REACH Solihull

An evaluation of a public engagement in priority setting exercise

Final report

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EXECUTIVE SUMMARY

REACH (Reaching Economic Alternatives that Contribute to Health) is a deliberative group exercise based on a board game, where citizens are asked to discuss and prioritise a range of interventions that address the social determinants of health. It is designed to facilitate public involvement in difficult choices over budget allocation and to increase awareness of the wider determinants of health and wellbeing. There are four rounds in the game:

- Round one – choices are made as an individual
- Round two – in a small group of 3 to 5 people
- Round three – as a whole group
- Round four - as an individual again

In spring 2014 the Health Services Management Centre and the Institute for Local Government, in collaboration with Solihull Health and Wellbeing Board (HWB) ran three REACH events in Solihull (the version was modified to include only rounds 1, 2 and 4). The aim was to test and appraise the value of the game for citizens and decision-makers in Solihull.

The choices made by participants before and after the group discussions were relatively consistent, demonstrating that most people stuck to their original decisions, but gained an understanding of opposing opinions and an appreciation of how compromise has to be reached in order to make group decisions. Some chose to vote to achieve group decision, others argued it out to consensus.

When making decisions participants drew on a wide range of considerations including: the effectiveness and cost of interventions; alternative ways in which the money could be spent (opportunity cost); issues of personal responsibility and equity; levels of need, and age.

The process evaluation indicates that overall participants found the REACH events accessible, stimulating and enjoyable. The total cost of running the events was £2,100 not including facilitator time and printing costs and not withstanding venues which were provided free of charge.

The outcome evaluation with participants found the following:

It is currently unclear how the Health and Wellbeing Board intend to use and/or take forward this stream of work. However the approach taken has since been presented to international audiences – including the originators of the US REACH game – and has been well received. Participants in the game generally felt that outcomes should be fed into strategy and decision making, although there was some cynicism expressed as to whether this would happen in practice.

The evaluation suggests that participative benefits were felt by those involved in that people welcomed the opportunity to have their say and the level of debate and interaction appeared to be very high. The educative benefits of the REACH exercise are demonstrated through the enhanced awareness of both the social determinants of health and the challenges of allocating scarce public resources.
Overall the evaluation supports the use of REACH UK although some questions remain over how best to incorporate the instrumental aspects of the game into local strategic planning and decision making.

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1. Introduction and aims

Background

Following the Marmot (2010) report into health inequalities in England, there has been a renewed emphasis on the need to tackle wider determinants of health and wellbeing, such as work, housing, and social care, and in so doing to connect areas of public service that have until now remained structurally and professionally disparate. There has been some acknowledgment that the dominant medical model of healthcare has failed to tackle these root causes of health and health inequalities, and health service reform has seen public health responsibility transferred to local government and the institution of multiagency Health and Wellbeing Boards (HWB) with responsibility for tackling local inequalities (DH 2010). However reforms are taking place against a backdrop of austerity and resource scarcity suggesting the need for prioritisation of service investment and disinvestment options. Furthermore, established methods and aides for setting priorities typically adopt a narrow definition of what constitutes health care costs, benefits and services. As a result, there is little by way of guidance for those seeking to assess and/or rank programmes designed to address wider determinants of health.

The Marmot review also advocates the empowerment of citizens and communities through participatory decision-making at local levels, suggesting the need for engagement which is participative and which fosters active deliberation. This call is echoed in the health care priority setting literature where meaningful public participation has been relatively rare to date (Waite & Nolte 2006, Williams et al 2012). The REACH exercise therefore offers an invaluable opportunity to:

- develop a priority setting tool with relevance to the agenda of health inequalities and wider determinants of health,
- develop a deliberative methodology for involving citizens in priority setting, and
- raise overall awareness of the challenges of service design and delivery in a context of austerity.

The game

REACH (Reaching Economic Alternatives that Contribute to Health) is a deliberative group exercise based on a board game, where citizens are asked to discuss and prioritise a range of interventions that address the social determinants of health. It was developed by academics in the USA (Pesce et al 2011).

Blacksher and colleagues argue that deliberation is, (1) based on balanced factual information that increases participants’ knowledge of the subject, (2) includes diverse perspectives of citizens to provide a balance to expert opinion, and (3) creates an environment where all participants have an equal chance to give their views, be heard, and consider alternative views (Blacksher et al 2012). The game is designed to include these three factors, through the use of an information booklet, and facilitated group discussions.
An English version of the US REACH game was developed by Dr Kate Warren, Specialty Registrar in Public Health. The game content was modified to reflect the Marmot framework for reducing health inequalities, and with the input of a group of expert advisors;

- Dr Iestyn Williams, Senior Lecturer at HSMC, expert in healthcare priority setting
- Dr Marion Danis, Department of Bioethics, National Institutes of Health, US Department of Health
- Hilary Brown, Senior Fellow at HSMC, expert in patient and public involvement
- Catherine Mangan, Senior Fellow, Institute of Local Government Studies, University of Birmingham
- Sangeeta Leahy, Senior Public Health Specialist, Solihull Metropolitan Borough Council

In the REACH game, participants select interventions based on simple descriptions of how the interventions work and an estimate of their relative costs (indicated by the size of the segment on a pie chart, see Figure below). The resources held by participants are not sufficient to fund all available interventions and therefore choices have to be made, by allocating a limited number of stickers to the various segments on the game board. In several rounds of the exercise, people work on their own and in small groups to establish priorities for themselves, their neighbourhood, and their city. In between rounds people are given the chance to reflect on the impact of their choices by considering Story Cards. These give a brief overview of a real-life case study of someone who has benefited from a similar intervention, which serve to illustrate the potential impact of having selected (or not selected) the relevant intervention. Insight from a final group discussion, as well as pre- and post-game questionnaires, is collated and fed back to decision makers.

**Figure 1: Game materials**
Full versions of the game materials are available on request. Intended outcomes of using the game include:

- **Instrumental**: To what extent were outputs from the REACH exercise influential in subsequent strategy and decision making in the area?
- **Participative**: To what extent was democratic accountability promoted and/or enhanced through engagement process?
- **Educative**: To what extent does the REACH exercise enhance awareness of socioeconomic interventions for health? To what extent did the exercise generate informed deliberation regarding the resource allocation/prioritisation process?

**The process**

In November 2013, HSMC presented an opportunity for collaboration with Solihull Health and Wellbeing Board (HWB) to run a series of REACH events in Solihull in Spring 2014. The aim of the events was to test and appraise the value of the game for citizens and decision-makers in Solihull.

Solihull HWB had written a Health and Wellbeing Strategy for Solihull, which was based on the Marmot framework, and had consulted on the strategy, but there had been no public involvement in deciding which areas of work were a priority for action. A lack of public engagement in the work of the Board was subsequently highlighted as a local challenge, during the Local Government Association peer challenge process in February 2014.

The re-developed game was test-run in two deliberative events held at the University of Birmingham in January 2014. Participants in the events (total=32) were made up of postgraduate students (drawn from health and social care organisations) and ten service users. Overall, the events ran smoothly and feedback was positive, and only minor amendments were found to be necessary.

The final version was used in three deliberative events in Solihull in April 2014 (described in the Section 2).

This version was also run with two groups of postgraduate students in January 2015 and observations from these events are included in Section 7.
2. Profile of groups

Recruitment for the Solihull events was facilitated by Sangeeta Leahy, Senior Public Health Specialist, Solihull MBC, and carried out by AgeUK Solihull, North Solihull Partnership and Healthwatch Solihull.

Table 1: Summary of events

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Recruitment by</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1/4/14</td>
<td>AgeUK</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>8/4/14</td>
<td>North Solihull Partnership</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>9/4/14</td>
<td>Healthwatch</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

The aim of the recruitment strategy was to obtain a broad demographic spread of participants in order to generate a more balanced and varied debate. A breakdown of participants by demographic characteristics, with Solihull population references from the 2011 Census, is given in the tables and figure below.

Although we heard from a broad range of ages, the geographical spread was limited due to the small number of events, and men were under-represented.

Table 2: Sex

<table>
<thead>
<tr>
<th></th>
<th>Number (%) of participants</th>
<th>Solihull population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>8 (24)</td>
<td>49</td>
</tr>
<tr>
<td>Female</td>
<td>26 (76)</td>
<td>51</td>
</tr>
</tbody>
</table>

Table 3: Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Number (%) of participants</th>
<th>Solihull population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>30 (88)</td>
<td>89</td>
</tr>
<tr>
<td>Non-white</td>
<td>4 (12)</td>
<td>11</td>
</tr>
</tbody>
</table>
Figure 2: Age group

Table 4: Electoral ward

<table>
<thead>
<tr>
<th>Electoral ward</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bickenhill</td>
<td></td>
</tr>
<tr>
<td>Blythe</td>
<td>1</td>
</tr>
<tr>
<td>Castle Bromwich</td>
<td>3</td>
</tr>
<tr>
<td>Chelmsley Wood</td>
<td>2</td>
</tr>
<tr>
<td>Dorridge and Hockley Heath</td>
<td>1</td>
</tr>
<tr>
<td>Elmndon</td>
<td>1</td>
</tr>
<tr>
<td>Kingshurst and Fordbridge</td>
<td>7</td>
</tr>
<tr>
<td>Knowle</td>
<td>1</td>
</tr>
<tr>
<td>Lyndon</td>
<td></td>
</tr>
<tr>
<td>Meriden</td>
<td></td>
</tr>
<tr>
<td>Olton</td>
<td>1</td>
</tr>
<tr>
<td>Shirley East</td>
<td></td>
</tr>
<tr>
<td>Shirley South</td>
<td></td>
</tr>
<tr>
<td>Shirley West</td>
<td></td>
</tr>
<tr>
<td>Silhill</td>
<td></td>
</tr>
<tr>
<td>Smith's Wood</td>
<td>7</td>
</tr>
<tr>
<td>St Alphege</td>
<td>2</td>
</tr>
</tbody>
</table>
3. Results

In understanding these results, the reader is reminded that the scenarios and programmes presented to the participants, although based on reality, were hypothetical. The size of the programme, its cost, its target audience and other factors are variable and these will have affected the choices made by participants. This will be discussed further in Section 4, for example, if speed limits cost less, more people would have chosen it. However, in the absence of a “real” choice scenario, deliberation can be used to stimulate debate and to generate understanding between people with opposing opinions, as part of an ongoing strategy of engagement with citizens.

The original REACH exercise involves 4 rounds, including a round in which the full group deliberates together (Goold 2005). However for expediency the Solihull project used 3 rounds in the game:

- Round one – choices are made as an individual
- Round two – in a small group of 3 to 5 people
- Round three – as an individual again, following a whole group discussion

The choices made by participants before and after the group discussions were relatively consistent (as seen in the Figure below), demonstrating that most people stuck to their original decisions, but gained an understanding of opposing opinions and an appreciation of how compromise has to be reached in order to make group decisions (see Section 6 for illustrative quotes from participants). Some chose to vote to achieve group decisions, others argued it out to consensus.

Figure 3: Participants’ choices
Some participants chose not to use all of their funds on the available programmes, and some suggested alternative programmes which they would like to see funded, including suicide prevention, addiction services, cognitive behavioural therapy and litter/graffiti removal.

The process of decision-making differed between groups; some considered the programmes in the order they were presented, others took a strategic approach, for example choosing a group of programmes which are synergistic, others came at it from a financial perspective by committing to larger wedges first. The game is non-prescriptive in terms of how group determinations are reached.

Throughout the games and in subsequent interviews participants voiced their opinions on how realistic the games are, based on their perceptions of actual decision making. These perceptions diverged and included, for example, comments such as ‘in real life it wouldn’t happen like this’ and ‘it would probably be like this in real life’. Often the perception of participants appeared to be that real life decision making would be more rational – i.e. drawing on evidence-based assessment and rigorous processes – than the game depicts. Others identified the budgetary constraints as being over-simplified:

‘In real life I would know that some of these services could be funded from elsewhere so I would spend the money on one program and then apply for funding for another but that’s because I have some experience. Also in real life you wouldn’t fund all of something but you would put some money into lots of programs’ (Participant in event one)

The influence of somebody with personal experience of the issue under debate, or a ‘champion’ for a particular cause, was seen as influential in persuading others within a group to select a particular intervention:

‘It seems a lot of this is, obviously what happens in a discussion of this nature, it’s coming from personal experiences of individuals and it really depends how strongly that individual voices their opinion in the group discussion, which I think would happen in reality in any type of committee meetings etc. anyway’ (Participant in event one)
4. Drivers of decisions

Participants in the deliberations were given an opportunity to explain their decisions after the events and these discussions were audio-recorded. This section describes some of the drivers identified and includes selected verbatim quotes.

Effectiveness

A key discussion point in each of the events was the extent to which the programmes were likely to achieve significant benefits. Here participants drew on the information provided but also their own experiences and judgement:

‘Youth advice, right a drop-in service is not going to be used because you’ve got to actually get the bottle to go in there and ask for help. You need designated youth centres where you can build relationships with these kids and then you find out their problems. They don’t just drop in.’ (Group one participant)

‘I personally didn’t choose speed limits because I think nobody takes any notice’ (Group three participant)

Cost

Perhaps unsurprisingly cost was also frequently mentioned in discussions over how to allocate the budget. More often than not, costs were considered relative to benefits. In other words, participants were prepared to forego some benefit if the costs were perceived to be excessive.

‘We felt that youth advice was important but it was eight dots. If it had been two or three it would have definitely gone in.’ (Group one participant)

‘I would probably have picked speed limits if it were two or three sticker area. I think it’s too big a slice compared to everything else’ (Group two participant)

‘I thought some were too big, needed less dots. I’d happily put less dots in some of them’ (Group three participant)

Opportunity cost

In two of the events (2 and 3) the principle of opportunity cost was invoked in defence of decisions taken with participants alluding to the need to trade off benefits. Participants in the first event were more equivocal in this regard, often preferring to make appeals for a greater overall allocation.

‘With better health care and housing people are living longer. We are an ageing society so what resources are there have got to be stretched further or a bigger chunk has got to be taken out of the overall budget which will mean something else will suffer. That’s just a fact’ (Group two participant)
‘I think it would be good but when you’re faced with all those different choices on that piece of paper it’s just like well I can’t look at that at all when there’s these other issues. In an ideal world then perhaps yes’ (Group three participant)

**Prevention**

Although each of the programmes included in the game was selected because they addressed the determinants of health and wellbeing, participants argued that investment in some would negate (or reduce) the requirement for others.

‘If you can get the parents educated and knowing what to do with their children, eventually hopefully their children will follow suit and a lot of them it will cut down the money you need to spend on things like youth advice and education’ (Group one participant)

‘We chose parenting courses because we thought that with the childcare and probably family learning as well because you can have young offenders and parents and youth advice there’s less chance of offending’ (Group three participant)

**Deservingness vs equality**

The extent to which deservingness should feature in decision making was hotly debated. Whilst some felt that lifestyle, personal choice and contribution should be a significant driver, others contested this arguing that it was difficult and/or unfair to establish who does and doesn’t deserve to be prioritised. The principle of equity (or equality) was invoked as an important consideration for resource allocation.

‘We’ve [older people] paid it in. I’m sick of hearing people say we’re taking it out – we’ve actually paid it in. But then it doesn’t mean we can’t open it all out to make sure everyone has a share of the pot’ (Group two participant)

‘For example the weight management, I think a lot of that is down to willpower. You can put people on a course for eight weeks and hold their hand … but a lot of it comes down to willpower … if they’ve got the willpower they’ll lose weight’ (Group two participant)

‘We chose the living wage. I mean it’s just about equality of life. The poorer you are you eat a lot of bad food and you can be poor because you’re spending a lot of money on childcare. It’s all interlinked’ (Group three participant)

**Age**

In general, participants did not cite age as being an important driver of their decisions although some did note the relative lack of programmes targeted specifically at older age groups. A minority expressed the view that age should be a consideration:
‘I think generally children should have the priority because the more you can educate people to do things healthily the problem’s going to move away so ... and the children are going to go home and tell their older people as well’ (Group three participant)

**Population need**

In a small number of cases participants made direct reference to the importance of collecting information on population need in addition to generic effectiveness information.

‘I think you need to look at population as well. Like how many people are say older in one area, how many people are younger? Because you can’t say ‘well in Solihull we’ll have more for older people’ if there’s more younger people so you have to look at the population and break it down that way’ (Group three participant)
5. Process evaluation

A post-event survey showed that the vast majority of participants rated the events highly in terms of enjoyment, user-friendliness, and level of involvement (as seen in the Table below). Observations from facilitators at the events showed that the level of debate was stronger when the groups were mixed in terms of age group, sex, and background, and when participants were encouraged to sit in a circle and discuss the issues with each other, rather than facing the front and addressing the facilitator.

Table 5: Post-event evaluation survey results

<table>
<thead>
<tr>
<th>Number of respondents who agreed or strongly agreed</th>
<th>Event 1</th>
<th>Event 2</th>
<th>Event 3</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I found it enjoyable</td>
<td>7</td>
<td>14</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>2. The instructions were easy to follow</td>
<td>7</td>
<td>14</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>3. The amount of information about the different programmes was about right</td>
<td>6</td>
<td>14</td>
<td>9</td>
<td>97</td>
</tr>
<tr>
<td>4. The way the group reached a decision was fair</td>
<td>6</td>
<td>14</td>
<td>9</td>
<td>97</td>
</tr>
<tr>
<td>5. I had a chance to give my views</td>
<td>7</td>
<td>14</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>6. My views were listened to</td>
<td>7</td>
<td>14</td>
<td>8*</td>
<td>100</td>
</tr>
<tr>
<td>7. It was clear how the views of the group would be fed back to the Health and Wellbeing Board</td>
<td>5</td>
<td>14</td>
<td>9</td>
<td>94</td>
</tr>
</tbody>
</table>

*1 blank response

Examples responses from interviews include:

‘It was interesting and it flowed very well. By that I mean you weren’t stuck for things to do and the time went very quickly’ (Participant in event two)

‘I thought it was interesting, it was really interactive. It gave us an opportunity to appreciate the value for money and a better understanding of what it what it was we were funding, why we were funding and like different arguments for its importance or lack thereof’ (Participant in event three)
The total cost of running the events was £2100 (expenses and incentives) plus University staff time and printing costs. Support in kind was provided by Solihull MBC, who provided the venue for two of the events and a small amount of staff time for administration, and AgeUK and Solihull Healthwatch who assisted with recruitment. Comments were made by some participants that the £50 incentive payment was excessive and that they would have participated without the incentive, although none of the participants turned down the gift and it is likely to have increased attendance.
6 Outcome evaluation

In the period since the events were held, the approach adopted has been validated at academic conferences to audiences which include the originators of the US version of the REACH game (Warren and Williams, 2014). We also sought to collect evaluative data on the three dimensions of instrumental, participative and educative benefits (Williams et al. 2014).

**Instrumental**

Instrumental outcomes can be measured by the extent to which outputs from the REACH exercise are influential in subsequent strategy and decision making. The evaluation team and Solihull H&WBB are still in talks over the future strategy with regards to the REACH game. Participants in the events expressed a view on the instrumental potential and likely outcomes in follow up interviews.

On balance, interviewees were noncommittal as to the preferred role that the events, in the form that they were run, should play in decision making and strategy building:

‘If everyone says the same thing then that should be taken notice of. For example everyone in our event wanted the main focus to be on services for children because that helps everyone in the long run’ (Participant in event three)

‘I think it should go to whoever the relevant body is who decide upon funding and I think they really need to think very long and hard before they decide who gets what money and look at the benefits and not just hand out the money … and they should take notice of the people who live in the area’ (Participant in event two)

However there was a hint of cynicism in responses to the question ‘what do you think the events will be used for?’

‘At the end of the day it’s just discussions between people and I think at the end of the day it isn’t going to make the slightest difference to anybody. If someone could say that x, y, z’s come out of it I would be interested but I don’t see x, y, z coming out of it’ (Participant in event three)

‘I hope people listen. When it comes to it I think they will allocate money where they see fit. I don’t think generally people’s views are taken on board – i.e. the local people in the local community. I hope it is but I don’t think it will be’ (Participant in event two)

The results of the three events and participant evaluation were fed back to members of the Solihull Health and Wellbeing Board at a development session on 1st July 2014. Members agreed that two-way dialogue seemed to be more productive in engaging people in these issues than one way information-giving or consultation.

Members agreed that this methodology of deliberation around priority setting could be useful to raise awareness of the challenges that the Board face in allocating scarce resources, and to defend the process of decision making at strategic levels.
The implications of attempting to design the game around ‘real life’ decision options were considered. Benefits include a more direct line of influence from citizen to decision-making, which could result in a feeling that their input is more worthwhile. Barriers include the difficulties of balancing the views of citizens alongside other considerations such as national priorities, political pressures, financial constraints, as well as the need to involve much larger numbers of citizens in order to make the views representative of the population as a whole. It was also felt that keeping the game hypothetical, but realistic, allowed more freedom of expression and a sense of fun to develop in the events, allowing flow of discussion that would not otherwise be achieved (Hardie, 1988:57 in Mitton 2011). If citizens were asked to debate actual funding decisions, they would inevitably take the discussion more seriously and require additional information in order to come to a decision.

In order to explore potential next steps, Board members asked Healthwatch Solihull to take forward discussions with HSMC on their behalf, and consider how the REACH game or similar methodologies could be integrated into an ongoing programme of engagement with citizens about health and wellbeing and the work of the Board.

HSMC will carry out follow-up interviews with Board members once progress has been made on this work, in order to further evaluate the instrumental benefits of the game.

**Participative**

Participative outcomes can be measured by the extent to which participants feel they have chance to express their views, and have respectful debate with others. Overall the participants in all three events valued the deliberation process:

‘It was easy to understand and to follow, and it was well run. And it’s good to meet people in the area and to have the banter ... Especially the second round when we discussed as a group and had a heated debate. That was the most enjoyable part’ (Participant in event one)

‘I didn’t always agree with the people I was on the table with but that’s all part of a healthy discussion and it was nice to hear how people would tackle things perhaps differently to how I would tackle things ... In the end two agreed against one so I had to concede’ (Participant in event two)

‘It gave us an opportunity to have a go at each other’s views which is always fun’ (Participant in event 2)

‘I think the important thing was for us to know why people felt the way that they felt as opposed to trying to change minds’ (Participant in event two)

These comments indicate that the nature of the deliberation was both high-level and rewarding for participants. The over-arching aim of generating informed and mutually respectful discussion appeared to have been achieved:
‘Different views. We had to basically compromise. What we found was the group decision – if you go back to what you originally thought, do you agree with the group decision or your own? And 50% agreed with the group decision and 50% their own, which we thought was interesting’ (Participant in event one)

‘My choices were the same at the end as at the start. Maybe if I had more time and information on some of the other programs I might have changed my mind. I went for the programs that I know work and are valuable’ (Participant in event one)

‘We talked them into spending money on green spaces because we think it’s something as a community we should have … but we then had to compromise on the ones that cost less money. So for example I had got down business support but the group as a whole chose other things’ (Participant in event three)

Clearly, these events are of a modest scale and scope and therefore it is important not to claim undue participative benefits. However they do suggest that the complex and difficult business of allocating resources for health and wellbeing can be tackled by citizens.

**Educative**

Educative benefits can be gauged by the extent to which the REACH exercise enhances awareness of both the social determinants of health and the challenges of allocating scarce public resources.

In the United States, research conducted by the team who invented the REACH game found differences between before and after opinions on determinants of health; specifically more people afterwards thought that income and neighbourhood were important for health. Due to small numbers of participants, we were not able to demonstrate a statistically significant before-after difference in opinions, although the percentage who agreed that income and neighbourhood are important for health and wellbeing increased in two of the groups (see Figure below). There was however, quite a marked difference in opinions between groups, with people in the Chelmsley Wood event rating income and neighbourhood as less important than lifestyle.
The reasons for this observation can only be guessed at. It may be a chance finding, and a larger sample size would be needed in order to substantiate an association. It may be a reflection of political viewpoints about personal versus collective responsibility for health. It could be that the citizens in Chelmsley Wood and surrounding areas have experienced lower incomes and less affluent neighbourhoods, but feel a sense of resilience despite their circumstances. There were some comments made in the group discussion which corroborate this latter argument:

‘They [people in affluent areas] don’t know how to work on benefits, they don’t know how to do things like that. We know, we’re brought up with the fact that we’ve gotta survive, you know what I mean’ (Participant in event two)

‘If you do your own ideas you can raise money that way, we do it, that’s how we do it, instead of asking everyone for money all the time, we come up with events to raise money to put back into [a local project]’ (Participant in event two)

However, it could also be supposed that the people who attended these events are a self-selected group of interested citizens, who may have higher levels of resilience than the general population in those areas, and this could have skewed the results.

Overall comments and subsequent interviews indicate that many participants already had a sound grasp of the social determinants of health and therefore the main educative benefits related to understanding of the challenges of making spending decisions in a context of resource scarcity.

‘The game was useful in making me think about how these decisions are made and should be made. I hadn’t thought about those things before’ (Participant in event one)
There was a load of people there discussing things that are quite taboo and can be quite controversial. It was interesting to hear views across quite a broad spectrum, how you can justify what causes could have more money than others’ (Participant in event two)

I think it’s very difficult to pinpoint an area that gets money and another doesn’t so that’s obviously difficult’ (Participant in event three)

‘It was very useful, simply because I didn’t know much about exactly the kinds of things the NHS funds. It was quite shocking to learning about the kinds of things money was going towards ... the job stuff, green spaces, traffic lights stuff like that ... which I think should be done by other agencies like the job centre and law enforcement’ (Participant in event two)
7. Additional observations from events held with postgraduate students at the University of Birmingham

During January 2015 two further deliberative events were held with postgraduate students at HSMC, as part of a Masters module on Public and User Involvement. The game was run as though it was a real-life event involving members of the public and students were asked to reflect on the ability of the exercise to engage people in priority setting, the logistics of running these kinds of events for members of the public and their own personal experience of taking part in a deliberative exercise of this nature.

**Ability of exercise to engage the public**

Overall, participants felt the game was enjoyable and had the potential to engage members of the public in the complexities of priority setting. However, there were a number of comments about whether the conceptual nature of the exercise, rather than a ‘real-life’ scenario, would act as a barrier to engagement. It was also suggested that the pre-determined nature of the services ‘on offer’ may disengage people if they could not feel a sense of ownership with the potential choices from the outset.

Though materials were simplified, participants commented on the presence of some jargon within the briefing and some assumption of prior knowledge which might act as a barrier to engagement - notably, the use of the term Health and Wellbeing Board and whether the majority of members of the public would have any knowledge of what the remit of this group was.

Other suggestions for improving engagement included the use of more visual representations of information, the inclusion of locally specific data, and the use of real-life costings for services. The latter in particular was felt likely to facilitate a quite different kind of debate than was evident with indicative allocative proportions.

In general though, participants felt the game stimulated debate and was not overly complicated.

**Logistical considerations**

The amount of preparation and planning involved in running this kind of event was commented on by a number of participants. This related to all aspects of the delivery of the event and not just the preparation of materials for the day. The selection of, and invitation of, participants was seen as a particular challenge, with the composition of the whole group and sub-groups to be thought about carefully to ensure a diverse range of views and experiences were represented, while ensuring an equal balance of power among participants, as far as practically possible. This latter point was made in relation to the inevitable presence of professionals with some experience of health and social care services in the body of the public and how this might influence either the contribution of other participants, or the nature of the discussion.

The need for strong facilitation skills was therefore also recognised by participants, particularly with regards to providing a clear explanation of the rationale for undertaking the exercise and how the outcomes of the exercise would be used. It was also suggested that have table facilitators might be
helpful to ensure that everyone’s voice was heard and that more confident participants did not dominate the discussions.

The opportunity to consider an individual response to the exercise before attempting to determine a group decision was appreciated and noted as a means for less confident participants to establish their ideas and views before being asked to share these with the group.

Many participants felt that they did not have access to enough information to make well-informed decisions and that they were forced to make a number of assumptions about what services would deliver and for whom. Various suggestions for improving this were given, including the provision of a researcher in the room who could be called upon by participants as required to provide additional information and facts and figures. An alternative view was provided which suggested that the level of information provided had ensured accessibility for a wide range of likely participants and had simplified complex issues appropriately. There was some confusion however over the use of the different colours used in the materials and whether this was significant and represented services that could be linked together, or shared a common purpose.

The use of the story cards divided opinion – some participants felt they were helpful and engaging, while others felt the first person narrative was too anecdotal. Some participants also felt that the story cards were consistently positive and there was no criticality about the services on offer.

The requirement for reinforcement of purpose at the end of the exercise was considered important as was the need for information on what would happen after the event to participants’ views and comments.

**Nature of Deliberative Events**

Though most participants felt they had enough time and opportunity to explore the rationale behind their decisions, others felt these had not been fully explored. Most participants felt the process had been inclusive and democratic though a number felt there had been an unequal share of voice within groups at times.

Some commented that the game could potentially feel quite intimidating for people if they were not used to being challenged on their opinions by others while others commented that the exercise had provided a ‘safe space’ within which to test out their thoughts and had helped them to challenge their own assumptions and unconscious beliefs about specific issues. Others noted that they had been very conscious of being open-minded and respectful of other people’s opinions and not making judgements about their values.

There were differences of opinion as to whether the presence of individuals with particular experiences of services was helpful. Personal stories told by other participants could help to explain the relevance or importance of a particular service but this might be at the expense of another service for which there was no ‘champion’ present. A number of participants commented that they felt a sense of responsibility as they made their decisions about how their views and opinions might affect other people’s lives and were conscious that there would be ‘winners and losers’. Some participants also noted that it was difficult not to let their choices be influenced by whether they or
their family would be likely to personally benefit or not from their decisions, if the exercise was a real-life situation.

The means by which groups made their decisions and achieved some form of consensus was explored in some depth by participants. For some groups, it was important to consider how the package of services they choose to fund would work as a whole and if synergies could be maximised and therefore additional value be obtained. Other groups made strategic decisions on the basis of future gain, rather than immediate impact, so services for children were expressed as ‘investing in the future’ and ‘preventative options’ rather than problem resolution. Many groups opted to take a democratic approach and vote to achieve an agreed allocation, while others preferred to continue to debate the issues until consensus was achieved. Some participants commented that given the artificial nature of the exercise, their group discussions had been less passionate than they might have been in real life, if real funding was at stake.

8. Conclusion

There is a drive to engage members of the public in wider debates about health and wellbeing, and particularly the social determinants of health, which should be championed by the Health and Wellbeing Board. This is currently seen as a challenge in some areas. The REACH game aims to achieve this through deliberation, rather than through traditional empowerment approaches to engagement used in health services in the recent past (Blacksher 2013). The aim is to achieve informed, respectful debate between citizens, which allows people to develop an understanding of different perspectives and priorities. The game has been successfully modified to enable its use with members of the public in England, and participants found the game enjoyable and easy to follow.

This project was a small scale pilot of the approach, which has demonstrated that the game can achieve benefits, particularly for the participants, and specifically educative (a greater appreciation of the role of decision makers and the challenges of priority setting in a resource scare environment), and Participative:

“the most important aspect of citizen participation for a healthy democracy would appear to be not to have real power and a say in decision-making. Much more important are aspects of democratic citizenship, that is: the development of civic skills, the increase of public engagement, and the opportunity to meet and discuss neighbourhood issues and problems” (Michels & De Graaf 2010)

The instrumental benefits of producing fairer, more appropriate resource allocation decisions are yet to be established, and further work is planned with Solihull Healthwatch and Health and Wellbeing Board in order to evaluate the utility of the REACH game for these organisations.

The implications, both positive and negative, of attempting to design the game around ‘real life’ decision options have been considered. There is a choice to be made between the use of deliberation for “sense-making” in open-ended discussions, or for “problem-solving”, consensus
generating purposes in discrete scenarios (Duffield Hamilton et al 2006). The REACH game in its current form has shown most promise for the former.

Successful recruitment is a key determinant of success for this methodology, not for the purposes of representativeness, but rather to ensure that the participants have a diverse range of views and therefore a lively debate can be sustained, and that participants can learn from one another’s opinions and values. Incentive payments were found to be a useful tool to achieve diversity in the sample during this project.


