

Patient and Public Involvement Strategy 2007-2010

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David Levitt	0.1	13.07.07	PPI Committee
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1. Introduction

Patient and Public Involvement (PPI) in one form or another has a long history in the NHS, although it has rarely had a high profile. Whereas elements such as value for money, health needs assessment and clinical effectiveness have been central to the planning, design and delivery of healthcare services, this has not been the case with PPI – until now.

PPI – the active engagement with and involvement of service users, carers and the wider public – is undergoing a step-change in the NHS, as signified by government plans and legislation since 2001. Regulatory requirements are becoming increasingly public/patient focused and new legislation in 2008 will further underline the central importance of PPI in a new NHS that needs to work in partnership with patients as the only way of meeting health needs and wants within allocated resources.

Bedfordshire PCT needs to be at the forefront in developing PPI. It is a key element in the Trust's emerging five year strategy, *A Healthier Bedfordshire*. This will require a more strategic and planned approach to PPI. This strategy sets out the objectives and contingent work streams aimed at establishing the structures, processes and resources needed to achieve this. It provides a framework to promote and develop a culture within the Trust that puts PPI at the heart of its work to improve services, patient experiences and health.

This document is available in large print, audio-cassette, Braille and other languages on request.
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2. What is Patient and Public Involvement (PPI)?

In this document, the term 'patients and the public' encompasses patients, service users, carers, individuals, groups and communities.

PPI has rather loosely been seen as encompassing any activities or initiatives that share a commitment to involving the public. As such, it means different things to different people, which can be categorised as:

- **A mechanism for expressing personal choice.** While the views of individuals are clearly important for the individual and in influencing change, there is a tension with more collective forms of involvement. For example, the promotion of individual 'patient choice' may be seen by some as a less egalitarian way of driving up quality
- **A mechanism for securing legitimacy and accountability for decisions.** This aims to open up decision-making, with the added benefits of better decisions and better public understanding and consequent support for decisions that may often be contentious
- **A mechanism for changing attitudes and behaviour.** This works both ways: more involved, better informed patients taking more responsibility for their health; and the NHS learning from the involvement of patients (eg in research and training) to influence the relationship between the NHS and patients towards partnership.

Among the potential benefits, PPI can:

- Improve the planning of services
- Help to prioritise and make best use of limited resources
- Inform the setting of performance standards relevant to public needs
- Provide early warning, assessment and minimisation of potential problems
- Influence the development of more appropriate, more cost-effective services
- Improve understanding among the public of health services and create local ownership
- Promote openness and accountability
- Enable more individual influence over issues affecting personal health
- Facilitate better health and health outcomes.

A working definition of PPI, focused on outcome rather than activity:

PPI is about empowering people to tell us what they need and want from their health and care services and then giving them the power to influence beneficial change and improve theirs and others' experience of care.

Further information on levels of involvement and PPI methods is available to staff from the PCT's PPI Toolkit on the PCT staff intranet, starfish.

3. The national context

PPI is not new to the NHS. Community Health Councils were established in 1974 and more recent developments, in part prompted by the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary (2001), have included the establishment of PPI Forums and Health Overview and Scrutiny Committees to facilitate more direct forms of user involvement. From *The NHS Plan* (DH, 2000) to *Our Health, Our Care, Our Say* (DH, 2006), Government policy has made clear the growing importance of PPI. The Department of Health's *Commissioning Framework for Health and Wellbeing* (DH, 2007) and its response to the feedback on its consultation document *A Stronger Local Voice* (DH, 2006), further underline a stronger role for patients and the public in influencing the commissioning and provision of local health and social care services.

In 2008, the Local Government and Public Involvement in Health Bill will abolish the Commission for Patient and Public Involvement in Health (CPPIH), remove the statutory powers of PPI Forums and establish a new framework for strengthening PPI to meet the challenges of *Commissioning a Patient-led NHS*. It has five elements:

- **Local Involvement Networks (LINKs)** – based on geographical areas (local authority areas with social services responsibilities) rather than organisations to broaden representation and involvement and extend PPI into social care services, thereby gathering views on the patient's journey.

LINKs can formally refer issues to Overview and Scrutiny Committees and to Strategic Health Authorities (SHAs)

- **Overview and Scrutiny Committees (OSCs)** – focusing on the work of commissioners. OSCs can formally refer issues to SHAs¹
- **Stronger and more explicit duties to involve and consult** – requiring a structured process for commissioners to involve, consult *and respond* to the views it receives through, for example, a PCT prospectus
- **A stronger national voice** – through the establishment of a networked body at national level
- **A stronger voice in regulation** – through user involvement with regulator bodies and through regulators development of assessment criteria for PPI.

Patient Advice and Liaison Services (PALS) and the Independent Complaints Advocacy Service (ICAS) will be retained. The Department of Health is soon to issue new guidance on NHS complaints regulations, which will form part of a single complaints process for health and social care by 2009. Additionally, the recent Carruthers' review (DH, 2007) sets out a series of recommendations for ensuring effective stakeholder engagement in major service change and reconfiguration.

By any measure, PPI has moved up the agenda significantly over the last five years and continues to do so. It must be seen as a critical mechanism for change within the NHS. The PPI strategy should be seen as a living document to reflect this evolving PPI agenda within the NHS.

See section 14 for references to further reading on the background to and development of PPI within the NHS.

4. Scope of the strategy

This strategy is aimed at all Bedfordshire PCT staff who are involved in planning, commissioning and providing healthcare services. The strategy is a public document and should also be seen as relevant to key PCT partners in service commissioning and provision, including local authorities, independent contractors, practice based commissioning consortia, NHS trusts, voluntary sector and private sector providers.

The PPI strategy is informed by the Trust's strategic intentions document, *A Healthier Bedfordshire*, which sets out our aims and priorities for improving the health and wellbeing of its residents over the next five years. The PPI strategy should be read in conjunction with the Communications Strategy. Together, they articulate the Trust's approach to public engagement. It should also inform and link to other key Trust strategies and plans as they emerge, including Commissioning, Provider Development, Public Health, Clinical Governance and Workforce.

¹ OSC's have three specific powers:

- To receive and comment on major service developments and variations (Section 7, Regulation 4)
- To undertake 'own initiative' studies into any aspect of the local health service and to make recommendations to appropriate NHS bodies
- To refer to the Secretary of State for Health matters that the committee has not been adequately consulted on that the committee believes are not in the interests of local health.

5. Purpose of the strategy

The strategy provides a framework to promote and develop a culture within the Trust that puts PPI at the heart of its work to improve services, patient experiences and health.

Strategic objectives

- To raise awareness and understanding of PPI among our staff, partners and the public.
- To put in place within the PCT effective organisational structures, processes and resources to ensure a supported, coordinated and comprehensive approach to systematic PPI throughout the commissioning cycle.
- To encourage the development of organisational structures and processes outside the PCT, such as primary care based patient participation groups (PPGs), that support effective PPI.
- To empower patients and the public, including those who are seldom heard, to become involved in shaping their own health and the wider health agenda.
- To ensure compliance with statutory and regulatory requirements in respect of PPI.
- To ensure effective monitoring and evaluation of PPI and to include equality data on gender, ethnicity and disability.

Underpinning the strategy is the principle that effective PPI occurs at two levels:

- **Individual:** closest to where care is delivered – understanding the patient's experience and how it can be improved
- **Collective:** closest to where decisions are taken – giving citizens a voice in shaping service design, delivery, policy and priority setting.

The strategic objectives need to inform actions that take account of both perspectives, which encompass the spectrum of involvement.

6. Where we are at present

- Both former PCTs had developed PPI strategies and operational plans. A range of PPI related activities, such as patient surveys, focus groups, patient groups and health needs assessments, have continued in the new organisation. There is a well functioning Patient Advice and Liaison Service and a process for responding to and learning from complaints.
- The new PCT has established a PPI Committee to monitor PPI activity and oversee the implementation of the PPI strategy. The committee is chaired by a non-executive director, with representation from all directorates (apart from Finance) and a PPI Forum representative. The committee reports to the Integrated Governance Committee and will produce quarterly and annual reports.

- Provider Services is establishing a Patient Services Focus Group reporting to the Provider Services Board as part of its governance arrangements in readiness for independent status.
- In the new PCT's first *Standards for Better Health* self-assessment, the PCT declared itself compliant against the Healthcare Commission core standards C13, C14, C16 and C17, which relate to PPI.
- The Fitness for Purpose Review in early 2007 highlighted some notable examples of PPI such as activities to involve gypsies and travellers and homeless people in health needs assessments and some good practice in monitoring PPI. However, the Board to Board review asked that the PCT give much greater priority to measuring and improving patient experience.
- The PCT has a strong working relationship with its Patients' Forum, whose members are involved in a number of key committees and planning groups.
- PCT representatives attend the Bedfordshire Health and Adult Social Care Overview and Scrutiny Committee (OSC). The PCT aims to be more proactive in further developing its relationship with the committee.
- The PCT Health Panel has 240 members, who are consulted on various issues from time to time. However, membership does not yet reflect the profile of the adult population in terms of age and ethnicity.
- There are five Expert Patients Programme (EPP) support groups that continue to meet. The PCT arranges speakers and has consulted with the groups on various issues. An expert patient sits on the Steppingley Development Reference Group.
- The PCT has links with the Black and Ethnic Minority (BME) local communities through the Bedfordshire Diversity Forum.
- Around one third of GP practices have some form of patient participation group (PPG), with a wide variation in arrangements and activities. A small number of practices aspire to set up a PPG and the remainder, well over half, have no stated aims to do so.
- The Bedfordshire PPI Forum has representation on two of the five Bedfordshire PBC consortia.
- The PCT has consulted on its draft five-year strategy, *a Healthier Bedfordshire* and public engagement will continue through the development of emerging strategies and plans. Both former PCTs have undertaken or supported local and regional formal public consultations on a number of issues, including proposed premises developments, service reconfigurations and mental health strategy development.

7. Where we need to be

Although there are various examples of effective PPI and pockets of good practice across the PCT, there is a lack of strategic direction and coordination of efforts to ensure the best principles of PPI are systematically applied in pursuit of the Trust's key aim to work with individuals and communities for a healthier Bedfordshire.

Involvement at a strategic level

Supportive systems and processes need to be in place at a strategic level to enable a high quality and consistent approach to PPI. This is an essential requisite to ensure that PPI is integrated into everyday working. It requires:

- A coherent strategy and practical work plans
- Senior commitment and leadership
- Proper resourcing and support
- Clear roles, responsibilities and accountability
- A commitment to partnership working
- Effective mechanisms for monitoring, evaluation and sharing of learning
- Recognition that additional efforts are required to ensure PPI reflects equality and diversity issues.

It is not surprising that the process of organisational reconfiguration has had a negative impact on the continued development of PPI, as the new organisation has needed to take a breath to first establish and then adjust to new organisational structures, functions and personnel.

The Trust now needs to pick up the pace in further developing a patient-led organisation. This will be especially challenging during a time of continued radical change in the health and social care landscape that will see:

- The PCT's changing role to focus on the commissioning of services (including the development of practice based commissioning) as the means through which services are managed, controlled and developed
- The imminent separation and independence of the PCT's provider arm as part of the move towards greater choice of service providers and service delivery, including NHS Foundation Trusts as well as many other providers from the independent sector
- Greater integration of health and social care, with more joint commissioning and the delivery of more services within the community
- Accelerating reconfiguration, with new models of care delivery being developed to provide the right care in the right place, shifting more care from secondary to primary care settings, enabling acute hospitals to concentrate on more complex and specialised services.

With commissioning moving to centre stage and with an increasing mix of providers, old systems of user involvement focused around individual NHS institutions are no longer appropriate. PPI needs to be directed by the PCT as a commissioning organisation and aligned to the commissioning cycle. The diagram

3. Partnerships and commissioning

- Supporting GP practices, PBC consortia and Provider Services to develop their PPI capability.
- Aligning PPI activities to support joint commissioning with the local authority.
- Strengthening relationships with the third sector.
- Working proactively with local PPI bodies (OSC, PPI Forum / LINK).
- Embedding PPI requirements and standards in contracts and Service Level Agreements (SLAs).

4. Monitoring and reporting

- Establishing mechanisms to monitor the effectiveness of PPI activities and seeking opportunities to involve service users in them.
- Adopting standards by which to evaluate PPI and learning from this so as to foster continuous improvement in our PPI processes.
- Establishing clear reporting and escalation processes.
- Sharing the outcomes of PPI involvement with those who have been involved and with the wider public.

An annual PPI work plan will be developed on the basis of these work streams. This strategy identifies the following areas as top priorities for action within the first six months:

- **Review the role and functioning of the PPI Committee** – the PPI Committee is the key focal point for overseeing, coordinating, driving and evaluating PPI. Although only recently established, further consideration needs to be given to the membership required to enable the committee to fulfil its role.
- **Establish PPI governance arrangements in Provider Services** – in advance of organisational independence, Provider Services will need clear lines of accountability and processes for PPI monitoring, coordination and evaluation.
- **Directorate-led reviews of PPI activities** – each directorate involved in service planning, design and delivery needs to have clear oversight of its PPI activities, developing team/service/directorate level PPI plans aligned to directorate objectives and to the Trust's strategic aims as set out in *A Healthier Bedfordshire*.
- **Further develop external relations with key PPI partners** – recognising that PPI is underpinned by a complex set of relationships between a multiplicity of bodies, the Trust needs to develop a clear set of objectives and actions in relation to key partners, including (but not exclusively):
 - Arrangements for PPI to support joint commissioning with local authority bodies
 - The promotion of a common understanding among providers and commissioners of how they collectively use patient feedback to improve patient experience
 - A proactive approach to informing OSC work plans
 - Involvement in shaping development of the LINK, including maintaining effective working relationships with the PPI Forum through transition

- The development of effective working relationship with the local Voluntary and Community Sector (VCS) bodies.
- **Develop and promote PPI support resources** – identify and share good practice in PPI across the Trust and promote PPI channels such as the PPI Forum and PCT Health Panel. Utilise *starfish* as the primary communications channel within the PCT and with appropriate external partners. Assess and address PPI training needs.
- **Support the development of PPI in PBC consortia** – practice based commissioning will become the pre-eminent process for service planning, design and delivery. The Trust needs to work with the PBC consortia to develop effective and practicable models of PPI as an essential part of the commissioning process.

All of the above support the development of an integrated, no boundaries approach to PPI that enables the sharing and best use of information, knowledge and intelligence on patients' experiences of care across primary, community and secondary settings in order to improve patient experience and develop services.

9. Resource implications

PPI has to be embedded within the organisation. As such, it becomes another integral part of people's jobs and not a bolt-on activity. However, it is equally important to understand that effective PPI requires resources – people, time and money. PPI, like other key business activities, is undertaken to generate a set of benefits and directorates need to budget for effective PPI.

The PCT currently has limited corporate PPI capacity to support a broad range of PPI functions needed to drive PPI at the heart of the organisation. These include PPI development, promotion and coordination, public consultation, practical support, advice and training, PALS and complaints. The breadth and depth of the PPI agenda and its now critical importance to effective commissioning requires serious consideration of the resources the PCT can commit to this key area of work. High profile public consultations that are not sufficiently resourced and supported may also present serious risks to the organisation's reputation.

10. Review and evaluation

1. PPI strategy and work plan

The PPI strategy covers a three-year period and should be reviewed and refreshed annually by the PPI Committee. The PCT PPI work plan spans one year and should be reviewed after six months by the PPI Committee. Directorate and team PPI plans will be informed by and feed into the PPI strategy and work plan and their arrangements for review should be aligned accordingly.

2. PPI activities

Every PPI activity should be evaluated to assess its success and impact on service planning, development or delivery against the following criteria:

- **Representation** – participants should be broadly representative of the affected population
- **Inclusiveness** – the involvement process should provide sufficient opportunities to overcome barriers to those who might wish to be involved
- **Independence** – the involvement process should be conducted in an unbiased way
- **Early involvement** – participants should be involved as early as possible in the process
- **Influence** – the outputs of involvement should have a genuine impact on policy or practice
- **Transparency** – the process should be transparent, enabling those involved to see and understand how decisions are being made
- **Resource availability** – participants should have access to the appropriate resources to enable them to successfully fulfil their brief
- **Task definition** – the nature and scope of involvement should be clearly defined
- **Structured decision-making** – involvement should include a structured process for taking account of feedback in decision-making
- **Cost effectiveness** – involvement should, in some sense, be cost effective
- **Feedback** – the outcome of PPI activity should be fed back to participants.

Evaluation will be part of PPI activities recorded on the PPI database and feeding into the annual PPI report. Measurable success criteria should reflect best practice and national targets as set out in *Standards for Better Health* and other documents that include such measures as patient satisfaction and access. Through the PPI Committee, the PCT should also, over time, develop its own PPI metrics relating to measures such as provision of information, development of consultation groups, response to user views and so on.

11. Consultation on this strategy

The PCT consulted on draft version 0.2 of this strategy over a period of four weeks, from 10 August to 7 September 2007. The strategy was sent to stakeholders in local NHS organisations, local government, practice based commissioning groups, voluntary and community organisations, Bedfordshire PCT PPI Forum and a sample of PCT Health Panel members. The full list is attached as appendix 1.

The PCT received eight responses on behalf of organisations and from individuals. The scope and aims of the strategy were broadly welcomed. The table below details our response to the specific comments received.

Comment	Response
1 Important to recognise that regulatory requirements stress the importance of public involvement in addition to a specific patient focus.	Second paragraph of the introduction to the strategy now includes reference to public and patient focus.

2	Strategy needs to stress the importance of the PCT, social services and acute trusts working together to improve patient experience.	Section 4, 'Scope of the strategy', has been amended to include specific mention of NHS trusts. Section 8, 'How we will get there', has been amended to include explicit mention of the importance of joint working to most effectively utilise patient feedback.
3	Strategy should set out in more detail the specific powers of overview and scrutiny committees.	This is now captured in a footnote to Section 3, 'The national context'.
4	Strategy should seek to encourage the development of patient participation groups in GP practices and in larger dental practices.	Section 5, 'Purpose of the strategy', contains an additional strategic objective: 'To encourage the development of organisational structures and processes outside the PCT, such as primary care based patient participation groups (PPGs), that support effective PPI'.
5	The Bedfordshire and Luton Health Overview and Scrutiny Committee has now been replaced by the Bedfordshire Health and Adult Social Care Overview and Scrutiny Committee.	This has been amended in Section 6, 'Where we are at present'.
6	The PCT should ensure patients and the public are kept informed of current and planned changes.	This is implicit in Section 8, 'How we will get there', which includes a specific point on creating opportunities for involvement.
7	The strategy should seek to involve service users in PPI monitoring.	Section 8, 'How we will get there', has been amended to include this.
8	PCT should ensure that the public is kept informed of the outcomes of PPI.	Section 8, 'How we will get there', has been amended to include an additional element within the 'monitoring and reporting' work stream to: 'report the outcomes of PPI involvement to those who have been involved and to the wider public.'
9	The strategy does not contain any mechanisms to ensure that participants in PPI are broadly representative of the affected population.	Representation needs to be addressed on a 'case- by-case' basis. The strategy recognises the importance of providing practical tools to support effective PPI.
10	Mental health is a specialist area and may be marginalised by the generic health agenda.	This point equally applies to other 'specialist' groups. The strategy recognises the importance of working with a wide range of partners, including the third sector, who have particular expertise in these areas.
11	Glossary should include 'intermediate care'.	This has been added.

12. Adoption of the strategy

The revised draft of the PPI strategy will be presented to the Integrated Governance Committee in October 2007 for discussion and approval and to the PCT Board in November 2007.

13. Glossary of terms used in this document

Acute Care – short-term medical treatment, usually in a hospital, for patients having an acute illness or injury or recovering from surgery.

Clinical Governance – the collective term for the NHS quality assurance systems. Patient safety and experience are key priorities.

Commission for Social Care Inspection (CSCI) – the independent agency that registers, inspects and reports on social care services in England.

Commissioning – the process of assessing local needs, planning, procuring (buying) and monitoring services provided by individuals and organisations.

Community Services – a range of health and care services provided in local communities, such as district nursing, health visiting and various community therapy services.

Expert Patients Programme (EPP) – a free NHS-based training programme that provides opportunities to people who live with long-term chronic conditions to develop new skills to manage their condition better on a day-to-day basis.

Healthcare Commission – the independent ‘health watchdog’ for England, responsible for checking that healthcare services meet the required standards in safety, cleanliness, waiting times and many other areas.

Independent Complaints Advocacy Service (ICAS) – a statutory national service launched in September 2003 to support patients and their carers wishing to pursue a complaint about their NHS treatment or care.

Independent contractors – includes GPs, dentists, pharmacists and optometrists who work closely with the PCT to deliver primary care services to the public.

Intermediate care – a range of integrated services to promote faster recovery from illness, either preventing unnecessary acute hospital admission or supporting timely discharge from hospital and maximising independent living.

Local Involvement Network (LINK) – a new statutory arrangement to promote the involvement and participation of people in the planning, design and improvement of local health and social care services. LINKs will be based on local authority social services areas and will be established from April 2008 onwards, replacing PPI Forums.

NHS Foundation Trust – hospitals that remain part of the NHS, but which have more freedom in how they are run and greater accountability to their local population, who can become foundation trust members and be elected as governors.

Overview and Scrutiny Committee (OSC) – a local authority committee, comprising councillors and PPI Forum representatives, established to review, scrutinise and report on any matter relating to the planning, provision and operation of health local health services (also covers adult social care in Bedfordshire).

Patient Advice and Liaison Service (PALS) – a confidential service for patients, their relatives and carers to help resolve concerns and provide advice about accessing NHS services.

Patient Participation Group (PPG) – patients forming a group, with the support of the GP practice, to take an interest in local healthcare services and the development of their GP practice.

PCT Health Panel – Bedfordshire residents aged 16 and over that the PCT consults with on a range of health issues from time to time. Any adult registered with a GP in Bedfordshire can join.

PPI Forum (also known as the Patients' Forum) – an independent statutory body made up of local volunteers to help local people have their say in decisions about local health services. There is a PPI Forum for each NHS hospital trust and PCT.

Practice Based Commissioning (PBC) – GP practices and other primary care professionals working together to commission local, patient focused services. Bedfordshire has five locality based PBC consortia.

Primary Care – the initial contact for many people when they develop a health problem, usually their GP, alongside other frontline health professionals such as nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists.

Provider Services – the part of the PCT that provides a range of community health services such as podiatry, health visitors, district and school nurses. This will become an independent organisation in 2008.

Secondary Care – specialised medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary health care services.

Service Level Agreement (SLA) – a formal agreement between the PCT (as commissioner) and a service provider (eg hospital trust) that sets out the type, level and quality of the healthcare service to be provided.

Social Care – a broad range of services aimed at ensuring the independence and well-being of individuals, provided and commissioned by local authority social services departments.

Standards for Better Health – performance framework document for the NHS and social care, which sets out the level of quality all organisations providing NHS care are expected to meet or aspire to in England.

Strategic Health Authority (SHA) – known locally as The NHS East of England, it is one of 28 regional outposts of the Department of Health, undertaking high level planning and performance management.

Voluntary and Community Sector (VCS) – also known as the ‘third sector’, it includes any group or organisation that is managed or run by volunteers on a not-for-profit basis serving communities of interest, identity, association or neighbourhood.

14. Further reading and useful websites

E. Andersson, J. Tritter and E. Wilson E (Eds) *Healthy Democracy: the future of involvement in health and social care*. London: Involve / Centre for Involvement, 2007.

Audit Commission. *Connecting with users and citizens: public sector management paper*. London: Audit Commission, 2002.

I. Carruthers. *Service Improvement: Quality Assurance of Major Changes to Service Provision*. DH, Gateway reference: 7857 (2007). Available online at <http://www.dh.gov.uk>

A. Chisholm. *Patient and public involvement in PCT commissioning*. Oxford: Picker Institute Europe, 2007.

Department of Health: *The NHS Plan*. London: DH, 2000.

Department of Health. *Shifting the Balance of Power*. Leeds: DH, 2001.

Department of Health. *Strengthening Accountability: Involving patients and the Public: policy and practice guidance on Section 11 of the Health and Social care Act 2001*. London: DH, 2003.

Department of Health. *Building on the Best: Choice, Responsiveness and Equity in the NHS*. London: HMSO, 2003.

Department of Health. *Our health, our care, our say*. London: DH, 2006.

Department of Health. *Concluding Review of Patient and Public Involvement. Recommendations to Ministers from Expert Panel*. May 2006. Available online at <http://www.dh.gov.uk>

Department of Health. *A Stronger Local Voice*. London: DH, 2006.

Department of Health. *Commissioning Framework for Health and Wellbeing*. London: DH, 2007.

Developing Patient Partnerships. *Effective practice-based commissioning: engaging with local people*. London: DPP, 2006.

Involve. *People & participation: How to put citizens at the heart of decision-making*. London: Involve, 2005.

I. Kennedy. *Learning from Bristol: The Report of the Public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary*. London: HMSO, 2003.

D. Mason and P. Edwards. *Service Reconfiguration, Consultation and Judicial Review, 2nd edition*. London: Capsticks, 2006.

M. Mythen and Dr T. Coffey (Eds). *Patient Power: the impact of patient choice on the future NHS*. London: New Health Network, 2004.

D. Wanless. *Securing good health for the whole population: final report*. London: DH, 2004.

Commission for Patient and Public Involvement in Health: <http://www.cppih.org>

Department of Health: <http://www.dh.gov.uk>

Health Voice Network <http://www.patient.co.uk>

Healthcare Commission: <http://www.healthcarecommission.org.uk>

Involve: <http://www.invo.org.uk>

National Association for Patient Participation: <http://www.napp.org.uk>

NHS Centre for Involvement: <http://www.nhscentreforinvolvement.nhs.uk>

Patient Opinion: <http://www.patientopinion.org.uk>

PPI Specialist Library: <http://www.library.nhs.uk/ppi>

The Patients' Association: <http://www.patients-association.org.uk>

The Picker Institute Europe: <http://www.pickereurope.org>

Consultation stakeholders
Local NHS
Luton & Dunstable Hospital NHS Trust
Luton tPCT
NHS East of England
Bedfordshire & Luton Mental Health and Social Care Partnership NHS Trust
Bedford Hospital NHS Trust
East of England Ambulance Service NHS Trust
Local Government
South Bedfordshire District Council
Mid Beds District Council
Bedfordshire County Council
Bedford Borough Council
Leighton-Linslade Town Council
Dunstable Town Council
Joint NHS Scrutiny Committee
PBC groups
Chiltern Vale Health
Leighton Buzzard Locality
Ivel Valley Health Partnership
West Mid Beds Locality
Horizon Health Commissioning
Voluntary, community and public
Advocacy Alliance (Health Reference Group)
Bedfordshire Disability Resource Centre
Bedfordshire Advocacy Service for Older People
Voluntary Action Luton
Voluntary and Community Action South Bedfordshire
Bedfordshire Rural Communities Charity
Community and Voluntary Service Mid and North Beds
Bedfordshire and Luton Mind
Older Peoples Action Group
Dunstable and District Association of Senior Citizens
Bedfordshire Diversity Forum
Age Concern Bedfordshire
Bedfordshire Race Equality Council
Bedfordshire PCT PPI Forum
Sampled members of the PCT Health Panel

