating these into corporate language. There are existing skills among commissioning body staff, partner organisations and various community groups that are important assets for starting the engagement process.

As identified by Chadborn[40], Henderson[10], Lindsay[30] and Mason[28], establishing relationships and building engagement mechanisms should not happen in isolation from existing groups and forums which clients participate in, or lead. Where local, grassroots, community-based and/or user-led groups already exist, these can be important for recruiting participants.

Similarly, the grey literature recommended a range of existing forums, groups and organisations that could form the basis for building relationships and connecting with clients. Mason and the NSW Association of Children's Welfare Agencies (ACWA)[28] examined the value of non-government organisations and, in particular, the potential to draw on their existing links to children and families. The Australian Government Department of Health[39] indicated that it is a requirement for Primary Health Networks seeking to involve clients in commissioning to engage with existing consumer, carer,

advocacy, Aboriginal and Torres Strait Islander and transcultural groups. The Lancashire Children and Young People's Trust[2] recommended connecting with young carers groups and government advisory groups.

Lesson 7: Engage in culturally safe and culturally relevant ways

Client engagement in commissioning is not only important for its potential to shape better health and human service outcomes, it is recognised as a right, as a part of citizenship. As such, it is important that this right is extended to diverse groups of people in relevant and appropriate ways.

The Australian Government Department of Health[39] noted that:

> *"Effective consumer and carer engagement and participation recognises diversity and supports inclusion and participation of vulnerable or hard to reach population groups. This can include: Aboriginal and Torres Strait Islander peoples; people from CALD, multicultural, migrant and refugee backgrounds; people living in rural and remote areas; people who identify as lesbian, gay, bisexual, transgender, intersex and queer; people with intellectual disability; and other vulnerable groups. Targeted approaches to engagement and participation will be needed for some of these groups, which may be through advocacy based groups and community organisations, and/or require preparation of tailored, translated and culturally appropriate information."*

Engagement with Aboriginal and Torres Strait Islander people

Henderson et al.[10] found facilitating engagement through existing Aboriginal Community Controlled Health Organisations was important in order to understand local needs and connect with the existing community-led governance structures. The Australian Government Department of Health, in setting out the importance of engagement with Aboriginal and Torres Strait Islander people as part of the commissioning of mental health services, noted the importance of looking beyond service-specific groups (i.e. specific health or human service groups). The department noted it can be useful to *"develop cross-sectoral mappings of services that can be used with primary health care to promote broader connections, as well as for needs assessment, services planning and advocacy"*.[39(p. 5)] While not eligible for inclusion in this Evidence Check, as it was out of the date range and not related specifically to commissioning, the NSW Family & Community Services' Aboriginal Consultation Guide[54] is an existing tool that offers useful guidance about the importance of self-determination as a fundamental principle in engagement, as well the value of internal consultation (drawing on the knowledge and expertise of staff within the organisation) and external consultation (seeking input from groups and professionals outside the organisation).

Engagement with people from culturally and linguistically diverse backgrounds

Chadborn et al.[40] found having effective relationships and skills in place to engage with people from culturally and linguistically diverse backgrounds was another argument for giving third-sector organisations a role in commissioning. Commissioners and third-sector key workers involved in this study considered that local non-government workers who shared cultural identities and had existing community connections were important for engaging clients in the commissioning process—speaking the same language was important but not as important as shared cultural identity. The Australian Government Department of Health[39] noted the importance of tailored approaches to engaging with

culturally diverse groups, recommending connecting via advocacy and community-based groups. They also suggested that specific, translated and culturally appropriate information be produced for particular cultural and linguistic groups.

Engaging young people and children

While none of the peer-reviewed literature focused specifically on children and young people, five of the 10 grey literature results focused on children and/or young people.[2,28,45,48,51] The grey literature recognised the specific strategies that are required to recruit, engage and give voice to young people and children. The UK Local Government Association (LGA) and National Youth Association (NYA) commissioning guide[51] recommended that young people should be involved in all stages of commissioning and that their input was required for:

1. Understanding—clarifying local outcomes, needs, resources and priorities

2. Planning—considering different ways in which the desired outcomes can be achieved effectively, efficiently, equitably and in a sustained way

3. Doing—implementing the plan using the resources available

4. Reviewing—monitoring delivery and its impact against expected outcomes.[51(p. 5)]

The Lancashire Children and Young People's Trust[2] reiterated the importance of young people's participation at all stages of the commissioning cycle. Its guide offers practical tools such as a checklist for young people's engagement that outlines approaches, including 'taster' opportunities to build young people's familiarity and confidence to participate and drawing on sources such as local artists to support creative approaches to engagement.

Conclusion

This Evidence Check focused on the evidence for effective, authentic approaches to client participation in human services commissioning. Effectiveness has many dimensions. It refers to cost-effectiveness and the efficient use of limited resources, the representativeness of engaged clients, the extent to which client engagement influences decision making, the extent to which the capacity and skills of client representatives are built, the outcomes achieved from commissioned projects, and the sustainability and workability of partnerships and collaborations. The limited body of literature available for this Evidence Check did not offer conclusive evidence as to the most effective modes of client engagement in commissioning. It did not offer specific insight into whether modes of engagement such as broad public forums, small-scale consultations, client-specific advisory groups, client representative positions on existing advisory groups or client surveying were more or less effective than other approaches. It also did not provide specific detail in relation to the ways in which client engagement approaches may or may not be effective. For example, there was no evidence to indicate whether some approaches were more cost-effective than others, or that some approaches contributed to better health and social outcomes than others. However, the literature did offer important guidance in relation to the ways in which any of these modes of client engagement might be implemented in order to fulfil the expectations of those clients who take part, and other stakeholders in the commissioning process.

Recruit

The evidence consistently highlighted the challenges in finding, recruiting and engaging with representatives of diverse client groups. This was particularly difficult when working with people who were marginalised or in crisis. The key message from the literature was to draw on existing groups led by, or comprising, people from the client group, or non-government organisations who already have relationships with the client group. The risk of this approach is that the voices of a limited number of clients (those who choose to and have capacity to take on advisory and advocacy roles) are heard. However, snowballing methods can be useful in this approach, where local grassroots, user-led and non-government groups are the first point of contact and are then asked (and resourced) to draw on their networks to engage more broadly.

Recommendations:

- Identify and build links with relevant user-led and non-government groups at local and state levels.

- Facilitate partnerships with user-led and grassroots groups as part of the commissioning process; encourage joint tendering between user-led and grassroots groups (who have strong local knowledge and relationships) and experienced service providers (who have strong service delivery and administration capacities).

- Engage with the 'third sector' rather than duplicating engagement processes and establishing new relationships from scratch; acknowledge the strength and value of existing community leadership and engagement forums, particularly Aboriginal community-controlled organisations; ensure commissioned service providers demonstrate a strong history, and embedded values, of engagement with the local client group and community.

- Recognise and work with the limitations of 'representativeness'. There is not an ideal solution to having a representative sample of clients engaged in commissioning processes; this is particularly pertinent in Communities and Justice services where many clients may be involuntary participants, may be experiencing fluctuating periods of crisis and are likely have other immediate priorities.

Engage

The time, energy and expertise contributed by people who choose to take on participatory and/or representative roles in human services commissioning is substantial. People are less likely to engage, and are more likely to disengage, where they do not feel clear about their role, its purpose or its impact on decision making and outcomes. Engagement in forums that are dominated by professionals can be very daunting and communication across professional and non-professional stakeholders can be challenging.

Recommendations:

- Have role descriptions for all types of client engagement (whether long- or short-term) that clearly set out the role's purpose, expectations, requirements, time frames, support (e.g. payment, travel, training, mentorship), relationship to other stakeholders and how the role will influence decision-making.

- Deliver tailored, relevant, multimodal training to clients and professional stakeholders who will be part of the engagement activities; training should seek to reduce hierarchical barriers and recognise the learning required from client and non-client participants in order to work collaboratively.

- Allocate dedicated resources, including funds, staff and time, to set up and sustain client engagement groups; participants must, at the very least, be reimbursed for any expenses incurred. Staff (including senior management) should be allocated roles, and the necessary time, to support and sustain client engagement mechanisms. Allocating adequate resources to support and sustain client engagement groups is important, whether it is a mechanism set up for the specific purpose of a commissioning project (e.g. a specific advisory group) or where it is an existing group that has been asked to collaborate (e.g. a local user-led group); setting up peer support among client participants can help.

- Develop, enhance and promote the additional benefits of participant involvement in commissioning such as relevant training, certification, social connections and public recognition.

Feedback

Client engagement is most effective where the impact of participation is defined and made transparent to all involved. Clients must be able to see evidence that their engagement has influenced decision making. This is key to avoiding perceptions of 'tokenistic' participation, and in order to sustain ongoing engagement. The nature of the commissioning cycle is iterative, and clients who contribute time, ideas and energy need to be informed of the outcomes, proceeding phases and their role throughout.

Recommendations:

- One-off 'consultation' is insufficient; even where the scope of client engagement is limited to consultation on a particular need or issue, there must be follow-up communication with those clients about the findings from the consultation and how those findings will be used.

- Use a range of communication methods to engage with, and report back to, clients. Discuss with them their preferred modes of communication and adapt communication tools accordingly; this may include face-to-face, telephone, social media, email, website, written materials, group or individual approaches to communication (and combinations of these).

Research and evaluate

Research and evaluation to build the empirical evidence base is essential in order to address the substantial knowledge gaps. This requires evaluation of the implementation of particular client engagement strategies in order to measure and identify impact and effectiveness.

Recommendations:

- Participatory action research processes may be particularly useful in this context. There is an imperative to forge ahead with client engagement in commissioning. Participatory action research methods offer opportunities to conduct research in 'real time' and to engage, train and even employ clients as collaborative evaluators and researchers; further, it is a model that has demonstrated promise in engaging culturally diverse people and communities in the research and service design process.[55]

Innovate and sustain—let the community lead

Participants in the various studies reviewed here consistently reported the importance of having a meaningful impact on the decision making associated with commissioning. It was also repeatedly noted that client engagement was most effective where clients were engaged at the earliest stages of the commissioning cycle and throughout the cycle. This requires approaches to commissioning that draw heavily on community development models—working within the community[6(p. 25)] and facilitating leadership from within the community.

Recommendations:

- Explore the potential for community-led models of development to be applied to the commissioning process; examples such as Justice Reinvestment in Bourke[32] and the Yawuru Wellbeing Project[31] offer useful examples for understanding and applying such community-led approaches.

- Community collaboration and localised approaches to engagement align well with DCJ's commissioning model, which emphasises target-group-specific outcomes and offers opportunities to build service provider capacity and cross-sectoral relationships. Continuing to develop DCJ's approach to commissioning in this way offers scope for client-centric commissioning that overcomes some of the critiques of timebound and competitive commissioning models. Documenting case studies and evaluating DCJ's model of commissioning will offer important evidence to support client-centric commissioning.

- Consider attempts to de-couple mechanisms for participation from government bodies; resourcing for 'backbone', grassroots or 'container' organisations, as per collective impact approaches, could be one model that achieves this end.
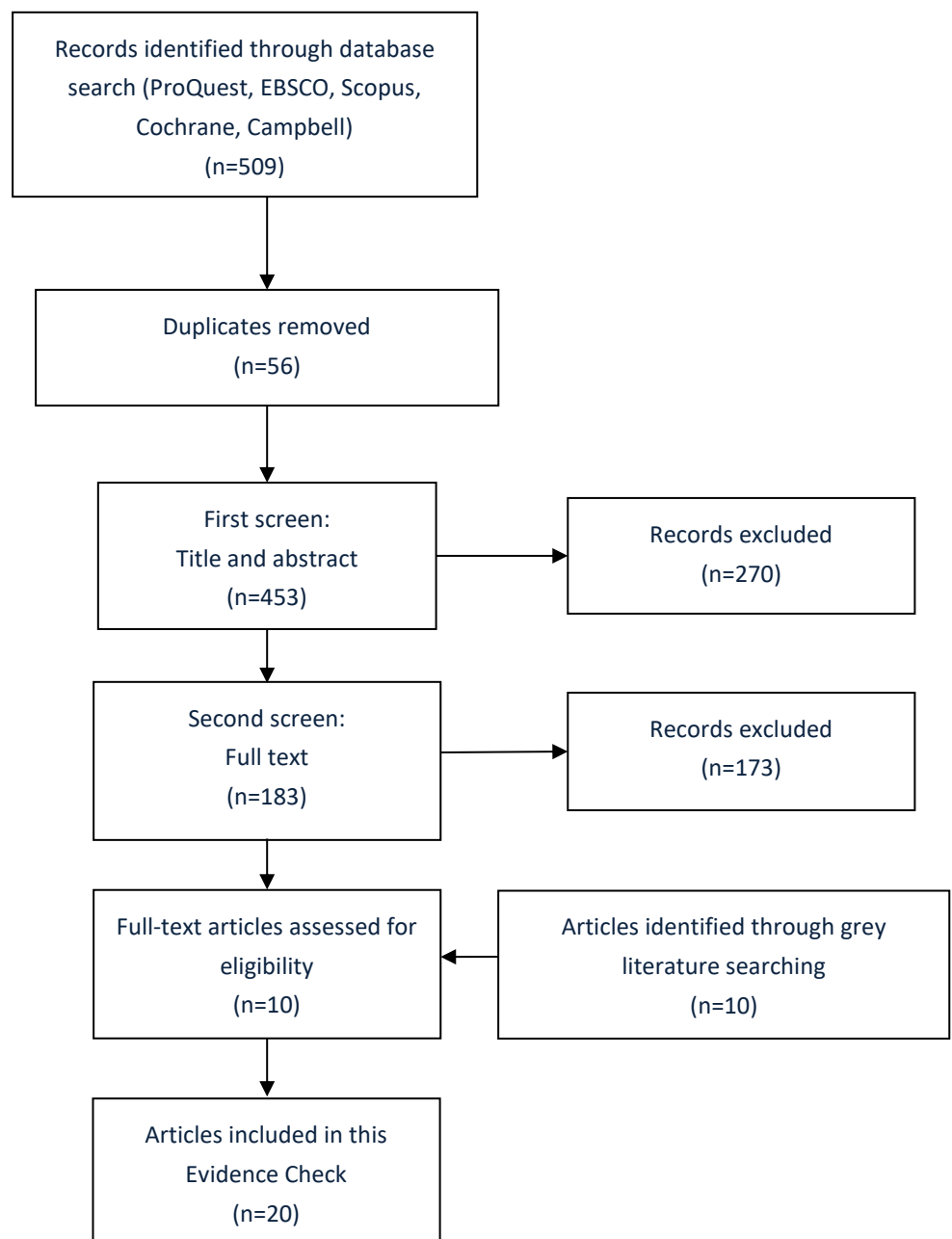
References

1.   National Health Service England. Framework for patient and public participation in Health and Justice commissioning. Leeds, UK: NHS England/Public Participation Team; 2017.
2.   Tiffen L, Peake H, Bailey A. How to effectively involve children and young people in commissioning. Preston, UK: Lancashire Childrens and Young People Trust.
3.   Dickinson H, Gardner K, Moon K. Outcomes-based commissioning and consumers. An Evidence Checkrapid review brokered by the Sax Institute for the NSW Department of Family and Community Services. June 2017. Sydney: Sax Institute; 2017.
4.   Cheesmond NE, Davies K, Inder KJ. Exploring the role of rurality and rural identity in mental health help-seeking behavior: A systematic qualitative review. Journal of Rural Mental Health. 2019;43(1):45-59.
5.   The World Cafe. World Cafe Method 2020 [Available from: http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/.
6.   Kretzmann J, McKnight JP. Assets-based community development. National Civic Review. 1996;85(4):23-9.
7.   NSW Government Communities & Justice. Building Stronger Communities: NSW Government; 2019 [Available from: https://www.dcj.nsw.gov.au/about-us/building-stronger-communities.
8.   NSW Government The Treasury. NSW Government Commissioning and Contestability Policy: Policy and guidelines paper. NSW Government; 2016.
9.   Gardner K, Davies GP, Edwards K, McDonald J, Findlay T, Kearns R, et al. A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy. Australian Journal of Primary Health. 2016;22(1):40-9.
10.   Henderson J, Javanparast S, MacKean T, Freeman T, Baum F, Ziersch A. Commissioning and equity in primary care in Australia: Views from Primary Health Networks. Health & Social Care in the Community. 2018;26(1):80-9.
11.   National Health Service England. Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England. Leeds, UK: NHS England.
12.   NSW Government. NSW Government Commissioning and Contestability Practice Guide. Canberra: NSW Government Treasury and Financial Services and Innovation; 2016.
13.   Costa DSJ, Mercieca-Bebber R, Tesson S, Seidler Z, Lopez A-L. Patient, client, consumer, survivor or other alternatives? A scoping review of preferred terms for labelling individuals who access healthcare across settings. BMJ Open. 2019;9(3):e025166.
14.   Lammers J, Happell B. Consumer participation in mental health services: looking from a consumer perspective. Journal of Psychiatric and Mental Health Nursing. 2003;10(4):385-92.
15.   Farmer J, Taylor J, Stewart E, Kenny A. Citizen participation in health services co-production: a roadmap for navigating participation types and outcomes. Australian Journal of Primary Health. 2017;23(6):509-15.
16.   O'Mara-Eves A, Brunton G, McDaid D, Oliver S, Kavanagh J, Jamal F, et al. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Southampton (UK): National Institute for Health Research; 2013.
17.   Sarrami-Foroushani P, Travaglia J, Debono D, Braithwaite J. Key concepts in consumer and community engagement: a scoping meta-review. BMC Health Services Research. 2014;14(1):250.
18.   Arnstein SR. A Ladder Of Citizen Participation. Journal of the American Institute of Planners. 1969;35(4):216-24.
19.   Popay J. Community empowerment and health improvement: the English experience. In: Morgan A, Davies M, Ziglio E, editors. Health Assets in a Global Context: Theory, Methods, Action. New York: Springer; 2010. p. 183-95.
20.   Daya I, Hamilton B, Roper C. Authentic engagement: A conceptual model for welcoming diverse and challenging consumer and survivor views in mental health research, policy, and practice. International Journal of Mental Health Nursing. 2020;29(2):299-311.
21.   Gee A, McGarty C, Banfield M. Barriers to genuine consumer and carer participation from the perspectives of Australian systemic mental health advocates. Journal of Mental Health. 2016;25(3):231-7.
22.   Brett L, Siette J, Nguyen A, Jorgensen M, Miao M, Westbrook J, et al. At the grassroots of home and community-based aged care: strategies for successful consumer engagement. BMJ Open. 2019;9(11):e028754.

23.   Nabatchi T, Sancino A, Sicilia M. Varieties of Participation in Public Services: The Who, When, and What of Coproduction. Public Administration Review. 2017;77(5):766-76.

24.   Beresford P. Public Participation in Health and Social Care: Exploring the Co-production of Knowledge. Frontiers in Sociology. 2019;3(41).

25.   Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AMN. Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Global Health Action. 2015;8(1):29842.

26.   Milton B, Attree P, French B, Povall S, Whitehead M, Popay J. The impact of community engagement on health and social outcomes: a systematic review. Community Development Journal. 2011;47(3):316-34.

27.   Bath J, Wakerman J. Impact of community participation in primary health care: what is the evidence? Australian Journal of Primary Health. 2015;21(1):2-8.

28.   Mason J, Association of Children's Welfare Agencies. Commissioning for outcomes in NSW – an NGO perspective. Redfern, Sydney: ACWA; 2018.

29.   Mathie A, Cunningham G. From clients to citizens: Asset-based Community Development as a strategy for community-driven development. Development in Practice. 2003;13(5):474-86.

30.   Lindsay C, Pearson S, Batty E, Cullen AM, Eadson W. Street-level practice and the co-production of third sector-led employability services. Policy and Politics. 2018;46(4):571-87.

31.   Bolzan N, Gale F. The Citizenship of Excluded Groups: Challenging the Consumerist Agenda. Social Policy & Administration. 2002;36(4):363-75.

32.   KPMG. Maranguka Justice Reinvestment Project: Impact Assessment. Report for Justice Reinvest NSW. Sydney; 2018.

33.   Kania J, Kramer M. Collective impact Stanford Social Innovation Review. FSG. 2011;Jan 21:36-41.

34.   Yap M, Yu E. Community wellbeing from the ground up: a Yawuru example, Bankwest Curtin Economics Centre Research Report No.3/16. Curtin, WA: Curtin University of Technology; 2016.

35.   National Health and Medical Research Council. NHMRC levels of evidence and grades for recommendations for guideline developers. Canberra: National Health and Medical Research Council; 2009.

36.   Carroll C, Booth A. Quality assessment of qualitative evidence for systematic review and synthesis: Is it meaningful, and if so, how should it be performed? Research Synthesis Methods. 2015;6(2):149-54.

37.   Carroll C, Booth A, Lloyd-Jones M. Should We Exclude Inadequately Reported Studies From Qualitative Systematic Reviews? An Evaluation of Sensitivity Analyses in Two Case Study Reviews. Qualitative Health Research. 2012;22(10):1425-34.

38.   Jun GT, Canham A, Altuna-Palacios A, Ward JR, Bhamra R, Rogers S, et al. A participatory systems approach to design for safer integrated medicine management. Ergonomics. 2018;61(1):48-68.

39.   Australian Government Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Consumer and Carer Engagement and Participation. Canberra: Commonwealth of Australia; 2016.

40.   Chadborn N, Craig C, Sands G, Schneider J, Gladman J. Improving community support for older people's needs through commissioning third sector services: a qualitative study. Journal of Health Services Research & Policy. 2019;24(2):116-23.

41.   Local Government Association, NHS Clinical Commissioners. Integrated commissioning for better outcomes: A commissioning framework. London: LGA and NHS Clinical Commissioners; 2018.

42.   Evans DH, Bacon RJ, Greer E, Stagg AM, Turton P. 'Calling executives and clinicians to account': user involvement in commissioning cancer services. Health Expectations. 2015;18(4):504-15.

43.   Schölvinck A-FM, Schuitmaker TJ, Broerse JEW. Embedding meaningful patient involvement in the process of proposal appraisal at the Dutch Cancer Society. Science and Public Policy. 2019;46(2):254-63.

44.   Healthcare Quality Improvement Partnership, National Institute for Health Research Collaboration for Leadership in Applied Health Care and Research. HQIP Case Study: Exploring Patient Involvement in Commissioning Services. Wessex, UK: HQIP and NIHRC LAHCR; 2015.

45.   Participation Works Partnership. How to involve children and young people in commissioning. London: Participation Works and British Youth Council; 2017.

46.   O'Shea A, Chambers M, Boaz A. Whose voices? Patient and public involvement in clinical commissioning. Health Expectations. 2017;20(3):484-94.

47.   Frawley T, Carroll L, Casey M, Davies C, Durning J, Halligan P, et al. Evaluation of a national training programme to support engagement in mental health services: Learning enablers and learning gains. Journal of Psychiatric and Mental Health Nursing. 2019;26(9-10):323-36.

48.   Community Services Industry Alliance. Commissioning for outcomes: An industry-led approach. Woolloongabba, QLD: CSIA; 2018.

49.		Sanders K, Omar SB, Webster J. Working collaboratively to develop a patient experience definition and strategy to inform clinical commissioning. International Practice Development Journal. 2015;5(2).

50.		Lorenc A, Robinson N. A tool to improve patient and public engagement in commissioning sexual and reproductive health and HIV services. Journal of Family Planning and Reproductive Health Care. 2015;41(1):8-12.

51.		Local Government Association, National Youth Agency. A Practical Guide to Commissioning Services for Young People. Part 10 Involving Young People in Commissioning. Leicester, UK: National Youth Agency; 2012.

52.		Petsoulas C, Peckham S, Smiddy J, Wilson P. Primary care-led commissioning and public involvement in the English National Health Service. Lessons from the past. Primary Health Care Research & Development (Cambridge University Press / UK). 2015;16(3):289-303.

53.		Hare P. Dementia without Walls: reflections on the Joseph Rowntree Foundation programme. Working with Older People. Community Care Policy & Practice,. 2016;20(3):134-43.

54.		NSW Family & Community Services. Aboriginal Consultation Guide. Sydney: NSW Government Department of Communities and Justice; 2011.

55.		Dudgeon P, Scrine C, Cox A, Walker R. Facilitating Empowerment and Self-Determination Through Participatory Action Research:Findings From the National Empowerment Project. International Journal of Qualitative Methods. 2017;16(1):1609406917699515.

Appendices

Appendix 1: Flow chart for article selection

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┌─────────────────────────────────┐
│ Records identified through      │
│ database search (ProQuest,      │
│ EBSCO, Scopus, Cochrane,        │
│ Campbell)                        │
│ (n=509)                          │
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│ Duplicates removed              │
│ (n=56)                           │
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┌─────────────────────┐          ┌─────────────────────┐
│ First screen:       │─────────▶│ Records excluded    │
│ Title and abstract  │          │ (n=270)             │
│ (n=453)             │          └─────────────────────┘
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┌─────────────────────┐          ┌─────────────────────┐
│ Second screen:      │─────────▶│ Records excluded    │
│ Full text           │          │ (n=173)             │
│ (n=183)             │          └─────────────────────┘
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┌─────────────────────┐          ┌─────────────────────────┐
│ Full-text articles  │◀─────────│ Articles identified     │
│ assessed for        │          │ through grey literature │
│ eligibility         │          │ searching               │
│ (n=10)              │          │ (n=10)                  │
└─────────────────────┘          └─────────────────────────┘
                │
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┌─────────────────────┐
│ Articles included   │
│ in this Evidence    │
│ Check               │
│ (n=20)              │
└─────────────────────┘
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Appendix 2: Data extraction tables

Author year (country)	Title	Study design	Aims	Peer-reviewed (PR) or grey (G)	Strength of evidence (/10)	Health (H), human services (HS)	Client group	Commitments required (reimbursement, training, staffing)	Recommendations and implications, as identified by the authors
Chadborn 2019 (UK)	Improving community support for older people's needs through commissioning third-sector services: a qualitative study	Purposively selected study sites, managers from NHS and local authority commissioning organisations (health, public health, social care) and third-sector groups (managers, key workers) invited to participate; members of existing user groups (representatives of older people) invited to take part in focus groups. They used a framework approach to analysis that *"facilitated the collation and comparison of data on similar topics elicited from the three stakeholder groups (commissioners, third-sector providers and the public). Emergent findings were discussed*	To explore whether service data from third-sector services was fed back to commissioners and whether this could improve intelligence about the population and hence inform future commissioning decisions	PR	7	H, HS	Older people in the community	Make better use of existing data being collected (underused resource); proposes use of standardised assessments of beneficiaries and collation of this data to inform service provision; partnerships between commissioners and third sector; knowledge and advocacy of third sector	Not all third-sector organisations are robust businesses. If the commissioning process ends up preventing third-sector commissioning, then the potential benefits will be lost. Disparities exist between the bureaucracy of commissioning governing bodies and third-sector processes. Assessment data collected by third-sector agencies (where commissioned to deliver contracts) is not used in the commissioning process and is an

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		with the wider study team and the study's External and Public Advisory Group (consisting of representatives from the East Midlands Later Life Forum. The advisory also included representatives of the health sector, third sector and academics). External and Public Advisory Group was consulted regularly on the design and management of the study. Preliminary findings were presented to interviewees for validation. In drawing the final inferences, findings were triangulated between the sampled groups (commissioners, third-sector providers and public representatives)"[(p. 119)]							undervalued resource. The third sector is considered a 'voice' for the community. Recommendations are to use third-sector agencies: as commissioned service providers, to assess needs, to engage with the 'voice' of the community; to build capacity of third-sector resources and recognise their organisational and administrative limitations, and where data is collected from clients in order to assess needs and outcomes, use it (that is how authentic needs can be understood)

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Evans et al. 2015 (UK)	'Calling executives and clinicians to account': user involvement in commissioning cancer services	Participatory evaluation with four qualitative case studies based on semi-structured interviews (n=22) with project stakeholders—consisting of National Cancer Action Team (NCAT) steering group professionals and cancer service users (patients and carers)—observation and documentary analysis. Users were involved in every stage from design to analysis and reporting; for example, some service users were recruited as project workers (field studies), and users were offered the opportunity to comment on the use of their information in the report	To identify how users were involved as local cancer service commissioning projects sought to implement good practice, and what has been learned	PR	6	H	Current or past service users (patients and their carers) of cancer chemo-therapy and radiotherapy services	It takes time to develop and sustain user involvement. *"Professionals need to allow sufficient time for genuine involvement because time is needed for training, familiarization and relationship building"*.[(p. 513)] Having senior management ownership (for example, taking an active interest, developing close working relationships) and commitment towards user involvement is critical	Few services users had prior experience of involvement in strategic committees and so would have benefited from training in this area. Users valued being involved from the start, being well briefed, having clarity about their roles, having peer-support, training, continuity, consistent feedback and information on how their involvement was impacting on services, and financial reimbursement
Frawley 2019 (Ireland)	Evaluation of a national training programme to	Participants in the training program completed an exit	To evaluate a PPI training program across nine regional	PR	8	H	Public and patient	In 2017, a training program was delivered to	Participants (service users, their families and carers) indicated

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	support engagement in mental health services: Learning enablers and learning gains	survey (self-reported learning gains) (n=54 surveys, RR 60%)	administrative units in a national mental health service				involvement in mental health services (forums)	forum participants (n=90) in each of the nine Community Healthcare Organisation (CHO) areas. The program was delivered over five days and consisted of the following themes: 1. Managing challenges and fostering resilience 2. Meeting skills; Leadership, team building and sustainability 3. Understanding our mental health services 4. Communi-cation and presentation skills	an overall positive experience but suggested all stakeholders should work together to co-produce the training (design, delivery and evaluation) and emphasise individual needs and local contexts. Training programs should be inclusive and not make artificial or actual distinctions between program participants who are health professionals and those who are non-professionals, such as service users. Participants wanted training in conflict resolution skills, interpersonal and facilitation skills and how committees work effectively

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Henderson et al. 2018 (Australia)	Commissioning and equity in primary care in Australia: Views from Primary Health Networks	Semi-structured key informant interviews (n=55) from 6 case study sites (Primary Health Networks servicing metropolitan, regional, rural and remote areas); involving 23 senior staff, 11 board members and 21 members of clinical and community advisory councils or health priority groups	Examine the impact of population health planning in regional primary health organisations on service access and equity	PR	9	H	Broad client group— Australian users of primary healthcare including mainstream and ACCHO (Aboriginal Community Controlled Health Organisations) services	Service redistribution requires collection of population health data; less fragmented service delivery (commissioning may not be most appropriate model)	Short time frames for commissioning process restricts community consultation. ACCHOs are already community-led and run (and are therefore a key point of community engagement). Outside providers may not have localised knowledge. Community engagement already exists within the models of governance in some organisations (particularly ACCHOs) —but commissioning processes may undermine these existing models by creating competition between community-led and 'outside' services

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Jun et al. 2018 (UK)	A participatory systems approach to design for safer integrated medicine management	Action research. Prior to workshops semi-structured interviews were carried out with 5 representative stakeholder groups (general practitioners, social care managers, community pharmacists, and commissioners). 3 participatory workshops planned and facilitated by method experts were held with 30 representative stakeholders (patients, carers, district nurses, GPs, community pharmacists, hospital pharmacists, hospital doctors, social care workers and commissioners) and evaluated (observations, document analysis and surveys)	1. Evaluate the outputs and the applicability (usefulness and ease of use) of methods for a participatory systems approach to health system design in the community setting 2. Identify practical challenges and requirements for successful application	PR	5	H	Older people and carers, stake-holders (general practice, social care, community pharmacists and Commissioners)	Detail not reported, but research team comprised 3 methods 'experts' and 3 healthcare professionals. Patients and carers were one of a number of stakeholder groups. Participation in workshops was inconsistent. Only detail on reimbursement noted that GPs were reimbursed due to requirement to backfill their roles during attendance	A participatory systems approach can be *"effectively and efficiently applied in the context of stakeholders' limited time for participation and their limited design knowledge".*(p. 59) However, there were concerns about the difficulty of recruiting 'hard to reach patients and carers' who were then under-represented, as were busy staff due to work commitments (healthcare professionals)

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Lindsay et al. 2018 (UK)	Street-level practice and the co-production of third-sector-led employability services	Semi-structured stakeholder interviews (n=62) were conducted with third-sector service providers (frontline managers, workers) and service users (n=71) from five local authority areas, over a 2-year period	Research questions: What evidence was there for co-governance and co-management of employment-seeking services under the 'Making it Work' (MIW) program and what were the implications for street-level services? What evidence was there of co-production of employability among service users and key workers? What were the facilitators of, and barriers to, effective co-production?	PR	6	HS	Lone parents with complex needs (disability, long-term unemployment, disadvantage) who are seeking employment (Scotland)	Time and resources for an extensive program of engagement and relationship-building at the start of the program[(p. 582)]; e.g. key workers engaged in leaflet dropping, door-knocking and connecting with healthcare services, childcare providers and community hubs	Third-sector and grassroots organisations were important for collaboration, co-management of services, and co-production. Governance and funding approaches based on partnerships (rather than contractualism and competition for outcomes) and localised models of service design and delivery (i.e. community development approach) aided collaboration (co-management of services and user voice co-production)

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Lorenc et at. 2015 (UK)	A tool to improve patient and public engagement in commissioning sexual and reproductive health and HIV services	The authors were commissioned to develop a patient and public engagement (PPE) training product / toolkit for commissioners of sexual and reproductive health services in London. This paper reports on that process and includes a description of the steering group and consultation phase		PR	4	H	Commissioners of sexual and reproductive health services	A steering group (voluntary sector, professional and clinical services, commissioners and patient representatives) was set up to guide the project and provide expert input throughout the process. From this, they developed an online resource, 'SHAPE' (Sexual Health And Public Engagement), with 11 instalments on different topics (strategic planning, procurement, performance management and improvement)	PPE may be affected by a lack of clarity, de-prioritisation, lack of expertise and public trust. Barriers to PPE included confidentiality, stigma, staff fear, organisational commitment, capacity, time, de-prioritisation, cost and skills/training. Stigma associated with sexual and reproductive health makes these the least likely to be heard voices

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O'Shea et al. 2017 (UK)	Whose voices? Patient and public involvement in clinical commissioning	Ethnographic two-phase study. Twenty-four observations across two types of clinical commissioning group meetings with patient and public involvement, follow-up interviews with NHS staff and lay members (n=14), and a lay member (patient, members of the public) focus group (n=5)	The paper aimed *"...to explore patient and public representation in a NHS clinical commissioning group and how this is experienced by staff and lay members involved"*[(p. 484)]	PR	9	H	Users of NHS clinical health services and lay people who were participants in NHS clinical commissioning groups	Role sustainability was an issue for lay members due to factors such as lack of IT skills and facilities and/or financial resources needed to travel to meetings	Importance of providing resources for PPI and clarifying the PPI role for patients and lay members (re expectations; group purpose; who they are meant to be representing or informing—especially when not associated with any particular organisation; how to contribute effectively). Other issues identified were participant representation and lack of diversity
Sanders, Omar and Webster 2015 (UK)	Working collaboratively to develop a patient experience definition and strategy to inform clinical commissioning	Patients, service users, carers, health and social care workers and representatives from the voluntary sector in north-west London. Various workshops, summits and forums were held to develop a shared definition of	To develop a shared definition of patient experience and a patient experience strategy to influence the clinical commissioning of care	PR	5	H, HS	Patients, service users, carers, health and social care workers and representatives from the voluntary sector and CCGs	Details not reported, but there was extensive engagement with diverse stakeholders, including patients and representative	Values underpinning the collaborative process were important, including: working collaboratively, being evidence-based, being asset-based (using first-person language and the

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		patient experience and a patient experience strategy to influence the clinical commissioning of care. Documentary synthesis and analysis was also used. Feedback and engagement was sought via existing groups such as the Clinical Commissioning Groups' (CCG) patient and public engagement committees, patient and carer groups						groups, via workshops, forums, etc.	direct words of users, and not translating them into jargon), being continuous and iterative. Working inclusively with service providers is critical to ensure their buy-in from the outset. Values-based approaches are effective for capturing the voice of patients, service users, carers and the community
Schölvinck et al. 2019 (Netherlands)	Embedding meaningful patient involvement in the process of proposal appraisal at the Dutch Cancer Society	Three-phase action and reflective case study on the involvement of ex-cancer patients reviewing grant proposals at the Dutch Cancer Society (DCS). Initially a Patient Advisory Committee of ex-cancer patients was involved in assessing proposals; later on, patient reviewers were installed on the	To explore: How can the embedding of meaningful patient involvement in proposal appraisal at DCS be enhanced, considering the facilitating and impeding systemic factors influencing such a development?	PR	5	H	People who have had diagnoses of cancer, ex-patients and patient reviewers	Lack of tools and formal structures for patient involvement impeded early efforts. This improved as patients' involvement moved towards formal roles on Scientific Committees	A cultural shift is required in order to include patients; some patient reviewers thought it important to stay abreast of developments and technical aspects, others considered they were there to represent their own stories and views. There was a lack of

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		Scientific Committee that reviews proposals. Semi-structured interviews with patient reviewers, policy staff and researchers (n=15); an intervention plan was developed and presented at 4 workshops attended by patient reviewers and patients; then followed by (third stage) meetings, evaluations and interviews							consensus about which research was considered worthwhile or relevant. *"More reflexivity is needed to incorporate patient involvement into the 'DNA' of all stakeholders. Emphasis on rules and regulations at an organization should be considered a starting point and backbone of the system's innovation"*(p. 262)
Australian Government Department of Health (n.d.) (Australia)	Primary Health Network primary mental health care flexible funding pool implementation guidance: Consumer and carer engagement and participation	Guidance tool developed by the Department of Health for the purpose of outlining Primary Health Networks' responsibilities and strategies for the engagement of consumers and carers in their work, including commissioning	To provide guidance about engaging consumers of primary healthcare services and their carers	G		H	People with lived experience of mental illness	Collaborative partnerships with Aboriginal and Torres Strait Islander communities, transcultural groups and services; contractual arrangements with service providers that	Consumer involvement is important at all stages of the commissioning cycle. Recognise diversity and use targeted approaches to include diverse groups (consumer, carer, advocacy, Aboriginal and Torres Strait Islander

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								require them to demonstrate a rights-based approach to consumers and carers	and transcultural). Ensure workforce development includes training about rights of consumers
Local Government Association (LGA) and NHS Clinical Commissioners 2018 (UK)	Integrated Commissioning for Better Outcomes: A commissioning framework	Framework developed by LGA and NHS Clinical Commissioners, then tested with sponsors and stakeholders and piloted with professionals. Intended audience for the framework is health, council and other allied commissioners. Details a framework for integrated commissioning in health and social care services and provides a useful list of resources	The purpose of the Integrated Commissioning for Better Outcomes framework is to support the general integration agenda across health and local government and promote consensus on good practice. The framework has been funded by Department of Health & Social Care (DHSC), and jointly commissioned by the LGA and NHS Clinical Commissioners (NHSCC)	G		H, HS	General public (health and social care consumers)	Joint analysis and plans; involvement at all stages including decommissioning; good information to service providers; tools such as surveys, personal visits, research	Focus on the benefits for the '3 Ps', people, places and populations, with the individual person at the heart of the approach. Draw on principles of community development: asset-based, co-produced, social capital, inclusive and equitable, empowerment

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Community Services Industry Alliance (CSIA) 2018 (Australia)	Commissioning for outcomes: An industry-led approach	Semi-structured interviews were held with a range of community service organisations, peak bodies, place-based collectives and relevant government departments, and rapid desktop review of policy and investment documents conducted	Interviews sought to provide greater understanding of where the journey towards commissioning for outcomes currently is in Queensland and provided local context to inform the recommended next steps. Explored commissioning for outcomes and how the community services industry can influence and shape a commissioning approach in Queensland that is focused on achieving better outcomes for at-risk children and families accessing child and family services	G		HS	Children and families, Queensland	Advocates for increased role of community services industry in commissioning and facilitating engagement with service users	To actively help shape a commissioning approach to child and family services in Queensland, the community services industry could: 1. Develop Community Service guidelines, principles and rules of engagement about how to engage service users across the commissioning cycle 2. Build capability in innovative ways in which to co-design and co-produce outcomes with service users. Key elements of the commissioning cycle where service users could make a significant

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									contribution are: co-design, co-production, developmental evaluation, insights (understanding needs)
Healthcare Quality Improvement Partnership (HQIP) 2015 (UK)	Case study: Exploring patient involvement in commissioning services	Service-user researchers recruited via voluntary groups, existing networks and university student recruitment. Service-user researcher advisory group formed. Service-user researchers developed methodology, collected and analysed data. Data collected through observation and participation in public commissioning board meetings, reflective diaries and workshop evaluation	The aim is to: 1. Determine the level of input and influence lay representatives have on commissioning 2. Explore what in the self-management arena is prioritised in commissioning, and how	G		H	Health service users	Service-user researchers designed and planned the project and undertook a series of observations of commissioning board meetings	Engage service users in evaluation processes, engage existing networks such as user groups. Manage expectations: recognise that research is a slow process—strategies are needed to sustain enthusiasm and engagement

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Lancashire Children and Young People's Trust (n.d.) (UK)	How to effectively involve children and young people in commissioning	How-to guide developed by members of the Lancashire Participation Network (LPN), which includes professionals from services and organisations that support implementation of the Lancashire Active Participation Strategy. Case studies from members of the network were also included	Members of the LPN developed a how-to guide for engaging with young people. The guide has recommendations and case studies from members of the network	G		H, HS	Children and young people; people wanting to engage with young people in commissioning services	Consideration should be given to valuing young people's contribution but also to implications for factors such as tax and income for payments; options for payment include payment, gift voucher, celebration, event, thank you card, services charge, recognised/ accredited certificate	Participation should happen at all stages of the commissioning cycle—a checklist provided to help design and evaluate young people's involvement in the commissioning cycle. Different approaches to participation may be required at different stages of commissioning. Draw on existing youth participation mechanisms and groups; consider diverse groups of young people and try to include young people with direct needs related to the services

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Local Government Association and National Youth Agency, n.d. (UK)	A Practical Guide to Commissioning Services for Young People	Guide developed by the National Youth Agency as part of the 'Routes to Success' program with the LGA. Includes various guidance resources and tools. Offers an overview of policy and legislative contexts, case studies and top tips for ensuring effective involvement by young people in commissioning. The guide also has a self-assessment tool to identify organisational strengths and weaknesses in involving young people in the commissioning process	To provide practical information on how to effectively engage with young people in commissioning (understanding, planning, doing, reviewing)	G		H, HS	Children and young people	Out-of-pocket expenses should definitely be covered, additional financial incentive may be paid, important to reward and recognise participation in other ways, such as accreditation	Trust young people; avoid tokenism; make clear young people's roles and ensure they understand the parameters of their involvement; young people's involvement should be as flexible as possible and should not be a one-off contribution; young people's involvement does not have to be through formal decision-making processes; allow sufficient time; provide support and training; provide feedback to young people on their involvement and what's changed; make it fun; recognise and celebrate involvement

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Mason J. and Association of Children's Welfare Agencies (ACWA) 2018 (Australia)	Commissioning for outcomes in NSW—an NGO perspective	Workshop conducted with government and non-government stakeholders involved in commissioning of services for children and families in NSW. From this, a series of semi-structured interviews was conducted with 20 representatives of organisations involved with out-of-home care (OOHC). Key documents and research reports were also analysed	To identify what kind of system the NGO sector is seeking for the commissioning of services such as OOHC, and the basis for NGO participation at various points in the commissioning cycle	G		HS	Clients of out-of-home care (OOHC) services	NGOs and peak bodies important advocates and potential connectors for engaging with children—peak bodies need to be adequately resourced to do the work	NGOs and peak bodies are important advocates and potential connectors for engaging with children—peak bodies need to be adequately resourced to do the work; rhetoric about child-centred practice and children's voices does not match with practice reality. Need accountability to service users. Shared accountability was impossible without clarity of roles between the department, providers and regulators

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National Health Service (NHS) England, n.d. (UK)	Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England	Statutory guidance for clinical commissioning groups (CCGs) and NHS England. Under the National Health Service Act 2006 CCGs and NHS England have duties to involve the public in commissioning	The aim of the guide is to support clinical commissioning staff to involve patients and the public in their work in a meaningful way to improve services, including giving clear advice on the legal duty to involve. The guidance links to an extensive range of resources, good practice and advice that will support staff to involve patients and the public	G		H	General public and clinical commissioning staff	Public involvement in governance; annual reports on public involvement; promote involvement opportunities in range of ways; consider legal duty to involve; asset-based community development approach	Reach out to people rather than expecting them to come to you; promote equality and diversity; seek participation from people who experience health inequalities; value people's lived experience; provide clear and easy to understand information; plan and budget for participation and involve people as early as possible; be transparent; tell people about the evidence base for decisions; invest in partnerships; review experience; recognise people's contributions and give feedback

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National Health Service (NHS) England 2017 (UK)	Framework for patient and public participation in Health and Justice commissioning	This framework to strengthen patient and public participation in health and justice commissioning was co-designed with members of a stakeholder group for Patient and Public Participation in Health and Justice Commissioning. Membership of this group includes user groups, the voluntary sector and commissioners	The aim of the framework is to describe how NHS England involves patients and the public in the commissioning of health and justice services. The intended audience are NHS commissioners of health and justice services, patients and carers, general public, voluntary sector, and providers of health and social care services. It includes case study information and an appendix of practical tips for commissioners	G		H, HS	Users of health and justice services, e.g. people in prison, families, children and their carers, immigrants and people from minority backgrounds, victims and survivors of sexual assault	Patient and public networks; tools for national and regional involvement; peer-led approaches; advocacy; bid evaluation teams; workshops and lessons learnt sessions; particular principles and strategies for groups such as offenders and victims	People using health and justice services may face specific barriers to engagement (e.g. stigma, disability, health and wellbeing needs, digital/remote access, non-English-speaking background and poor literacy). Involve people in ways that are appropriate to their needs and preferences, and provide them with the necessary information, resources and support to enable them to participate. Service users who have experienced serious assault or trauma may need emotional support to get involved. Report back to those you have involved about

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									the impact of their participation and explain how their participation has influenced commissioning, and if not, why not. Engage clients based on experience, diversity, equity, transparency, governance and assurance. Health and justice service users may have had poor experiences of engagement approaches previously and participation approaches may need to develop over time to build confidence. Mechanisms to consult and engage with service users should not add to system complexity

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Participation Works Partnership (PWP), n.d. (UK)	How to involve children and young people in commissioning	How-to guide about commissioning and ways to involve children and young people in the process, which was produced as part of the British Youth Council's Youth Voice program, with the Department for Education. Case studies including: panels of young people assessing tenders, work through youth organisation to facilitate sessions to identify young people's priority needs, Young Devon accredited training program for young commissioners	How-to guide about involving children and young people in commissioning services	G		H, HS	Children and young people	Identify champions within commissioning body and link these champions to young people and participation specialists; train and support the young people; clarify good participation practice with commissioners; long-term relationships; fun and creative approaches; clear feedback mechanisms; reward and recognise; opportunities for young people and commissioners to be in the same room; share expertise and resource	Prioritise evaluation at start and evaluate impact of participation and overcome some negative perceptions and fears about working with young people. Real involvement takes time and resources; give feedback; be flexible and avoid jargon; build the capacity of commissioners to work in participatory ways; plan involvement around children and young people's availability; build on current participation and relationships; involve adults from across the organisation— from senior executives, councillors and board members down; involve

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								across sectors; partnerships with diverse groups	groups of children and young people rather than isolated individuals; make it fun and accessible

Appendix 3: Summary of relevant evidence reviews

Citation	Gardner K, Davies GP, Edwards K, McDonald J, Findlay T, Kearns R, Joshi C, Harris M. A rapid review of the impact of commissioning on service use, quality, outcomes and value for money: implications for Australian policy. Australian Journal of Primary Health 2016;22(1):40–49. https://doi-org.ezproxy.newcastle.edu.au/10.1071/PY15148
Description and key points	A healthcare economics-focused systematic review of 36 papers against all aspects of the 'commissioning cycle' (O'Brien 2013). Papers from UK (30), Finland (1), US (4), New Zealand (1). No Australian literature found meeting the criteria. A lack of evidence overall substantially limits the ability to address the domains in question and to propose a preferred model.
Findings relevant to this Evidence Check	Consumer engagement is not an identified element in the commissioning cycle used for this Evidence Check. Predominantly, the studies reviewed focused on population groups (defined by geography) rather than subpopulation (defined by specific need within a geographic area). This contrasts with Australian commissioning practice where subpopulations, rather than populations, have been the focus. The discussion states that *"successful commissioning relies on detailed knowledge of service and sector as well as information sharing and networking"* (Checkland et al. 2012). Further, direction setting and decision making should be held at a local level to enable good commissioning outcomes. Investment in commissioning skills is critical. The European Observatory found *"engagement of consumers and providers … is critically important but has proven difficult to sustain"*. *"Trust and legitimacy for commissioning"* is built on the slow but crucial process of providers and consumers being informed and contributing to the commissioning process. This requirement must be mandated in policy. The authors indicate that the purpose and policy surrounding commissioning shape the nature of the process and the outcomes.
Key relevant messages	**Relationship building and legitimacy require a commitment of time and individual and political will as well as upskilling of practitioners and resourcing of consumers.**

Citation	Hare P. Dementia without Walls: reflections on the Joseph Rowntree Foundation programme. Working with Older People 2016;20(3):134–143. https://doi-org.ezproxy.newcastle.edu.au/10.1108/WWOP-06-2016-0012
Description and key points	An article focusing on a multi-activity program of work undertaken by the Joseph Roundtree Foundation (JRF) addressing dementia experiences outside institutional settings in the United Kingdom. It integrates learning

	from JRF evaluations and the program manager's reflections. A particular focus is on the movement to involve people with dementia and their families in policy; community and service delivery changes for people with dementia; and JRF's role in commissioning projects to achieve those ends.
	While the evidence includes independent program evaluations, the overall tone of the paper is discussion and reflection.
Findings relevant to this Evidence Check	People with dementia want to be setting the agenda for social change relating to dementia-friendly cities and be part of implementing meaningful projects. Funding bodies and higher-level organisations should not only consult but also enable consumer involvement in agenda setting through connecting local people and groups with opportunities to be involved and facilitating consumer-friendly contexts and processes
	Local groups need appropriate funding to ensuring capability to participate in agenda setting and decision making. But new groups may take time and support to establish themselves within an area. There is no magic fix for reaching people who are isolated. 'Social prescribing' by health professionals might help.
	The needs and capacities of people with dementia change with progression of the disease. Therefore, they need to see results from participation in a timely way and to have mechanisms and processes that accommodate changing abilities and needs.
	An enabling structure in one location, that supports community groups to contribute and flourish, may lead to those groups seeding or supporting groups in other areas.
	In this JRF program the fundamental motivation appears to have been *"how do we make processes more open to people with dementia and how do we ensure people with dementia and their families are setting the agenda for what needs to be done, how it should be done and by whom?"* rather than *"what input might they have as we generate services that will meet their needs?"*
	Specific tasks and activities in which people with dementia and their families participated are named (e.g. participating in panels deciding on project funding). These were described as positive processes with substantial learning for the organisation.
	This paper suggests a model of consumer involvement founded on an absolute ethos of meaningful engagement and participation of people who are affected by the decisions made and the projects implemented. It also includes the place of evaluation contributing to an action learning model for rollout of the program.
Key relevant messages	**Service-user participation in agenda-setting and project commissioning decision making is possible and desired by this group (people with dementia) but commitment is needed from the**

	relevant organisations and the processes need to be developed over time through an action learning approach.

Citation	Manthorpe J, Harris J, Mauger S. Older people's forums in the United Kingdom: civic engagement and activism reviewed. Working with Older People 2016;20(3):165–178. https://doi-org.ezproxy.newcastle.edu.au/10.1108/WWOP-02-2016-0002
Description and key points	Older people's forums are a model of advocacy in the UK with the members seeking to influence local, regional and national policy and practice on issues relating to older people. They are initiated and run by those they represent— by older people, for older people. In more recent times, active membership and funding are both declining. Model of research—scoping review. Academic and grey literature, not evaluated for quality, is described; lessons learned regarding membership, structures and effectiveness are presented. There is no information about the number of items reviewed.
Findings relevant to this Evidence Check	Membership of forums: these are self-organising, active lobby groups; as such, education, professional background or union membership, pro-social values (including religiosity), and health and financial stability lead to more active membership. Diversity of membership is more likely in London. People's active involvement is sustained by the rewards they experience. Motivations and prompts: A two-way process—doing something for the community or giving back at the same time as gaining personal wellbeing or reinforcing a positive sense of self. Practical motivations, such as responding to issues of concern and being heard by policy makers. Secondary benefits include getting information about government and where to get help as well as social activities and support. Change in life circumstances (e.g. retirement, bereavement) often lead to participation. Place, and making a contribution on 'hot topics' were stronger motivators for participation than people seeing themselves as service users. Getting broad, representative and highly active membership is difficult and currently not happening. Often the same people attend meetings or events and may represent the same perspectives each time. Structural aspects: Tiers of forums—local (of which there can be many in one geographical area) and regional (which represent concerns/interests regionally and nationally as well as engaging in capacity building for local groups). Levels of independence—fully independent; fostered by a local statutory body but without direction setting; created by a statutory body to provide advice to them. Effectiveness: Establishment of forums isn't quick or easy—time is required to build trust and develop credibility with potential membership as well as with policy makers etc. The continually changing landscape of government agencies, processes and planning groups was a barrier to forums'

	contributions. In one region, forum members' professional backgrounds provided skills and relationships/contacts to draw on for lobbying and reaching their goals. The more politically focused a forum becomes, the more internal contentions and conflicts may arise.
Key relevant messages	**Groups similar to older people's forums (that is, self-governing, representative groups with an established model and purpose) may provide an independent and pre-existing point of contact for engagement and participation in commissioning but they can't be considered to be representative and may need some resourcing to sustain their involvement over time.**

Citation	Petsoulas C, Peckham S, Smiddy J, Wilson P. Primary care-led commissioning and public involvement in the English National Health Service. Lessons from the past. Primary Health Care Research & Development 2015;16(3):289–303. https://doi-org.ezproxy.newcastle.edu.au/10.1017/S1463423614000486
Description and key points	In the UK service commissioning is one of the significant vehicles of patient and public involvement (PPI) in healthcare. It arose as part of the introduction of a market model for health service decisions that developed on the back of *"lack of public confidence in the way health and care services were run"*. Commissioning is done locally for acute and primary care and mental health and nationally for dental services, national General Medical Services contracts and specialist and tertiary services. Legislation in 2012 completely restructured these processes with a resulting emphasis on PPI as a 'duty' to ongoing engagement throughout the commissioning process.
	Method: a scan of literature relating to *"PPI only as it relates to primary care-led commissioning in the English NHS since the early 1990s"*. 116 papers were retained and reviewed from 607 original items retrieved. Realist evaluation frame of context-mechanism-outcome informed the analysis.
Findings relevant to this Evidence Check	Policies have emphasised PPI but success has been limited. Continual changes have been highly disruptive. Philosophically, PPI models sit on a spectrum between a democratic approach (restoring citizen and user voice) and consumerism (customer choice and satisfaction). Since 2013 new models of PPI have been rolled out.
	In late 1990s a new government emphasised and created new models for commissioning with PPI as a key intention; but with limited skills at the local level and short time frames with multiple priorities to be achieved, there was limited realisation of these intentions. Without substantial commitment to capacity building and social infrastructure to enable participation the models fell back to tokenism.
	New structures in place by 2004 ensured that a higher level of PPI involvement was achieved but the approaches taken lacked clarity and were inconsistently implemented. The commissioning bodies seemed to place emphasis on the existence of PPI processes but not on the effectiveness of

	PPI—that PPI existed, not that it made a difference. Reaching marginalised groups remained a difficulty.

The discussion is not positive about any ability to show effectiveness of PPI and any deep commitment to its principles or practice. For example: *"PPI remains a 'window dressing' exercise with actual implementation of policy by local managers being rather lukewarm and unsuccessful"*[(p. 296)]

The conclusion notes that there is little definition of what PPI is or of how to assess what effectiveness would look like. Therefore, assessing whether it is achieved or what it might be achieving is very difficult. |
| Key relevant messages | **Policies, structures and top-down imperatives do not achieve meaningful and <u>effective</u> input when these are not accompanied by useful definitions and stability in institutional structures and are not matched at the local level with a strong sense of purpose, agency and individual commitment to the process and outcomes. How to reach and engage marginalised groups is an open question in this research. It acknowledges the differences between active and passive, direct and indirect participation (as per Arnstein 1969).** |

Appendix 4: Additional resources

Peer-reviewed articles

Boivin A, L'Espérance A, Gauvin FP, Dumez V, Macaulay AC, Lehoux P, Abelson J. Patient and public engagement in research and health system decision making: A systematic review of evaluation tools. Health Expectations 2018;21(6):1075–1084.

Cheverton J, Janamian T. The Partners in Recovery program: mental health commissioning using value co-creation. Medical Journal of Australia 2016;204(7)(suppl.):S38–S40.

Coultas C, Kieslich K, Littlejohns P. Patient and public involvement in priority-setting decisions in England's Transforming NHS: An interview study with Clinical Commissioning Groups in South London sustainability transformation partnerships. Health Expectations 2019;22(6):1223–1230.

Reports and reviews

Dean, J, Silversides K, Crampton J, Wrigley, J. Evaluation of the Bradford Dementia Friendly Communities Programme. Joseph Rowntree Foundation, UK, 2015. Available from: www.jrf.org.uk/report/evaluation-bradford-dementia-friendly-communities-programme

Dickinson, H. Commissioning public services evidence review: Lessons for Australian public services. Melbourne School of Government, University of Melbourne, Australia, 2015. Available from: https://government.unimelb.edu.au/__data/assets/pdf_file/0004/2654428/Commissioning_Public_Services_Evidence_Review.pdf

Harden A, Sheridan, K, McKeown A, Dan-Ogosi I, Bagnall, A. Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK. Institute for Health and Human Development, University of East London, UK, 2015. Available from: www.nice.org.uk/guidance/ng44/evidence/evidence-review-5-community-engagement-barriers-and-facilitators-pdf-2368403681

Innovations in Dementia CIC, ECRED (The University of Edinburgh). Making an Impact Together: Sharing the learning on dementia activism from and across the DEEP network. Dementia CIC and ECRED, UK, 2016. Available from: www.dementiavoices.org.uk/wp-content/uploads/2016/11/Making-An-Impact-Together.pdf

NHS City and Hackney Clinical Commissioning Group. Patient and public involvement report 2018–19. NHS, UK, 2019. Available from: www.cityandhackneyccg.nhs.uk/Downloads/Get-involved/Patient%20and%20Public%20Involvement%20Report%202018-19FINAL.pdf

NHS Oxfordshire Clinical Commissioning Group. Annual report of patient and public involvement by Oxfordshire Clinical Commissioning Group, NHS, UK, 2018. Available from: www.oxfordshireccg.nhs.uk/documents/corporate/annual-report-patient-and-public-involvement.pdf

Randall, R. Consumer co-creation in health: innovating in Primary Health Networks. Australian Healthcare and Hospitals Association and Consumers Health Forum of Australia, 2016. Available from: https://ahha.asn.au/sites/default/files/docs/policy-issue/evidence_brief_14_consumer_co-creation_in_health_innovating_in_primary_health_networks_0.pdf

SERIO, Plymouth University. Public Engagement in Health: A Literature Review. Healthwatch England, 2018. Available from: www.healthwatch.co.uk/sites/healthwatch.co.uk/files/Healthwatch%20England%20Literature%20Review.pdf

Guides and frameworks

Department of Family & Community Services NSW. Aboriginal consultation guide. Department of Family & Community Services NSW, Australia, 2011. Available from: www.facs.nsw.gov.au/download?file=322228

Department of Health and Human Services Victoria. Client voice framework for community services. Victoria State Government, Australia, 2019. Available from: www.dhhs.vic.gov.au/publications/client-voice-framework-community-services?_ga=2.253459721.1419998329.1583279797-2141518279.1583279797

Healthcare Improvement Scotland, Scottish Health Council. Evaluating participation: A guide and toolkit for health and social care practitioners. Healthcare Improvement Scotland, 2013. Available from: http://scottishhealthcouncil.org/publications/research/evaluation_toolkit.aspx#.XjN3mCNxXIU

Ministry of Health. Commissioning Framework for Mental Health and Addiction: A New Zealand guide. Ministry of Health, Wellington, NZ, 2016. Available from: www.health.govt.nz/publication/commissioning-framework-mental-health-and-addiction-new-zealand-guide .

Moore T, McDonald M, McHugh-Dillon H, West, S. Community engagement: A key strategy for improving outcomes for Australian families. Australian Institute of Family Studies, Child Family Community Australia, 2016. Available from: https://aifs.gov.au/cfca/publications/community-engagement

Nabatchi T. A manager's guide to evaluating citizen participation. IBM Center for the Business of Government, US, 2012. Available from: www.businessofgovernment.org/sites/default/files/A%20Managers%20Guide%20to%20Evaluating%20Citizen%20Participation.pdf

Panos London. Beyond consultation: a guide for health commissioners. How staff and service users can work together to improve health services. Panos, UK, 2012. Available from: http://panoslondon.panosnetwork.org/wp-content/files/2012/03/Beyond-Consultation-a-guide-for-health-commissioners.pdf

Seale B. Patients as partners: Building collaborative relationships among professionals, patients, carers and communities. The King's Fund, UK, 2016. Available from: www.kingsfund.org.uk/publications/patients-partners

Suomi A, Freeman B, Banfield M. Framework for the engagement of people with a lived experience in program implementation and research. Lifespan Suicide Prevention Project, Australia, no date. Available from: www.blackdoginstitute.org.au/docs/default-source/lifespan/anu-lived-experience-framework.pdf

Tembo D, Morrow E, Worswic, L, Lennard D. Is Co-production Just a Pipe Dream for Applied Health Research Commissioning? An Exploratory Literature Review. Front Sociol 2019;4: 50. 10.3389/fsoc.2019.00050

User Voice. The Power Inside: The role of prison councils., User Voice, London, UK, 2010. Available from: www.uservoice.org/wp-content/uploads/2012/01/User-Voice-The-Power-Inside.pdf

Walker B, Public Health England. Service user involvement: A guide for drug and alcohol commissioners, providers and service users. Public Health England, 2015. Available from: www.gov.uk/government/publications/service-user-involvement-in-alcohol-and-drug-misuse-treatment

Youth Affairs Council of Victoria. Involving young people: Guiding principles. YACVic, Victoria, Australia, 2013. Available from: https://yerp.yacvic.org.au/get-started/involve-young-people/involving-young-people-guiding-principles