

**Evidence Check**

# Outcomes-based commissioning and consumers

An **Evidence Check** rapid review brokered by the Sax Institute for the NSW Department of Family and Community Services. June 2017.

Stages 1 and 2 of an **Evidence Check** rapid review brokered by the Sax Institute for the NSW Department of Family and Community Services.  
June 2017.

**This report was prepared by:**

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June 2017.

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**Suggested Citation:**

Dickinson H, Gardner K, Moon K. Outcomes-based commissioning and consumers: Stages 1 & 2: an Evidence Check rapid review brokered by the Sax Institute ([www.saxinstitute.org.au](http://www.saxinstitute.org.au)) for the NSW Department of Family and Community Services, 2017.

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# Outcomes-based commissioning and consumers: Stage 2 report

An **Evidence Check** rapid review brokered by the Sax Institute for the NSW Department of Family and Community Services.

June 2017.

This report was prepared by Helen Dickinson, Karen Gardner and Katie Moon.



Family &  
Community  
Services

**FACSIAR**  
INSIGHTS, ANALYSIS AND RESEARCH

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# Executive summary

Family and Community Services (FACS) New South Wales is working to improve its services through a focus on consumer outcomes. This reform process is informed by a new commissioning approach and the NSW Human Services Outcomes Framework. This review is one of a series commissioned to inform this process, building a picture of the evidence base about the most effective ways to improve consumer wellbeing.

FACS commissioned this Evidence Check via the Sax Institute, to improve its understanding of what models or approaches to outcomes-based commissioning of human services have been effective in improving client outcomes. This scoping review is the second stage in a two-stage review process on consumer engagement and outcomes-based commissioning and seeks to answer the following questions:

- When and how have consumers been involved in outcomes-based commissioning?
- Where consumer involvement is documented, what evidence of effectiveness in improving client outcomes is provided?

To answer these questions, we conducted a systematic review of the literature, exploring when and how consumers have been involved in commissioning processes and where it is reported whether evidence is provided of effectiveness of outcomes-based commissioning in improving client outcomes.

We searched academic and grey literature using a variety of terms relating to commissioning, outcomes and concepts specific to the eight different steps of the commissioning cycle. This process generated 2000 articles, accounting for duplicates. We reduced this number to 99 articles after applying study inclusion and exclusion criteria and, in the final sample, included 36 articles as relevant to consumer engagement and commissioning. The majority of these articles were from the English health sector and were commentaries or reviews rather than empirical research. These articles did not present original data but reviewed the notion of consumer engagement in the context of commissioning. There was a significant lack of large-scale quantitative studies.

From the review we identified attempts to engage consumers in all parts of the commissioning process, although a greater number focused on the first four stages of the process, suggesting most research has tended to focus on engagement in service delivery rather than commissioning. The majority of the articles described initiatives where consumers have been engaged in a range of different processes, with many outlining the challenges of undertaking such an activity.

We found a distinct lack of evidence relating to the effectiveness of outcomes-based commissioning in improving client outcomes. Although many sources described the theoretical benefits of consumer engagement, little empirical data existed to demonstrate these outcomes in practice. Within the literature we observed a distinction between two categories of perceived benefits of consumer engagement: 1) benefits for consumers participating in commissioning processes; and 2) improvements in services. A few studies suggested an effect of the benefits, fewer demonstrated improvements to services. Where these were indicated, improvements to services included improvements to service environments (e.g. decor, food) and improved access to services. The review revealed no evidence of the effectiveness of outcomes-based commissioning in improving client outcomes, even with a broad definition of 'evidence'.

Perhaps the most universal element of the reviewed literature was the detailed description of the challenges of consumer engagement in commissioning. The dominant challenges identified were:

- When and how have consumers been involved in outcomes-based commissioning?
- Lack of clarity about what consumer engagement means within the context of commissioning

- Limited detail of engagement processes and measurable effects of these processes
- Lack of evidence of the skills and competencies that professionals and consumers require to engage with these commissioning activities
- Lack of empirical evidence to demonstrate the most effective ways to engage consumers and describe the anticipated outcomes of that engagement
- Limited number of established methods to engage a representative number of consumers in commissioning processes
- Challenges associated with conducting meaningful and effective engagement.

The review offers a number of observations and lessons on best practice consumer engagement:

- Commissioning approaches typically seek to engage different types of stakeholders at various parts of the commissioning process and often for different purposes
- Groups or communities of interest may not be homogeneous and may display a great deal of differentiation in terms of needs, interests and motivations
- Some groups may prove difficult to engage in the commissioning process without careful safeguards being put in place
- Not everyone will welcome consumer engagement; for example, some professionals in particular may find consumer engagement a challenge to their expert belief
- Time is one of the greatest resources for effective consumer engagement in commissioning
- Engagement can be a difficult process and can claim much in terms of emotional resources.

The Evidence Check identified and provided some recommendations in relation to engaging consumers in the commissioning process, in particular that commissioners should:

- Not exceed their authority or fail to carry through on commitments, as this can lead to distrust in the commissioning process
- Be clear about who they are seeking to engage and for what purpose
- Give careful consideration to the ways in which different groups of consumers are identified and stratified
- Consider how the confidentiality of individuals can be maintained
- Tackle problems of stigma, fear and lack of appropriate skills
- Use a range of different means to achieve representativeness, which depends on who or what needs representation
- Consider how inequality will be addressed as part of any involvement process
- Think about how consumer engagement can be embedded within the entire organisational change agenda
- Commit appropriate resources to any consumer engagement activities.

Ultimately, we find engagement needs clarity of purpose and any approach should be tailored to this. Effective client involvement needs time and investment, and to embark on such a process without this can be counterproductive. There is a lack of evidence relating to commissioning and consumer engagement, which is challenging in terms of informing the development of these approaches but affords an exciting opportunity to build the evidence base. This means it is important to invest in rigorous measurement that includes looking at what activities are effective in improving client outcomes.

It should be remembered that commissioning is a young field, as are attempts at widespread consumer engagement. Over the next few years the field is likely to develop and grow in terms of the evidence base, provided, in part, that we achieve consistency in terms of how engagement and commissioning processes are described and measured.

# Introduction

Family and Community Services (FACS) supports more than 800,000 people across NSW both through direct service provision and non-government organisations (NGOs) that it funds to provide services. FACS aims to:

- Enable each child in NSW to have the best possible start to life
- Help vulnerable young people build their capacity for a good future
- Improve social and economic outcomes for Aboriginal people
- Provide support to vulnerable adults and families so they can participate fully in community life
- Build strong and inclusive communities.

FACS is attempting to improve how it measures the impact of services on clients by better capturing the effect of services on client outcomes, in addition to measuring outputs.

The NSW Human Services Outcomes Framework (the Outcomes Framework) was developed in 2015 and is used to focus FACS commissioning cycles on seven high-level wellbeing outcomes for clients and service users in the following domains: home; safety; education and skills; economic; health; social and community; and empowerment. Achieving and measuring the client outcomes in these domains is a FACS priority.

The Outcomes Framework helps focus FACS' collective effort on using the best-available evidence and data to inform how it commissions and delivers services and how it measures their impact on client outcomes. It makes transparent the continuum from what FACS delivers to how people benefit and what outcomes they achieve. The framework recognises that there are many effective interventions to support improved wellbeing across domains and also recognises linkages between each of the domains — i.e. increased wellbeing in one domain will have effects on wellbeing in other domains. The Outcomes Framework also identifies key stages in an individual's life cycle.

This Evidence Check is one of a series of reviews commissioned by FACS to inform the application of the Outcomes Framework to FACS. The reviews are building a picture of the evidence as to the most effective ways to improve wellbeing for FACS clients at each stage of their life in each of the domains. This review includes evidence of effective programs and services delivered to clients. It also looks at understanding how FACS can operate most effectively to design, commission and deliver services to its clients.

FACS commissioned this scoping review via the Sax Institute, to improve its understanding of what models or approaches to outcomes-based commissioning of human services have been effective in improving client outcomes. This review is the second stage in a two-stage review process on consumer engagement and outcomes-based commissioning. Stage 1 of the process comprised a literature search to determine whether there was sufficient evidence to answer questions about the link between consumer engagement in outcomes-based commissioning and improving client outcomes. In this scoping exercise, we found insufficient quality evidence to warrant a full systematic review of the evidence base (see Appendix 2). FACS determined that a new review should be conducted exploring the following questions:

- When and how have consumers been involved in outcomes-based commissioning?
- Where consumer involvement is documented, what evidence of effectiveness is provided?

This Evidence Check sets out the findings of the review and the presentation of the evidence relating to these two questions. As we demonstrate through this report, although much has been written about the importance of consumer engagement in commissioning and the positive impact this should have in theory, the evidence of practice is yet to catch up. Although a variety of different methods of engagement are identified in the evidence, these methods are often not well described and limited evidence is available as to

their effectiveness in improving client outcomes. Plentiful accounts of the challenges of engagement exist within the evidence base and there is a sense that engaging consumers in commissioning processes can be a difficult and resource-intensive process.



# Background

Before setting out an account of the methodology adopted in this study, we first provide an overview of what outcomes-based commissioning is conceived to be within the context of the FACS review process. 'Commissioning' is a term that has gained currency only recently in the Australian policy context. As noted by a number of authors, no single authoritative definition of commissioning exists and the term means different things to different people.<sup>1,2</sup> The definition of commissioning that FACS works with describes it as "a process of determining cost, client and community outcomes — taking into account needs and assets — to select, design and evaluate the most resource-efficient service or response and, if applicable, contract options to ensure effective delivery of results over the short and long term". The idea is to take a more holistic approach to achieving client and community outcomes and to deliver more targeted services. An important part of this process is engaging with a variety of stakeholders to ensure that effective outcomes are delivered.

As the above definition suggests, commissioning is a complex process that typically comprises a number of different functions. As such, commissioning is often presented as a cycle made up of a series of different stages of activity. Figure 1 sets out an overview of the FACS commissioning cycle, demonstrating the eight different stages that make up this approach. Each of the different stages is in itself a complex set of activities. Table 1 breaks down the different steps in the commissioning cycle, describing what each step is intended to do and why it is important. It should be noted that subsequent to the commencement of this project, the wording of the FACS commissioning cycle has been amended slightly, although this does not have significant implications for the findings of this Evidence Check.



Figure 1: FACS commissioning cycle

**Table 1: Description and importance of the eight steps in the FACS commissioning cycle**

<b>Step</b>	<b>Description</b>	<b>Why this step is important</b>
Assess needs and resources	Understand your target population and the resources available to meet their needs	Helps us to define outcomes in client terms
Agree outcomes	Define and prioritise outcomes and the sequence of achievements needed to meet them	Helps us focus on clients by underpinning all commissioning steps with agreed outcomes
Design services and responses	Design and cost each of the services and processes that will form an integrated system	Helps us base responses on evidence, which could include formal research and client and frontline experience
Define roles	Define all roles and responsibilities in the service system	Helps us hold each player accountable for their contribution to client outcomes
Shape supply	Actively manage the market to ensure the right amount and quality of services can be provided	Helps us make available a market that can perform the roles required for the system to work optimally
Procurement	Develop and execute the procurement strategy to engage the providers	Helps us set clear performance expectations with providers
Manage performance	Manage the performance of the system and provider to ensure expectations are met	Helps us measure how the system is performing against expectations and to continually improve performance
Evaluate outcomes	Determine whether outcomes are being achieved and identify opportunities for systematic change	Helps us determine whether what we did had an impact on client outcomes and to systematically improve outcomes

Having set out the background to the FACS commissioning approach, we now move on to provide an account of the methods adopted in this project.

# Methods

In this section we set out an account of the methods we adopted in this systematic review of the literature. In this Evidence Check we examined all steps of the commissioning cycle to identify when and how clients have been involved in outcomes-based commissioning processes and, where this is reported, whether there is evidence of effectiveness of outcomes-based commissioning in improving client outcomes.

## Peer review literature

We undertook preliminary iterative searches of the literature in the databases below.

- ProQuest
- Scopus
- PsycInfo
- Medline
- Cochrane and Campbell Collaborations

We identified a series of search terms for each of the stages in the FACS commissioning cycle so that we could source material relevant to these broad activities (Table 2). For each step in the cycle, we entered a set of search terms into the databases (type of intervention, outcome of interest, engagement, relevant search terms for step, Table 3). These terms had been tested in a previous scoping review (see Stage 1 report) to ensure that they would capture the most relevant articles. We scanned the article titles to identify those that were potentially relevant.

**Table 2: Search terms for each step in the FACS commissioning cycle**

Step	Commissioning cycle step terms
Step 1: Assess needs	"Needs assess*" OR "Service plan*" OR "Regional plan*" OR "Workforce plan"
Step 2: Agree outcomes	"agreed outcome" OR "agree outcomes"
Step 3: Design services	"service" AND "design" OR "redesign" OR "coproduction" OR "co-production"
Step 4: Define roles	"role"
Step 5: Shape supply	"Service redesign" OR "Commissioning" OR "Decommissioning" OR "Shape suppl*" OR "Provider develop*" OR "Market develop*" OR "Priority setting" OR "set priorit*" OR "Resource allocation" OR Ration*
Step 6: Procurement	Contract* OR Contest* OR "Value-Based Purchas*" OR "Managed Care" OR "Group Purchas*" OR Reimburs* OR Incentiv* OR "Pay for performance" OR "pay-for-performance"
Step 7: Manage performance	"Performance manag*" OR "Performance measur*" OR "Performance Monitor*" OR "Contract manag" OR Accountab*
Step 8: Evaluate outcomes	"evaluat*" OR "success"

**Table 3: Search terms across all steps of the FACS commissioning cycle**

Grouping	Search terms
Type of intervention	Commissioning OR "social impact bond*" OR "pay for performance" OR contestib* OR "payment by result*" OR "outcome* based contracting" OR "outcomes based funding" OR "outcome* based payment"
Outcome of interest	Outcome* OR "client satisf*" OR "client enabl*" OR "patient experienc" OR "patient reported outcome" OR "patient-reported outcome" OR "quality of life" OR "quality of lives"
Engagement	"Consumer engagement" OR "Consumer involvement" OR "Consumer collaboration" OR "Consumer consultation" OR "Consumer partnership" OR "Consumer choice" OR "Consumer feedback" OR "Patient engagement" OR "Patient involvement" OR "Patient collaboration" OR "Patient consultation" OR "Patient partnership" OR "Patient choice" OR "Patient feedback"

### Study inclusion criteria

We included studies conducted since the year 2000 and incorporated key aspects of commissioning, including, but not limited to, health, education and justice services. To increase the number of potentially relevant studies, we did not specify a focus for client groups nor did we impose a restriction regarding methodological quality. To be included, studies had to report on commissioning or key elements or activities of commissioning processes and consumer engagement. Qualitative and quantitative studies were included as were reviews, commentaries and relevant expert opinion pieces.

### Study exclusion criteria

Studies were excluded if they did not explicitly include some elements of commissioning and report on at least some aspect of consumer engagement. Many articles used the term 'commission' or 'commissioning' in a way that was unrelated to the concept as used by FACS. A large number of articles also spoke about topics in a general sense (e.g. health) and mentioned commissioning in passing, but did not provide any commentary about this or how it had been implemented. Other articles focused on commissioning in research, for example health research. Newspaper articles, theses and conference proceedings were also excluded. See Figure 2 for an overview of the PRISMA framework.

### Grey literature

We undertook preliminary searches of the international grey literature, focusing predominantly, although not exclusively, on health sources as this is where most international experience in commissioning is found. In doing so we searched the following: The King's Fund, The Health Foundation and The Nuffield Trust.

We examined the grey literature within Australia, including information contained on the websites of specific programs, such as Headspace, Partners in Recovery (PIR), the National Disability Insurance Scheme, Primary Health Care Research & Information Service (PHCRIS); Home and Community Care (HACC) and programs within the Department of Veterans' Affairs (e.g. Home Care and telehealth programs such as Health Direct Australia).

### Relevant articles

Across the five databases, the search terms generated a total of 2866 articles from within the peer review literature. Removing duplicates reduced the number of potentially relevant articles to 1991. Applying the study inclusion criteria, we generated a list of 99 relevant articles. The 99 identified articles were retrieved and read in full, at which point a further 68 articles were excluded. The remaining 31 articles were read in detail and analysed according to the types of activities, and impacts reported, related to the commissioning cycle step. A further five articles were identified through a review of references within these articles (see Figure 2).

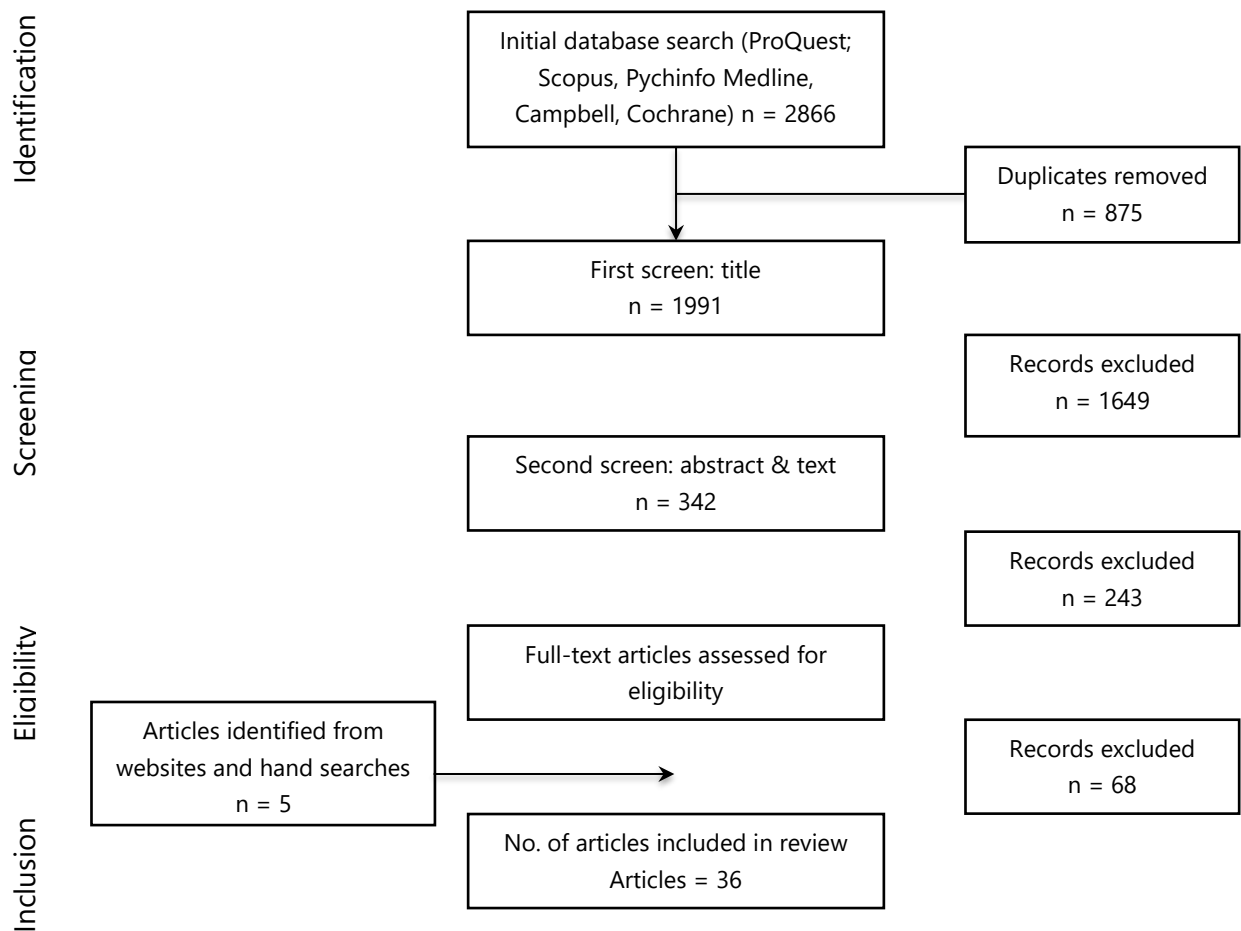


Figure 2: PRISMA framework detailing the numbers of articles excluded through screening and eligibility processes

Table 4: Searched databases, total number of articles returned using search criteria for each of the steps in the FACS commissioning cycle, less duplicates

Database	Step in commissioning cycle								TOTALS	Less duplicates
	1	2	3	4	5	6	7	8		
ProQuest	32	348	38*	66*	169	139	84	59*	935	248
Scopus	60	1	297	397	250	654	282	529	2470	1226
PsycInfo	8	0	0	0	2	80	22	0	112	98
Medline	94	0	0	0	92	237	617	0	1040	956
Cochrane and Campbell Collections <sup>^</sup>	-	-	-	-	-	-	-	-	44	23
<b>TOTALS</b>	<b>194</b>	<b>349</b>	<b>335</b>	<b>463</b>	<b>513</b>	<b>1110</b>	<b>1005</b>	<b>588</b>	<b>2866</b>	<b>1991</b>

\*First search term in title, given at least 1000 returns and up to 3600.

<sup>^</sup> It is not possible to search the Cochrane and Campbell Collections by the step in the commissioning cycle so results are displayed as a total.

## Data analysis

All relevant articles were imported into NVivo, a qualitative data analysis software program, to be coded. To test the coding framework the three authors coded the same four articles, selected at random from the final set of papers to be included in the study, to ensure a high level of inter-coder reliability. Where codes were applied differently, the researchers refined and re-defined the codes to ensure consistency in the coding process. Once the final list of codes was agreed, the articles were divided among the researchers, who each undertook manifest content analysis.

## Coding results

The results of the coding can be summarised according to the total number of sources (i.e. the number of articles that were coded to a particular code) and references (i.e. the total number of codes assigned across all articles) (Table 5). The codes most commonly assigned were challenges, method of engagement and description of benefit. The codes least commonly assigned were to each of the steps in the commissioning cycle. Note that we applied codes irrespective of whether the authors were talking about the concept in general or specific terms to ensure that the greatest amount of material was available for further analysis. This approach meant that not all of the references necessarily provided useful information, but this data is indicative of the relative distribution of the literature base.

**Table 5: Codes developed for consumer engagement within each step of the FACS commissioning cycle**

Code	Sources	References
1. Consumer engagement description	11	19
2. Description of benefit	15	31
3. Method of engagement	15	38
4. Challenges	22	97
5. Engagement in step 1 in cycle	6	13
6. Engagement in step 2 in cycle	2	2
7. Engagement in step 3 in cycle	8	11
8. Engagement in step 4 in cycle	1	3
9. Engagement in step 5 in cycle	2	2
10. Engagement in step 6 in cycle	1	1
11. Engagement in step 7 in cycle	1	5
12. Engagement in step 8 in cycle	1	4
13. Outcomes measured	5	14

**Table 6: Codes developed for consumer engagement within steps of the FACS commissioning cycle**

Reference	Code												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Alborz et al. 2002			X	X			X						
Anderson et al. 2017		X	X	X		X					X	X	
Attree et al. 2011		X		X	X	X	X		X				X
Baldwin and Wilson 2009		X	X										
Batalden et al. 2016							X						
Bechtel et al. 2010							X						

Barker 2015		X	X	X																
Bradshaw 2008		X	X	X																
Carr et al. 2011		X	X					X												
Cheverton and Janamian 2016		X	X	X																
Coleman et al. 2009	X			X																
Cotterell et al. 2011		X		X																
Evans et al. 2015		X	X	X	X															
Gandy and Roe 2013	X	X																		
Gates and Statham 2013	X																			
Gott et al. 2002								X												
Horridge et al. 2016	X				X															
Hudson 2015	X	X																		
Ingold and Hicks 2015	X	X																		
Katterl et al. 2011					X															
Lorenc and Robinson 2015		X	X	X																
Martin 2009	X	X		X										X						
Millar et al. 2016	X	X		X																
O'Shea et al. 2017				X	X															
Panzera et al. 2016				X	X			X	X											
Paterson 2004				X	X															
Petsoulas et al. 2014																				
Petsoulas et al. 2015				X	X															X
Sampson et al. 2012	X			X																X
Sanders et al. 2015	X			X																X
Schehrer et al. 2010				X	X	X									X					
Sexton 2010	X			X																
Sloper 2003								X												
South 2004				X	X															
Watt et al. 2000																				
Webster 2016				X																X
Wise 2011				X																

\* Refer to Table 4 for code names.

Having set out the methodology used to generate the evidence base we now move on to examine the findings.

# Findings

In this section we report on the findings derived from the literature search. For each of the findings sections we provide first a high-level account of our findings and then move into the detail. For further insight into the individual sources, Appendix 1 provides an overview of the included articles along with detail of the methods employed and the implications drawn by authors concerning consumer engagement in commissioning processes.

As Appendix 1 illustrates, the articles generated through the review process were dominated by studies from the health sector. This finding is perhaps to be expected given that commissioning has probably garnered greatest traction within the health field to date.<sup>1</sup> The sample is also dominated by contributions from a British context, most typically from England, again representing where the major portion of this evidence lies. In terms of the methodologies adopted in these various studies, we find a great majority are commentary or review pieces that do not present original data but review the notion of consumer engagement in the context of commissioning approaches. Where sources comprise empirical research, these articles are typically qualitative approaches or mixed methods, with a significant lack of large-scale quantitative studies within the sample we collected. Moreover, most of the research reported tends to relate to the experiences of different stakeholders through the processes of consumer engagement, rather than interrogating the outcomes of this engagement in terms of commissioning.

## **Question 1: When and how have clients been involved in outcomes-based commissioning?**

The initial intention of this review process was to identify and examine the different stages of the commissioning cycle in the articles reviewed. This task proved to be challenging given that most of the articles reported on particular commissioning activities or approaches and did not necessarily distinguish between different parts of the commissioning cycle. Many articles included in the review reported on activities that cross different stages of the commissioning cycle. Overall, we found limited detail in these accounts.

In the sections below, we present findings relevant to the four double-steps of the FACS commissioning cycle and present evidence relating to these functions along with relevant cases where consumers have been engaged in the commissioning process. However, it is important to note that in many cases there are just brief descriptions of the interventions, with most of the reporting concerned with various stakeholders' experiences of these processes. Within these articles, we found a greater number of sources of evidence that related to the first four stages of the commissioning process rather than the latter four. Evans et al. provide an explanation for this, arguing that most research has focused on engagement in service delivery, "*with relatively little attention to commissioning*".<sup>3</sup> (p. 505) Schehrer and Sexton<sup>4</sup> expand on this, explaining that experience to date has concentrated on provision and development of existing services, because the focus is often on what currently takes place rather than informing or shaping future provision. The tension between current and future commissioning needs is something we will return to on a number of occasions in this Evidence Check.

### **Assess needs / agree outcomes**

These parts of the commissioning process are concerned with understanding the target populations and the resources available to meet their needs, and then defining and prioritising outcomes and the sequence of achievements needed to meet them. Overall, we found a number of initiatives that engaged consumers so as to better understand the needs of different consumer groups. Typically, these initiatives tended to focus on examining operational issues rather than engaging in more strategic planning activities. As such, there are a number of examples of the impact that this involvement had in terms of changing practices or



information sources, but less evidence of this having an impact in terms of consumer wellbeing more broadly.

A number of the studies within the Evidence Check<sup>5-7</sup> reported seeking to engage consumers in activities to help provide better insights into particular populations and to prioritise outcomes, incorporating a range of different approaches. Within these approaches we can distinguish between some that are more passive in the sense that they involved the collection of service-level data or preferences via satisfaction surveys or questionnaires. More active approaches typically engaged consumers in groups or boards with specific remits about aspects of data collection and/or decision-making.

Barker<sup>8</sup> reports on a range of different initiatives to achieve better consumer engagement in orthopaedic surgical interventions. The review reports that a range of tools and methodologies have been used to try to “capture the patient voice, but traditionally there is a reliance on patient satisfaction questionnaires, NHS inpatient surveys, collation of patient-reported clinical outcome measures and data from complaints, incidents or patient liaison services contacts”.<sup>8 (p. 70)</sup> Many of these initiatives aimed to garner better insights into consumer perspectives regarding treatment preferences and priorities to balance the perspectives of professionals and treatment protocols.

Similarly, Horridge et al.<sup>7</sup> report on a project to develop a Disabilities Terminology Set and quantify the multifaceted needs of disabled children and their families in a district disability clinic population. This data was to be used to develop local care pathways and for service planning. Consumers and families were engaged within this process via a ‘traffic light tool’ that was completed in the waiting room at disability clinic review appointments. This tool covered a variety of different areas and aimed to enable families to bring the issues that mattered most to them to the consultation process. These were then captured in the follow-up clinical letter and the children’s electronic health record. The 8392 electronic clinical letters covering 1999 children were then reviewed and, as a result of this process, a number of additional terms were developed that captured the multifaceted needs of children with disabilities in detail.

Attree et al.<sup>6</sup> report on a qualitative study into the engagement of stakeholders in cancer services. Partnership groups were established across various case study sites that sought to improve cancer services through the engagement of a range of partners. Approaches to these activities varied across the sites, with consumers involved in different activities, although Attree et al. noted these activities tended to be more ‘operational’ rather than ‘strategic’. For example, many of the groups were garnering the experience of consumers so that the type and quality of information available to patients and carers could be improved (e.g. through redesigning leaflets and web resources). Fewer examples were given where consumers had influenced resource allocation decisions, although at one site it was reported that consumers had influenced the spending of a significant amount of money in a different way from what healthcare professionals had initially planned.

Building on the experience of the networks reported by Attree et al., Evans et al.<sup>3</sup> report on multidisciplinary steering groups that were established to bring together commissioners and consumers to improve cancer services. The authors report in this qualitative study that these steering groups used a “mixture of consensus discussions, short presentations, a dragon’s den exercise and open space discussions”.<sup>3 (p. 20)</sup> to identify priority principles and recommend practical action. However, beyond mentioning these mechanisms little else was provided of their detail.

Watt et al.<sup>9</sup> report on a qualitative study designed to investigate childcare needs in Scotland. The authors note that previous approaches to this kind of exercise have struggled to elicit sufficient and quality information from consumer groups. Part of the reason for this is that consumers are overwhelmed with demands on their time and do not see the value of engaging in this kind of activity. A further reason relates to the inaccessibility of some approaches to garnering information from these groups. These authors report employing a participatory research approach, where consumers were engaged to help design the processes

and tools that would be used to elicit data. As a result, the questionnaire that had previously been used to collect data was replaced by more deliberative and face-to-face processes of discussion. The authors report that commissioning professionals and consumers rated the revised process as significantly better than the previous approach.

Katterl et al.<sup>10</sup> compares the different needs assessment processes within primary healthcare organisations across Australia, New Zealand, England, Scotland and Canada. One aspect the review focuses on is consumer engagement. The report notes community based approaches that rely heavily on public consultation and consumer involvement in determining priorities and needs were popular within primary care in the past, but are less used today. The team suggests this is perhaps due to the amount of time these processes take, but also is possibly due to a perceived loss of control over priorities by health authorities. All the countries involved in the review have introduced legislation requiring health organisations to consult the public and some have established formal community consultation groups when undertaking needs assessment and health service planning. The composition of these boards varies across countries, typically comprising healthcare professionals, organisational managers, consumer representatives and the public. Overall, the research found there are a number of points at which consumers might be engaged in needs assessment processes. The review suggests the development of a framework that explicitly lists consumers' roles and what they should expect to happen with any information that they provide could assist in managing expectations. Such an example of community engagement is offered in New Zealand and has been used to variable success (Coster et al.)<sup>11</sup>

Sloper and Lightfoot<sup>12</sup> undertook a survey exploring the ways in which children and young people with physical disabilities or chronic illness had been engaged by commissioners of services. Only 27 initiatives were found within the whole of England over a period of 12 months, although the authors note this is likely an under-representation of the actual number. These initiatives focused on different parts of the commissioning cycle, and the authors do not break them down according to specific elements. However, it is of note here as the authors report that changes were made to commissioning priorities as a result of some projects. What was common across these different initiatives is that they were typically initialised and designed by adults. Only one project was identified that was designed and initialised by children and young people, suggesting that genuine co-production was missing in many cases. A range of different methods were used to engage children and young people. These included a graffiti wall, group discussion, individual discussion, question-and-answer sessions, a steering group, relaxing/eating out, visual arts, design, drama, drawing, role-play/drama, making videos and photography. Of these methods the verbal approaches (discussion) were most common. Initiatives often used more than one method and consulted children both individually and in a group. Although children had involvement in decision-making in a few examples, this was rarely direct and typically happened via committees or intermediary groups.

In their opinion piece study of health and social care commissioning, Schehrer and Sexton<sup>4</sup> see a tension in needs assessment processes caused by the understanding of key terminologies. They argue the difference between need, want and aspiration is not as clear as it may appear. This can pose challenges for consumer engagement in differentiating between these ideas. It is also important to note that the needs of individuals and populations are not static and will change over time and place. So, too, are there tensions between the needs assessment models of different agencies. For example, different assumptions will underlie the way health organisations conduct needs assessments from, say, human services departments. It has often been argued that engaging consumers should help overcome this dissonance — after all they are not institutionalised into the same ways of thinking. However, these authors found that as consumers navigate or experience these different assumptions on a day-to-day basis, they often mirror them, separating their needs according to different government agencies.

## Design services / define roles

These aspects of the commissioning cycle are concerned with designing and costing services and processes and defining roles and responsibilities in the service system. Most of the sources we found in the Evidence Check process were concerned with aspects of service design rather than defining roles. Again, a variety of initiatives and factors described in the literature contributed to the relative success of service design. The overwhelming message from these discussions is that any approaches need to be specifically designed for their purpose and this can be a time-consuming and challenging process to make successful.

The examples in the previous section relating to networks and steering groups also played a role in service design and defining roles within systems. Martin<sup>13</sup>, in a qualitative report, suggested consumers were involved in commissioning discussions regarding services, *"sitting alongside service staff as they made their case for extensions of funding or coverage"*.<sup>13 (p. 6)</sup> In this case the involvement of consumers was typically to act as advocates alongside existing service providers to support providers to win more funding or responsibility. The report concluded that consumer engagement was considered crucial by providers because the real-life experience of these individuals was able to counter aspects of the formalised data compiled by commissioners.

Carr et al.<sup>14</sup>, in a qualitative study, reported on the effect of different governance models on the development of service redesign proposals within English primary care services. They drew attention to the work of Bate and Robert<sup>15</sup> and their model of experience-based design (ExBD). This method is a continuation of existing improvement methods linked to ideas from the social movement literature that focus on citizen- or user-led initiatives for change (Bate et al.)<sup>16</sup> The two core elements of ExBD are the experience element, which focuses on improving the whole experience of the product or service, and the participatory element, which directly involves users in the design and development of a product or service. ExBD is about co-designing services, seeing consumers as co-designers of products and services and therefore integral to the improvement and innovation process (Bate and Robert).<sup>17</sup> A range of tools have been used in ExBD, many of which follow a process of Appreciative Inquiry, which seeks to understand user 'journeys' and 'experience maps', highlighting 'touch points', which are the points of contact with services that have particular emotional or cognitive resonance (Bate and Robert).<sup>17</sup>

Drawing on this work, the organisations that Carr et al.<sup>14</sup> researched adopted a variety of different methods to engage consumers and share their experiences. As these authors describe:

*"One PBC [Practice-Based Commissioning] group, when redesigning the stroke care pathway, benefited greatly from the input of local chapters of stroke support associations, which offered valuable insights into their experiences of the healthcare and rehabilitation services, sharing the stories, memories, and impressions of both patients and carers. The GP lead also took the PCT [Primary Care Trust] board executives on a walk through the service, following the patient care pathway, which proved to be an illuminating and emotional experience. In another PBC group examining a different care pathway, the GPs took a sample of the patient notes and plotted patients' interactions with the various healthcare services and agencies as they were treated for their conditions".*<sup>14 (p. 27)</sup>

Although the examples of service design given above were described as being based on processes of co-design, in fact consumers were often not very active in the design process — being sources of evidence and information rather than active participants. Albortz et al.<sup>18</sup> found similar patterns in their study of the mechanisms that Primary Care Groups in England used to engage communities. These authors found public meetings and consultation of local patient groups typically were used to engage consumers, but it was less common to make use of *"more systematic methods of consultation, such as patient questionnaires or focus groups"*.

Batalden et al.<sup>19</sup> report on the ImproveCareNow initiative, a network of patients, families, clinicians and researchers for improving the health, care, service and costs experienced by children and adolescents with inflammatory bowel disease in the US. This project was developed to alter how a range of stakeholders engage the healthcare system. A formal design process was developed that sought to shift the hierarchical, provider-driven network into one where the different stakeholders work together as partners in improving individual health, clinical healthcare services and network operations. The authors state that three important elements were required to develop this co-produced network: (1) clear and consistently articulated shared purpose (to improve disease remission rates) and values (to promote all network members as equal partners), (2) readily available resources to make participation easier for all and (3) processes and technology to support collaboration and knowledge sharing.<sup>19</sup> (p. 513)

Cheverton and Janamian<sup>20</sup> report on an initiative by the Brisbane North Primary Health Network to apply a value co-creation approach with partners and end users, engaging more than 100 organisations in the development of a funding submission to the Partners in Recovery Program. A value co-creation approach has been applied in a number of mental health commissioning examples internationally. Such an approach involves thinking about where different forms of value are created within various networks and the ecosystem as a whole. *“It involves redefining the way an organisation engages with individuals, partners and stakeholders by bringing them into a process of value creation and engaging them in enriched experiences throughout the journey, in order to design new products and services, transform management systems, and increase innovation, productivity and returns on investment”.*<sup>20</sup> (p. 538) Cheverton and Janamian describe that:

*“Agency chief executive officers and senior managers meet with consumer and carer representatives as the CMC [Consortium Management Committee] every 6 weeks. Service managers within agencies also meet 6-weekly and direct delivery staff meet in learning sets every month. A client information management software platform is used by all agencies, providing staff across eight separate agencies direct access to client information. An analysis tool enables real-time interrogation of both outcome and process data, and program-wide reports ... A separate website has been co-created by public and private health providers as a system navigation tool updated directly by providers (<http://www.mymentalhealth.org.au>). Additionally, an annual forum brings together the wide and diverse range of stakeholders initially involved in the program’s development phase”.*<sup>20</sup> (p. 539)

This approach has facilitated the ongoing co-creation of quality improvements and the potential for integration with clinical data from primary care or public mental health services. PIR regularly produces short videos, circulated on YouTube and other social media platforms, which update stakeholders on progress and showcase new initiatives. Information is available in a widely distributed electronic quarterly newsletter and through an interactive website (<http://www.northbrisbane.pirinitiative.com.au>). This approach provides both accountability for those delivering and opportunities for prioritising new initiatives.

Schehrer and Sexton<sup>4</sup> recorded a number of examples of consumer involvement in their study of English health and social care commissioning that related to service redesign and some service decommissioning. They argued that, to some extent, consumer involvement was seen as a way of *“legitimising unpopular decisions”*.<sup>4</sup> (p. 28) They explain: *“One interviewee felt that you could always get the decision you wanted from a user group by carefully choosing the users you asked to participate. In particular, commissioners highlighted the tension between existing service users who might be very attached to existing services and resistant to change, and those not using the current service because it did not meet their needs and future service users with different needs and expectations”.*<sup>4</sup> (p. 28) This point raises the issue of what motivates consumers to give up their time and energy to become involved in this kind of activity; it raises the question of whether there is a possibility that this factor might affect the type of evidence generated. It is also important to note that, in some of the cases observed by Schehrer and Sexton, consumer engagement in decision-making did not prevent decisions being overturned by elected officials who had received complaints from other constituents.<sup>4</sup>

In relation to exploring the various roles within the system, Petsoulas et al.<sup>21</sup> also studied initiatives in primary care in the context of the English National Health Service. They found a range of 'deliberative' methods being used, *"in which lay people were given resources to develop their understanding of institutional interests. Others pursued 'outreach' methods with open agendas in which officers tried to engage with local people on their own terms. In involving or reaching marginalised groups a variety of strategies were employed, for example, trying to engage people on their own turf or trying to provide the necessary support, such as interpreters"*.<sup>21 (p. 293)</sup> On the whole, consumer engagement was described as being rather passive as it did not typically start from the consumer or public perspective. The authors found only one community development approach across the various case studies. There were few examples of direct dialogue between providers and users that fully explored the differences in perspective.

### Shape supply / procurement

These facets of the commissioning cycle are concerned with managing the market and developing a procurement strategy to appoint providers. We found few examples of the use of mechanisms to engage consumers in these areas, although there was some discussion within the literature of the challenges of engaging consumers in this part of the process.

One exception is Bradshaw<sup>22</sup>, who discusses the relative merit of the mechanisms of choice and contestability as a form of consumer engagement. Within a system that makes use of market forces and choice, in theory consumers are engaged in commissioning processes to the extent that they select the providers they receive services from and this in turn should have implications in terms of market management. Further consideration is given to this issue in the report by Schehrer and Sexton.<sup>4</sup> They note that procurement is a crucial component of commissioning approaches as it is the point where intentions are translated into actual services. These authors argue, therefore, that it is important to involve consumers at this stage as a reality check. Consumers may become aware that no appropriate providers exist at this point or the desired provider is not affordable. The authors argue that opening up this component of the commissioning process to consumer scrutiny is important in building trust. The report points to an example from England where a commissioner of day-care services engaged consumers from a Somalian background in order to assess the cultural sensitivity of the services. As a result of this process one of the organisations bidding for the contract was rejected as not being sufficiently able to respond to the needs of the group and the other provider was rejected by the commissioner as not meeting the local authority's standards. The contract was not awarded and the local authority continued to deliver the service in-house.<sup>4</sup>

### Manage performance / evaluate outcomes

These parts of the commissioning process are concerned with managing the performance of the system and providers and determining whether outcomes are being achieved so as to identify opportunities for systemic change. We identified a few examples where this had been achieved, but these were typically associated with accounts of the difficulties encountered in achieving this.

Anderson et al.<sup>5</sup> report on different ways to measure value from the perspective of families of children and youth with special healthcare needs. They give as an example an effort in the US to measure quality through health insurance whereby a set of children's healthcare quality measures were developed for voluntary use by state Medicaid and children's health insurance programs. This example included a series of questions regarding children's health measures, access to services and aspects of information and decision-making that were completed by consumers and used to judge the quality of services. These authors note that although progress was being made in this space, it was a complex and slow process. In addition to these measures there were also suggestions that questionnaire surveys be conducted with groups of consumers picked at random and a family advisory committee be created to *"provide authentic feedback for improving services. At the population level, quality measurement should engage family organizations to identify trends they are seeing based on the assistance they provide regularly to families throughout the community"*.<sup>5 (p. S101)</sup>

These authors note that family-led non-profit advocacy organisations have been important in providing technical assistance, helping to spread family perspective and expertise nationwide and playing an active role in efforts to improve and measure quality.<sup>5</sup>

Bechtel and Ness<sup>23</sup> argue that historically consumers have not been engaged in the design or delivery of payment models. In the isolated examples of engagement, it has typically followed the creation of a new model by professionals and policy makers. They argue consumer engagement has often been seen as a process of education, teaching consumers how to engage with the system. However, they argue this process does not create effective systems because we do not know what consumers value most in their everyday lives. These authors report on work done with the National Partnership for Women and Families in the US, which sought to gauge the views of consumers and their families about the issues that were most relevant to them. Through interviews, focus groups and other engagement activities this project developed a series of consensus statements about what quality meant within the context of these services. The paper describes a series of factors that consumers identified as being crucial to high-quality services. Some of these accorded with the literature and viewpoints of professionals, while others were new or suggested a different emphasis. However, although this study identifies these factors it does not operationalise them as measures of quality. It concludes that such factors should be taken into consideration in assessing the relative merit of services, but notes this had not been achieved within the authors' service area at this time.

Carr et al.<sup>14</sup> similarly reported the introduction of a series of design quality indicators in the English National Health Service, created to facilitate evaluation from a consumer perspective. Their work included the Achieving Excellence Design Evaluation Toolkit, which was updated to include ASPECT (A Staff and Patient Environment Calibration Tool) to allow for a more focused evaluation of the impact of building design on the expert consumer.

To evaluate their co-creation approach, Cheverton and Janamian<sup>20</sup> explained that they *"recruited and trained a team of consumer evaluators who collectively designed the client data collection tool, approached clients directly (and not through their service provider) for interviews, facilitated qualitative workshops, and analysed the data collected"*. This process reported positive results for consumers, with fewer numbers reporting difficulties in connecting to relevant services and a reduction in unmet need.

## **Question 2: Where consumer engagement is documented, what evidence of effectiveness is provided?**

As we noted in the Stage 1 report, a number of recent commentaries on the commissioning literature have mentioned insufficient research evidence of high-quality data on the outcomes of commissioning processes in public service contexts.<sup>1, 24, 25</sup> Our findings from this second part of the review further support these observations.<sup>3, 6, 8, 13, 14, 21, 22, 26, 27</sup> Overall, we found little evidence of impact on consumers<sup>28</sup>, although there is general consensus that this is something that *should* intuitively have a positive impact. The studies discussed below represent evidence drawn from qualitative research.

Many of the sources that discussed the impact of consumer engagement in commissioning typically focused on describing what were thought to be the various benefits in theory. Often these benefits were described as being very broad. For example, Martin notes, *"Public involvement is seen as a means of driving up service quality, reducing health inequalities and achieving value in commissioning decisions"*<sup>13 (p. 123)</sup>, and Baldwin and Wilson note, *"The purpose of engaging service users is to improve the health and wellbeing of the population"*.<sup>29 (p. 344)</sup> Demonstrating impacts of this nature is a challenge given their broadness and the timescales over which many of these research projects ran.<sup>27</sup> Evans et al. argue *"user involvement in commissioning is an important, complex and under-researched area of health care"*.<sup>3 (p. 513)</sup> Yet Sanders et al. note: *"It seems that defining impact is complex as it depends on a number of factors, such as context, people and resources, and it is recognised that some forms of impact, such as that on strategic decision making, can be difficult to demonstrate"*.<sup>27 (p. 13)</sup>

These findings suggest consumer engagement in commissioning approaches may be easier to talk about in theory than to realise in practice. This point is illustrated by Carr et al.<sup>14</sup>, who reported some evidence of the 'potential' to redesign care pathways taking into consideration consumer experience, but found barriers in moving beyond this step into the co-design of services. A number of factors in relation to this point included the time demands on professionals and, for some services, the relatively limited experience that consumers would have of them (e.g. dermatology). Carr et al. concluded, "*Meaningful collaboration and engagement with a representative group of patients to improve services was an aspiration rather than a reality*".<sup>14</sup> (p. 58) To this extent, some of the challenges experienced in the commissioning literature are not dissimilar to those reported within the wider consumer engagement literature, where there are clear messages about the challenges these approaches involve for public services.<sup>30</sup> Little wonder, then, that Bradshaw concludes, "*The task for policy makers and managers as far as user involvement is concerned, is to move from aspiration to reality*".<sup>22</sup> (p. 673)

In attempting to identify the impact of consumer engagement, Attree et al.<sup>6</sup> distinguish between two categories of the perceived benefits of consumer engagement (albeit acknowledging that some overlap occurs between these categories). The first category is developmental, referring to the perceived benefits for participating individuals. The second is instrumental, referring to the improved quality of decision-making for services. In relation to instrumental impact, Attree et al. observed some improvements at an operational level in their study of cancer services, for example improving the type and quality of information available to patients, access to services, and care environments. At a strategic level, however, in terms of planning and commissioning cancer care, the evidence of their influence was less compelling. The authors concluded that although "*progress had been made towards meaningful partnership working*"<sup>6</sup> (p. 56), it was still open to question whether priorities were actually driven by service users. Evans et al. made similar findings in their study, identifying that the key question for most consumers was "*who sets the agenda*".<sup>3</sup> (p. 509) Schehrer and Sexton, however, found consumer "*involvement in strategic commissioning was seen as very useful in a number of different ways, while also posing tensions and challenges. The commissioner in one borough felt that user involvement had been very helpful in raising the profile of a particular service area locally and this higher profile translated into the allocation of more funding for the service area by councillors*".<sup>4</sup> (p. 27) There is, however, no specific data offered to demonstrate this, beyond these observations.<sup>4</sup>

In terms of the developmental category of impact, Gott et al.<sup>26</sup> cite a number of studies that have found individuals with cancer who have been involved in their care provision cite this as a valuable process and one that has given them greater confidence. Evans et al.<sup>3</sup> found where consumers felt their issues were on the agenda and professionals were listening, they saw evidence of developmental impact and were satisfied with the process. However, where this did not occur the impact was less positive and consumers were generally dissatisfied. Millar et al.<sup>31</sup> expressed concern that only those consumers who were engaged in commissioning initiatives might demonstrate positive outcomes and that the effect might go little further than this in terms of commissioning outcomes. In this case, it was believed the involvement of consumers, while having a positive effect for this group, in a broader sense "*may have been largely symbolic*".<sup>31</sup> (p. 215) Overall, Evans et al.<sup>3</sup> concluded it was easier to demonstrate the impact consumers had on commissioning processes, for example where consumers held clinicians and managers to account for promised service improvements. It was also possible to demonstrate the impact on professional learning processes, and in terms of increased understanding and confidence of consumers. However, the "*most difficult type of impact to demonstrate is impact on outcomes*".<sup>3</sup> (p. 511)

As Hudson<sup>32</sup> notes, one of the significant challenges in judging the effectiveness of outcomes-based commissioning in improving client outcomes relates to its underpinning rationale. Is this about giving individuals rights (a say in the services they use); is it for an instrumental purpose (as a means to an end); or

about citizenship (creating new opportunities for active citizenship and connecting people to the public realm)? This level of detail is often missing from research into these initiatives and possibly even from these initiatives themselves. Overall, we may conclude, therefore, that there is limited evidence of the effectiveness of outcomes-based commissioning in improving client outcomes, even where we have adopted quite an expansive definition of what comprises evidence.

### Gaps in the evidence

As we have demonstrated in the previous sections, there are perhaps more gaps in the evidence base than there are answers provided. Many of the descriptions of engagement initiatives are rather limited both in terms of the amount of detail offered of the various initiatives and the impact that these have had. What we did find significant was the descriptions of the challenges in making a reality of consumer engagement in commissioning processes and the gaps in the evidence base that those working with these approaches found.

In a systematic review of the evidence of the impact of commissioning on health service use, quality, outcomes and value for money, Gardner et al.<sup>33</sup> identified a number of barriers to the implementation of commissioning and a number of these apply equally to the implementation of consumer engagement in commissioning approaches. The skills and capacity of the workforce are identified as a major challenge.<sup>1, 34, 35</sup> There are particular challenges in the context of consumer engagement when we see high staff turnover because turnover undermines relationships between stakeholders.<sup>2</sup> Gardner et al.<sup>33</sup> argued this finding points to a need to invest significantly in developing the skills of the workforce who are involved in commissioning processes. We would add further that there is an urgent need to identify precisely what kinds of skills and competencies are necessary to encourage effective consumer engagement.<sup>3</sup>

In addition to the gap in knowledge about the skill and capacity needs of professionals, there are also gaps for consumers engaging in these roles. Evans et al. found *“significant development needs for a wide range of professionals involved in commissioning”*<sup>3 (p. 512)</sup>, reporting that professionals were engaged in steep learning curves. Additionally, they found consumers *“also have development needs on how to work effectively within commissioning groups”*. Similar gaps were also identified by Attree et al., who note that commissioning is a *“complex task requiring specialist expertise and knowledge”*.<sup>6 (p. 14)</sup> Recruitment can also be a challenge for this type of role, particularly if seeking individuals to engage when they are undergoing a difficult period in their life. For example, the cancer networks that Attree et al. examined found that engagement is demanding in terms of time and commitment, and the nature of cancer as an illness can mean sustained participation is difficult.<sup>6</sup> Aside from identifying that consumers need time and support to develop effective strategic skills, there is a gap within the literature concerning what it is precisely that consumers require so that they can engage in commissioning processes. As Evans et al.<sup>3</sup> note, *“Remuneration and wider non-monetary approaches to valuing user involvement remain a complex and contested issue in commissioning.”* Also missing in the evidence base, therefore, is detail about the appropriate payment or reward structures for consumers who engage in these processes.<sup>5</sup>



# Discussion

As this report demonstrates, although consumer engagement is said to be an important component of high-quality commissioning processes, there is a lack of empirical evidence to demonstrate the most effective ways to achieve this or the impact it should have in terms of outcomes. As Schehrer and Sexton write: *"... though the term 'user involvement' has been used for many years, people are not always clear what it means in practice. Mention user involvement in a variety of settings — organisational development, commissioning and now strategic commissioning — and there will be a broad consensus that it is 'a good thing'. However, if you ask people to go beyond this to detail what it looks like, what its purpose is and how structures and models will enable it to become a reality, the picture gets far less clear"*.<sup>4 (p. 5)</sup>

Although we identified a number of articles that explore consumer engagement in commissioning, most of these articles lack detailed descriptions about how consumers have been engaged within commissioning processes or to what effect. As Paterson described, *"whilst there is a growing and valuable literature about the theory of such involvement much less has been written about practice"*.<sup>36 (p. 150)</sup> A range of different approaches were mentioned within these sources, with some seeming to engage consumers more actively than others. Although we found some evidence for how consumers have been engaged in all aspects of the commissioning cycle, we found the greatest range and quality of evidence for the first parts of the cycle that relate to the planning elements in identifying needs, the outcomes to be met through these processes and designing services. Many of the sources identified in this Evidence Check focused on describing the experience of different stakeholders through the engagement process, but generated far less detailed descriptions of what was actually done in these attempts or the kind of impact that the endeavours had on the outcomes of commissioning processes. However, it is important to acknowledge that these observations are indicative of both the broader literature on commissioning<sup>1</sup> and also on consumer engagement.<sup>32</sup>

As a review into consumer engagement in healthcare by the University of New South Wales found, *"at best, most evidence is mixed, meaning that the impact of consumer and community engagement is not clear that it is context dependent or that it requires further study"*.<sup>37 (p. 18)</sup> In reviewing a number of studies of consumer engagement, Hudson<sup>32</sup> argues one of the challenges in measuring how well this is done is that there is not currently agreement on 'engagement metrics'. Because limited tools are available to measure or assess consumer engagement and evaluate outcomes, it may take some time to be able to measure this definitively and it can be *"difficult to disentangle from other interventions"*.<sup>32 (p. 13)</sup> A number of these points draw attention to the fact that the field of commissioning is still relatively young, as are many different attempts to engage consumers within these processes. Over the next few years it is likely that we will see this field develop significantly and the evidence base grow as the number of accounts of commissioning grow and there is greater consistency in how initiatives are described and measured.

What we found the greatest evidence of within our review process were the challenges and problems encountered by organisations when seeking to engage consumers in commissioning. From the evidence derived for this Evidence Check, it is clear that engaging consumers in commissioning processes is difficult. Even in contexts where organisations have a legal mandate to engage consumers in commissioning processes, e.g. the English National Health Service, the evidence suggests these attempts have been limited in practice and *"most had not yet achieved a great deal in terms of having an impact on policies and decisions"*.<sup>18 (p. 26)</sup> Similarly, Anderson et al.<sup>5</sup> found that although Accountable Care Organisations in the US are required to engage consumers, how this is done varies. They concluded that *"it is not enough to have a process or policy in place regarding consumer engagement; it must be operationalized and continuously assessed to be effective"*.<sup>5 (p. S103)</sup> Simply exhorting organisations to enter into greater amounts of consumer

engagement will not fix this situation and what is required instead is careful thought and consideration to ensure that the most effective approaches are constructed. What is clear from the evidence collated through this Evidence Check is that context is crucial and consumer engagement approaches need to be appropriately crafted so they are relevant to the particular group, purpose and component of the commissioning cycle they are aimed at.

Although we did find many gaps in the evidence base and therefore some difficulty in identifying high-quality evidence for the two questions this Evidence Check is based on, the literature does contain some helpful guidance about consumer engagement that can be used to craft appropriate and relevant approaches within particular contexts.

**Broad lessons on consumer engagement**

The first lesson on consumer engagement is that commissioning approaches typically seek to engage different types of stakeholders at various parts of the process and often for quite different purposes.<sup>27, 31, 32</sup> It is important, therefore, that commissioners are clear about who they are seeking to engage and for what purpose. This is so that any initiatives are appropriately planned (of which there is more below), but also because not to do so can set up a false sense of what is to be achieved. As Watt et al.<sup>9</sup> explain, *“Getting local people on-board only to let them down, once again, acts as a further step towards disempowerment. Local people, already very disillusioned by the previous disbanding of projects aimed at improving communication, can only feel less powerful through devoting their time, energy and enthusiasm into a project which is later abandoned, once again, by the ultimately more powerful party.”* Table 7 outlines some of the different types of consumer engagement that might be entered into, the purpose, and some examples of each type of approach.

**Table 7: Types of consumer engagement**

Type of engagement	Purpose	Examples
Communication	To provide consumers with information	Reports, plans, presentations, meetings
Consultation	To obtain consumer and potential consumer ideas, suggestions, complaints and feedback, as well as published consumer research	Paper-based and web-based questionnaires, workshops, focus groups
Negotiation	To reach mutually agreed decisions	Proactive engagement and discussions with consumer forums, membership and/or leaders of projects, steering groups, monitoring groups
Participation	To work together to accomplish commissioning decisions. Consumers represented on and actively engaged in all stages of the commissioning cycle	Designing and implementing research. Active involvement and responsibility as members of board, ‘mystery shopper’ etc.

Adapted from Baldwin and Wilson.<sup>29</sup> (p. 347)

A further note on this point is that even when different groups or communities of interest have been identified it is important to recognise that they may not be homogeneous groups and are *“likely to conceal a great deal of differentiation in terms of interest groups, needs and wishes”*.<sup>13</sup> (p. 127) Different groups will value factors in various ways.<sup>5</sup> It is crucial, therefore, to give careful consideration to the ways in which different groups of consumers are identified and stratified. Some groups may prove difficult to engage in the commissioning process without careful safeguards being put in place. As Lorenc and Robinson<sup>38</sup> note, this is

particularly the case in sexual and reproductive health and HIV/AIDS services due to stigma and confidentiality issues. Careful consideration will need to be given in these cases as to how the confidentiality of individuals can be maintained and to tackle issues of stigma, fear and lack of appropriate skills.

The concept of representation can be useful in helping to think about some of the problems we have identified. As O'Shea et al. describe, *"representation warrants greater attention, because when it comes to making decisions there will always be a few who decide on behalf of others"*.<sup>39 (p. 485)</sup> One of the rationales that is often given for consumer engagement relates to improving the representativeness of decision-making bodies. Yet, O'Shea et al. argue that insufficient attention is sometimes paid to those who are engaged and whether these are broadly representative of the groups that are sought. This point is particularly true with respect to those who are most seldom heard. A range of different means can be used to achieve representativeness, which depends on who or what needs representation. In some contexts, a narrow characteristic (e.g. gender, age and ethnicity) may be appropriate, but it is important that minority groups do not become marginalised in these processes. Where characteristic-sharing is not the chosen course it may be because this approach is not an important factor, or that an individual is being asked to act on behalf of another person or group for decision-making purposes. Here, the responsiveness and accountability of the representative to those they represent are important considerations. The crucial takeaway point is that representation is an essential issue and we need to think through who or what we are asking people to represent if individuals and groups are to be appropriately engaged.

An important point to consider in engagement processes is that consumers and professionals often experience disparities in terms of the control they have over the design and delivery of services. Millar et al. found that *"if inequalities are not addressed as part of involvement itself this can perpetuate injustice, reinforcing a lack of respect, lack of power and lack of resources. It can also isolate service users, instead of providing opportunities for their mutual support and empowerment"*.<sup>31 (p. 215)</sup> This point is important because it draws attention to the potentially negative implications of consumer engagement, within a literature where the aspirations for consumer engagement in commissioning processes are typically most often written about in a largely positive sense.

As Bradshaw<sup>22</sup> highlights, it is important to remember that not everyone will welcome consumer engagement. Some professionals in particular may find consumer engagement a challenge to their expert belief and so care needs to be taken to ensure that it is possible to engage consumers in an effective way and to avoid undue hostility from professionals, particularly where this approach challenges conventional service delivery practice. It should perhaps go without saying, but corporate commitment, in the form of leadership, resources and strategies, is essential.<sup>21</sup> As Schehrer and Sexton remind us, it is important that commissioners do not exceed their authority or fail to carry through on commitments, as this can lead to distrust in the process. *"Users noted that, if consultation was to take place about commissioning, they needed to believe that planners/commissioners and so on really wanted to know what users thought. This is true whether the discussion is about new services/ideas or is a part of a cuts/decommissioning agenda"*.<sup>4 (p. 24)</sup> If consumer engagement is to bring about change, it needs to be carefully thought through as to how it will be embedded within the entire organisational change agenda.

As indicated above, effective consumer engagement that goes beyond a 'tokenistic' approach and genuinely seeks to engage consumers is time-consuming and can be difficult to achieve. As an example of this, Albortz et al.<sup>18</sup> studied English Primary Care Trusts (PCTs) and the extent of their consumer engagement processes. PCTs were legally mandated to 'communicate and consult with local people', but an assessment of these processes found that, *"After 18 months of operation, more than two-thirds of PCG/Ts (69%) had written plans for public involvement, and four out of five (81%) had a public involvement committee or working group. However, only around a fifth of these committees or working groups (21%) had a designated budget and most budgets were £5000 or less"*.<sup>18 (p. 22)</sup> A number of the organisations studied found it difficult

to generate meaningful engagement activities in an expedient way, and many engagement processes remained at a relatively low base. Albortz et al. argue the common methods in use (e.g. newsletters, public meetings, focus groups, questionnaires) typically proved largely ineffective and more experiments are required that adopt innovative approaches. What this means is that consumer engagement activities must be entered into carefully and with the appropriate resources. As Sanders et al. comment, *“Engagement must be genuine — bad engagement is more damaging than no engagement”*.<sup>27 (p. 17)</sup> This sentiment is echoed in a number of other articles included in our study, drawing attention to the importance of approaching consumer engagement in a thoughtful and methodical way.

Evans et al.<sup>3</sup> found, quite simply, that time was one of the greatest resources for effective consumer engagement in commissioning. They note this is a *“long-term process and often is more challenging and takes more time than professionals initially anticipate”*.<sup>3 (p. 513)</sup> Time is needed for genuine engagement for training and relationship building. Where engagement is poorly planned and executed, it risks setting up *“a vicious cycle of cynicism about future involvement; by contrast, well planned and well conducted involvement can lead to a virtuous cycle of valuing and therefore investing in involvement”*.<sup>3 (p. 513)</sup> Involving consumers early on in the planning stages before commissioning groups are formally established is suggested as a positive approach<sup>3</sup>, although the reality is that this may be difficult to achieve in many cases. However, thinking carefully about how to remunerate consumers for their engagement is something that is within the power of most commissioning processes. Engagement can be difficult and claim much in terms of emotional resources. Many projects start out with good intentions about engagement but plans are not always realised, particularly because of many different conflicting priorities.<sup>3</sup>

Ultimately, as Schehrer and Sexton observe, *“Best practice in user involvement implies a whole systems approach to ensure that participation/involvement becomes a part of daily life rather than a one-off activity for the whole organisation — from senior management to frontline staff”*.<sup>4 (p. 18)</sup> Rather than being an add-on, or something an organisation does in part, this needs to be central to the core of the institution. Such a task involves a significant change of culture, in addition to thinking about the processes of the organisation in a different way.

# Conclusion

This Evidence Check is one of a series of reviews commissioned by FACS to inform implementation of the Human Services Outcomes Framework. The reviews are building a picture of the evidence base as to the most effective ways to improve wellbeing for FACS clients at each stage of their life in each of the domains. This approach includes evidence reviews of effective programs and services delivered to clients. It also includes understanding how FACS can operate most effectively to design, commission and deliver services to its clients. FACS commissioned this scoping review via the Sax Institute, to improve its understanding of what models or approaches to outcomes-based commissioning of human services have been effective in improving client outcomes. This review is the second stage in a two-stage review process on consumer engagement and outcomes-based commissioning. Stage 1 of the review comprised a literature search to determine whether there was sufficient evidence to answer questions about the link between consumer engagement in outcomes-based commissioning and improving client outcomes. From this exercise, we found insufficient quality evidence to warrant a full systematic review of the evidence base (see Appendix 2). This means there is currently limited evidence that outcomes-based commissioning improves client outcomes.

FACS determined that a new review should be conducted exploring the following questions: When and how have clients been involved in outcomes-based commissioning? Where client involvement is documented, what evidence of effectiveness is provided? In total, we identified 32 sources that were included in this Evidence Check from the peer review and grey literature. Overall, we found there was a lack of detail about the ways in which consumers have been engaged in commissioning processes and the effectiveness of outcomes-based commissioning in improving client outcomes in these engagement initiatives.

Overall, it was difficult to disentangle the different parts of the commissioning process in terms of how consumers have been engaged within different stages. Although we found some evidence for how consumers have been engaged in most of the stages of the cycle, we found the majority of this evidence related to the first parts of the commissioning process (steps 1–4). A variety of engagement methods were uncovered including the use of consumer service data, consumer questionnaires, working groups, board and partnership groups. However, there was often a lack of detail accompanying these initiatives, making it difficult to work out precisely how these different approaches were used and how similar or different initiatives were from one another.

Many of these studies described the experience of being part of one of these initiatives and how this felt for professionals and/or consumers. Common across these accounts was a sense of frustration and a clear sense of the various challenges that consumer engagement posed and of the difficulties involved in getting it right for all. A major gap we identified in the literature related to the ability to clearly confirm the impact that different initiatives have in terms of commissioning outcomes. The vast majority of literature we were able to identify was qualitative, meaning we were only able to report on perceptions of client impact. This is not to say these initiatives did not have an impact, but that it can be difficult to measure their impact and say with certainty what the impact has been.

We identified a number of gaps in the evidence base, going beyond simply the ways in which these initiatives are described and the impact they are thought to create. There are also gaps in the skills and capabilities of the commissioning workforce and the consumers engaged in these processes. Also uncertain are the most effective ways to resource and reward involvement in these types of initiatives. Beyond these gaps we did find a number of broad lessons relating to consumer engagement in commissioning. What our findings suggest is that there are various purposes and means for engaging consumers in commissioning

processes and these require careful thought so they can be crafted to the specific context that they will be used in.

The Evidence Check offers a number of observations and lessons on best practice consumer engagement:

- Commissioning approaches typically seek to engage different types of stakeholders at various parts of the commissioning process and often for quite different purposes
- Groups or communities of interest may not be homogeneous and may display a great deal of differentiation in terms of needs, interests and motivations
- Some groups may prove difficult to engage in the commissioning process without careful safeguards being put in place
- Not everyone will welcome consumer engagement; for example, some professionals in particular may find consumer engagement a challenge to their expert belief
- Time was one of the greatest resources for effective consumer engagement in the commissioning process
- Engagement can be difficult and claim much in terms of emotional resources.

The Evidence Check identified and provided some recommendations, in particular that commissioners should:

- Not exceed their authority or fail to carry through on commitments, as this can lead to distrust in the commissioning process
- Be clear about who they are seeking to engage and for what purpose
- Give careful consideration to the ways in which different groups of consumers are identified and stratified
- Give careful consideration as to how the confidentiality of individuals can be maintained and to tackling issues of stigma, fear and lack of appropriate skills
- Use a range of different means to achieve representativeness, which depends on who or what needs representation
- Consider how inequality will be addressed as part of any involvement process
- Think about how consumer engagement can be embedded within the entire organisational change agenda
- Commit appropriate resources to any consumer engagement activities.

Ultimately, the main message to take from this evidence is that consumer engagement is not simple and straightforward to achieve. It is important, therefore, that this is carefully planned and appropriately resourced. It should be clear to both commissioners and consumers why the engagement is taking place and what it should achieve, that an appropriate mechanism for engagement has been designed and that the results of this process will be used to inform particular activities or processes. Doing engagement poorly can lead to damaging relationships between commissioners and consumers and in the long term could lead to poorer outcomes.

The lack of evidence relating to commissioning and consumer engagement is problematic in terms of having a good evidence base to inform the development of any approaches, although it also offers an exciting opportunity to help build this. However, this will require investment in documentation and rigorous measurement, including describing key strategies and activities and examining which of these are effective in improving different aspects of service delivery and client outcomes.

The field of commissioning is young and the evidence base will develop further over the coming years. In the meantime, there are some important factors that we have pointed to in this Evidence Check that can be used to help plan approaches to consumer engagement in commissioning. It is important that we remember that many of the issues we are seeking to overcome through commissioning approaches have

been endemic in our systems for much of our recent history. It is to be expected, therefore, that overcoming these issues while working in an engaged way with consumers — which will be new to many within our system — will take an effort to get right.

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## Appendix 1: Overview of articles included in Stage 2

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
Alborz et al. <sup>18</sup> 2002	England/ Health (Primary Care Groups/Trusts)	<p>Design: Mixed method.</p> <p>Data: Longitudinal survey of 72 (15%) of the PCG/Ts in England; telephone interviews; postal questionnaires.</p> <p>Aim: Determine how PCT/Gs have informed and consulted local communities and the perceived impact of this consultation on decision-making.</p>	<p>81% of PCG/Ts had public involvement working groups. Methods of consulting the community:</p> <ul style="list-style-type: none"> <li>• Consulting Community Health Councils (CHCs) (87%)</li> <li>• Holding public meetings (75%)</li> <li>• Consulting local patient groups (67%).</li> </ul> <p>Only 31% of chairs felt effective at consulting; most CHC reps reported little or no consultation with the CHC in areas such as commissioning, service development or clinical governance; 14% of CHC reps rated PCG/T consultation with the public as effective; 87% said local communities were unaware of the existence of PCG/Ts; 70% commented on weaknesses in PCG/T efforts at public consultation.</p>	<p>No.</p> <p>Qualitative evidence from interviews with consumer participants suggested variation in the impact of PCT consultation on decision-making.</p>	<p>Public participation is being taken seriously by PCG/Ts, but most are struggling to develop effective ways of involving local communities. Efforts to involve the public may become little more than token gestures.</p>

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
Anderson et al. <sup>5</sup> 2017	US/ Children and Youth with Special Health Care Needs (CYSHCN)	Design: Commentary. Data: N/A. Aim: Assess 3 elements of value from the perspective of families of (CYSHCN): 1) the role of families in the delivery of care; 2) consumer perspectives on what constitutes quality and healthcare; 3) healthcare financing literacy, decision-making, and costs.	A future policy and research agenda is needed to advance the integration of consumer perspective into value-based purchasing and value-based insurance design: <ol style="list-style-type: none"> <li>1. Identify and prioritise needs and preferences of CYSHCN and their families in designing, implementing and evaluating value-based purchasing and value-based insurance design initiatives.</li> <li>2. Engage the expertise and experience of family leadership organisations.</li> <li>3. Create educational tools and incentives to increase health and healthcare financing literacy.</li> <li>4. Increase price transparency and provide other plain-language decision-making tools.</li> <li>5. Integrate clinical nuance into value-based insurance design strategies.</li> </ol>	No.	
Attree et al. <sup>6</sup> 2011	England/ Health (Cancer Services, Primary Care Trusts/Groups)	Design: Qualitative study, documentary analysis and in-depth case studies. Data: 5 partnership groups, 40 interviews with core group members and key	PCT/Gs required to involve and engage all stakeholders in shaping policies and decisions, expected to:	No. Qualitative evidence drawing on interviews suggested cancer partnership networks can improve services by contributing to patient information, enhance access to cancer care and	The evolution of open, participatory relationships between service users and professionals, and recognition of the value of experiential knowledge are seen as key factors in influencing cancer care. The provision of dedicated resources

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
		<p>stakeholders in cancer services.</p> <p>Aim: Explore the influence of the cancer network partnership's service user involvement activities on cancer care.</p>	<ul style="list-style-type: none"> <li>Place GPs, nurses, social services and the local community at the forefront of the development and provision of health services</li> <li>Adopt processes and mechanisms to allow participation by groups, organisations and individuals not represented on the governing board</li> <li>Ensure regular communications with wider stakeholder groups</li> <li>Communicate with local people and ensure public involvement in decision-making about local services.</li> </ul> <p>Cancer network partnership groups are at their most influential at the grassroots level — contributing to patient information resources, enhancing access to services, and improving care environments.</p>	improve care environments.	to strengthen service user involvement activities is vital.
Baldwin and Wilson <sup>29</sup> 2009	UK/ Health and Social Care	<p>Design: Commentary.</p> <p>Data: N/A.</p> <p>Aim: Explore the concept and problems surrounding commissioning and provide examples of</p>	<p>Securing the service user at the centre from the outset gives a clear message and enables people to become involved and have their voices heard.</p> <p>Commissioners require appropriate skills, knowledge and experience to provide quality health and social care; both providers and commissioners have transferable skills that can be identified,</p>	No.	<p>Understanding commissioning has potential to widen participation and influence local commissioners to use resources effectively and efficiently, designing services to achieve health and wellbeing for patients and, above all, promoting and securing user involvement. Outcomes specified need to be</p>

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
		how health and social care practitioners can engage with the concept of commissioning to inform and influence commissioners.	tailored and nurtured; for example, leadership, and vision and change management. Needs assessment includes garnering the baseline data for a population's health and wellbeing, including identifying shortcomings in services provision as well as informing plans to achieve equity, fair user access and fair allocation of resources. Planning and partnership require robust user and carer involvement, strong community engagement, access to 'hard-to-reach' groups and innovations in delivery of services; also, population profiles, the political, professional, economic, environmental, sociological and technological features that will influence the choice of service design.		capable of measuring the short- and long-term health gain of the population, including the expected changes in health status such as clinical outcomes and patient satisfaction, and measures of use of resources, providers' business processes and value for money.
Batalden et al. <sup>19</sup> 2016	US/Health	Design: Review. Data: N/A Aim: Develop a model of healthcare service co-production.	Years after introducing the construct of shared decision-making, the principles are rarely employed in patient-clinician encounters. Even after training, many patients and professionals inconsistently apply newfound skills and orientation. Conversations revert easily to professional-centric priorities and professionals slip into providing healthcare service as a product — a quantum of advice, a package of evaluation and management. When productivity pressures increase, professionals migrate towards 'what's-	No.	Healthcare is not a 'good' produced by healthcare professionals, rather it is a 'service' co-produced by patients and health professionals. Areas for action include:  1. Education of professionals and the public 2. Healthcare system redesign 3. Redesign outside and at the edges of the healthcare system

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			the-matter-with-you medicine' and away from 'what-matters-to-you medicine'.		4. Measurement of good healthcare service.
Bechtel et al. <sup>23</sup> 2010	US/Health	<p>Design: Case study.</p> <p>Data: Meetings, focus groups, survey.</p> <p>Aim: Determine how people in focus-group and survey research reacted to some of today's most-talked-about delivery system and payment reforms.</p>	<p>Historically, consumers have not been engaged in the design of new healthcare delivery and payment models. When they have been engaged, it has tended to be after physicians, employers or health plans have constructed a new model. Then consumer engagement has typically been conducted under the guise of 'education' and designed primarily to convince or compel consumers to participate in it. This is an oft-repeated pattern in healthcare, reflecting the pervasive notion that if we simply build a system the 'right way', patients will embrace it. The problem with this approach is that non-consumer stakeholders often don't know what matters to patients in terms of what has the most impact on their ability to get and stay well.</p> <p>We need to help consumers and caregivers develop new skills and pathways for becoming informed and activated patients. Developing an 'ecosystem' of electronic tools and community resources should be explored as a promising support for helping</p>	No.	<p>Research at the National Partnership for Women and Families suggests that a truly patient-centred healthcare system must be designed to incorporate features that matter to patients — including 'whole person' care, comprehensive communication and coordination, patient support and empowerment, and ready access. Without these features, and without consumer input into the design, ongoing practice and evaluation of new models, patients may reject new approaches such as medical homes and accountable care organisations.</p>

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			consumers engage as partners in their care and reach their health goals.		
Barker <sup>8</sup> 2015	UK/Health	Design: Commentary. Data: N/A. Aim: Assess the contribution of qualitative research studies to inform the redesign and patient-focused commissioning of services (reference to elective orthopaedic surgical services).	Patient participation is linked to better treatment results, higher patient satisfaction and services that are more responsive to patients' needs. Existing healthcare quality frameworks are failing to capture the importance of diverse experiences of healthcare delivery. The use of qualitative research using methodologies such as focus groups and individual interviews can explore issues with patients to a much greater depth and allow the true voice of patients to emerge.	No.	Well-conducted qualitative research exploring patients' experiences, knowledge and experiences of conditions can be used for the benefit of others and when designing and commissioning healthcare services.
Bradshaw <sup>22</sup> 2008	UK/Health	Design: Commentary Data: N/A, expert opinion. Aim: Review the conceptual and ideological basis for current policy in relation to users.	Service improvement can be captured by: <ol style="list-style-type: none"> <li>1. Personalising care through working partnerships and involvement in decisions</li> <li>2. Involving users in policy making</li> <li>3. Offering user selection and choice and improving care and treatment options through provider contestability</li> <li>4. Securing user participation in policy making.</li> </ol>	No.	Involvement policies began as benign benevolence; users now find themselves as the means for the distribution of resources in a way that was originally unintended. While the intention was to include users in the determination of their own care, they are being used simultaneously, through the notion of user choice and satisfaction, as a tool to drive



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					market solutions to the delivery of more efficient healthcare.
Carr et al. <sup>14</sup> 2011	UK/Health	<p>Design: Documentary review.</p> <p>Data: Document analysis; interviews with Practice-Based Commissioning (PBC) case study stakeholders.</p> <p>Aim: Investigate governance models of PBC and the connections between and respective contributions of evidence-based and experience-based methods in the redesign of healthcare services.</p>	<p>Three PBC governance models identified:</p> <ol style="list-style-type: none"> <li>1. Centralised model: a large and highly integrated PBC group that became an Industrial and Provident Society managing the majority of the Primary Care Trust (PCT) commissioning framework</li> <li>2. Satellite model: 6 PBC groups supported by staff assigned from the PCT</li> <li>3. Evolutionary model: a PBC group with a weak, still-evolving connection with the PCT.</li> </ol> <p>When frameworks for engagement or dialogue with patients or third-sector agencies are available, clinicians can invest their time in engaging with patients, understanding patients' narratives and designing an improved patient experience. When this is lacking, the limited time clinicians have to commit to PBC is consumed by administrative demands, precluding meaningful engagement with patients, compromising effectiveness and limiting</p>	No.	An evidence/experience gap exists where PBC consortia (and PCTs) are searching for off-the-shelf models of best practice for particular clinical pathways, which may not be applicable in the local context, nor provide the best outcomes for patients, particularly those with co-morbidities.

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			the potential for innovation in the redesign of the care pathways.		
Cheverton and Janamian <sup>20</sup> 2016	Australia/Mental Health Services	Design: Commentary. Data: N/A. Focus: Provide a description of an Australian approach to co-creation in commissioning mental health services.	The Australian Government's Partners in Recovery (PIR) program requires multiple sectors, services and consumers to work collaboratively. Brisbane North Primary Health Network applied a value co-creation approach to develop a funding submission to PIR. These were the key elements of public and consumer engagement:	No.	The co-creation and collective impact approach was part of the plan to achieve co-created outcomes, which included: new initiatives; changes to existing interventions and referral practices; an increased understanding and awareness of end users' needs; better outcomes for consumers and their families; and resource application to create lasting system improvements.

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			<ul style="list-style-type: none"> <li>• A client information management software platform was used by all agencies, providing staff across eight separate agencies direct access to client information</li> <li>• An analysis tool enabled real-time interrogation of outcome and process data, and program-wide reports, facilitating ongoing co-creation of quality improvements and potential for integration with clinical data from primary care or public mental health services</li> <li>• Short videos, circulated on YouTube and other social media platforms, updated stakeholders on progress and showcase new initiatives</li> <li>• A team of consumer evaluators was recruited and trained to design a tool to evaluate the effects of the program, including interviews, facilitated qualitative workshops and analysis.</li> </ul>		
Coleman et al. <sup>40</sup> 2009	England/Health	Design: Interviews, document analysis. Data: 131 interviews, 130 observations.	No clear plan of how to use the local PBC incentive scheme to encourage GPs to engage with patients and the public. Were the patient and public involvement (PPI) representatives 'advocates' or 'representatives'? How did they obtain	No.	The evidence suggests that, while the importance of PPI in PBC is generally acknowledged, no clear agreement exists about what it means or how it can be achieved. Particular problems included

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		Aim: Assess progress of patient and public involvement (PPI) in relation to PBC to inform a wider World Class Commissioning agenda.	their legitimacy? It seems here that links with 'neighbours' and 'the population' were valued, but they seemed to be fortuitous rather than designed into the system.		concerns about what it means to 'represent' the public, the mechanics of putting it into practice and the danger that those with particular concerns might hijack the agenda. The diagram of the commissioning cycle used in many documents has 'patients/public' at the centre, with arrows pointing towards almost every stage of the cycle. However, evidence from PBC suggests that engagement processes are not straightforward.
Cotterell et al. <sup>28</sup> 2011	UK/Health (Cancer)	Design: focus groups, interviews, thematic analysis. Data: 8 focus groups, 9 interviews. Aim: Explore the personal effects of involvement on the lives of service users affected by cancer.	Three main themes identified: 1. Expectations and motivations for involvement — the desire to improve services and the need for user groups to have a clear purpose 2. Positive aspects of involvement — support provided by user groups and assistance to live well with cancer 3. Challenging aspects of involvement — insensitivities and undervaluing of involvement by staff.	No. Qualitative evidence drawing on consumer perceptions suggested involving consumers can have an impact on their lives.	Study identified that involvement has the capacity to produce varied and significant personal effects for involved people. Involvement can be planned and implemented in ways that increase these effects and that mediate challenges for those involved. Ways to increase positive effects for service users include looking at: the value service providers attach to involvement activities; the centrality with which involvement is embedded in providers' activities; and the capacity of involvement to influence policy, planning, service delivery, research and/or practice.

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Evans et al. <sup>3</sup> 2015	UK/Health (Cancer Services)	<p>Design: Qualitative evaluation.</p> <p>Data: 4 case studies drawing on 22 semi-structured interviews with project stakeholders; observation; document analysis.</p> <p>Sample: 4 of 28 geographically based cancer networks.</p> <p>Aim: Identify how users were involved as local cancer service commissioning projects sought to implement good practice and what has been learned.</p>	Service users and professionals may have different perspectives on the effect of user involvement in commissioning; meaningful involvement requires time; users should be involved from the beginning; senior management involvement and PPI facilitator support and training are important.	No.	Service users can play an important role in commissioning cancer services, but their ability to do so is contingent on resources being available to support them.
Gandy and Roe <sup>41</sup> 2013	UK/ End of Life (EoL) Services	<p>Design: Qualitative.</p> <p>Data: Action learning workshop with 24/29 invited people.</p> <p>Aim: Determine how locally developed EoL care profiles could</p>	If care profiles are used to commission local EoL services, the potential exists to facilitate consistent and comprehensive information for patients and carers about available services at each EoL stage. Clear information about the local services	No.	EoL care profiles enable local services to be commissioned in detail, which is a catalyst and essential precursor to an inclusive and explicit approach to planning and resourcing services for

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		support the development of Advanced Care Plans (ACPs) and the British Government's 'putting patients and the public first' agenda.	commissioned, with sufficient level of detail, is essential.		individual patients and the population as a whole.
Gates and Statham <sup>42</sup> 2013	UK/ Disability Services	Design: Qualitative. Data: Focus groups with 10 learning disability nursing students, 25 health and social care students, and 6 academic staff from 5 universities.  Aim: Test a consensual and strategic approach to inform future workforce requirements in education commissioning.	Focus groups highlighted problems associated with a declining disability workforce, challenges associated with career pathways and the need for new roles in disability support.	No.	Enhanced engagement with stakeholders can provide significant benefits and new insights to inform the commissioning process.
Gott et al. <sup>26</sup> 2002	UK/Health	Design: Review. Data: Documents/literature. Aim: Consider some of the ways service	Evidence that although local Health Improvement Programmes have identified cancer care as a priority, establishing the consultative mechanisms to involve users has not occurred. A Cabinet Office report noted that " <i>Lack of</i>	No	A number of respondents in the study identified the Calman–Hine reforms as a valuable prompt to developing user involvement. But full implementation of the spirit as well as the letter of the Calman–

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		developments in cancer and the evolution of user involvement strategies co-exist.	<i>resources and the reluctance of health professionals and managers to hand over any power, have fuelled public scepticism about user involvement</i> " (Cabinet Office, 1999). Also, tension exists between the perspectives of user and provider, of user and public and of user and carer.		Hine Report will require practical commitment by providers to the user involvement agenda and also financial investment, including the appointment of dedicated personnel. Further, it will require the capacity to think outside the established and easy assumptions that have seen past attempts at involvement fail. The next, and perhaps most challenging, task is to recognise and engage with the forces of exclusion that inhibit the majority of users from becoming involved.
Horridge et al. <sup>7</sup> 2016	UK/ Children's Disability Services	Design: Audit of clinic records. Data: Audit of electronic clinic letters of children attending paediatric disability clinics (June 2007 to May 2012) to count the number of needs per child. Aim: Determine appropriate terms for consistent recording of needs and issues.	The required number of clinic appointments correlated strongly with the number of needs identified. Children with intellectual disabilities, cerebral palsy and epilepsy had more than double the number of conditions, technology dependencies, and family issues than those without. Disabled children who subsequently died had the highest burden of needs (p=0.007). Counting numbers of needs and issues quantifies complexity in a straightforward way.	No. Audit of client records suggested engagement can underpin service planning and care pathway development.	Detailed data on client needs obtained from clinical audit generated outputs useful for local care pathway development and service planning. This approach could underpin needs-based commissioning of services.

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Hudson <sup>32</sup> 2015	UK/NA	Design: Commentary. Data: N/A. Aim: Describe a conceptual framework for locating different sorts of public and patient engagement (PPE) activity and provide practical illustrations.	Conceptual framework for PPE posed: <hr/> Choice      Better information. Better performance monitoring/ feedback. <hr/> Voice      Patient reference groups. Civil society assemblies. Digital strategy. <hr/> Representation      Voice. Citizens panels/juries. Patient leaders.	No.	Greater conceptual clarity and clearer understanding of the purpose of PPE as a prerequisite for change is needed.
Ingold and Hicks <sup>43</sup> 2015	UK/ End of Life (EoL) Care	Design: Mixed methods. Data: Epidemiological, corporate, comparative. Aim: Describe the Health Needs Assessment (HNA) and discuss the contribution public health approaches can make to	Paper analysed published data; interviewed and surveyed staff; compared results with other regions to describe the epidemiology of dying in the city and used these data to estimate future needs. Study recommendations included:	No. Mixed-method study suggested health needs assessment can improve services.	Public health HNA focuses on improving services in relation to increasing clinical effectiveness, efficiency, service planning, audit and evaluation, clinical governance and equity.



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		improving palliative care.	<ul style="list-style-type: none"> <li>• Developing a performance management system to give commissioners accurate real-time data to inform future service decisions</li> <li>• Negotiating plans for a managed clinical network or alternative framework for delivery of the new service model</li> <li>• Commissioning nurse-led hospice beds</li> <li>• Commissioning some services to work over 7 days</li> <li>• Increasing district nursing capacity</li> <li>• Developing a single point of access to care</li> <li>• Improving access to medicines</li> <li>• Improving EoLC discharges from hospital and hospice.</li> </ul>		
Katterl et al. <sup>10</sup> 2011	Australia/Health	Design: Review. Data: N/A. Aim: Summarise the literature of needs assessments in primary healthcare across nations.	While the overarching reason for undertaking needs assessments was to improve the health status of their populations, in all countries reviewed, the main purpose of needs assessments in primary healthcare was to reallocate limited healthcare funds in a more equitable and efficient manner.  Challenges were encountered in community consultation for needs	No.	Several elements of needs assessments identified that may contribute to better planning and more successful implementation of strategies: <ul style="list-style-type: none"> <li>• Educational strategies to improve health professionals' understanding and skills in assessing health needs</li> </ul>

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			<p>assessments. Community engagement was undertaken in a number of different ways by regional organisations. Although some established consultation groups or forums, most also sought public feedback on need. Managing community expectations is challenging and this can be exacerbated by an inappropriate approach to consultation.</p>		<ul style="list-style-type: none"> <li>• Involving local public health teams for support and guidance, starting with a simple, well-defined health topic to develop experience and confidence</li> <li>• Ensuring sufficient time, resources and commitment are available. Sharing time and resources among health professionals reduces each individual's commitment and strengthens the team Encouraging inter-agency collaboration (e.g. social services, local authorities, volunteer groups)</li> <li>• Integrating results of needs assessments with planning and purchasing to ensure changes are implemented.</li> </ul> <p>Overall, the literature suggests the optimal approach to conducting needs assessments in primary healthcare is to gather the best available information; involve clinicians in the process; and ensure needs assessment is closely connected to the planning process.</p>

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Lorenc and Robinson <sup>38</sup> 2015	UK/ Sexual and Reproductive Health Services (SRHS)	Design: Commentary. Data: N/A. Aim: Report on the design of a training product for commissioners of SRHH services on public and patient engagement (PPE).	Training manual for commissioners developed through a process that established an expert steering group, held consultations with members of PPE groups.	No.	A tool for supporting PPE called SHAPE (Sexual Health and Public Engagement) is an online resource, consisting of 11 instalments on different topics and a set of self-assessment questions. A policy gap in practical guidance on methods, processes and standards for PPE exists.
Martin <sup>13</sup> 2009	UK/Health (Cancer Services)	Design: Qualitative. Data: Interviews with 12 user-group members, 5 staff supporting user groups, 28 staff from pilots. Observation of 33 meetings. Aim: Present summary and analysis of the forms that public involvement in commissioning take, drawing on pilots that implemented a new care pathway for patients with a history of cancer.	Public involvement in commissioning can encompass a variety of interest groups whose inputs may include population needs assessment, evaluation of service quality, and advocacy of the interests of a particular patient group or service. Although each of these roles can be legitimate, significant tensions can exist between them.	No.	Reconciling competing interests of public interest groups will be crucial to achieving policy aspirations for quality, cost-effectiveness and equity.

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Millar et al. <sup>31</sup> 2016	NA/Mental Health	<p>Design: Review.</p> <p>Data: 134 papers analysed to discover main attributes, antecedents and consequences of service-user involvement to produce a definition of concept.</p> <p>Aim: Explore and analyse the concept of service-user involvement within the field of mental health care.</p>	Five main attributes of service-user involvement within the context of mental health care were identified: a person-centred approach, informed decision-making, advocacy, obtaining service-user views and feedback, and working in partnership.	No.	Identification of exemplars of public and patient engagement would help to communicate exactly what service-user involvement means in practice and how the concept can be communicated and used to its full potential.
O'Shea et al. <sup>39</sup> 2017	UK/Health	<p>Design: Ethnography.</p> <p>Data: Two-phase study involving 24 observations across public meetings and reference group meetings; 14 interviews with NHS staff and lay members; focus group with 5 lay members.</p> <p>Aim: Explore patient and public</p>	Perceptions of what constitutes legitimate representativeness varied among respondents, ranging from representing an individual patient experience to reaching large numbers of people. A lack of clarity exists about the role of lay members in the work of the clinical commissioning group.	No.	Although the clinical commissioning group provides resources to support patient and public involvement, there continues to be a lack of clarity about roles and scope for impact.

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		representation in an NHS clinical commissioning group and how it is experienced by staff and lay members in a large, inner-city borough with a diverse population and different social class/affluence.			
Panzer et al. <sup>44</sup> 2016	Australia/Health	Design: Case study. Data: Action research based on 4 cycles of planning. Aim: Determine how participatory regional health workforce planning processes can accurately model current and projected local workforce requirements.	By focusing on extending competencies and skills sets, local health professionals form a stable and sustainable workforce. Concrete examples of initiatives generated from this process include developing a chronic disease inter-professional teaching clinic in a rural town and renal dialysis being delivered locally.	No. Case study suggested participatory regional health workforce planning can accurately model local workforce requirements, which in turn can contribute to service improvement.	Needs-based loco-regional health workforce planning can be achieved successfully through participatory processes. This type of planning can also assist the new Primary Health Networks to commission health services that meet the needs of the population and contribute to service and system improvement and innovation.
Paterson <sup>36</sup> 2004	UK/Health	Design: Qualitative. Data: Literature review, email, telephone, letter responses from 43	Clear roles and tasks and a consumer-friendly research environment enabled consumers to contribute, gain confidence and gradually widen their areas of involvement. One respondent said: " <i>All sorts of different funding bodies want you</i>	No.	Researchers wanting to find consumers to work with can ask consumer organisations or support groups directly; advertise in their newsletters; ask if they could attend a group meeting to

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		<p>individuals, interviews with 10 individuals.</p> <p>Aim: Assess consumer involvement in complementary medicine research.</p>	<p><i>to get 'the patient's viewpoint' but it's actually almost impossible to get an expert patient. I haven't really been able to get hold of anybody appropriate, even from a patient-based charity. It's all very well thinking of involving patients, how do you actually go about it?"</i> (Head of Research Unit).</p>		<p>discuss the research; ask if a special focus group could be formed for the purpose; advertise in national consumer health magazines, surgeries and hospitals; ask healthcare professionals to suggest it to suitable patients. Consult a group of consumers initially, then select a smaller number from this group for more long-term collaboration.</p>
Petsoulas et al. <sup>45</sup> 2014	England/Health	<p>Design: Case study.</p> <p>Data: 8 Clinical Commissioning Group (CCG) case studies, 96 interviews, observation of 146 meetings and analysis of policy documents.</p> <p>Aim: Explore the attitudes of CCGs towards outsourcing commissioning support functions during the initial stage of the reform.</p>	<p>Many CCGs were reluctant to outsource core commissioning support functions (such as contracting) for fear of losing local knowledge and trusted relationships. Others were disappointed by the absence of choice and saw Commissioning Support Units as monopolies and a re-creation of the abolished Primary Care Trusts. Many expressed doubts about the expectation that outsourcing of commissioning support functions would result in lower administrative costs.</p>	No.	<p>Outsourcing vital commissioning support functions may not be the preferred option of CCGs. Considerations of high transaction costs, and the risk of fragmentation of services and loss of trusted relationships involved in short-term contracting, may lead most CCGs to decide to form long-term partnerships with commissioning support suppliers. This option, however, limits competition by creating 'network closure' and calls into question the Government's intention to create a vibrant market of commissioning support provision.</p>
Petsoulas et al. <sup>21</sup> 2015	England/Health	<p>Design: Literature review.</p>	<p>Little engagement between general practices and their patients or local communities. Early surveys of CCGs, such as that by the Patients Association and</p>	No.	<p>Challenges include complexity of rationales for PPI; the need for representativeness, including reaching seldom-heard groups;</p>

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		<p>Data: Scan of social science databases.</p> <p>Aim: Review studies or evaluations of GP commissioning and Total Purchasing Pilots, Primary Care Groups, Primary Care Trusts and Practice-Based Commissioning.</p>	<p>the Policy Research Unit in Commissioning and the Healthcare System are reporting that most CCGs have a PPI lead and a strategy. This data does not necessarily lead to effective engagement in decision-making about commissioning priorities.</p>		<p>meaningful rather than tokenistic engagement; drawing on service users' experiences and ensuring choice. User participation levels are often reported to be low. Involvement groups also tend to be self-selective and therefore not necessarily representative of the community. Limited involvement may be caused by: lack of enthusiasm or variable public interest, attitudes of health professionals, lack of insight into appropriate methods of involvement.</p> <p>Little evidence of actual engagement activity. Research supports Australian review that the effects of consumer and community engagement are not clear.</p>
Sampson et al. <sup>46</sup> 2012	England/Health	<p>Design: Qualitative.</p> <p>Data: Telephone surveys with 77 (in 2009) and 91 (in 2010) Primary Care Trusts (PCTs).</p> <p>Aim: Determine the extent to which PCTs</p>	<p>Reported levels of public and patient involvement in developing and shaping initiatives were considerably lower than for clinicians. Evidence of a statistically significant increase in involvement over the two years, with patient or public involvement of any sort (local patients, organisations or general public) increasing from 35% to 51% of initiatives.</p>	No.	<p>Surveys showed limited involvement of practice-based commissioners in PCT commissioning, even though the study focused largely on long-term conditions that new types of commissioners were supposed to be more involved with. Finding in line with other research on PBC,</p>

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		employed processes associated with quality commissioning and to assess whether changes occurred in these processes during a policy drive to improve commissioning.	The most commonly reported expected outcome was a reduction in emergency admissions.		which shows that it has not brought about the widespread change in clinical engagement that was envisaged. Policy drive for improving patient and public involvement appeared to have had some effect. Varied challenges associated with the delivery of a clinician-led commissioning model.
Sanders et al. <sup>27</sup> 2015	England/Health	<p>Design: Qualitative, values-based approach.</p> <p>Data: Literature reviews, workshops, events, ongoing engagement, meetings.</p> <p>Aim: Engage with patients, service users, carers, health and social care workers and representatives from the voluntary sector to develop a shared definition of patient experience and a patient experience strategy to influence</p>	Engagement process embraced the role of voluntary organisations, recognising the valuable role they play in facilitating engagement with the wider community. Engagement was facilitated by going out into the community, meeting people at local events and in local venues. When is engagement 'good enough'? The greatest outcome is not what is in the definition or the strategy created by the process, but the extent to which people engaged with the process and therefore felt ownership of and championed the definition and strategy, and were committed to using it to influence and shape services.	No.	Reliance on the framework alone might deny individuals, groups or communities the opportunity to engage fully with the notion of patient experience by sharing what is important to them. Engagement is not a single, one-off approach; instead it has multiple components, is ongoing and multifaceted, which is reflective of both individuals and communities.



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		the clinical commissioning of care.			
Schehrer and Sexton <sup>4</sup> 2010	UK/General	Design: Opinion piece. Data: N/A. Aim: Reflect on the pressures and tensions that could have an impact on all parties participating in user involvement in general and commissioning in particular.	Users need to articulate the outcomes they want, which are often very different from those perceived by professionals involved.  Many of the cultural norms are output/activity driven rather than outcome/process driven.  Need to be clear about whether user involvement in commissioning is an ambition in itself or a means to achieve positive outcomes in health and social care. That might seem obvious. However, it is necessary to be overt and systematic in linking process (user involvement) and outcome so that all involved in its support as well as its operation are clear about why user involvement is seen as a major component in the provision of health and social care services.	No	The commissioning principles include both principles for user involvement per se and criteria for effectiveness, which are implied in outcomes such as reduced health inequalities and increased social inclusion. Best practice in user involvement implies a whole systems approach to ensure that participation/involvement becomes a part of daily life rather than a one-off activity for the whole organisation — from senior management to frontline staff.
Sexton <sup>25</sup> 2010	England/Health	Design: Interviews on perspectives of the value and impact of user involvement in	Contributions of service user involvement to service design, planning and delivery: Inform needs assessment processes <ul style="list-style-type: none"> <li>Provide feedback on quality assurance processes and activity</li> </ul>	No. Interviews on the perceived impact of user involvement suggested that it can improve service planning.	Culture may be as important as, if not more important than, structure when engaging with service users in service design and delivery. Service sectors will have their own cultural norms and

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
		<p>commissioning and other areas.</p> <p>Data: 6 local authorities and 7 user groups.</p> <p>Focus: Determine what constitutes meaningful and viable service-user involvement in commissioning, and strategic commissioning.</p>	<ul style="list-style-type: none"> <li>• Provide insight into uptake and accessibility (physical and psychological) of services</li> <li>• Highlight areas that cross traditional service sector boundaries</li> <li>• Contribute to discussion in areas that transcend particular interests such as transport and housing</li> </ul> <p>Particular examples highlighted by commissioners were:</p> <ul style="list-style-type: none"> <li>• Raising the profile of a particular service and translating it into allocation of more funding for the service area as a whole</li> <li>• Help in service redesign and/or decommissioning some services</li> <li>• Being involved in various stages of a tendering process including selecting a preferred provider.</li> </ul>		<p>experience about service-user involvement, making it difficult to transfer learning across an individual authority and between organisations, for example between a local authority and a PCT. It can be difficult to identify and maintain motivation. Investment required ensuring all parties have the necessary level of skill, knowledge and trust in each other to engage as partners in a process.</p>
Sloper <sup>12</sup> 2003	UK/Health	<p>Design: Quantitative survey.</p> <p>Data: 99 health authorities; 410 NHS trusts.</p> <p>Aim: Investigate the extent and nature of involvement of physically disabled or</p>	<p>A variety of methods used for consultation, including child-friendly methods such as drawing, drama and making a video. 17 initiatives reported that children’s involvement had resulted in service changes, but only 11 went beyond consultation to involve children and young people in decision-making about service development. Only a third of the organisations had someone with</p>	<p>No.</p> <p>Survey of 410 NHS trusts suggested consumer engagement improved the service environment (e.g. decor, recreational activity, food) and changed clinic times and ward routines.</p>	<p>The involvement of this group of children and young people in service development in the NHS is at an early stage. The failure of policy documents on user involvement to identify children and young people as a group for whom methods of consultation need to be developed, and the lack of people with designated</p>

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
		chronically ill children and young people in local health service development.	designated responsibility for children's involvement.  Seventeen initiatives reported changes in services. The largest group of changes involved service provision: changes to the hospital environment (7), including ward decor and recreational facilities; food (4); clinic times (2); and ward routines (4).		responsibility for developing children's involvement, may be a reason for slow progress in this area. The initiatives identified show that such involvement is possible and can have a positive impact on services.
South <sup>47</sup> 2004	England/ Primary Care Trusts	Design: Interviews and audit of community involvement activity.  Data: 16 semi-structured interviews.  Aim: Identify the challenges faced by PCTs in implementing patient and public involvement.	Initial audit showed activities were predominately clustered around consultation for PCTs' status and information. Repeat audit found the range of involvement activities had increased over an 18-month period: PCTs were involved in a greater range of consultation activities and evidence of patient and/or public involvement in some decision-making processes. Two PCTs had health improvement groups with wide community and voluntary sector representation and all four PCTs were working with a broad range of partners, from small community groups to district organisations.	No.	The PCTs were found to be engaging with individuals and groups from the community and voluntary sector through a range of different structures and processes. Considerable commitment to patient and public involvement was reported but concerns existed over implementation. A number of influencing factors were identified, including national policy, organisational factors, leadership, workload, access to experienced workers and the pattern of local community activity. PCTs will need to develop a range of mechanisms and use different approaches simultaneously as they seek to work with different communities.

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
Watt et al. <sup>9</sup> 2000	UK/Social Justice	Design: Semi-structured interviews. Data: Not provided. Aim: Devise a model — to be employed by a council in the east of Scotland — for engaging local people in the identification and assessment of expressed need and unmet need in relation to early years services.	Obstacles identified that are helpful for all parties considering enhancement of community participation at strategic planning and policy-making levels: <ul style="list-style-type: none"> <li>• Unexpressed agenda</li> <li>• Continuous exchange of information</li> <li>• Inter-departmental cooperation of the implementing agency</li> <li>• Continued commitment from the implementing agency</li> <li>• Detailed feedback to all participants by the commissioning body/research team</li> <li>• Visible and enduring changes.</li> </ul>	No.	Need a continuous exchange of all information between all relevant parties — between the commissioning body and the research team, internally between sub-departments of the implementing body and between the research team and the participants. The principal factor highlighted continually is communication.
Webster <sup>48</sup> 2016	UK/Family or Social Service	Design: Literature review. Data: N/A. Aim: Review critical lessons from English commissioning and US healthcare marketplace reforms to meet the needs of children and young people in out-of-home care.	Expected outcomes relate to the nature and extent of services provided, such as multidisciplinary health assessment. English experiences show that effective commissioning goes beyond identifying desirable service types to encompassing accurate service specification, prediction of costs and stratification of risk, requiring sophisticated commissioning skills. Commissioning outcomes may also aspire to improving population health status, such as immunisation or mental health.  <b>UK dataset content examples</b>	No.	Questions for commissioning for children and young people in out-of-home care: <ul style="list-style-type: none"> <li>• Which health service process measures and which child health status measures could be adopted and tracked?</li> <li>• How would health professionals be enabled to track each child's journey through healthcare cycles?</li> <li>• How could aggregated OOHC population health data be collected, analysed and disseminated?</li> </ul>

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
			<p>Number of children in out-of-home care (OOHC):</p> <ul style="list-style-type: none"> <li>• % of children 0–4 years with up-to-date developmental assessment</li> <li>• % of eligible children with annual health assessment</li> <li>• % of eligible children who have had emotional and behavioural assessment</li> <li>• Average emotional wellbeing score among children in OOHC</li> <li>• % of children with up-to-date immunisation.</li> </ul> <p><b>US dataset content (select) examples</b></p> <ul style="list-style-type: none"> <li>• Physical health status</li> <li>• Mental health status</li> <li>• Cognitive development</li> <li>• Social-emotional development</li> <li>• Adaptive behaviour/daily living skills</li> <li>• Neurodevelopmental status</li> <li>• Cognitive development</li> <li>• Language development</li> <li>• Depression symptoms</li> <li>• Trauma symptoms.</li> </ul>		<ul style="list-style-type: none"> <li>• How would the system assure that appropriate treatments, therapies and other health interventions are provided for each child according to identified needs?</li> </ul> <p>Review highlights the Australian health system’s relative immaturity for OOHC populations compared with those in England and the US. Lack of robust longitudinal Australian health data is a barrier, as is a heavy reliance on at-risk children and their carers navigating healthcare systems alone. Clinical leadership, as well as government aspirations for improved health outcomes for these children will be vital if they are to be achieved.</p>
Wise <sup>49</sup> 2011	England/Health	Design: Opinion piece. Data: N/A.	Modernisation plans would give patients, local authorities and the public real clout over the shape of NHS services. At present it is weakened by distant	No.	The charities say they support the Government’s aim to put involvement of patients and democratic accountability at the

Author/s and year	Country/topic	Study design, data collection and aim/s	Description of engagement and/or relevant results	Did the study provide evidence of effectiveness of consumer engagement?	Implications drawn from results by authors
		Aim: N/A.	administrators, inadequate powers for public and patient groups, and a democratic deficit.		heart of the healthcare system. But there <i>“is a gap between rhetoric and reality”</i> .

# Appendix 2: Outcomes-based commissioning and consumers: Stage 1 report

## Background

Family and Community Services (FACS) supports more than 800,000 people across NSW both through direct service provision and through non-government organisations (NGOs), that is funds to provide services.

FACS aims to:

- Enable each child in NSW to have the best possible start to life
- Help vulnerable young people build their capacity for a good future
- Improve social and economic outcomes for Aboriginal people
- Provide support to vulnerable adults and families so that they can participate fully in community life
- Build strong and inclusive communities.

FACS is attempting to improve how it measures the impact of services on clients by better capturing the effect of services on client outcomes, in addition to measuring outputs.

The NSW Human Services Outcomes Framework (the Outcomes Framework) was developed in 2015 and focuses FACS on seven high-level wellbeing outcomes for clients and service users in the following domains: home; safety; education and skills; economic; health; social and community; and empowerment. Achieving and measuring the client outcomes in these domains that occur as a result of FACS programs and services is a priority.

The Outcomes Framework helps focus FACS' collective effort on using the best available evidence and data to inform how it commissions and delivers services and how it measures their impact on client outcomes. It makes transparent the continuum from what FACS delivers to how people benefit and what outcomes they achieve. The framework recognises that there are many effective interventions to support improved wellbeing across domains and also recognises linkages between each of the domains — i.e. increased wellbeing in one domain will have effects on wellbeing in other domains. The Outcomes Framework also identifies key stages in an individual's life cycle.

This review is one of a series commissioned by FACS to inform the Outcomes Framework. The reviews are building a picture of the evidence as to the most effective ways to improve wellbeing for FACS clients at each stage of their life in each of the domains. This includes evidence reviews of effective programs and services delivered to clients. It also includes understanding how FACS can operate most effectively to design, commission and deliver services to its clients.

FACS commissioned this scoping review via the Sax Institute, to better understand what models or approaches to outcomes-based commissioning of human services have been effective in improving client outcomes. The question specifically explored in this review is:

**What models or approaches to outcomes-based commissioning have been effective in improving client outcomes in the human services sector (including health, education and justice)?**

In the first instance this review was commissioned as a scoping exercise, as a number of recent articles have suggested there may not be significant volumes of research evidence suggesting the existence of high-quality data pertaining to the outcomes of commissioning processes in public service contexts (e.g. Dickinson<sup>1</sup>; Harris et al.<sup>24</sup>). This review was exploratory in nature, seeking to establish whether there was sufficient evidence to warrant a more detailed study exploring how consumers have been involved in outcomes-based commissioning approaches that have been effective in improving client outcomes.

This brief report provides summary information on the searches undertaken to date to scope and test the comprehensiveness of the literature available to answer this question. The review draws from a search of the Australian and international literature on commissioning. The focus of the review is on Australia, OECD countries and other countries with similar health and social systems, and includes evidence sourced from material published in English after 2000.

**Methods**

In this section we set out an account of the methods we adopted in this scoping review.

**Peer review literature**

We undertook preliminary iterative searches of the peer review literature in the databases outlined below.

- ProQuest
- Scopus
- PsycInfo
- Medline
- Campbell Collaboration
- Cochrane database of systematic reviews

Search terms related to the target population, type of intervention, setting and outcomes of interest are shown in Table 8. We entered combinations of these terms into the relevant databases and completed a preliminary review of article titles to identify potentially relevant material. Initial experiments using these terms indicated that where the target population was removed from the search terms this generated an unmanageable number of sources (>90,000 items) and an initial scan revealed the items that were largely irrelevant to the aims of the study.

**Table 8: Approach to building search terms**

Grouping	Search terms
Target population	aborigin* OR homeless* OR child* OR "young people" OR youth* OR "at risk" population* OR vulnerab*
Type of intervention	commissioning OR "social impact bond*" OR "pay for performance" OR contestib* OR "payment by result*" OR "outcome* based contracting" OR "outcomes based funding" OR "outcome* based payment**"
Setting	health care OR education* OR criminal justice OR child* and family service
Outcome of interest	Outcome* OR impact* OR benefit* OR effect*

**Study inclusion criteria**

To be included in the review, studies had to have been conducted since 2000 and incorporate key aspects of commissioning of health, education and justice services with a focus on purchasing services for homeless, Aboriginal or Torres Strait Islander, vulnerable children or 'at risk' populations. Studies had to report on



commissioning or key elements or activities of commissioning processes for the target group and one or more of the following: impacts on care; client outcomes or benefit; cost containment. Qualitative and quantitative studies were included. Studies were excluded if they did not explicitly include some elements of commissioning and report on at least some impact, outcome or benefit. Papers drawing on expert opinion, commentaries, newspaper articles, theses and conference proceedings were also excluded.

**Grey literature**

As this study sought to include high-quality evidence, we did not search the grey literature at this initial scoping stage of the research.

Our searches across five databases generated a total of 192 articles, which have been screened to generate 54 articles of potential interest (Table 9).

**Table 9: Searched databases, total number of articles returned using search criteria and potentially relevant articles selected from title and abstract content**

Database	Articles identified	Potentially relevant (duplicates removed)
ProQuest	64	13
Scopus	43	11
PsycInfo	5	2
Campbell	20	0
Cochrane	0	0
Medline	57	
Ovid	57	
OECD Library	1	0
<b>TOTALS</b>	190	54

The 54 identified articles were retrieved and read in full, at which point a further 37 articles were excluded as they did not cover issues relating to the commissioning or assessing process, impact or outcomes. The remaining 17 articles were read in detail and assessed according to the types of impact reported (process, impact on service use/delivery, client outcome, cost/value).

**Findings and discussion**

Table 10 (Appendix 3) sets out an overview of the 17 articles that were read in full for the review and an overview of their content, approach and findings in terms of consumer outcomes. What this table clearly demonstrates is that very few of these papers actually explored the impact of commissioning on consumer outcomes. This is either because the papers did not focus on commissioning per se, but on a subset of activities that may or may not be involved in commissioning approaches (e.g. implementation of a performance-based contracting arrangement), or the papers did not report consumer outcomes.

Many of the articles either relied on interviews and perceptions of professionals as a proxy for the impact that commissioning activities had on consumers, or in some cases conducted an audit of clinical data from patient notes as part of an audit process. In either case, very few of the papers reported data relating to consumer outcomes and those that did were in relation to very niche areas and typically reported a mixed picture in terms of the efficacy of the intervention. Overall, therefore, we found no new data concerning the outcomes of commissioning and no significant additions to an already limited evidence base.

It is important to note that this does not necessarily mean that commissioning does not improve consumer

outcomes. As a number of authors have argued, commissioning is difficult to evaluate (Dickinson<sup>1</sup>; Smith and Woodin<sup>50</sup>). It is a broad set of different functions and the types of outcome we are often trying to achieve through these processes can take a significant amount of time to realise. What this exercise confirms is that there is insufficient evidence to proceed to a full Evidence Check. However, what this review process does indicate is that there is a significant body of work in relation to the processes and practices of commissioning and it may therefore be more fruitful to conduct more targeted searches of the various constituent components of the commissioning process.

## Appendix 3: Overview of articles included in Stage 1

Table 10: Overview of articles included in Stage 1

No.	Authors	Title	Year	Country	Description	Impact on client outcomes
1	Cheverton J, Janamian T. <sup>20</sup>	The Partners in Recovery program: mental health commissioning using value co-creation	2016	Australia	Description of approach taken to establish Partners in Recovery program in Brisbane North.	Client outcomes not reported as such but evidence of reduction in unmet need and fewer problems for consumers in connecting to relevant services.
2	Albanese, F; Hurcombe R; and Mathie, H <sup>51</sup>	Towards an integrated approach to homeless hospital discharge: An evaluation of different typologies across England	2016	UK	Small-scale evaluation of fund for discharging homeless people from hospital.	Client outcomes not measured but staff reported perceptions of positive health and accommodation outcomes as a result of the project.
3	Farr, M <sup>52</sup>	Co-Production and Value Co-Creation in Outcome-Based Contracting in Public Services	2016	UK	Realistic synthesis of how different outcome-based contracting mechanisms are implemented and the implications for consumers and outcomes.	Limited client outcome data and different across cases. Some approaches report a positive impact, but others more negative. Concludes more research needed in terms of consumer experiences.
4	Gill PJ; Hislop J; Mant D; Harnden A <sup>53</sup>	General practitioners' views on quality markers for children in UK primary care: a qualitative study	2012	UK	Qualitative interviews with GPs to explore development of benchmarks or standards to measure and improve quality of care for children.	No consumer outcomes reported. GPs supported development of standards but there was significant disagreement about how this should be done and how they should be used.

No.	Authors	Title	Year	Country	Description	Impact on client outcomes
5	Glidewell L; West R; Hackett JE; Carder P; Doran T; Foy R. <sup>54</sup>	Does a local financial incentive scheme reduce inequalities in the delivery of clinical care in a socially deprived community? A longitudinal data analysis.	2012	UK	Longitudinal analysis of routine clinical data relating to clinical and public health priorities to explore whether pay-for-performance measures have an unfair impact in deprived areas.	Consumer data reported at aggregate practice level to show that higher practice deprivation led to poorer performance in five clinical areas.
6	Buckingham H. <sup>55</sup>	Accommodating change? An investigation of the impacts of government contracting processes on third sector providers of homelessness services in South East England	2010	UK	PhD thesis exploring the impact of government contracting on community providers of services for single homeless people.	No consumer outcomes reported. Detailed evidence about the challenges of contracting for community organisations, particularly those that are smaller and less professionalised.
7	Pithouse A; Parry O <sup>56</sup>	Children's Advocacy in Wales: Organisational Challenges for Those Who Commission and Deliver Advocacy for Looked After Children	2005	UK	Study exploring children's advocacy services in Wales.	No consumer outcomes reported. A number of organisational and practice issues related to the ways in which advocacy services were provided.
8	Arrowsmith ME; Majeed A; Lee JT; Saxena S <sup>57</sup>	Impact of pay for performance on prescribing of long-acting reversible contraception in primary care: an interrupted time series study	2014	UK	Prescribing data used to evaluate the impact of pay-for-performance program on the prescribing of long-acting reversible contraceptives in primary care.	No consumer outcomes reported, but rates of prescribing increased after the introduction of a pay-for-performance program.
9	Marks, L; Cave, S; Hunter, D; Mason, J; Peckham, S; Wallace, A <sup>58</sup>	Incentivizing preventive services in primary care: perspectives on Local Enhanced Services.	2011	UK	Semi-structured interviews in 10 purposively selected case study sites and online survey used to examine effectiveness of particular contracting arrangement in incentivising preventative health services.	No impact on client outcomes explored. Contracts were viewed by organisations as effective in incentivising preventive activity, although performance management was weak, there was little knowledge of how to operate incentives and contracts were seen as a risk in a financial downturn.

No.	Authors	Title	Year	Country	Description	Impact on client outcomes
10	Minshall I; Neligan A <sup>59</sup>	Have the New GP Contract and NICE guidelines improved the clinical care of people with epilepsy?	2014	UK	Retrospective audit of case notes of individuals on anti-epilepsy drugs following introduction of new contract for general practitioners.	Some consumer clinical outcomes reported to demonstrate that review rates had been improved but significant unmet need still existed.
11	Unützer J; Chan YF; Hafer E; Knaster J; Shields A; Powers D; Veith RC. <sup>60</sup>	Quality improvement with pay-for-performance incentives in integrated behavioral health care	2012	US	Quasi-experimental design with adults with depression before and after implementation of pay-for-performance program.	After implementation of the P4P incentive program, participants were more likely to experience timely follow-up, and the time to depression improvement was significantly reduced.
12	Chi FW; Parthasarathy S; Mertens JR; Weisner CM <sup>61</sup>	Continuing care and long-term substance use outcomes in managed care: early evidence for a primary care-based model.	2011	US	Longitudinal observational study of adults with substance abuse treatment, examining continuing care arrangements.	Improved remission levels where individuals received continuing care.
13	Lester H; Schmittziel J; Selby J; Fireman B; Campbell S; Lee J; Whippy A; Madvig P <sup>62</sup>	The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators	2010	US	Longitudinal analysis of patient notes to evaluate the effect of financial incentives in four clinical quality indicators.	Removal of financial incentives from clinical indicators led to screening rates falling in two indicators — diabetic retinopathy and cervical cancer.
14	Warren JS; Nelson PL; Mondragon SA; Baldwin SA; Burlingame GM <sup>63</sup>	Youth psychotherapy change trajectories and outcomes in usual care: Community mental health versus managed care settings	2010	US	Archival longitudinal outcome data from parents completing Youth Outcome Questionnaire analysed to compare routine outpatient mental health services in a public community mental health system and a private managed care organisation.	Outcomes reported as poorer for those in community setting compared with managed care organisation, suggesting need for setting-specific model heuristics to identify cases at risk for negative outcomes.

No.	Authors	Title	Year	Country	Description	Impact on client outcomes
15	Johnson RM; Johnson T; Zimmerman SD; Marsh GM; Garcia-Dominic O. <sup>64</sup>	Outcomes of a Seven Practice Pilot in a Pay-For-Performance (P4P)-Based Program in Pennsylvania	2015	US	Patient medical records reviewed to assess effectiveness of pay-for-performance program for minority patients receiving primary care.	Improvements in clinical quality measures in some practices, most impactful interventions related to medical chart documentation and education rather than medication adherence. Additional improvements in measuring, reporting and recording of data also observed.
16	McLellan,T; Kemp, J; Brooks, A; Carise, D <sup>65</sup>	Improving public addiction treatment through performance contracting: The Delaware experiment	2008	US	Evaluation of implementation of performance-based contract for all outpatient addiction treatment programs in Delaware.	Some consumer outcomes reported in relation to length of time individuals stay in treatment, but problems reported with this data. No control group so difficult to say that performance-based contracts 'work' without additional research.
17	Haley, SJ; Dugosh, KL; Lynch, KG <sup>66</sup>	Performance contracting to engage detoxification-only patients into continued rehabilitation	2011	US	Evaluation of implementation of performance-based contract in detoxification rehabilitation in Delaware.	Consumers reported as having higher numbers of detoxifications in a financial year, contrary to policy intent. Some improvements in transition rates, but the specific characteristics of detoxification patients may mean performance-based contracting needs significant shaping to be successful.