Reflections by Caroline Latta and Susan Ritchie
from PB Network Unconference 2015
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PB Conference Workshop on
Health and Wellbeing: Creating the Well society.

This time last year I had a call from the Consultation Institute asking if I would support the North of England Commissioning Support Unit (NECS) to do some Participatory Budgeting (PB). It was a bit different to normal calls from people wanting to do PB – they didn't have a small pot of money to offer to communities - they wanted to conduct a participatory process using the principles of PB but on a mainstream commissioning programme. So it was essentially Participatory Commissioning using PB principles.

There are generally two types of PB:

1. A small grants model where the public body (CCG, Police, Council etc.) allocates an amount of money for communities to 'bid' into to address a specific geographical need or an overarching theme. Done well, this process enables citizens to lead, deliver and monitor the process, and the wider community to decide on which ideas they like the best. This is the most popular form of PB in the UK
2. The other model was the one developed in Brazil and developed in austere times where there was political unrest (sound familiar?). It involves citizens in 'spending' or informing mainstream budgets, and it generally mirrors the annual budget process of the public body.

Model one can be delivered relatively quickly and is generally more familiar to the way in which UK public services like to work – it is a more inclusive model of grant funding. Model 2 involves *mainstream* budgets and as a result is a lot more contentious and seemingly difficult (it isn't actually that difficult but relinquishing a bit of power and having to be transparent with the budgets does cause some concern to those in official positions). It does however take time, which is sometimes a luxury for commissioners.

The circumstances of NECS meant that I was able to put into practice a hybrid (third model?) which I had been working on, and which addresses the short timescales that commissioners often have to work within. It uses PB principles to get the public involved in influencing the difficult decisions that strategic leads have to make about ever decreasing budgets, and provides a way of testing some of the commonly held (but often) incorrect assumptions that commissioners might make about citizens.

In short, the public were going influence the future configuration of mental health services in Newcastle and Gateshead by using real budgets, real services, and real experiences. This was neither going to be a 'nice thing to do' nor would it be easy to ignore the consultation finding. Right up my street! And what made it even better from my perspective is that it was a citizen who requested the use of PB (maybe a legacy of the work that my colleague Vince Howe did all those years ago in Newcastle?).

The model we used formed part of a wider piece of engagement work that NECS were doing. The findings from focus groups and listening events were used to help shape the

debate and dialogue at the PB events, and subsequently all were used to help develop future scenarios which could go out to consultation at a later date.

At the conference workshop Caroline Latta, *Senior communications and engagement locality manager, North of England NHS Commissioning Support Unit,* described her experience of conducting this type of approach.

A strong working group is needed with the right people on it who are able to commit the time to the developmental work. This is not fluffy stuff – it is real budgets and real services for vulnerable people so it must be as accurate as possible. You must have a finance lead on the group and you must have contract leads who know the detail of existing contracts. In the sprit of PB you must also have public representation on the group. You will need a good communications and engagement team in place to ensure the tangible deliberation tools are designed and compiled on the day.

The devil is in the detail – without the right contract managers and finance lead this could become 'decaffeinated' (see my other blog from the conference) and remember you could be FOI'd on this so don't skirt around the edges of the difficult conversations and data. Battle them out in this group so that you can be sure they are correct before wasting the public's time on deliberating false information.

It changes the conversation. The NHS has a duty to engage and consult, which has become even more important through case law, legislation and policy guidance. By using this model of engagement NECS had a different conversation with the public which went beyond them wanting everything, in every locality, to a more considered and challenging deliberation about how existing public resources could be better used to configure mental health services.

Participants chose between a range of inpatient options costed at different levels with different configurations of services (drawn from previous engagement, clinical expertise and contractual pricing). With a preferred inpatient 'bundle' in place they went on to select their preferred community services to compliment the inpatient bundle. This was a very different conversation to the more typical adversarial events about saving a hospital.

Shaping Options. Because of the detailed thinking of the working group, and the deliberative and inclusive nature of the events held, commissioners were better able to consider future scenarios to influence consultation options. NECS went from 6 scenarios to 24 sub scenarios to a final 5 options that will go to consultation on 12th November 2015.

Questions for the future:

- How can this be better evaluated? (See blog on evaluation?)
- How can this approach become the norm?
- Are there any academics who would be willing to support a control sample approach?

- To what extent can we ensure the existing services architecture is balanced with innovative and transformative bundles of services?
- How might we use more appreciative approaches before developing the budget boxes?

In a related later unconference pitch on

"How we can further develop PB principles for participatory engagement in commissioning decisions for health and other public sector commissioners?"

The key outputs were:

- Agreement that there was a strong role of PB to revitalise commissioning engagement – putting the patients in the shoes of commissioners and being in charge of health spending for the day.
- People thought it could be used as a different form of engagement dialogue
- The process was seen to be very educational for patients and the public and would lead to a better understanding of the difficulty of commissioning decisions by taking people on a journey.
- It would help reach people who had not previously been engaged in commissioning decisions
- The group thought it would lead to better commissioning decisions – to improve local services that would in turn mean better health outcomes for local people.

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