

Patient and public engagement and  
involvement in clinical commissioning;  
socio-material pedagogies of partnership

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## **Abstract**

Clinical Commissioning Groups (CCGs) in England are legally required to engage and involve service users (patients and carers) and the public. Direct engagement and partnership working with service users is an imperative for healthcare and healthcare improvement. It is less well-developed between clinical commissioners, who are predominantly general practitioners (GPs), and service users and the public.

A focused ethnography approach was used to explore service user engagement practices for commissioning and leading health and care services with clinicians in the process of strategic clinical commissioning. Two CCG case study sites in the south of England were studied; one urban and the other rural. The primary research question was:

*What does it mean to work in partnership as clinicians and service users to commission and lead services?*

Secondary questions related to the nature of engagement and involvement practices, by exploring if partners in engagement relationships could be viewed as trusted peers. Three focus groups, 15 observations and relevant artefacts such as reports and minutes of meetings, and 13 face-to-face interviews were undertaken. All 21 informants were either service users, lay representatives on CCG Governing Bodies or GP clinical commissioning Leads, residing and/or working within the boundaries of the CCG communities.

Four sets of situated learning practices were found as the CCG communities evolved to align with partnership working requirements for clinical commissioning; trust, leadership, learning and partnership. A practice theory lens was used to offer new insights with respect to the socio-material aspects of the situated learning. Using Wenger's seminal work on communities/landscapes of practice enabled a deeper analysis of the data examining participation, materiality, competence, boundary encounters and meanings. This articulated both the visible and hidden

practices shaping patient and public engagement and involvement (PPEI) in the two CCGs.

PPEI is a less well researched aspect of commissioning especially with GP clinical commissioners. Even less attention is paid to the socio-material context for this learning. The entangled and distributed quality of PPEI was found to be influenced by identification with present and past communities of practice and specific boundary encounters. The enablers, constraints and pre-requisites for PPEI in clinical commissioning were identified and these allow recommendations for both learning and practice.

PPEI for clinical commissioning will persist with the newer Sustainability and Transformation Partnerships (STPs) in the English NHS. Leadership and commissioning curricula for GP and other healthcare professionals must be cognisant of the socio-material practices of partnership working.

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## **Acronyms and definitions**

<b>ACS</b>	Accountable Care Systems
<b>ACO(s)</b>	Accountable Care Organisation(s)
<b>CCG(s)</b>	Clinical Commissioning Group(s)
<b>CHC</b>	Community Health Council
<b>CoP(s)</b>	Community of practice /communities of practice
<b>CSU</b>	Commissioning Support Unit
<b>FYFV</b>	Five Year Forward View
<b>FFT</b>	Friends and Family Test
<b>GB</b>	Governing Body
<b>GP</b>	General Practitioner
<b>GPFH</b>	GP Fund Holding
<b>HASCA</b>	Health and Social Care Act 2012
<b>HEE</b>	Health Education England
<b>HWB</b>	Health and Wellbeing Boards
<b>ICO(s)</b>	Integrated Care Organisation(s)
<b>ICS</b>	Integrated Care Systems
<b>IFR</b>	Independent Funding Request
<b>KPI</b>	Key performance indicators
<b>L-A-P</b>	Leadership-as-practice movement
<b>LINKs</b>	Local Involvement Networks

<b>LPP</b>	Legitimate Peripheral Participation
<b>NHS</b>	National Health Service
<b>OOH</b>	Out of Hours
<b>PBC</b>	Practice-based Commissioning
<b>PCG</b>	Primary Care Group
<b>PCT</b>	Primary Care Trust
<b>PIS</b>	Participant information sheet
<b>PPE</b>	Patient and public engagement
<b>PPEI</b>	Patient and public engagement and involvement
<b>PPG(s)</b>	Patient participation group(s)
<b>PPI</b>	Patient and public involvement
<b>R&amp;D</b>	Research and Development
<b>SHA</b>	Strategic Health Authority
<b>SMS</b>	Self-management support
<b>STPs</b>	Sustainability and Transformation Partnerships
<b>SU</b>	Service user/ carer
<b>TPP</b>	Total Purchasing Pilots
<b>VCS</b>	Voluntary and community sector
<b>WCC</b>	World Class Commissioning
<b>WHO</b>	World Health Organisation

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## Candidate's declaration

*I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree and does not incorporate any material already submitted for a degree.*

*Signed*



*Dated*

28 May 2019

## **Chapter 1: The context of clinical commissioning**

### **1.1 Introduction**

This PhD study began as an investigation of partnership working between clinicians (general practitioners) and service users and the public to commission and lead health and care services. The intention was to explore the experiences of the clinicians and service users/public and examine the underpinning knowledge, beliefs and practices of patient and public involvement. Particularly, how these were constructed to have purpose and meaning within the changing culture of the English National Health Service (NHS) following the Health and Social Care Act 2012 (HASCA). (1) The legislation intended general practitioners (GPs) to take on greater responsibility and accountability for the commissioning of services on the basis that they could do better than non-clinical managers and would be more responsive to the needs of patients. (2) New knowledge and understanding could therefore inform practice as well as curricula for health care professional education, especially where there would be a focus on leadership and commissioning.

In January 2014, when this Higher Education Academy sponsored PhD study programme commenced, public trust in the NHS and patient experience were to the fore. 'No decision about me without me' had already become the rhetoric of putting patients and public first as part of a shared decision-making agenda. (3) The HASCA had been enacted and new organisations called Clinical Commissioning Groups were nearly a year into 'meaningful engagement with patients, carers and their communities'. (4) The final public inquiry report into standards of care at Mid Staffordshire NHS Foundation Trust had been published the previous year in February 2013. (5). More commonly known as 'The Francis Inquiry', because it was chaired by Sir Robert Francis QC, was deeply shocking. There were 290 recommendations to address the failings and poor standards of care which had occurred between 2005 –2009 in that NHS organisation: recommendations to rectify the leadership culture; to provide an accredited leadership framework that emphasised patient safety and effective care; to listen to patients and the public. There were also recommendations for the United

Kingdom (UK) regulators of medicine (General Medical Council) and nursing (General Nursing and Midwifery Council) and the education providers too. Educational institutions were to ensure they selected candidates who would become compassionate and patient-centred health care practitioners.

This was about public trust in the broader sense and not just an NHS provider organisation and its secondary care hospital. The voices of patients and their families had not been heard and neither had it been easy for clinical staff to raise concerns because of the leadership model that had prevailed within the institution. Two further reports in 2013 addressed patient safety and standards of care as a follow up to the Francis Inquiry. One was from the National Medical Director for the NHS in England and examined the quality of care and treatment in 14 NHS hospital organisations where mortality rates had been persistently high. (6) The second, from the Institute of Healthcare Improvement, distilled the learning for the UK government and the NHS from the reports on the Mid Staffordshire Inquiry and Robert Francis' recommendations. (7)

Three key aspects of quality of health care are patient safety, clinical effectiveness and patient experience. (8) Quality improvement is dependent on patient experience and service user involvement for the design and delivery of health and care services. In my study I wanted to explore involving the public and engaging communities in the context of clinical commissioning to see if it was indeed 'meaningful' and could lead to quality improvement. However, as the author of the study I inevitably bring my own experiences, values and biases to this thesis. I have been an avid supporter of patient and public involvement for many years and participated with service users, carers and clinicians in a strategic partnership group for cancer services in the south of England. I wore two hats in that group; one as nurse lecturer and the second as facilitator of a patient support group for prostate cancer. In my senior lecturer role, I also led the service user involvement strategy group for a School of Nursing and Midwifery within a higher education institution for five years. My passion was to further develop the strategy so that academic colleagues would fully appreciate the importance and value of engaging and involving patients and carers throughout the process and design of our courses.

Listening to the patient and carer experience and learning how to improve services was a personal motivation for undertaking this study. It originated from nearly 20 years earlier when my father died with prostate cancer as opposed to from prostate cancer. It was a disease that caused him great distress as he came to terms with a cancer diagnosis and the changes he experienced from hormonal manipulation, including surgical castration. He had complete trust in his consultant urological surgeon. As a family, we later approached the consultant to ask what we could do in practical ways in memory of a husband, father and grand-father. At the time the emphasis was on donating money for prostate cancer research, but we insisted we wanted something local and contemporary for those men and their families experiencing prostate cancer. We were disappointed by an arrogant response from the consultant who came across as a hierarchical leader. He suggested money for the urology department, including for a piece of equipment not even used for prostate procedures, or money for the enjoyment of a clinical team party. Determined not to comply we set up a prostate cancer support group which is now part of a prostate cancer charity and continues to regularly attract attendances of 20 – 25 people, including men and their partners. Healthcare professionals willingly contribute to the programme of speakers praising the function and longevity of the group. They also engage with the charity when patient experience is integral to a research proposal or service evaluation.

This introductory chapter sets the scene for the thesis by providing a broad overview of the recent changes in commissioning and leading health and care services in the English NHS. It gives context to identify where partnership and patient and public engagement feature in the current landscape. More commonly referred to as patient and public involvement (PPI) a recurrent observation in the literature is the shifting terminology of public engagement (9-12); definitions, explanations and interpretations of PPI as it is practised, monitored and evaluated in an NHS continuing to undergo significant organisational change. The chapter looks at how commissioning of local secondary and community care services has evolved, and briefly explores the clinical leadership discourse and trajectory of PPI before leading to a narrative review of the literature in chapter 2.

Since the implementation of the HASCA in April 2013, the organisations responsible for leading and procuring health and care services have undergone considerable transformation. The commissioning (purchasing) and provider split that has dominated the English NHS since the early 1990s is blurring, even unravelling, as partnerships between organisations take on new forms to deliver integrated care. Commissioners, providers of NHS services, local government authorities and the voluntary and community sector (VCS) are collaborating to implement new models of health and (social) care services that are joined up and patient-centred.

A consequence of this rapid change has been that the HASCA is now seen as dysfunctional. (13) The Act, which endured a tortuous route through the UK Parliament, endorsed choice and competition. The purchaser and provider split was considered to be a permanent feature of the NHS and set in legislative stone. (13) However, the NHS strategy Five Year Forward View (FYFV) (8) published in 2014 highlighted three widening gaps requiring attention if quality of health and care was to be improved in austere times. The three gaps - health and wellbeing, care and quality, funding and efficiency – would require providers of services to work differently with commissioners. To join up services whilst continuing to improve the patient experience, ensure safety and clinical effectiveness, these being the markers against which the quality of health and care is measured. (8) FYFV also advocated a new relationship with people and communities to involve them directly in decisions affecting health and care services. (8) Therefore, it has become clear that integration of services and partnerships between providers and commissioners conflicts with some of the central tenets of the HASCA.

It is against this backdrop that the PhD project began. The new Clinical Commissioning Groups (CCGs) were less than a year beyond the HASCA authorisation. By the time I was analysing and synthesising my research data, there was speculation about the demise of CCGs with the ascendancy of Integrated Care Systems (ICS), Integrated Care Organisations (ICOs) and Accountable Care Organisations (ACOs). The aim of the PhD was to develop the evidence base for higher education to advance our understanding of patient and

public involvement in clinical commissioning. The pedagogic and practice research focused on two broad research outcomes to:

- identify how commissioners, leaders and members of the public and service users can engage as trusted peers in making significant decisions which shape local health and social care services, and
- consider how this could inform curriculum design on partnership, public engagement, and clinical leadership for students and postgraduate health professionals.

A glossary of key terms can be found at the back of the thesis to assist the reader with disciplinary terminology and to clarify meanings. There is also a list of acronyms and definitions at the beginning of the thesis. The phrase 'health and care' will be mostly used in preference to 'health and social care'.

## **1.2 Clinical commissioning groups (CCGs)**

Commissioning is the process by which health and care services are planned, purchased and monitored. (14) Since April 2013, CCGs have been accountable for over two thirds of the annual NHS budget in England (1); an estimated £75.2 billion in the financial year 2018/19. (15) As 'clinically led' organisations, CCGs are responsible for the planning and commissioning of local secondary and community care services (16) including:

- Urgent and emergency care,
- Elective hospital care including outpatient services,
- Community health services (services that go beyond the general practitioner),
- Maternity and newborn, and
- Mental health and learning disabilities

CCGs are statutory NHS bodies led by GPs which also have a legal duty to support the quality improvement of General Practice. (17) They are legally required to involve and engage service users (patients and carers) and the public

in the commissioning of services, improving on the design of services and decommissioning services where they are not efficient and effective. (1)

At the time of writing in Summer 2018 there were 195 CCGs listed on the NHS England website, some having merged since the original 211 were authorised in readiness for the HASCA. They liaise with local government authorities via a number of mechanisms including Health and Wellbeing Boards. (18) CCGs are membership organisations and commission for a population size of between 61,000 and 860,000 people. (16) The members of CCGs are local practices of GPs, known as General Practices, within the geographical area of the CCG.

By contrast, NHS England, as an executive non-departmental public body of the Department of Health, oversees the operationalisation of commissioning including the budget and planning. It also has a role in the performance management of CCGs. (19) It directly commissions some services including specialised healthcare services which is about 10% of the NHS budget. (16)

### 1.3 Clinical commissioning and the HASCA

Commissioning as a concept in health and (social) care has been in existence since the 1990 NHS and Community Care Act. Models of commissioning have changed over time, but service provision and the design of services are integral to the commissioning process. NHS Clinical Commissioners, the membership organisation for CCGs, offer a more detailed definition of the commissioning process:

**'Commissioning** is about getting the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, etc. It is an ongoing process, and CCGs must constantly respond and adapt to changing local circumstances. CCGs are responsible for the health of their entire population, and are measured by how much they improve outcomes.' (20)

Over the last 25 years clinical commissioning has been a way to give clinicians a central role in some or all of these activities. (17) The various attempts are elaborated in the brief history that follows in **section 1.4**.

Recent changes in commissioning have been introduced as a consequence of the HASCA. (1) The preceding White Paper *Equity and excellence; liberating the NHS* (3), was the UK coalition Government's draft policy for modernising the NHS in England. The resultant Health and Social Care Bill endured extensive debate and numerous amendments. It eventually progressed through the UK Parliament to become part of English law from April 2013. Intense opposition to the idea of 'Any Qualified Provider' competing with the usual NHS service providers was one factor that forced the government to pause the Bill's progression and convene a Future Forum. More importantly, there was considerable concern, including from patient groups, that the reforms would culminate in the Secretary of State neither overseeing a national health service nor being accountable to Parliament for its function in the health and care of the population of England. The forum undertook a listening exercise with NHS staff, patients and members of the public. (21) Stakeholders were concerned about the increasing marketisation and possible privatisation of NHS services, as well as who would lead and could take responsibility for large sums of tax payers' money moving from secondary care in hospitals to community services and primary care. The present incarnation of commissioning has been contentious and fiercely debated. It continues to undergo change within the new Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems outlined in **section 1.6**

#### **1.4 A brief history of commissioning in the English NHS**

The Conservative government reforms enacted in the NHS and Community Care Act 1990 brought the term 'commissioning' into everyday use for both managers and clinicians. Planning and procuring care were separated from the provision of care. (22) The rationale being that this would increase competition and drive efficiencies in a quasi-market (23) by introducing choice. It also removed the cross-boundary re-charging which applied when care was received outside the patient's local area. (23)

English health authorities responsible for geographical populations became the purchasers (24) and GP practices could become fund-holders if they so wished, thereby creating a market in the public sector although this was closely managed

by government. (21) At the same time secondary care hospitals and subsequently mental health, community and ambulance services could become self-managing provider NHS Trusts. Commissioning was seen as a driver for service improvement and in particular the quality of care delivered as long as four main steps were followed (22): assessment of need; setting priorities; contracting with providers; monitoring and reviewing service delivery.

Not all GP practices became fund-holders as the scheme was voluntary. GPs were able to purchase some surgical operations and outpatient services for their patients as well as medicines they prescribed. (21) Rather than insist all GP practices became fund-holders, the government allowed other models of GP-led commissioning including Total Purchasing Pilots (TPPs). **Table 1.1** shows the timelines for the various GP commissioning schemes. TPPs were allowed greater flexibility as all health services could be purchased by GP fund-holders either singly or in groups of practices. (19, 21, 24) Systematic performance monitoring was limited to budgetary compliance which was set in conjunction with the health authority. (19)

By 1997 a new UK government had been elected. New Labour abolished the GP fund holding and TPPs to end the internal market but did not abandon the purchaser-provider split completely. (21, 22, 24) Instead, Primary Care Groups (PCGs) were established which were subcommittees of the health authorities and responsible for improving the health of the population within the community served by the PCG. (21) The responsibilities of the PCGs therefore included developing primary care and community health services and commissioning secondary and tertiary services. The latter are the specialised services which are now commissioned by NHS England because there are fewer providers and smaller numbers of patients requiring these services.

In 2002 Primary Care Trusts (PCTs) were introduced and PCGs began to group together to form these larger new organisations. (22) By April 2004, there were 232 PCTs, (**Table 1.1**), each responsible for a budget of about £250 million and a population of approximately 250,000 people. (21) Most of the staff in a PCT worked in the provider arm delivering community services and public health

initiatives with just a few people in the ‘commissioning directorate’ managing the primary care contracts and commissioning acute, mental health and tertiary services. (21) At the same time, the health authorities were consolidated into Strategic Health Authorities (SHAs) responsible for larger geographical areas, overseeing the PCTs and strategic clinical networks.

**Table 1.1: GP commissioning schemes 1990 - 2010**

Year	GP commissioning scheme	
1991	GP Fund-Holding (GPFH) ≈ 80 Total Purchasing Pilots (TPPs)	Volunteer GP practices Concerns not all patients got equal access to services
1997		GPFH abolished by New Labour Government.
1999	481 Primary Care Groups (PCGs)	Sub-committees of 95 health authorities
2002	Primary Care Trusts (PCTs) introduced.	PCGs formed clusters to eventually become PCTs
2004	232 PCTs	Health authorities consolidated to 28 Strategic Health Authorities. Later becoming 10.
2005	Practice-based commissioning (PBC)	Voluntary scheme. GPs given indicative budgets.
2010	GP consortia	Recommendation from <i>Equity and excellence; liberating the NHS (3)</i>
2011	Pathfinder CCGs – four waves	
2013	211 authorised CCGs	Implementation of the HASCA from April

Practice-based commissioning (PBC) was introduced in 2005 with the aim of further engaging GPs in the commissioning process. The rationale for PBC was to allow GPs to use resources for their patients more effectively. (22) They had notional budgets, held by the PCTs, from which they could commission services

closer to home, for example, diabetes management and musculoskeletal therapies. (22, 25) However, it was increasingly apparent PCTs were too small to commission effectively from larger hospital and mental health trusts. (21) Costs of acute services were increasing as access to new innovations and technologies were implemented. Provider NHS Trusts delivering the health services were beginning to show financial deficits. PCTs therefore merged and reduced to 152 in number, geographical boundaries were altered to match those of local county councils providing social care, and the Strategic Health Authorities were further reduced in number. (21)

From 2006, PCTs were required to divest themselves of providing community services. The providers of community services could become Foundation Trusts, merge with an existing mental health or hospital Foundation Trust, or become a social enterprise. (21) Foundation Trusts, which first appeared in 2004, are public benefit organisations which have greater autonomy based on their ability to manage their finances and can reinvest any surpluses. (21) Despite the changes, PCTs struggled due to lack of resources and expertise and so the Department of Health developed a Framework for World Class Commissioning in 2007 to improve capacity and capability. It comprised 11 competences, listed in **Table 1.2** below, for assessing commissioning competence. The third competence is of importance to this study (26):

**Table 1.2: World Class Commissioning Competences (26)**

<ol style="list-style-type: none"><li>1. Locally lead the NHS</li><li>2. Work with community partners</li><li>3. Engage with public and patients</li><li>4. Collaborate with clinicians</li><li>5. Manage knowledge and assess needs</li><li>6. Prioritise investment</li><li>7. Stimulate the market</li><li>8. Promote improvement and innovation</li><li>9. Secure procurement skills</li><li>10. Manage the local health system</li><li>11. Make sound financial investments</li></ol>
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In 2010, the White Paper *Equity and excellence; liberating the NHS* (3) recommended the formation of GP commissioning consortia. GP practices within

the PBC model moved toward this organisational structure and eventually became CCGs. Implementation was in phases with some leading the way on a 'Pathfinder programme' in 2010. (27) For practical purposes and because of the imminent changes that would be part of the HASCA, PCTs initially grouped together into about 50 PCT clusters and were then abolished by the end of March 2013. (21)

### **1.5 Integrated and place-based commissioning**

Engaging and involving clinicians, patients and the public is part of a wider agenda around citizen and community engagement and empowerment. This actively encourages collaborations with local authorities, employers and voluntary and community services and is integral to the FYFV five-year plan. (8) Place-based commissioning of health care for a local population (28) is intended to change the commissioning landscape and break down barriers between so-called 'funding silos'. (29) The case for better co-ordinated health and care services around the individual was also argued in the Barker Report. (30, 31) The Better Care Fund (BCF) was created to incentivise the NHS and local government to work more closely together. (30, 31) New contractual models facilitated integration of the two budgets and joint commissioning. (32) In addition, 50 NHS England Vanguard sites were set up to report on five new models of care within local health economies. (29, 33) Integrated primary and care systems and multi-speciality community providers are the two models with greatest relevance to GPs.

### **1.6 Sustainability and Transformation Partnerships**

Planning guidance published in December 2015 required local health systems or economies to develop five-year Sustainability and Transformation Plans (STPs) to encompass all areas of CCG and NHS England commissioned activity. (28) Forty-four Sustainability and Transformation 'footprints' were established by NHS England. Intentions are to rebuild the health and care system around the needs of patients and communities, to break down organisational and hierarchical structures and build networks across the local health economy. (34) Plans must be developed with local patients and communities, engage clinicians and other health care professionals as well as wider partners in local government and voluntary, community and social enterprise networks. (35) STP implementation has been

criticised on a number of levels, not least the lack of patient and public involvement. (34, 36)

STP footprint leaders must be able to work across local systems in health and care, that is, the NHS, local government and the VCS. In Greater Manchester, where the desire for whole system change and the integration of health and care manifests as a devolved care budget of £6.2 billion from central government to the Greater Manchester Combined Authority, the 12 CCGs have joined together as a single association. (37) There are other examples of where CCGs are collaborating and jointly working to commission and lead health and care services.

STPs were renamed Sustainability and Transformation **Partnerships** in March 2017. (38, 39) However, current policy briefings refer more to partnering between organisations within Accountable Care Systems (ACS) where the various stakeholders are care providers and commissioners. (39, 40) Accountable Care Systems have since been renamed too and are now known as Integrated Care Systems (ICS). (41) STPs and ICSs have no legal standing as they are corporate bodies with no budgets of their own. (13) Hence, concern about the HASCA being fit for purpose.

## **1.7 Partnership with patients and the public for commissioning**

Whilst models and competence frameworks for commissioning use the language of engagement to describe relations between commissioners and communities (21), there is limited research on the impact of PPI in commissioning and leading health and care services. (42, 43) The evidence base is weak or emergent despite models of involvement and engagement having been described and advocated in practice. (9, 44, 45) The literature describes the service user as a 'consumer' and a 'citizen' with arguments for and against a consumerist choice free-market place in health and social care, and a democratic rights-based citizenship with entitlement to services (9, 43, 46).

Under section 14Z2 of the HASCA (1), CCGs are required to involve the public when commissioning services. As part of the authorisation process CCGs were required to address six domains, the second of which was *meaningful*

*engagement with patients, carers and their communities.* (4) The collective perspective of people and their communities is also embedded within the World Health Organization's Declaration of Alma-Ata in 1978:

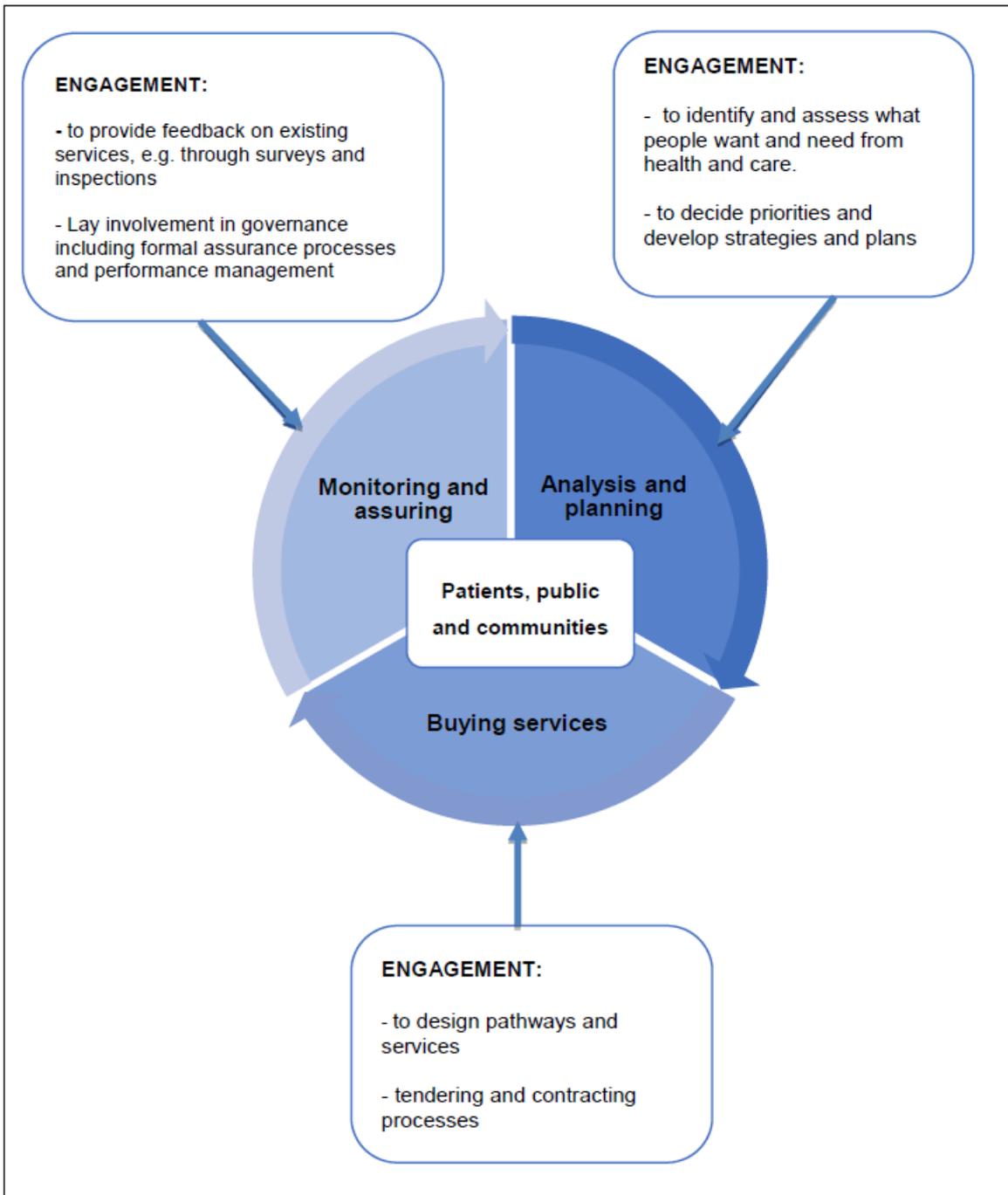
'The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.' (47)

Therefore, NHS clinical commissioners should be fostering new relationships and partnerships in the post HASCA environment. It requires a cultural shift so that patients are no longer 'grateful supplicants' but 'true partners' to whom the publicly-funded NHS must be accountable. (48) For this shift in accountability to be sustained it is also essential partnership and patient and public engagement are integral components of training and education programmes for health care professionals at the clinical commissioning interface.

NHS England published an interactive guidance document for commissioners in 2013, *Transforming participation in health and social care*, which looked at individual and public participation as well as insight and feedback on people's experiences of health and social care. (49) It included case studies and suggestions for methods of involvement or engagement. This was updated in 2017 as statutory guidance for clinical commissioners. (50) There have been other publications to guide the PPI process and methods for commissioning (51, 52) and more recently for STPs. (35) A framework for patient and public participation in primary care commissioning was published in March 2016 (53), thus introducing another acronym (PPP) when previously NHS England had been referring to 'patient and public voice' (PPV). Terminological instability is well-documented in the literature. (12, 54)

**Figure 1.1** is an adaptation from the statutory guidance (50) and reproduces the NHS commissioning cycle with its three broad stages (21, 55); strategic planning, procuring services and then monitoring and evaluation. The figure shows where lay knowledge and experience from service users and the public should contribute in 'partnership' through engagement. Ideally this should move beyond consultation and engagement to embrace delegation and empowerment and encapsulate co-design and co-production for community or place-based commissioning. (56, 57)

**Figure 1.1: The NHS Commissioning Cycle \***



\*Adapted from: Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England. (50)

## 1.8 Clinically-led leadership and GP clinical engagement

Much has been written about leadership and clinical engagement in health care in recent years (58-61), including medical engagement (62-64) but there is limited research, especially at NHS Trust Board level. (65) The changes in GP-led commissioning and the formation of CCGs have created further opportunity for GPs to take on clinical leadership roles; one view being that GPs know their patients and have a good understanding of their patients' needs. (66) Decision-making is closer to the patient however, this is not a new idea or solely confined to the UK. (67) The earlier brief history in **section 1.4** referred to the effects of the purchaser and provider split on GP practice since 1990. As clinicians, GPs are supposedly best placed to undertake a leadership role by engaging peer to peer and in partnership with other place-based stakeholders including patients, carers and the public. Arguably, this would lead to greater efficiency and improved relations between primary and secondary care. (66)

CCGs are membership organisations comprising GP practices, the majority of which are independent contractors or businesses (68) that provide NHS services now co-commissioned via CCGs. For GP leaders in CCGs this can create perceived conflicts of interest for health care commissioning. (69) In addition, GP practices are collaborating with other practices to work at scale. (70) Some have merged to become super-partnerships which are large scale single GP partnerships. (Here, 'partnership' refers to the GP partners who have invested in and co-own a General Practice.) The super-partnerships are where several GP practices have come together to provide services in a geographical area for the merged list of patients from those GP practices. Vitality super-partnership in the Birmingham and Sandwell area is an example and has over 50,000 patients and over 180 employees. (69) Others have federated through formal legal contracts with multiple GP practices or joined an informal network of GP practices. (69)

The drivers for scaling up General Practice include: increasing demand and patient expectation; workforce shortages and difficulty in recruiting and retaining general practitioners; regulatory requirements and financial incentives with the new CCG prime and alliance contracts for integrated care pathways. (70) *GP*

*Forward View* was published in April 2016 to address these issues including finding an additional 5,000 GPs in the next five years. (71) Further investment for work force development and GP premises development, plus support for managing workload and care redesign also feature. (71) An interim assessment by the Royal College of General Practitioners confirmed that some investment had been rapidly deployed as described in *GP Forward View*, but there had been delays in other areas such as the GP practice resilience programme. (72) GPs in CCG roles are therefore working and leading in this challenging General Practice milieu.

## **1.9 Conclusion**

What the future holds for CCGs is uncertain, but the rhetoric is clearly about whole system design and system leadership through the 'lens of place and community rather than institution', and instead of the 'distorting lens of acute services'. (34) In conclusion, this introductory chapter has set the context for the thesis with respect to clinical commissioning following the HASCA. It has addressed what form PPI might take in partnership with GP clinical leaders for commissioning health and care services. Chapter 2 reviews the literature with regards to how GPs have been clinically engaged for PPI in GP-led commissioning organisations.

## Chapter 2: Narrative review of the literature

'The whole arena of patient involvement within health care is riven with problems of meaning, definition and purpose. The topic is further complicated when one attempts to compare practices across Europe (or indeed elsewhere in the world) where health care organisation and delivery will have different histories, funding arrangement and challenges.' (73)

The review of the literature was a complex process and what follows is an account of my journey to locate the pertinent literature and then make sense of it by critical review and narrative synthesis. The review was originally undertaken in the summer of 2014 on what I thought would be a systematic or comprehensive review of PPI and GP clinical commissioning in the UK and beyond. I wanted to understand how GPs, or primary care physicians elsewhere, engaged with patients and citizens to decide what health and care services should be commissioned for local communities. However, as the quote above from Dent and Pahor indicates, patient involvement is complicated. They were offering a conceptual framework for understanding patient involvement based on three characterisations or ideal types: voice as a citizen, choice as a consumer and co-production as a participant. (73) Their paper was framed within the European system of hospital care. I wanted to examine primary care and community involvement for commissioning and leading health and care services. Ideas around co-production for commissioning and trusting relationships seemed somewhat elusive at this stage despite intentions embedded within the HASCA. Whilst their paper was helpful in realising the complexity of PPI (73), I still needed to find a way to navigate and uncover the relevant literature. This review traces those attempts and the decisions made along the way culminating in a narrative review updated in August 2018.

### 2.1 First attempts – scoping the literature

An initial scoping of the literature in 2014 for familiarisation revealed a plethora of publications reporting early findings and opinions on CCGs. These were often case studies providing preliminary data from ongoing projects but not published in peer-reviewed academic journals at that time. There were some commentary or expert opinion pieces, for example, Charlton's narrative on general practitioner

(GP) commissioning in England. (25) Case studies are frequently used to evaluate and research policy implementation (74) so it was unsurprising to see this approach, given the scale of NHS reform implemented from April 2013. The King's Fund, Nuffield Trust and The Health Foundation, all independent UK charities, working to improve health and the quality of care for the UK population, have frequently reported case study progress. Several of their policy analysts and researchers were involved with the CCG Pathfinder sites and subsequent reports. (17, 75-77) **Appendix 1** provides further information on the case studies that informed my reading at this time.

During this early period of CCG development, the 'Engagement Cycle' was integral to guidance for NHS clinical commissioning and comprised the five stages listed in **Table 2.1**. (78, 79) My research was to explore partnership working between clinicians and service users and the public to commission and lead health and care services. Reference to the stages of the Engagement Cycle might be helpful for the scope of the literature review particularly in respect of working 'with'. I wanted to understand the experiences of the clinicians, service users and members of the public. This included their knowledge, beliefs and engagement practices within the changing NHS commissioning environment.

**Table 2.1: Stages of the Engagement Cycle**

**Stage 1** – Working with communities to identify needs and aspirations.

**Stage 2** – Working with the public to plan and transform services.

**Stage 3** – Working with patients and carers to improve quality and safety.

**Stage 4** – Working with patients and the public to procure services.

**Stage 5** – Working with patients and carers to monitor services.

The PICO model is often used to formulate the scope of systematic reviews for answering researchable questions. (80, 81) It also helps uncover key search terms. The acronym stands for Population, Intervention, Comparison and Outcome. (81) **Table 2.2** shows how this was used in conjunction with the Engagement Cycle. (78) Activity might be designing new services, improving existing ones or decommissioning services that are no longer effective or efficient.

(1) However, the review did not focus on procurement and monitoring, stages 4 and 5 of the Engagement Cycle, as there was evidence for this from which local data could be extracted. Examples included service user feedback and patient satisfaction surveys implemented by service providers or national monitors for large scale reporting. The National Cancer Patient Experience managed by Quality Health is one such illustration, ([www.quality-health.co.uk](http://www.quality-health.co.uk)).

<b>Table 2.2: Scope of the review using the PICO model</b>
<p><b>P = population or perspective.</b>            Service users (patients and carers) and the public as citizens of local communities, and clinical commissioners who are GPs.            ‘Local communities’ are synonymous with the geographical area of the CCGs which are the <b>setting</b> for this review.</p>
<p><b>I = intervention.</b>            Working in partnership/collaboration to commission health and care services. The focus is commissioning new services and continuing with current provision of services.            There are elements of both design and service improvement as illustrated by the Engagement Cycle for CCGs. (78)</p>
<p><b>C = comparison.</b>            Working in partnership/collaboration for clinical commissioning as manifested in the former practice-based commissioning (PBC) and World Class Commissioning (WCC) eras. (82).</p>
<p><b>O = outcome.</b>            What does ‘good’ partnership and co-production in collaboration look like? What was the impact? What are the requirements of the relationship?</p>

My research question to interrogate the literature was as follows in **Table 2.3** with three supplementary questions to further enrich the inquiry. An ‘asset’ might be defined as something valuable or useful but a definition describing the assets that contribute to Asset-Based Community Design aided clarity. (83) An asset is a resource, talent, skill, idea that enhances capacity for change rather than focusing on what might be lacking or a deficit within a community. An asset can be individual, cultural, social, material including the physical environment. (83)

**Table 2.3: Initial literature review questions**

*What is the nature of engagement between service users and clinical commissioners to commission and lead health and social care services?*

*a. How is the engagement defined and described?*

*b. How is this measured in terms of process and outcome?*

*c. What skills and assets are required for engagement?*

## **2.2 Selecting the literature**

A comprehensive literature review was then conducted in early 2015 to appraise PPI in UK clinical commissioning for health and care since January 2010 using the review questions in **Table 2.3**. A comprehensive literature review is described as having a pluralistic approach, incorporating peer-reviewed publications and grey literature to embrace the philosophical positions of both the positivist and interpretivist. (80) The Luxembourg definition of grey literature is widely accepted (84) but has been refined by the Prague definition which also includes data contained within patents and other documents seeking intellectual property rights. (85) The grey literature could not be neglected as this is often the platform by which service user or patient-led organisations articulate collective views and experiences. These voices and messages should therefore not go unheeded, but it is important the review of quality is discerning.

The year 2010 was selected as a starting point because it was when the UK coalition government published its draft policy for modernising the NHS. (3) Inclusion and exclusion criteria were applied as listed in **Table 2.4**. Key search words proved challenging as this was an emergent area and the language employed had subtly shifted over time. (86) Search terms from a previous systematic review were considered (87) and advice and guidance sought from the medical school librarian. Stewart (12) remarks on the terminological instability saying this is not about semantics but the purposes of 'participation'. The terms "clinical commissioning" and "public engagement" were methodically checked in the thesaurus of each of the databases to be used. If the term was located, it was exploded within the thesaurus to see if it yielded further key words not yet

identified. Often the terms were not tagged or provided words already identified. The search was eventually conducted using the terms “clinical commissioning” and “patient engagement” with a string of key words associated with these concepts from existing literature as shown in **Table 2.5**.

<b>Table 2.4: Criteria for literature review conducted in 2015</b>
<p><b>Inclusion</b>            Published in last 5 years (since 2010)            Written in English            UK NHS commissioning of health and social care services for local communities*            Stages 1-3 of <b>Engagement Cycle</b> – service design and improvement            Empirical work for engaging and involving service users and/or the public in the process            Empirical work undertaken from 2010 onwards</p>
<p><b>Exclusion</b>            Publication pre-dates 2010 and NHS reform            Not published in English            Non-UK commissioning            Stage 4 of the Engagement Cycle; procurement            Stage 5 of the Engagement Cycle; monitoring and review            PPI and research            PPI and individual treatment/care plans            PPI and education of health and social care learners            Specialist commissioning which includes children, young people, mental health and offender health services</p>

\* Local communities are defined as the geographical areas now called CCGs.

<b>Table 2.5: Keyword search (Spring 2015)</b>
<p><b>Concept of clinical commissioning</b>            (clinical OR GP OR “general practice” OR “general practitioner” OR practice-based OR “practice based” OR “primary care”) AND commissioning</p>
<p><b>Concept of public engagement</b>            (patient or citizen or public or service or user or community or consumer or partnership or codesign or co-design or coproduce or “experience based design” or “experience-based design” or EBCD) and (engagement or involvement or participation or collaboration or working)</p>

The sources of evidence comprised nine internationally recognised bibliographic databases, (**Table 2.6**). The searches were carried out over a four-week period in February and March 2015. Each search was saved for future reference both within

the database and as a stored electronic record on a data stick. Notes were also taken of the procedure followed. For each database the key concepts of “clinical commissioning” and “public engagement” were first separately checked against the thesaurus. The string of words for “clinical commissioning” was used as the first search. No parameters were applied. The string for “public engagement” became the second search. Again, no limits were applied. Searches one and two were then combined to yield all papers with these concepts contained anywhere within the publication. A total of 2115 articles was located.

**Table 2.6: Sources of evidence**

Database	Date	No of articles	Selected articles by abstract	Full text selected	Included in review
CINAHL	20 Feb 15	99	11	0	0
ASSIA	22 Feb 15	75	15	6	0
Medline	24 Feb 15	159	17	3	1
HMIC	27 Feb 15	590	55	15	5
PsycINFO	2 Mar 15	862	25	4	0
AMED	10 Mar 15	4	0	0	0
EMBASE	10 Mar 15	325	27	5	1
GOOGLE	10 Mar 15	0	0	0	0
The COCHRANE LIBRARY	21 Mar 15	1	0	0	0
Professional networks, 2 <sup>o</sup> refs	Up until 21 Mar 15	1	1	1	1
<b>TOTALS</b>		2115	150	33	8

The librarian provided instructions for accessing a newer NHS online resource called *The Commissioning Handbook for Librarians*. This can search for evidence not located in the main healthcare databases, for example, CCG Board papers. It also contained a list of commissioning terms and acknowledged the Medical Subject Heading (MeSH) is not ‘searcher friendly’ for commissioning questions. Neither the list of terms nor the database yielded any additional sources. Similarly, with Google where an advanced search was used with the keywords *commission\** AND *engage\** AND *consult\** in the English language in the UK with no date restrictions. After searching seven screens the search was halted. One randomized trial process evaluation was found in the Cochrane Library but this had been conducted in Canada (88) and so did not meet the inclusion criteria.

Professional networking yielded one report through notification of a published report from the National Institute for Health Research (NIHR). (54)

The abstracts of the 2115 articles were reviewed carefully against the inclusion and exclusion criteria identifying 150 that required further scrutiny. Over one third (n=55) were identified from the Health Management Information Consortium (HMIC) database which includes grey literature. Duplicates (n=49) were removed together with conference abstracts (n=7). A further 61 papers were eliminated because the abstracts indicated commissioning for specialist services conducted at tertiary level rather than a local CCG, for example, offenders, children and complex mental health needs. Some abstracts referred to procurement or evaluation of a product or service consistent with stages 4 and 5 of the Engagement Cycle (78). These were outside the inclusion criteria and so were excluded. Full text was obtained for the remaining 33 papers that were then appraised using the Qualitative Research Checklist from the Critical Skills Appraisal Programme (CASP). (89)

Despite identifying eight full text papers (54, 90-96) the review yielded limited data. I could not answer the questions I had posed to interrogate the literature in any substantive way (**Table 2.3**). The voice of the service user was largely absent in the empirical work and where lay representatives or service users were mentioned, it was often in passing or by proxy with a health care professional or researcher collating feedback on behalf of the patient, carer. I concluded there were three main reasons. The first reason was the emergent nature of primary research in this field. Some empirical studies on GP commissioning had commenced prior to or were ongoing as the NHS reforms were implemented in 2013. The authors of these publications acknowledged this factor, commenting on how their findings may have been affected by changes in commissioning and recommended that further research was required. (54, 92, 96)

Secondly, the review identified a mix of quantitative and qualitative data and grey literature in the form of reports, surveys, expert opinion and 'thought papers.' Grey literature can be the platform by which service user or patient-led organisations articulate collective views and experiences as with The Patients Association

'blueprint' publication. (90) It should not be ignored but quality is difficult to judge by criteria such as the Qualitative Research Checklist from CASP. (89)

There has been an ongoing debate about the value of qualitative evidence and its contribution to informing evidence-based practice. Greenhalgh et al. (97) have collated six features of evidence-based medicine that they describe as producing biases against patients and carers. The hierarchy of evidence is one bias which can devalue the experiences of patients and carers. Systematic reviews and randomised controlled trials at the top of the hierarchy are considered objective and robust to provide clarity, whereas case report may be viewed as little more than anecdote and weak evidence. (98) Suggestions to combat this bias include considering narrative, ethnographic and phenomenological research designs as complementary evidence sources, but there remains a need for data to be appraised for rigour and relevance. (97)

Thirdly, the various definitions of patient and public engagement (PPE) / involvement (PPI) made it difficult to be confident in the consistency of the use of the terms for both application and interpretation. This is well-recognised in the literature with the definitions of PPE and PPI being described as 'contested' (11), having 'a remarkable degree of terminological instability' (12), an under-developed evidence base for its effectiveness (10) and conceptually muddled. (9) Yet a research paper from the King's Fund in 2010 (99) examining the quality of primary care was clear about how it used the definitions. Patient engagement entailed consultation type encounters about an individual's own health. (99) Patient involvement is where patients are involved in the design, planning and delivery of services. (99)

A lexicographic systematic literature review (100) searching biomedical and social science databases between 2002 and 2013 for peer reviewed publications in English, aimed to extract the main conceptualisations of patient engagement. The review identified 259 papers for inclusion. A software-based analysis demonstrated evolution of the concept from historical and disciplinary perspectives. The authors concluded that the dynamic nature of the term 'patient engagement' and indicative drivers can be perceived at individual, relational and organisational levels. Thus, I decided to accept that the terminology was contested

conceptually, and instead explore how the practices of PPE and PPI were performed and reported in the literature given the commissioning context; the relational and organisational levels (100) being of particular interest against the backdrop of NHS reforms. However, that was not easy as it was still early days after the authorisation of CCGs. The five years from 2010 until 2015 had seen limited PPI and GP commissioning research published in peer reviewed journals.

### **2.3 Further searching for the literature**

By Autumn 2015, a more pragmatic approach to a comprehensive literature review was required. There had been further changes in NHS commissioning processes, for example, co-commissioning and the GP contract. (75) The evidence base was expanding rapidly. In the space of one calendar month, the database Medline had amassed an additional 1,231 publications on the concept of *public engagement* using the key word and synonyms in **Table 2.5**. EMBASE similarly had an additional 1,838 publications. The growing number of publications was partly attributed to patient experience feedback, a central tenet of the NHS reforms and a component of quality measurement as articulated by Lord Darzi (82) and Professor Berwick. (7)The Friends and Family Test (101) as a measure of patient experience, whilst relevant to CCGs in terms of monitoring and responding if services should be improved or re-commissioned, had greater significance for service providers. Reports of how patient experience is collected and collated from individual feedback and technological innovations to improve the methodology was finding an audience in academic journals. But this was not what I was seeking for my PPI and GP commissioning literature review.

By this point I had read the material related to **Appendix 1** and ascertained the popularity of case study and ethnographic methods for researching the development of CCGs. I ran further searches with the same databases and added two further concepts for key word searches (**Table 2.7**). I had noted in the initial scoping and first review that some PPE and PPI studies were attributed to 'service improvement' so this was introduced as a keyword search together with 'clinical leadership'. The latter was to capture publications referring to clinical engagement and GP clinical Leads within CCGs. Boolean logic allows inclusion of several synonyms for a term with the operator 'OR'. (80) This was important given the

instability of the PPE and PPI terminology and the interchangeable terms used in the literature for the concepts being reviewed; clinical commissioning, clinical leadership, service improvement and public engagement.

<b>Table 2.7: Keyword search (Autumn 2015)</b>
<p><b>Concept of clinical commissioning</b>            (clinical OR GP OR “general practice” OR “general practitioner” OR practice-based OR “practice based” OR “primary care”) AND commissioning</p>
<p><b>Concept of clinical leadership</b>            (clinical or “clinical lead” or “clinical leads” or “clinical engagement” or medical or “medical engagement”) AND leadership</p>
<p><b>Concept of service improvement</b>            (Changing or improving or “quality improvement”) AND (“health services” or “health and social care services”)</p>
<p><b>Concept of public engagement</b>            (patient or citizen or public or service or user or community or consumer or partnership or codesign or co-design or coproduce or “experience based design” or “experience-based design” or EBCD) and (engagement or involvement or participation or collaboration or working)</p>

Database alerts were set up in case there were new publications appearing in the academic literature. I also set up ‘Table of Contents’ alerts for some journals including BMJ Quality & Safety and the Beryl Institute’s Patient Experience Journal. The web sites of NHS England, NHS Clinical Commissioners and the National Institute for Health Research (NIHR) were also reviewed for relevant publications. All three volumes (at that time) of the NIHR Health Services and Delivery Research journal were searched and one mixed methods evaluation identified. (102) The institutional web pages of academics publishing in the field of commissioning and PPI were also checked. One important paper charting two decades of GP commissioning by literature review was identified by this method. (24) It had not been discovered in the database search because it was an electronic publication ahead of print.

Twitter was useful for signposting to sources of evidence by following the account pages of the Health Service Journal, The Kings’ Fund, Nuffield Trust, The Health Foundation, Primary Care Commissioning, Inside Commissioning and fellow PhD

students within the PPI field. The use of Twitter to connect with a PhD student led to an exchange of useful publications including Aveling et al. (57, 103) and a visit to a collaborative event held by the North West London Collaboration for Leadership in Applied Health Research and Care (CLAHR). Twitter is increasingly recognised by researchers and academics as a quick way to connect with others in real time and exchange information. It is part of the burgeoning tool kit and skill set of the contemporary researcher. (104) At the CLAHR event I met Renedo and Marston, two researchers who had published a four-year ethnographic study on patient involvement in quality improvement interventions. (105) Their publication examined how patients construct ideas of 'quality improvement' when collaborating with health care professionals in service provider improvement teams. It was not included in the review as the findings showed patients tended to focus on individual responsibility and goals of self-improvement when discussing quality improvement. (105) It was not appropriate for commissioning of services for local communities.

#### **2.4 Deciding on a revised literature search strategy**

Given the limited and disappointing results from the early searches the search strategy was revised. New questions, inclusion criteria and key search words were formulated influenced by a key publication in the field during 2015. This used a realist evaluation of PPI initiatives in primary care commissioning since 1991. (19) My strategy was refined and then updated in August 2018 and is reported here as a narrative review. Research questions were changed to incorporate comparison with earlier versions of GP clinical commissioning before 2010 (**Table 2.8**):

**Table 2.8: Revised literature review questions**

*Q. What is different about GP clinical commissioning and PPI since the HASCA compared to previous manifestations of NHS primary care commissioning?*

*a. If commissioning is 'clinically led' what is meant by clinician engagement in CCGs for PPI?*

*b. Where and how do service users (patients and carers) and the public feature in clinical commissioning?*

The inclusion and exclusion criteria were also altered. **Table 2.9** has no mention of the Engagement Cycle as this was losing importance within NHS clinical commissioning. NHS England had since published guidance for commissioners (49) which cited Arnstein’s Ladder of Citizen Participation (106) focusing on a ‘ladder of engagement’. An interesting development since Arnstein’s eight ladder rungs move from manipulation to citizen control without any mention of ‘engagement’, and is a point which has been debated at length. (107, 108)

The review was carried out in a systematic manner with the purpose of providing an interpretation and critique to deepen understanding of PPI and GP clinical commissioning. It was not intended to produce generalisable facts based on probabilistic truth but a plausible account that has borrowed from the systematic tradition, for example, inclusion and exclusion criteria. A narrative review should provide an authoritative argument that is informed and convincing to experts in the field. (109) The key word search now entailed running searches separately and in combination across seven databases: EMBASE, Medline, PubMed, CINAHL,

<b>Table 2.9: Criteria for literature review conducted in 2018</b>
<p><b>Inclusion</b>            Published since 1990            English language            Full text            Strategic planning and procuring services            Health and care for local communities            Involves GP clinicians* in a leadership capacity            Involves patients / public / lay reps / community            Patient Participation Groups if involved in commissioning            Primary research / evaluation</p>
<p><b>Exclusion</b>            Before 1990  <u>Not</u> in English  <u>Not</u> expert opinion or comment  <u>Not</u> monitoring and evaluation  <u>Not</u> provider quality / service improvement  <u>Not</u> PPI and research  <u>Not</u> PPI and individual treatments / self-management / shared-decision making</p>

\*GP clinicians or equivalent for primary care elsewhere

HMIC, PsycINFO and Health Business Elite (HBE). **Tables 2.10** and **2.11** elaborate on these searches. ‘Service improvement’ as a concept was removed mainly because publications tended to focus on service provider improvement. ‘Buying services’ was added instead along with the word ‘commissioning’. The database Health Business Elite was included as it is peer-reviewed but many articles were opinion pieces only.

<b>Table 2.10: Searches carried out</b>
<p><b>1. Concept of clinical commissioning</b> (clinical OR GP OR “general practice” OR “general practitioner” OR practice-based OR “practice based” OR “primary care”) AND commissioning</p> <p><b>2. Concept of public engagement</b> (patient or citizen or public or service or user or community or consumer or partnership or codesign or co-design or coproduce or “experience based design” or “experience-based design” or EBCD) and (engagement or involvement or participation or collaboration or working)</p> <p><b>3. Concept of clinical leadership</b> (clinical or “clinical lead” or “clinical leads” or “clinical engagement” or medical or “medical engagement”) AND leadership</p> <p><b>4. Commissioning or “buying services”</b></p> <p><b>5. Combine 1 and 2</b></p> <p><b>6. Combine 1, 2 and 3</b></p> <p><b>7. Combine 2 and 4</b></p> <p><b>8. Combine 2, 3 and 4</b></p>

**Table 2.11** lists the sources of evidence by database. The articles included quantitative, qualitative and mixed methods research as well as some grey literature. The most productive searches for identifying suitable papers were the combination searches 5 – 8. Working via an Open Athens account and using the Health Database Advanced Search (HDAS) I identified 108 potentially useful abstracts. This included 10 additional papers from the British Nursing Index (BNI) from running searches 5, 6 and 8 on all databases together. HDAS includes the AMED (Allied and Complementary Medicine) and BNI databases. There were no suitable AMED papers. I refined the 108 abstracts further to 85 abstracts and then

removed duplicates (n = 22) conference abstracts and editorials. Similarly, papers discussing commissioning for strategic cancer networks, biobanking, drug action teams and CAMHS (Child and Adolescent Mental Health).

Fifty-four papers remained in my sampling frame, that was verified with a member of my supervisory team (BF). Thirty-nine papers were read in full and 10 eventually included in the literature review. The 10 papers were collated in a data extraction summary table to further assist analysis, (**Table 2.12**). They are assembled in chronological order and incorporate four papers (authors' names italicised) from the original literature search in 2015. (54, 90, 91, 93) Six of the 10 papers received NIHR funding. The data extraction tool was compiled to assist with evaluation of the papers by constant comparative method. (80) The date and author in the first column on the left was to ascertain whether the paper predated the HASCA reforms. The research question or purpose column was to ensure the focus was PPI and GP clinical commissioning. The methodology column was to establish any underpinning theoretical perspectives and preferred research design and methods as I favoured an ethnographic approach for my research. I wanted to gain further insight about the techniques used including the data collected and how it was analysed. The findings column in **Table 2.12** was important for understanding what is already known. The last column on the right was to consider how the discussion of study findings and recommendations might inform the questions posed for my literature review, (**Table 2.8**). However, this was not to be governed by pre-determined categories or themes. It was important that the themes were emergent.

**Table 2.11: Number of articles by sources of evidence – August 2018**

Searches	1	2	3	4	5	6	7	8	Saved by abs	Included in review
Databases										
CINAHL	744	104,305	4,461	1,544	174	12	346	12	27	4
Pubmed	1,967	60,301	21,289	3,966	4	0	13	0	0	0
Medline	1,164	146,223	7,180	2,788	169	10	290	10	41	41
HMIC	6	49	7	7	2	1	3	2	12	12
PsyclINFO	197	65,439	2,358	626	43	1	117	1	14	14
EMBASE	39	820	31	61	5	1	6	1	4	4
HBE	132	10,132	639	237	7	0	19	0	0	0
All databases					1,434	72		74	108	85

**Table 2.12: Data extraction tool – peer-reviewed publications and grey literature**

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p><b>2002</b></p> <p>Alborz, A, Wilkin, D, Smith, K (110)</p>	<p>To describe how PCGs/PCTs are informing, consulting and involving communities in their work. To examine effectiveness of efforts perceived by GP Chairs and local CHC representatives</p>	<p>Survey – using National Tacker longitudinal evaluation data. Oct – Dec 1999 Oct – Dec 2000</p>	<p>Random sample of 72 Primary Care Groups (PCGs) Two merged so 71 in year 2 when 6 PCGs had become PCTs</p>	<p><b>1999</b> 72 face-to-face <b>interviews</b> with PCG chairs, 56 <b>postal questionnaires</b> returned by lay board members</p> <p><b>2000</b> 67 <b>telephone interviews</b> with PCG chairs, 47 <b>postal questionnaires</b> returned by CHC representatives</p> <p>Fixed choice questions for both methods</p>	<p>94% of chairs were GPs, 80% of CHC respondents observed board meetings</p> <p>After 18 months 69% written plans for PPI, 81% committee or working group. 21% designated budget – mostly less than £5k</p> <p>Wide range of methods of consulting with communities. Range of approaches to keep people informed about work of PCGs/PCTs</p> <p>Wide spread public ignorance on existence of PCG/T.</p>	<p>Disagreement between CHC responders and chairs on how well interests of key stakeholders were represented in decision-making in PCG/T.</p> <p>Consultation with community limited. Mostly around application for Trust status.</p> <p>PPI <b>successes</b> – development of consultation mechanisms. PPI <b>weaknesses</b> focused on <b>attitudes, means and actions</b>, e.g. PCG not committed, lack of policy, over-reliance on specific representatives and groups, meetings poorly managed, professional voice crowding out others, other competing priorities.</p>
<p><b>2009</b></p> <p>Coleman, A, Checkland, K Harrison, S (111)</p>	<p>To assess the progress of PPI in relation to Practice-based commissioning (PBC) and suggest how findings can inform PPI developments in World Class Commissioning (WCC)</p>	<p>Qualitative component of mixed methods study.</p>	<p>Data drawn from study on development of PBC 2007 – 2009. Ten sites in total – early adopter PCTs and PBC consortia.</p>	<p>131 <b>interviews</b> including GPs, PCT and local authority respondents 130 episodes of <b>observations</b> and associated <b>documentation</b></p>	<p>Limited evidence of public engagement in PBC. PPI given low priority in NHS organisations – not addressed as a significant item</p> <p>Stakeholders held different views of PPI – issue of representativeness</p> <p>Different mechanisms for involvement – no clear plan for how should be done Some GPs felt they knew what is best and what their patients wanted</p>	<p>Often top-down directives with performance targets for PPI that prioritise evidence. Danger of resorting to tick box mentality.</p> <p>Should adopt a bottom-up approach and be free to 'say the unsayable', i.e. when PPI not needed or disproportionate to benefits.</p> <p>Reference to <i>Engagement Cycle (78)</i> in abstract.</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p>2011</p> <p><b>The Patients Association (90)</b></p>	<p>Concern about NHS reforms and where and how patient voice would be heard in commissioning. To produce a series of recommendations for CCG patient engagement strategies</p>	<p>Survey of GP pathfinder consortia 'Blueprint'</p>	<p>All 52 consortia approached. Led to Working Group from best examples.</p>	<p>January 2011 <b>Listening events</b> attended by 200 people across the country. 1,000 patients, family members and carers also surveyed about NHS reforms</p> <p>Not clear how responses were analysed or used.</p>	<p>12 (23%) GP consortia responded and 4 declined.</p> <p>5 had a patient engagement strategy in place</p> <p>Working Group produced 10 recommendations – 4 on service design and delivery - 6 on evaluation and monitoring.</p>	<p>Context specific - written at time of 'pause, listen and engage' exercise by NHS Future Forum. Not all aspects of NHS reforms were in place. Concerns may subsequently have not been founded.</p> <p>Case study illustrations provided.</p> <p>Importance of trust between patient and doctor emphasised.</p>
<p>2012</p> <p><b>Lotinga A, Glasby J (91)</b></p> <p>Second author is journal editor-in-chief.</p>	<p>Focus is the relationship between social care and GP practice. Joint commissioning and service integration.</p>	<p>Case study to explore current and future opportunities for joint work at CCG level.</p>	<p>Birmingham Health and Wellbeing Board commissioned Health Services Management Centre at University of Birmingham to run a series of workshops.</p> <p>3<sup>rd</sup> workshop</p>	<p>25 stakeholders; Lead GPs, Councillors, service users, local authority managers and PCT cluster managers</p> <p>Participants agreed to share and publish workshop discussions.</p>	<p>Focused on six main possibilities:</p> <ol style="list-style-type: none"> <li>1. Low level prevention more proactive, holistic, self-care</li> <li>2. Identify and target high cost, complex needs</li> <li>3. Broader primary healthcare team</li> <li>4. Address boundary issues to alleviate multiple locality structures</li> <li>5. Make it happen on the ground with more meaningful conversations</li> <li>6. Avoid more of the same. Test for CCGs to be viewed as the locally legitimate leader of the health and care system</li> </ol>	<p>Authors feel social care has been neglected since 1990s. Hoping for trusting and closer relationships to be established. 'sense of place and stability'.</p> <p>Opportunity for GPs to be clinically engaged. What citizens want from formal services.</p> <p>Scope for service users to contribute knowledge, skills and experience – 'natural community leadership'.</p> <p>(Scoping review with same title published for NIHR in 2013. Co-authored by Glasby, J. (112) but no service user contribution.)</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p>2013</p> <p><b>Zachariadis M, Oborn E, Barrett M, Zollinger-Read P (93)</b></p> <p>CLAHRC and NIHR funded</p>	<p>To explore relational challenges for GP leaders setting up network-centric commissioning organisations</p>	<p>Mixed method. Multi-site case study</p> <p>Theoretically-informed by innovation network theory</p>	<p>Six CCGs in East of England. Selected from first two waves of 'Pathfinder CCGs'</p>	<p>Feb – Dec 2011</p> <p><b>Interviews:</b> 56 healthcare professionals; 35 board members; 21 from various organisations including patient reps.</p> <p><b>Electronic survey</b> of CCG board members</p> <p><b>Observations</b> of 21 meetings</p> <p>Social network analysis with Gephi 8.0 software.</p> <p>External validity – presented findings at regional event with CCG board directors present.</p>	<p>Identified three network leadership roles for managing:</p> <ol style="list-style-type: none"> <li>1 Knowledge flows,</li> <li>2 Network coherence,</li> <li>3 Network stability.</li> </ol> <p>Two vignettes to show relational catalysts.</p> <p>Issues of trust in new relationships. Importance of knowledge exchange/brokers. Some good illustrations with PCT data sharing.</p> <p>Other examples where concerned about jobs when PCTs cease. Seen to be failing organisations.</p> <p>Tricked into 'Pathfinder' status to get professionals engaged with new policy. Difficulties engaging frontline GPs.</p> <p>Over half of CCG boards had patient representatives.</p>	<p>New breed of clinical leader required for 'sense-making' rather than controlling. 'Subtle leadership'.</p> <p>Importance of capturing patient views in a consistent and structured way. Building relational capabilities within networks. Innovation hubs of multi-disciplinary coalitions but no mention of patients being included.</p> <p>Concern about how lay representation should be operationalised. Piecemeal approach.</p> <p>Reluctance to invest scarce resources in PPI. Confusion voiced by leaders about the purpose and means.</p> <p>Tension between good knowledge networks with smaller localities and clusters but more purchasing power at scale.</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p>2014</p> <p><b>Peckham S, Wilson P, Williams L, Smiddy J, Kendall S, Brooks F, Reay J, Smallwood D, Bloomfield L (54) **</b></p> <p>NIHR funded</p>	<p>To examine how commissioners enable voice and engagement of people with long term conditions (LTC) and identify what impact this has on the commissioning process and pattern of services.</p> <p>5 objectives including</p> <p>-impact of patient/public voice on commissioning, how groups/patients/public get voice heard and by what mechanisms, how commissioners enable voice of people with LTC</p> <p>Named EVOC during project – <b>Engagement and Voice in Commissioning</b></p>	<p>In-depth case study design. Mostly qualitative data collection methods. Multi-layered approach. Participatory and interactive methods.</p> <p>Protocol adjusted as study carried out at height of NHS reforms. Abandoned Star Chart tool</p> <p>Two explanatory frameworks:</p> <p>Barnes plus Gibson et al. (113)</p> <p>Normalisation process theory (NPT)</p>	<p>Three CCGs. Purposeful selection:</p> <ol style="list-style-type: none"> <li>1. SE England</li> <li>2. Inner city in North England</li> <li>3. Large urban town in south of England.</li> </ol> <p>Each with three experiences of LTC – diabetes, rheumatoid arthritis and neurological conditions.</p> <p>Convenience sampling. Guided by theoretical data saturation.</p>	<p>Five phases from Oct 2009 – July 2013:</p> <ol style="list-style-type: none"> <li>1. Scoping national changes in commissioning.</li> <li>2. Contextualisation</li> <li>3. Evaluation of impact. <b>Interviews: 102</b> (Commissioner, provider and service user/rep from each case study)</li> </ol> <p>Follow up <b>workshops</b>. <b>Focus groups: 30</b> participants</p> <p><b>Observations: 10</b></p> <p><b>Documentary analysis</b></p> <ol style="list-style-type: none"> <li>4. Confirmation of outcome measures - expert reference group.</li> <li>5. Summative work shop in London in April 2013</li> </ol> <p>Framework analysis involving researchers and advisory group. Expert reference panel provided external verification of exemplars of PPEI</p>	<p>PPEI determined by national and local policies and clinical priorities</p> <p>Peripheralisation of PPEI. Occurs in silos. Fragility of PPEI.</p> <p>Loss of organisational memory with constant NHS changes.</p> <p>PPEI is a circular process. <b>‘Virtuous’</b> and <b>‘vicious’</b> circles. Latter leads to disengagement. CCGs carried out because:</p> <ul style="list-style-type: none"> <li>-Central to organisational ethos.</li> <li>-Statutory requirement.</li> <li>- Responding to external incentive such as funding.</li> </ul> <p>Commissioners define who has a legitimate lay voice:</p> <ul style="list-style-type: none"> <li>-Experience and useful skills</li> <li>-behaviour viewed as rational</li> </ul> <p>Providers see PPEI as a ‘fine-tuning’ of their service provision.</p> <p>Patients and the public. Wide scope for PPEI ranging from individual care to strategic involvement.</p> <p>Young people and adults different experience with PPEI so need different approaches.</p> <p>Authors explored ‘relationships’ and ‘trust’. Important these develop and that providers are also involved in developing PPEI.</p>	<p>Two broad areas where action required:</p> <ol style="list-style-type: none"> <li>1. Need for infrastructure and resources to support PPEI. Includes training and development. Common language and understanding.</li> <li>2. PPEI processes. Identified three areas that frame PPEI. Helpful for evaluative framework: <ol style="list-style-type: none"> <li>i. Is it moral? A right for tax-paying citizen in a democracy.</li> <li>ii. Is it approached methodologically? As a tool for quality improvement?</li> <li>iii. How the policy imperative is enacted. Does everyone have a voice, has quality improved, according to policy?</li> </ol> </li> </ol> <p>Need monitoring criteria for PPEI. Agreement on terminology,</p> <p>Urgent need for further research on now PPEI is being enacted post the HASCA.</p> <p>Importance of sharing research findings. Authors collaborated with PRUComm research on CCGs.</p> <p>Researchers to be encouraged to use participative approaches.</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p><b>2015</b></p> <p>Petsoulas, C Peckham, S Smiddy, J Wilson, P (19)</p> <p>Part of larger NIHR study</p>	<p>To examine the effect of previous PPI initiatives on health care commissioning and draw lessons for future development</p>	<p>Literature review since 1991.</p> <p>Medline, HMIC, Web of Science, Embase, CINAHLPlus databases.</p>	<p>607 papers 170 relevant to NHS and PPI. 116 papers finally selected</p>	<p>Realist evaluation – context, mechanism, outcome – <b>CMO</b>. (Pawson and Tilley, 1997) (114)</p> <p>Defined if consumerist or democratic perspective.</p>	<p><b>GPFH - C</b> – no mandatory obligations or clear guidance re GPs and PPI  <b>TPP - C</b> – Encouraged by Govt. to involve public. Few explicit requirements.  <b>GPFH and TPP</b>  <b>M</b> – GPs sceptical of PPI, low level involvement. Newsletters, PPGs, leaflets and posters to inform.  <b>O</b> – evaluation of PPI in TPP. Few examples and little involvement with CHCs despite requirement. GPs thought they were excellent proxies.  <b>GP Commissioning pilots becoming PCGs</b>  <b>C</b>- Organisations in transition. PPI one of many priorities. Better relationship with CHCs.  <b>M</b> – Used deliberative and outreach methods. Passive approach.  <b>O</b> – Little evidence of direct effects or to systematically embed PPI. Used to confirm corporate/ professional decisions. Consumerist feedback approach.  <b>PCTs and PBC</b>  <b>C</b> – PCT executive boards with lay members. No. of lay members reduced after 2006. NHS Appointments Commission – national criteria. PPI part of WCC standards.  <b>M</b> – Picker Institute surveys 2007 and 2009. Clear and consistent approach lacking. Focus on structure and process.  <b>O</b> – No impact on commissioning decisions. Lack of public understanding on PPI. Not reaching marginalised groups</p>	<p><b>Contextual factors:</b>  Lack of time and resources. Limited professional and public interest. Difficult to achieve representativeness and seldom-heard groups – democratic principles. Ensuring service user experiences contribute and choice is encouraged – consumerist agenda.</p> <p><b>Mechanisms:</b>  Direct/indirect involvement – absence or presence of mediating agents. Passive/active- health professionals or the public involved in decision-making or agenda setting. Deliberative/non-deliberative – face to face with public or not?  Little evidence about concrete <b>outcomes</b> achieved by PPI in commissioning. Limited tools for measuring or assessing PPI. Difficult to evaluate outcomes – may take years.</p> <p>PPI is window-dressing exercise, often passive, mostly carried out by managers. Avoids conflict between GP as commissioner and patient advocate.</p> <p>Lack of clarity about what PPI is and how effectiveness can be defined and measured.</p> <p>No concrete guidelines about nature and extent of PPI to help select appropriate model of involvement.</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p><b>2016</b></p> <p>O'Shea, A Chambers, M Boaz, A (115)</p> <p>Part of wider NIHR study looking at PPI in an NHS CCG</p>	<p>To investigate public representation in CCG board meetings and PPI reference group (RG) meetings</p>	<p>Exploratory case study using ethnographic methods</p>	<p>Large, diverse, inner city borough</p>	<p>Two phase case study February 2014 – August 2015</p> <p>1<sup>st</sup> phase – <b>non-participant observations</b> 14 CCG board meetings 10 RG meetings</p> <p>2<sup>nd</sup> phase – 14 <b>interviews</b> – 7 lay members, 3 staff RG members, 3 CCG board members, 1 member of public who regularly attended CCG GB meetings <b>Focus group</b> – 5 lay members (3 of whom were also interviewed)</p> <p>Thematic analysis</p>	<p>Recruitment and selection criteria – ‘jumping through hoops’ experienced by some lay members. Mostly, white middle-classed and retired.</p> <p>Networking and engaging with wider audience/community valued.</p> <p>Support and training important. Knowledge and skills required regarding commissioning process.</p> <p>What does representation mean? Role of RG not clear in terms of reference. ‘Shrouded in uncertainty.’ Better if belonged to an organisation.</p> <p>CCG board meetings more about <i>informing</i>. Limited time for public questions. Closed down at times.</p> <p>Staff members welcomed expertise by experience. Should not be representation just by characteristic.</p>	<p>Research instigated by chair of RG.</p> <p>One clinical lead mentioned but not clear if GP or not.</p> <p>RG lay members concerned not sufficiently diverse to represent the community. CCG ticking boxes if have met criteria.</p> <p>Lack of feedback on lay member input so lay members not sure if truly representing others.</p> <p>If representing a group or organisation representation appeared to be more legitimate. What is legitimate knowledge?</p> <p>Impact of PPI not clear in terms of how it affected strategic decision-making at CCG level. Lay members considered good practice only defined by evidence of service improvement.</p> <p>Results not generalisable. How can value of representation be valued?</p> <p>Cross reference to Peckham et al. (54) vicious and virtuous circles.</p>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p><b>2016</b></p> <p>Reidy, C Kennedy, A Pope, C Ballinger, C Vassilev, I Rogers, A (116)</p> <p>NIHR CLAHRC Wessex study</p>	<p>To explore how self-management support (SMS) is considered and conceptualised by CCGs and whether this is reflected in strategic planning and commissioning.</p> <p>To what extent commissioning decisions are made through engagement with patients and the public</p> <p>(as a means to develop locally appropriate services)</p>	<p>Multi-site, quasi-ethnographic analysis</p>	<p>Nine CCGs in south of England</p> <p>5 Vanguard sites</p>	<p>Three phase study June 2014 – May 2015</p> <p>1<sup>st</sup> Collection and analysis of 2-year operational plan and 5- year strategic plans</p> <p>2<sup>nd</sup> 10 <b>Semi-structured interviews</b> with commissioners in 6 CCGs including GP and lay representative</p> <p>3<sup>rd</sup> <b>10 observations</b> of GB meetings in 5 CCGs by service user researchers.</p>	<p>Not all CCGs being transparent with plans (from earlier study across England).</p> <p>Three themes identified from interviews:</p> <ol style="list-style-type: none"> <li>1. SMS conceptualisation driven by national agenda. Top down from NHS England. Centrally prescribed evidence and formal biomedical measures amenable to performance management. Local initiatives absent.</li> <li>2. Problem bringing in new knowledge about SMS into commissioning process. Good intentions but overshadowed by desire for 'fix it medicine'.</li> <li>3. Lack of capacity to engage PPI. Little detail about how and who would represent. CCG decide who to approach. Forward plans not clearly accessible on website.</li> </ol> <p>Observations – SMS decision-making absent at public facing meetings. Not implementing services coming from the community. Top down.</p>	<p>Financial drivers and structural limitations.</p> <p>Lip service. Commissioners not got capacity to move beyond traditional biomedical measures.</p> <p>Nationally driven financial incentives. Vanguards had artificial advantage because of monies allocated to develop integrated services.</p> <p>Difficult to know how a 'naïve member of the public' would go to raise issues.</p> <p>Service user researchers collated recommendations for good and bad practice at GB meetings.</p> <p>Board meetings are rubber-stamping.</p> <ul style="list-style-type: none"> <li>-little evidence of SMS or public engagement</li> <li>-no access to decision-making meetings.</li> <li>- Lots of jargon and financial data</li> <li>-unfriendly meetings</li> <li>-local voices not taking precedence so was it meaningful PPI?</li> </ul>

Date and author	Research question or purpose	Methodology	Sample	Data collection and analysis	Findings	Relevance to this review from discussion and study recommendations
<p><b>2016</b></p> <p>Croft, C Currie, G Staniszewka, S (117)</p> <p>Part of NIHR study CLAHRC West Midlands</p>	<p>What are the consequences of co-opting PI (public involvement) representatives into managerially defined roles?</p>	<p>Case study examining rational and normative ideologies of managerial control</p>	<p>Three CCGs</p> <p>No information about size and composition</p>	<p><b>37 interviews;</b> 6 GPs (2 in each CCG) 13 General Managers 1 Chief Executive 17 PI representatives</p> <p>Observed two CCG PI group meetings in each CCG (6 observations)</p>	<p>All three CCGs had 4 levels of public engagement: 1.Patient reference groups (PRG) 2.Representative from PRG attends CCG PI group 3.Lay representative on GB 4.Wider public consultation</p> <p><b>Case 1 – Managerial control.</b> Trivialised PI. Agenda set by managers. Peripheral to the CCG agenda. Did not change way CCG worked. No evidence of affecting service changes</p> <p><b>Case 2 – Increasing recognition of potential of PI</b> ‘Supportive culture’ but staff found it time consuming. Often repeat and explain things as public does not understand NHS. PI reps allowed to work in roles. Still managerially controlled. Managerial priorities.</p> <p><b>Case 3 – the potential of normative control</b> Hands off approach of managerial control. PI Group set agenda. Had small budget. Good relations with managers. Collaborative ethos and sense of belonging. Recognised their educative role for other PI reps</p>	<p>Limited guidance on PI. Managerial structures for PI may enhance PI credibility as ‘experts in laity’. (118)</p> <p>GP comment in Case 1 about PI groups make some valid points but ‘really peripheral stuff’.</p> <p><b>Case 1</b> - limited by organisation context. PI not integrated into strategic commissioning.</p> <p><b>Case 2</b> - struggled to break away from managerial control. Manipulation of PI outputs as shaped by managerial control. PI reps allowed to work in roles. ‘Accountable consultation’ as described by Litva et al. (119)</p> <p><b>Case 3</b> - normative approach to PI. Influenced strategic commissioning and saved money. Becoming expert representatives. Process of professionalisation.</p>

*\*\*Peckham et al. (54) use the abbreviation PPEI – patient and public engagement and involvement; the rationale being that you cannot involve people unless you first engage with them.*

A narrative review includes a broad range of papers that may not meet precise methodological standards but may still be relevant. Appraisal prompts (**Table 2.13**) described by Dixon-Woods et al. (120) for a critical interpretative synthesis methodology were helpful for judging the quality of papers.

**Table 2.13: Appraisal prompts for judging the quality of papers to be included in the review. From Dixon-Woods et al. (120)**

1. Are the aims and objectives of the research clearly stated?
2. Is the research design clearly specified and appropriate for the aims and objectives of the research?
3. Do the researchers provide a clear account of the process by which their findings were [sic] reproduced?
4. Do the researchers display enough data to support their interpretations and conclusions?
5. Is the method of analysis appropriate and adequately explicated?

Of the 54 papers reviewed only four papers were written with reference to primary care outside the UK. (121-124) The four papers referred to changes in primary care in Australia with the advent of Primary Health Networks and comparison with English CCGs. None specifically mentioned primary care physicians and PPI other than the cursory reference to the importance of engaging both consumers and physicians. They were therefore not included. There were no papers from the USA or New Zealand.

There were several papers about the role of PPGs (125-127) and although interesting with regards to the Direct Enhanced Service (DES) and incentivising patient participation, they did not refer specifically to any effect on commissioning decisions beyond the GP practices. They were therefore not included in the review but provided useful background information. Similarly, some papers were not specific as to whether the research participants were GP commissioners or commissioning managers and patients or lay representatives. The papers were

therefore not included unless the data collection referred to interviews, focus groups or observations with GP clinicians and service users/lay representatives.

Two papers (110, 111) predated the HASCA changes and the preceding White Paper. (3) Data for these papers were drawn from PBC, PCG and PCT commissioning structures. One other paper (19) reviewed the period from 1991 until the current CCG arrangements and so also provided evidence of PPI pre HASCA.

The themes emerging from the analysis and synthesis of the 10 papers are now presented. The analysis was influenced by my conceptual and theoretical framework for the thesis which is elaborated in chapter 3. This includes theories of social practice and conceptualising PPI as a practice or sets of practices. The elements of a practice are important to this discussion. Shove, Pantzar and Watson (128) list the elements of a practice as materials, competences and meanings. Materials are objects, tools, infrastructures, hardware and the body, and meanings the social and symbolic significance of participation. (128)

## **2.5 Trust in relationships**

Attuned to the idea of trust in relationships and how this might be characterised for clinical commissioning, I was mindful of where the words 'trust' and 'trusting' appeared in the selected papers. (This excluded the word Trust where it referred to an NHS provider organisation.) However, I did not want to force the theme or how 'trust' or 'trusting' acquired meaning.

Sometimes the word trust was used glibly and was difficult to qualify. The Patients Association report (90) expressed concern about GP consortia and what that might mean for trust between a patient and a healthcare professional. Clinical outcomes could be compromised if there was non-adherence to medicines for example. This focused on trust between the individual patient and doctor whereas Loting and Glasby (91) mentioned developing trusting and closer relationships as a result of integrated care. They were referring to the partnership working between NHS organisations and the local authority.

Elsewhere trust was mentioned in relation to knowledge exchange and brokering in new CCG relationships. Employees with commissioning responsibilities could be uncooperative at times as they had concerns about their job roles once PCTs ceased as commissioning organisations. (93) This hindered the development of trust and stability in the new collaborative networks and had ramifications for the new breed of clinical leader taking on 'subtle leadership'. Zachariadis and colleagues (93) refer to the importance of capturing patient views in a consistent and structured way but the multi-disciplinary coalitions in the new CCG 'innovation hubs' did not mention patients being included in discussions of the services to be purchased. This paper also referred to a GP feeling 'tricked' into pathfinder status as a ploy to engage frontline GPs with new policy. Consequently, it conveyed an element of mistrust.

One paper recommended that providers be included to develop relationships and trust for PPI. (54) However, overall, I was not gaining further insights as to how 'trust' was constructed or its characteristics.

## **2.6 PPI infrastructure**

This theme emanated from structures and resources (materials) in place for PPI practices notwithstanding that PPI is now a statutory requirement. CCGs have a duty to involve and consult with the public under the HASCA. Several papers referred to a lack of resources and the need for training and development to support PPI for all parties including clinicians, patients and lay representatives. (19, 54, 93, 116) There was a lack of capacity, including time, to explore what was important for patients other than using traditional biomedical measures (116) for determining successful outcomes of commissioned services. There was also limited guidance on public involvement including use of a common language and understanding. (54, 117) Historically, there had been no mandatory obligations on GPs to involve the public or suggestions of how to do so during the time of GPFH. (19) GPs could not see the value of using patient views as they considered they knew their patients' needs. Patients were considered not to be in the best position to provide an informed opinion. (19)

One paper referred to PPI structures that were in place through four levels of engagement. Similar structures are commonplace in CCGs in 2018 although PRGs are better known as PPGs. All three CCG cases in the study practised the four levels of engagement (117):

1. Patient reference groups (PRG)
2. Representative from PRG attending CCG public involvement group
3. Lay representative on Governing Body (GB)
4. Wider public consultation

Earlier publications pre the HASCA focused on the existence of a published PPI strategy. (90, 110) Alborz and colleagues (110) used PCG and PCT National Tracker evaluation data in 1999 and 2000 and then carried out interviews (telephone and face to face) with PCG chairs as well as postal questionnaires for the lay board and Community Health Council (CHC) representatives. The authors were looking for evidence of a written PPI plan with an established working group and designated budget. After 18 months 69% of the sample (71 PCGs) had written plans and 81% a PPI committee or working group but only 21% had a budget and this was mostly less than £5,000. They also explored the range of methods for consulting with communities. There were a wide range of approaches and the development of the consultation methods were considered PPI successes. (110) However, this same paper also reported that despite the PPI successes the consultation with communities was limited and mostly for applications to become a PCT. It was agreed there was widespread ignorance on the existence of PCGs and PCTs. Eighty-seven per cent (87%) of CHCs felt that local communities were largely unaware of the PCG or PCT.

A more recent paper by Reidy et al. (116) looked for evidence of how plans on CCG websites addressed self-management support (SMS). SMS is a priority for people living with long term conditions and an important component within integrated care systems to help achieve cost containment. (116) Two-year operational plans and five-year strategic plans were requested for analysis in nine CCGs in the South of England. Forward plans were not clearly accessible and there was little detail about who and how representatives were selected to

participate in PPI initiatives for SMS. Commissioners determined who they would approach. (116)

Another finding was that managerially defined structures for PPI may enhance credibility or influence so that patients or members of the public become 'experts in laity'. (117) A criticism would be that, by aligning agendas for management, it could run counter to the critical and distinctive voices required of representation. Other infrastructure features included recruitment and selection criteria which had lay representatives 'jumping through hoops' (115) and commissioners defining who has a legitimate voice. (54)

## **2.7 PPI processes**

The theme of PPI processes has parallels with the skills and competences that are elements of practices. Several papers referred to the skills required for PPI participation and the inherent mechanisms. (19, 54, 115)

Using a realist evaluation Petsoulas and colleagues (19) compared the PPI mechanisms during the different clinical commissioning eras. Low level involvement occurred during the period of GPFH and TPP, for example, producing newsletters and posters to inform sometimes via PPGs. Then more deliberative and outreach methods for the GP commissioning pilots and PCGs but this might depend on whether there was direct or indirect involvement and the presence of a mediator. PPI could be quite passive.

Returning to the four levels of engagement listed earlier, the authors were interested in examining rational and normative ideologies of managerial control. (117) Instead of focusing on criticisms associated with disengaged or sceptical healthcare professionals making assumptions about types of legitimate knowledge, their research question asked what are the consequences of co-opting public involvement representatives into managerially defined roles? Rational ideologies of control might mean that managers tightly control the PPI infrastructure and processes and therefore curb public involvement. They followed up three CCG case study sites with interviews and some observations of meetings. Two GPs were interviewed in each CCG as well as general managers and PPI representatives.

In the first case study site, there appeared to be a high degree of managerial control. (117) The agenda for meetings was set by the managers and PPI was trivialised. There was no evidence of PPI activity and discussion affecting service changes. In fact, PPI was not integrated into strategic commissioning. The GP acknowledged that patients made some valid points 'but it's really peripheral stuff' as they did not have the knowledge and experience that health care professionals had to make decisions.

In the second case study there was greater recognition of the importance of PPI with a supposedly supportive culture, but proceedings were still managerially controlled. Staff found it time consuming when they had to repeatedly explain things because the PPI representatives did not understand the NHS. There appeared to be manipulation of outputs and representatives were only allowed to occupy roles or give views on what managers determined. This was viewed as accountable consultation (119) and has been reported elsewhere with respect to role and representation. Maguire and Britten (129) discuss two similar 'acting for' roles; namely 'authorised representation' when a formal mechanism is used to elect a representative from a user group, and 'accountable representation' as a public contribution. The latter could be akin to Healthwatch providing feedback to a CCG as a recognised public voice.

The third case study demonstrated the potential of normative control with a 'hands-off' approach to proceedings on the part of the CCG managers. The PPI group set the agenda, had a small budget and their input influenced strategic commissioning with demonstrable savings. The PPI group appreciated the autonomy they could exercise when deciding not to work alongside PPI representatives from another CCG because they were managerially controlled. They were worried about their credibility if they worked with the other CCG and felt they had an educative role to prepare other PPI representatives. The authors (117) raised some interesting points about whether the professionalisation of the service users as PPI experts (130) was leading them down the path of rational management if they controlled who joined the group and who they worked alongside. However, it was decided the PPI group was exercising normative control as their genuine interest was to educate future representatives to do PPI

well. They were not being controlling and exclusive in the way they functioned and the good relations they enjoyed with management enhanced their sense of belonging and identity. (117) The partnership working could be described as transformative (57) whereas case studies one and two were more monologising (57) in nature. The managers wished to dominate the PPI groups and their outputs in the first two case studies.

Other PPI processes to report for this theme included a lack of feedback on lay member input, being unsure if you were sufficiently representative, and what the PPI reference group should be doing. (115) In a study investigating CCG board meetings and PPI reference groups (115) lay members were concerned that their knowledge and skills were lacking. They wondered if they could represent diverse communities when they were predominantly white and retired. There was greater acceptance if a lay person was representing a group or organisation. Knowledge seemed more legitimate and true. Although the authors concluded it was impossible to achieve true representation there were some illustrations of good practice during the study as the reference group established itself and the CCG embedded the PPI infrastructure. This included appointment of a PPI Lead, administrative support, regular meetings and training sessions. It was the reference group chair who suggested the research which did receive NIHR funding.

This theme of PPI processes, the doing, performing and the know-how, provides some insight for addressing the second part of the literature review question:

*b. Where and how do service users (patients and carers) and the public feature in clinical commissioning?*

The evidence so far, although not exhaustive across the 10 papers, suggests there are various roles that service users and the public occupy for clinical commissioning. These are often formalised and defined by the PPI infrastructure as it evolves in the CCG post the HASCA environment. It includes membership of PPGs, being a representative on a CCG PPI group or sitting on the GB as a lay member as well as participating as a citizen in wider community consultations. Some roles are tightly controlled in terms of recruitment and selection and some groups are also managerially controlled with respect to their function and outputs.

These roles did exist before CCGs but their outputs are perhaps more transparent now through research and the CCG improvement and assessment framework.

(131)

## 2.8 PPI outcomes

The ten papers revealed an eclectic mix of outcomes in relation to PPI and many were not affirming. The most relevant outcome for this review is what impact did PPI have on strategic commissioning decisions. The answer is very little or the PPI representatives and lay representatives did not know despite asking for feedback.

(115) Two studies confirmed that the PPI initiatives did not inform strategic planning. (116, 117) In the case of Croft and colleagues (117) that was not the complete story as the third case study with normative managerial control did influence strategic commissioning and made some financial savings.

The reasons for not responding to PPI input was often due to the wider systems and how CCGs would be judged on their performance. Centrally-prescribed evidence, national outcomes determined by NHS England such as the Quality Outcomes Framework, (132) or incentives as with the Vanguard models of care meant that these took precedence over listening to local input from PPI representatives. (116) PPI became lip service as there was no capacity to do more than adhere to target requirements. (116) It was a 'window-dressing' exercise often carried out by managers. (19) CCG managers leading on PPI meant that GPs could avoid the conflict of being both a commissioner and the patient advocate. (19) At this point I return to the first part of my literature review question:

*a. If commissioning is 'clinically led' what is meant by clinician engagement in CCGs for PPI?*

The 10 papers reviewed have provided little further insight into what 'clinically led' clinician engagement (by GPs) for PPI means. Some of the papers in the sampling frame of this review were discarded because PPI activity was carried out by commissioning managers and not GPs. The potential conflict between what a patient needs or desires and what a GP commissioner can provide, means that the PPI infrastructure with a lead manager and team is likely to persist. Someone other than the GP manages the process, however, recent research is identifying

GPs as study participants involved in work streams with PPI initiatives. (111, 116, 117)

The four-year NIHR study led by Peckham et al. (54) similarly identified national and clinical priorities taking precedence when it comes to PPI outcomes. The study was conducted just as the NHS proposed reforms were published. (3) It examined how commissioners enable the voice and engagement of people with long term conditions and what impact this had on the commissioning process. PPI was fragile and occurred in silos. The authors acknowledged that it was difficult to say whether PPI was done well because of the timing of the study. However, they did look at three case studies of long-term conditions (diabetes, rheumatoid arthritis and neurological conditions) to explore the role and impact of what they termed PPEI in commissioning. The PPEI acronym stands for 'patient and public engagement and involvement'. Engagement is a pre-determinant of involvement although a passive activity whereas involvement is active. (54) The three case studies included one site where there was a long history of PPEI and a strong emphasis on partnership working. The research team were able to elicit examples of service users influencing service development.

An important finding from the study of Peckham et al. (54) was the description of PPEI as a circular process. It is not linear but instead entails virtuous and vicious circles which has since been cited elsewhere (115) including in the context of GP clinical engagement with virtuous and vicious cycles. (24) It is included here in the PPI outcomes theme because the meaning it assumes, as with performing a skill or practice, has an impact on the learning that takes place and the opportunity it affords for reinforcement. The virtuous circle is like a positive feedback mechanism. The experience of success can lead to further engagement if it is not tokenistic whereas a vicious circle (or cycle) can lead to disengagement if participants think they have no influence. (24, 54) A key recommendation from the Peckham et al. study in addition to the need for infrastructure to support PPEI was the idea of an analytic framework to evaluate PPEI processes within the context of clinical commissioning. See **Table 2.12** and overleaf:

**An analytical framework for evaluating PPEI within the context of commissioning:**

- i. Is it moral? As a right for tax-paying citizen in a democracy.
- ii. Is it approached methodologically? As a tool for quality improvement, improved patient safety and increased efficiency?
- iii. How the policy imperative is enacted. Does everyone have a voice, has quality improved, according to policy?

Peckham et al. (54)

The research team also made a number of recommendations including further research to see how PPEI is enacted and encouraging researchers to use participative approaches (54), both of which resonated with me.

In concluding this theme, it is important to highlight the methods employed by Reidy et al. (116) The team included service user researchers who observed CCG GB meetings. In terms of 'meanings' attached to practices and PPI outcomes, the service user researchers produced supplementary materials which incorporated the social entities embedded within their experiences. They saw the meetings as a 'rubber-stamping' exercise and noted examples of good and poor PPI practice. Examples for the latter included the use of jargon, meetings being unfriendly and poorly signposted venues.

## **2.9 Conclusion**

*Q. What is different about GP clinical commissioning and PPI since the HASCA compared to previous manifestations of NHS primary care commissioning?*

To return to my literature review question in **Table 2.8** (and above), there has not been a great deal of difference in GP clinical commissioning and PPI since the HASCA. It is still too early to say what impact clinical engagement has made on PPI with the advent of CCGs. Given that more PPI infrastructure and processes have been put in place to demonstrate transparency, there are PPI leads and commissioning support managers who are taking on engagement and involvement roles with local communities and lay representatives. What GP Leads do in terms

of PPI and responding to the intelligence generated still requires further examination.

What this literature review does not reveal, or at least only skims the surface, is more about the contested terminology and position of patients and publics in PPI including issues of representation and power relations. I have read further to advance my understanding of the democratic deficit (voice), consumerist perspective (choice) and ideas on co-production of public services. I precis some of them below for clarity but have also taken time to engage with some of the conceptual frameworks relating to PPI that appear in the literature. (45, 73)

### **2.9.1 Patients, the public and lay representatives for PPI**

Patient and public involvement in health care decisions, often described as lay involvement, has been defined as:

*'Ways in which patients can draw on their experience and members of the public can apply their priorities to the evaluation of, development, organization and delivery of health services.'* (44)

The definition outlines the various interfaces where patients and carers (service users) and the public engage with clinicians, managers, commissioners, educators and researchers.

Whilst there is a substantial body of published work on patient and public involvement in research, service design and improvement, there is limited research for clinical commissioning. Much of the published literature both nationally and internationally relates to patient safety issues and patient experience with respect to quality improvement. (133) This has been partly in response to health care organisations failing to listen and not placing patients and their families at the centre of care. Other work is focused on shared decision-making with patients for individual treatment decisions because of the perceived benefits of health improvement and cost savings. At a collective level of involvement, for example, a new hospital service or a particular patient group using a community care pathway, co-design and co-production are seen as a way of working in partnership with patients and the public. (134) However, this can bring with it concerns about representation and legitimacy, tokenism and lack of

power. (115, 135) Co-production is favoured for community and citizen engagement and has gained significant traction with Asset-Based Community Development for public health and wellbeing in communities. (136) It is also seen as an essential component for implementing chapter two of FYFV. (137, 138)

With respect to power relations and lack of power, the seminal work of Lukes (139) was helpful in understanding how actual and potential power is exercised. How power is perceived and explained with reference to social practice (140) was also useful because of its relevance to my theoretical framework elaborated in chapter 3. Differentiating between power as an object or as an effect is important. The former refers to the capacity of a person or institution to exercise power over another and can be the property of an individual such as a monarch or a collective social actor such as the state. (140) However, power is a contested concept. Lukes (139) cites Hannah Arendt, the American philosopher and political theorist, and her view that power is not the property of an individual to act alone. It should be consensual and based on the rule of law and power of the people. The legitimacy of power is therefore gained from getting people together to think and act. It is 'power to' as opposed to 'power over'. (139) The sociologist Talcott Parsons put forward the idea that increasing the power held by an individual or collective does not mean taking power away from others, (cited by Callaghan and Wistow (141)). It is a specific mechanism and legitimised by the furtherance of collective goals – a system property. (139) Conversely, Callaghan and Wistow (141) refer to the German sociologist and political economist Max Weber's conception of power as a finite resource which a group can gain to the detriment of another group. Power must be redistributed for participation to be effective as with PPI in primary health care decision-making. (141)

Power with capacity to deliberately influence the actions of others is synonymous with agency and can illustrate power effects. (140) Lukes (139) expounded on this application in his three views of power with reference to American politics and decision-making. The one-dimensional or pluralist view described observable behaviours that conveyed power and influence when addressing conflicts of interest. However, if interests are not known or are subjective, then the two-dimensional view of power reveals how social and political values within

institutional practices are used to undermine, minimise or suppress concerns. It may appear that there are no conflicts. Referring to the 'rules of the game' cited by Bachrach and Baratz, Lukes (139) explains their typology of power; coercion, influence, authority, force and manipulation. The three-dimensional view of power addresses bias in the systems and culture of the institution or organisation. (139, 141) It can be an insidious use of power since manipulation and authority do not involve conflict. However, there may be latent conflict when the real interests of those excluded or not conscious of their interests are identified. (139) It is not difficult to draw parallels here with the earlier mention of the 'The Francis Inquiry' (5) in chapter 1 and the associated publications advocating a change in culture and leadership style. (6, 7)

If 'power relations' are the relations shaping action and the capacity to act, then Watson's (140) chapter was helpful for understanding power as an effect of performances of practices. He dismisses understandings of power as an object or property and instead draws attention to Foucault's framing of governmentality and governing. How this is practised, including in institutions such as CCGs, provides insight into power. He asks how the conduct of conduct is practised and calls for the development of concepts and methods that can grasp what is being practised.

The effects of power were evident in most of the 10 papers reviewed for this chapter but clearly more so in some, for example, Croft and colleagues (117) examining rational and normative ideologies of managerial control. Another paper, (141) not in the review, was useful for looking at power and forms of capital in PPI and decision-making in primary care at governing board level. Published in 2006, it refers to PCGs and PCTs predating the HASCA, but the findings are analysed with reference to Lukes' work (139) and Bordieu's (142) concepts of habitus and field. The authors address types of capital (cultural, symbolic and social) in relation to a changing PPI landscape. They comment on how this might affect legitimacy and participation with newer terminology and descriptors entering the field such as 'citizen' and 'consumer'.

Defining who the public and patients are remains challenging and contested. There have been suggestions that the two should be disentangled if we are to understand and measure the impact of patient and public involvement in health

care decisions. (143) This would appear to be no different for PPEI for clinical commissioning. Patients can only provide a sectional or 'single issue' view, based on their experiential knowledge, whereas the public has a societal interest as citizens. Patients' involvement in their own health care is a response to counter medical paternalism whereas citizen or public involvement has evolved to address voter apathy, mistrust in public institutions and the democratic deficit. (143) Lay representative roles on a CCG GB on the other hand are specified in the HASCA legislation. There should be at least two lay representatives contributing their experience and knowledge from working at senior level in other organisations. (144) They are independent and usually one lay representative will have responsibilities for governance and the other for patient and public involvement (PPI). Other lay representative roles have since appeared, for example, for primary care governance. (144) The participants in my study included GB lay representatives and GP clinical leaders from two CCGs, one urban and the other rural, members of the public and patients and carers.

### **2.9.2 Adopting PPEI as the preferred terminology**

**Patient and public engagement and involvement (PPEI)** will be used from this point onward in the thesis as the preferred term and abbreviation for patient and public engagement (PPE) and patient and public involvement (PPI). This is for consistency and in keeping with the rationale explained earlier in **section 2.8** in the work of Peckham et al. (54)

The next chapter addresses my conceptual and theoretical framework for the thesis ahead of my methodology in chapter 4.

## **Chapter 3: Conceptual and theoretical framework**

### **3.1 Introduction**

In this chapter I present my research philosophy by explaining the conceptual and theoretical framework that informed my study. It explores the assumptions, norms and meanings attributed to the domain of practice which I describe as patient and public engagement and involvement (PPEI) for clinical commissioning. PPEI, my preferred term and acronym for this study, was derived from the preceding literature review and explained with reference to research carried out by Peckham et al. (54) The premise being you cannot involve service users and the public unless you first engage them.

Ideas about partnership, trusted peer relationships, clinical leadership, organisational change and learning are integral to practice and learning as the preceding chapter has outlined. Some of these concepts are highly contested within clinical commissioning and continue to evolve in the post HASCA milieu of the NHS. Whilst some have been addressed earlier, this chapter explores three of the concepts in more detail (partnership, trust and leadership) and positions them with respect to my theoretical perspective on knowledge production. This requires me to make known how I see the world as a researcher, as well as a practitioner and educator, and the theoretical lens I have employed for the purposes of the research study. Namely, to see learning as a social practice within 'communities of practice' and that practice theories might shed new light on PPEI for clinical commissioning.

### **3.2 Theoretical perspective**

Despite a predominantly realist view of the world through schooling and early professional training as a nurse, my later undergraduate studies stimulated an interest in constructionism as an epistemological theory. Nettleton's (145) paper on the social construction of the profession of dentistry and the 'policing of the mouth' profoundly changed how I viewed the nature of knowledge, the theories of how we come to know what we know and the resultant shared understandings. The 'social' in social constructionism is more about the manner of meaning-

making. Knowledge made known through the socially constructed nature of the world and the interactions of the people and objects within that sphere. (146, 147) Meaning which is constructed by how we engage with objects or materials in the world and interpret them and the associated experiences in our mind and consciousness. A social world where knowledge and meaning are never fixed but always dynamic. (148) This inevitably includes the researcher and his/her experiences of the research process and the knowledge discovered and subsequently made known. **Table 3.1** highlights some of the experiences and tensions that impacted my thinking and reflexivity throughout the PhD. Some had more resonance at key points within the study such as during the design phase and the data generation. The table was compiled with reference to my diary entries which included a general journal as well as separate sets of field notes for the two CCGs where I conducted my research. The impact the researcher has on the data elicited is part of the reflexive process made known in good qualitative research. (147) Equally, acknowledgment of the impact of the research process on the researcher. (147) These aspects are also explored in **section 4.12** of the methodology chapter and in the discussion chapter in **section 9.6**.

**Table 3.1: Social world dynamics of becoming a researcher**

### **1. Prior research experience**

Early career experiences as a clinical nurse researcher in an academic surgical unit at a London teaching hospital prepared me for the loneliness of being a researcher. Sometimes, it is only you who are enthusiastic about collecting the data in the research (clinical) field. Others are pre-occupied with their own projects and the daily activities of providing patient services. I learnt to remain focused and determined despite additional projects being assigned to me. This later helped with my resilience as a PhD researcher and in anticipating the highs and lows of working on a research project. It also taught me the importance of networking and finding like-minded individuals with similar projects.

Later, as an educator, I assisted a principal study investigator and experienced researcher. However, becoming a PhD researcher meant I had to take the lead and be responsible and accountable for progress in line with ethical approval of the study. This was daunting, even with supervisory guidance, as it would only be me in the field. I worried about the project timelines especially when there was some slippage with gaining entry to the research field in one of the CCGs. I realised I would have to be flexible with regards to my research protocol and concluded that it was not detrimental if I began with observations instead of focus groups.

**Table 3.1 continued**

**2. The etic or outsider view.**

Having no primary care experience as a practitioner and limited prior knowledge of clinical commissioning was initially a concern. I doubted my credibility as a researcher. I felt like an imposter, but it was not a pre-requisite for the study and allowed me to pursue the etic view of an outsider. (149) Reading current literature for my review in chapter 2 enabled familiarity with the latest research and NHS guidance on clinical commissioning. I was therefore informed even if I was not a clinician involved in commissioning. This prevented me from being distracted by organisational targets and imperatives for PPEI for clinical commissioning although the counter argument might be that I was not culturally immersed in the field. However, participants would perhaps respond more openly to someone who was not within the CCG organisations.

**3. The emic or insider view**

Not having clinical involvement did not mean being without an insider or emic view. (149) My years of experience running a patient support group and attending strategic cancer network partnership group meetings, as well as leading on a service user and carer involvement strategy within education, meant I had an inside view on what patients and the public are thinking. I wanted to capitalise on this knowledge without being biased toward raising the patient voice. It allowed me to pick up on cues from what was not being said at meetings which I could pursue in the interviews. It also enabled me to quickly become familiar with data content because of the transferable nature of my knowledge.

**4. Thinking outside the box**

Early in the study I was asked by an academic if it was because I am a nurse that I wanted to approach my project in this way, that is, using wholly qualitative methods and a practice theory conceptual framework. This felt a threat to my professional integrity and although surprised by the remark it magnified my 'imposter' thoughts. Reflecting on this, it was my determinedness to research in a different way to produce an original PhD study, together with what I describe as an intuitive 'gut feeling' that I could generate richer data, that prevailed. Relevant reading for underpinning theory under supervisory guidance also endorsed the path I was taking and helped me gain confidence to persist with the project. My disciplinary background was of less significance than owning my conceptual framework for analysis and interpretation of my data.

Individuals and groups of individuals socially define a reality but so too can organisations. Organisations create a form of reality with specific meanings, shared understandings and values. To identify with those meanings and values and experience that sense of belonging and trust, individuals and groups will align with the organisational discourse. Discourses can be viewed as a form of social practice. (148) They give rise to structures and institutions populated by

professional communities that speak a common language and practise according to shared values and policy overseen by legislation. (150) The NHS and PPEI for clinical commissioning are an illustration of where such a discourse and policy alignment resides. As indicated in the first chapter, public involvement in NHS and (social) care commissioning processes was initiated with the purchaser and provider split following the NHS and Community Care Act 1990. (151) Given the 25-year history, I was therefore curious as to how partnership working with various stakeholders would construct a trusted peer relationship for PPEI for clinical commissioning post the HASCA.

The changing nature of engagement and involvement together with the language employed presents challenges for a researcher in this field. Service user and public engagement theory is contested (44, 78, 113, 152, 153) and the language of citizen participation has 'a remarkable degree of terminological instability'. (12) The lack of consensus together with criticisms of engagement and involvement as unrepresentative (129) or tokenistic and encouraging professionally socialised participants (130) prompted me to look differently at PPEI. Instead, to view it as a developing practice or set of practices where meaning and competence change over time together with the materials (physical entities such as surveys, reports and minutes of meetings) used to execute the practices. If the practice changes over time, how has it been carried and how are old and new practitioners (GP commissioners, service users and lay representatives) sustained and recruited? These ponderings helped shape the research as I considered practice theory as a lens for illuminating both my methodology and findings. The subsequent sections further explain practice theories and Communities of Practice (CoP), the latter being an illustration of a social learning practice theory.

### **3.3 Practice theories and the socio-material**

Practice theories are a sub-type of cultural theory. (154) They are concerned with the everyday social practices of life and the tacit knowledge or 'know how' and associated social relations. As a body of ideas, they emerged in the 1970s on the premise that practices consist in organised sets of actions and link together to form wider complexes and constellations. (155) There is no one unified theory of

practice but theories of social practice are popular as part of the contemporary 'practice turn' within the social sciences. (154, 156) Thus it is a growing field of study with increased interest in the socio-material relations of everyday work and professional learning. (157, 158) In addition, within healthcare and organisations and the increasing emphasis on relational approaches to care and leadership. (159) The appeal of theories of social practice was their application in organisational studies and professional education and practice, including medical education, (157, 160) both of which are important to this study.

The writings of Tara Fenwick (157, 161), Davide Nicolini (156), Silvia Gherardi (162, 163) and Elizabeth Shove (128, 164) influenced my decision to select a practice theory lens for pursuing the research. Re-centring our understandings of social life and associated phenomena as 'practices' places the knowledge and knowing in the doing/activity, as opposed to an acquisition model where knowledge resides in the head of the professional or a person within the organisation. (158, 165) Similarly, strategic knowledge which can be thought of as a commodity residing with persons in the work of organisational management is secondary to the knowledge located in the collective, situated activity. (165) Knowledge acquisition and transfer has been replaced as cognitive attributes of the individual by a participatory mode where practice, knowledge and the environment become entangled in the social and material. (158) This can dissipate the effects of power and representation in such a way that the ontology or sense of being/reality is altered. The world is viewed in relational terms and knowledge, meaning and discourse are transformed. (156) Shove, Pantzar and Watson (128, 164) illustrate this well with their work on understanding change. They argue that unlike other practice theories which focus on reproduction of social life, their slim line version has vast potential for understanding complex change and challenges and could influence public policy. Their interests include public health policy where behaviour change can often focus on individual choice, context, and structural conditions (164) depicting the structure and agency dichotomy within the social sciences. How much power or autonomy does the individual have within the structure of healthcare systems for health promotion, for example, giving up smoking or reducing alcohol intake, when set against individual social conditions? A paradigm shift is suggested to focus instead on material and symbolic elements

within the 'lives' of social practices. (164) This leads to exploration of why people are recruited to certain practices and not others and how participation is sustained. Motivation and commitment become the outcomes of engagement rather than the pre-conditions in the above health promotion illustrations. (164) Practices rather than the practitioners are the units of analysis. (156) I considered this could equally apply to PPEI practices for clinical commissioning.

Fenwick similarly explores these ideas where she argues for the growing interest in the socio-material relations of every day work and why 'matter' matters to medical education. (157) She differentiates between the material and social forces:

**Material** - the 'everyday stuff of our lives' (157) – organic and inorganic such as furniture, pass codes, forms, checklists, minutes, databases, technological.

**Social** – symbols and meanings, fears, desires, cultural discourses, politics.

Context is crucial for clinical practitioners when learning in practice and GP clinicians in Lead CCG roles are no different. Metaphors of knowledge acquisition and transfer have been superseded by situated learning where ongoing participation and active engagement within communities need to be understood. (157) There are several theories of social practices. Gherardi describes four of which situated learning is one important and significant strand (163):

- situated learning,
- activity theory,
- the cultural perspective, and
- actor-network theory.

Although the theories are different most practice theories agree on the constituent parts of a practice. Gherardi lists these and they are produced in **Table 3.2** below. Shove, Pantzar and Watson with their version of slim line practice theory simplify by describing practices as made up of elements comprising materials, competences and meanings. Elements must be actively integrated to form a practice, (**Table 3.2**).

**Table 3.2: Constituent parts of a practice**

Gherardi (163)	Shove, Pantzar and Watson (128)
Actions Individuals Contexts Artifacts* Rules Symbols Texts Discourses Embeddedness	Elements comprising: <b>Materials</b> – objects, tools, infrastructures, hardware and the body <b>Competences</b> – multiple forms of understanding and practical knowledgeability <b>Meanings</b> – social and symbolic significance of participation at any one moment

\* Artefacts in British English

Shove, Pantzar and Watson describe a practice as:

*‘a practice’ consists of a composite patchwork of variously skilled, variously committed performances enacted and reproduced by beginners and old-hands alike.’ (128)*

Where there are loose-knit patterns of practices they are described as bundles based on their co-location and co-existence. (128) Complexes are described as stickier and more integrated combinations of practices. (128) Elsewhere these links are referred to as a nexus of practices. (155) This is useful for distinguishing between practices- as-performances and practices- as-entities.

Defining practices as entities is helpful for understanding how a practice emerges, persists and disappears. (128) Materials are the only elements which move and have physical characteristics. If the necessary materials are not at a new location the practice may fade, expire or alternatively be modified. With PPEI this might entail material examples such as feedback from focus groups, citizens’ juries, or national experience surveys favoured at certain times according to policy initiatives. The Friends and Family Test (FFT) is one such tool (material) driven by NHS policy to provide feedback from experiences as to whether a patient would recommend a service to friends and family members. However, the FFT has been criticised for pursuing target response rates to the detriment of good qualitative

data, and generating copious pieces of feedback which are resource heavy in terms of processing the metric. (166) Publications such as toolkits and statutory guidance (50, 52, 167, 168) are other examples of materiality to advise and guide what might be useful according to the purposes of patient and public involvement.

Competences and meanings (**Table 3.2**) can be modified by extension, contraction or change and incorporate historical, temporal and spatial perspectives. Shove, Pantzar and Watson (128) provide several illustrations including the example of hula-hooping which gained great popularity as a practice but then passed as a fad (an entity). Competence and know-how can travel if there are practitioners at the new destination who have first-hand experience and can unpack and embed the practical knowledge. However, forms of what they describe as 'cosmopolitan knowledge' can travel as they are not dependent on local understanding and have a global recognition. (128)

Meanings can travel very rapidly and it was this that prompted further interest in practice theory given the aforementioned terminological instability. (12) PPEI practices in clinical commissioning, a relatively new set of practices, have been influenced by what has gone before with respect to competences, know-how, policy imperatives and lay involvement within the five categories of patient and public involvement described by Tritter. (44) These categories are treatment decision making, service development, service evaluation, education and training of health staff, and research (44), several of which are relevant to this study.

### **3.4 Communities of practice and situated learning**

The research was also informed by practice-based approaches to learning, particularly situated learning theory and Communities of Practice (CoP) (156, 165, 169, 170) that give emphasis to the socio-material. Conventional behavioural /cognitive theories of learning are not adequate for understanding learning. (171) A body of knowledge is not just contained within books constituting 'head knowledge' but within the various communities of people who contribute to the application and evolution of the practices. (158, 172) Participation is critical for learning, living and working with others within a social paradigm of learning. (170, 171)

As stated earlier, situated learning is one of four types of practice theories. (163) Lave and Wenger have been described as part of the first generation of practice theorists (155) with their account of legitimate peripheral participation (LPP) as a way of engaging in social practice that includes learning as an integral constituent. (170) LPP, including the learning of knowledgeable skills, is a social process between 'newcomers' and 'old timers' that can enable the newcomer to become a full participant in a socio-cultural practice. (170) These theories are useful for social science research concerned with knowing and learning in everyday activity. (158) They view learning as a practice and so are concerned with how the knowledge and learning of practitioners emerges from and is an effect of everyday activity. They can provide new insight into practical knowledge, the tacit knowledge or knowing, associated with professional competence and learning in organisations. (162) Using a social theory of learning can inform what learning might be but also what can be done to support it in various practical contexts. (173)

The primary focus of Wenger's CoP theory is learning as social participation. As active participants in the practices of social communities we construct our identities in relation to those communities and create a sense of belonging. (169) His social learning theory comprises four interconnected components (169):

**1. Meaning** which is a way of talking about how we experience life and the world as meaningful. This can be either as an individual or collectively and is **learning as experience**.

**2. Practice** which is a way of talking about shared histories and perspectives, social resources and frameworks that sustain mutual engagement. This is **learning as doing**.

**3. Community** which is a way of talking about the social arrangements in which we think it is worth participating. This is **learning as belonging** and our participation (if agreed by the community) would deem us competent.

**4. Identity** which is a way of talking about how learning changes who we are. This is **learning as becoming**. Our personal histories of becoming are within the context of the communities to which we belong.

**Table 3.3: Concept of practice including both the explicit and tacit. Adapted from Wenger (169)**

Social	Material
What is said/unsaid	Language
What is represented/assumed	Tools
Subtle cues	Documents
Untold rules of thumb	Images
Recognisable intuitions	Symbols
Well-tuned sensitivities	Well-defined roles
Specific perceptions	Specified criteria
Underlying assumptions	Codified procedures
Embodied understandings	Regulations
Shared world views	Contracts

The concept of practice conveys doing activity in both a social and historical context and includes the explicit and tacit. **Table 3.3** adapts Wenger’s explanations of a practice elicited from his research field work with the claims assessors and their communities of practice in his seminal text. (169) It separates out some of the social and material aspects of the doing and is equally relevant to PPEI for clinical commissioning but is not an exhaustive list. The following sections elaborate further some aspects of Wenger’s work (169, 172) to show its relevance to this study. Wenger’s later work is published under the name of Wenger-Trayner.

### **3.4.1 Modes of identification and the domain of practice**

Conforming or aligning with the PPEI discourse for clinical commissioning led me to consider more closely the work of Wenger-Trayner (169, 172, 173) from the last twenty years or so. He describes 'alignment' as a mode of identification within a landscape of practice where participants are learning together. (172) It is not merely compliance or passive submission but should entail a two-way process. It requires the ability to communicate and direct energies for a common purpose, to co-ordinate perspectives and actions, deploy methods, apply criteria, and ensure needs are addressed. (169) This endeavour appeared to be consistent with learning to lead and partner with others for clinical commissioning.

Alignment does concern power and can amplify it, but it can also disempower where there is a prescriptive process. The landscape can be at institutional, organisational and professional level, even governmental. It is best understood as a complex system of CoPs and the boundaries between them and constitutes the social body of knowledge of the practitioners. (172) In my study I perceived the landscape to be at organisational level; that is CCGs in the English NHS after the HASCA.

Identification, previously known as mode of belonging (169), includes two other modes, 'engagement' and 'imagination', as part of a framework of social learning theory for practice-based learning. (172) Engagement is the in the moment lived experience of doing activities such as talking, writing, reflecting and producing and has the most immediate relation to a landscape of practice. (172) There is local knowing and meaning in each practice and no practice can claim to represent the whole in a complex system. (172) It is the practitioners who produce the practice even when there is a standard or prescribed way of performing and in turn the practices can inform and influence one another. Practices are like mini-cultures and the boundaries between can generate conflict as well as collaboration, but they also produce learning opportunities with new insights. (172) I envisaged PPEI practices taking place within the GB meetings and in the GP locality member groups of both CCGs. Also, in the work of the committees that engage with service users and the public to make, and lead on, significant decisions which shape local

health and care services. The various committees are also CoPs although not all will have been convened informally. They form constellations of CoPs with their own trajectories and boundaries. Sometimes an encounter at the boundary may have to be brokered. CoPs both separate and interlock yielding a complex social landscape of shared practices. (169) The peripheries, boundaries, connections, overlaps and encounters all contribute to the situated learning and negotiation of meaning within a community.

Imagination, the third mode of identification, entails thinking about how things could be and making connections across time and space based possibly on what has gone before (histories) including personal experiences. (169) Wenger describes imagination as a creative process similar to looking at the apple seed and seeing the tree. (169) Journeying through the landscape the tools of imagination comprise language and pictures for stories and images to interpret one's own participation or non-participation. (172) However, it is important to be wary of stereo-types and in the context of this study that might be lay representatives and service users perceived as the 'usual suspects', professionalised or un-representative. (130)

All three modes of identification – engagement, imagination and alignment – function inside CoPs and across boundaries. (172) I envisaged this to be the case with multi-disciplinary working across the different systems within health and care, for example, working with public health, the VCS and local authorities for NHS clinical commissioning. However, in my study the practitioners of interest within the various CoPs are the GP Leads (clinicians), service users and lay representatives.

### **3.4.2 Competence and knowledgeability**

A CoP does not refer primarily to the group of people participating but the social process of negotiating competence in a domain over time. (173) Competence is the dimension of knowing negotiated and defined within a single community of practice by the community members. (172) It is a learning partnership and has a social dimension to it in that members of the community are perceived as competent or otherwise. 'Domain' is Wenger's preferred term for the area in which a community claims it can legitimately define competence and replaces his original

term 'joint enterprise'. (173) For the purposes of this study the domain is PPEI for clinical commissioning. **Figure 3.1** presents a visual representation of how I perceive CoPs for PPEI for clinical commissioning. It illustrates how I envisage this within the landscape of CCGs in 2018 and was influenced by the research settings for my PhD study. I saw the communities (of practice) to be the various groups that convene for CCG business that should include and hear the patient and public voice. GP Leads (clinicians), lay representatives and service user representatives are integral to the communities if PPEI practices are to take place. The depiction of the communities is not exhaustive since new ones are convened according to policy priorities and some may have an intermittent influence depending on current NHS commissioning work streams.

Examples of communities are represented by the coloured circles some of which overlap or have distinct boundaries with one another. The orange circles are related to the GB; the green circles the local authority and VCS. PPGs are coloured purple. Although each GP practice should have a PPG, not all are actively engaged or involved with clinical commissioning. Hence, some sit outside the domain of practice of PPEI for clinical commissioning. PPGs are often networked within a CCG either by locality or a CCG-wide network group. They may also have contact with a local Healthwatch affiliated to Healthwatch England, the independent national champion for health and social care services, (see **Glossary**). Healthwatch and the PPG Network are therefore also depicted by the colour purple in **Figure 3.1**. The communities within the domain of practice or overlapping with it should be involved in partnership working for PPEI in clinical commissioning. The domain is bounded by a red line. The nearer the centre of the domain the more embedded the PPEI practice. Others may not be in the domain of practice but affect it because of past histories, for example, a service user group which has previously contributed to a quality improvement initiative for a local service provider. This might be an organisation within the VCS and so it sits at the boundary of the domain of practice.

Outside of the domain but influencing it and consequently the landscape of CCGs are other larger and more hierarchical entities. NHS England, the local authority



with its remit for population health and (social) care, plus the newer Integrated Care Systems (ICSs) and STPs. Each has or will have work streams that impact CCGs and providers of services. The work streams are colour-coded for ease of understanding; blue for NHS England, green border for local authority and blue border for STPs/ICSs. Providers of care services also impact the landscape. Some will be more involved than others, depending on whether service user experience affects how services are perceived by the clinical commissioners. In addition, GP Federations also impact the domain of practice in both providing and co-commissioning primary care services. The GP Federations affect the domain of practice where patient experience evidence is generated and this informs commissioning decisions. Finally, Health Education England (HEE) sits at the periphery of the landscape because it supports workforce provision to ensure the right staff are in place with the right skills, values and behaviours.

Whilst considering competence it is useful to note the concept of knowledgeability. Introduced to account for the complexity of relations across a landscape, it describes a person's relations to the many practices across a landscape. (172) Knowledgeability, like competence is not just an individual characteristic within a CoP. Practitioners are expected to be competent in their own practice but also to have knowledge of relevant practices within the landscape and domain of a CoP in which they specialise. (172) This is important for leaders and multi-disciplinary working when participating in PPEI practices for clinical commissioning. A practitioner may not have competence in a practice but despite their non-participation be expected to represent a CoP and provide reliable information and services whilst having full accountability.

'Claims to knowledgeability are negotiated within the politics of knowledge in a landscape of practice.' (172)

### **3.4.3 Reification and participation**

Participation is a source of identity and broader than just engagement and so this ultimately affects the development of a CoP. Wenger (169) is keen to stress that reification goes hand in hand with participation to negotiate meaning in a CoP.

Together they give rise to what he describes as the 'duality of meaning'. If both are controlled so are the meanings that can be created in a situation or context and the kinds of person participants can become with respect to their identities. Reification consists of both processes and products that capture practice and participation and make them concrete. Wenger (169) argues that reification is not just objectification since it reflects practices and meaning which are always ongoing and incomplete. He refers to the politics of participation and reification. In my study I anticipated reification to manifest in the material objects that make up PPEI practices for clinical commissioning. Reification is a source of remembering and forgetting and so can reinforce policies and legislation, for example, the duty for commissioners to involve and consult with the public as made explicit in section 14Z2 of the NHS Act 2006 and amended by the HASCA. (1)

#### **3.4.4 Criticisms of CoPs**

Having embraced practice theory and the socio-material as a theoretical lens to conceptualise PPEI for clinical commissioning as a social practice, it would be remiss not to consider the criticisms of CoPs particularly. Fenwick (157), summarising critiques, refers to the limited analysis of power relations in the workplace and the conservatism and managerialism of CoPs. Generalised ideas about community and practice almost romanticise professional workplaces. Wenger-Trayner has acknowledged some of these criticisms particularly about power and argues his theory of learning is profoundly political. Learning from a social perspective entails the power to define competence at a local level but it remains a learning theory. (173) He suggests there are other theories that can be used to explain power and they can be added in what he calls a 'plug and play' mode citing Bourdieu's concept of habitus (174) for social stratification.

Fuller's critique of CoPs (171) advances six themes collated from workplace learning researchers, the first theme being the adequacy of learning as participation. LPP as a learner/apprentice to becoming a full member of the community implies continuity and perpetuation of practice. So where do changes in practice occur for improvement? Defining the community is a second theme. The broad interpretation of a community considers the need to belong in order to

learn whereas a narrower interpretation of a CoP could be a tight knit group. The third theme concerns the idea that CoPs are harmonious and stable places. CoPs are often subject to conflict and turmoil and it is the constant change that brings about new learning. Fuller (171), citing activity theorist Engeström, says the participation metaphor is not adequate to bring about organisational change if it relies on imitation and socialisation which are described as 'first order learning'. Engeström's 'expansive learning theory' requires second order investigative learning and a (third order) collaborative approach if transformational learning in organisations is to occur.

The fourth theme is a challenge is to the concept of novice-expert and LPP since some apprentices will have considerable knowledge. Learning is not a one-way transmission which leads to Fuller's fifth theme drawing attention to the different trajectories learners experience. People will have different participation experiences and so adaptation from past CoPs may be required. The sixth theme or critique focuses on the significance of learning across CoPs rather than remaining within one community. Crossing boundaries or boundary encounters between past, present and future CoPs can significantly shape both individual and collective learning. (171)

### **3.5 Partnership**

Returning to some of the concepts inherent in PPEI for clinical commissioning, I focus now on partnership. Partnership and co-production are terms increasingly used in guidance and advice for place-based commissioning and STPs, as are phrases about building trust and relationships. (34, 35, 56) Partnership is difficult to define when it can refer to an organisational form or type of relationship that may entail unequal power and authority. The term 'collaboration' has been suggested as more helpful. (21) Carnwell and Carson (175) in their chapter on concepts of partnership and collaboration, distinguish between partnership as something that is or exists (who we are) and collaboration which is something you do (what we do). A concept analysis that considers context is more helpful given that partnership in health and care is strongly influenced by policy which rapidly changes over time and place. (175) They also offer a definition of partnership as:

‘a shared commitment where all partners have a right and an obligation to participate and will be affected equally by the benefits and disadvantages arising from the partnership.’ (175)

Defining partnership is useful given the slippage in PPI terminology generally reported in the empirical literature. (12, 86, 87, 153) Bellows et al. (133) in their research looking at meaningful and effective patient engagement in a large Canadian health system, reported stakeholders used multiple terms interchangeably for patient engagement. Providers also used the word partnership when referring to stakeholders across all levels of the organisation. The research team (133) opted to use the World Health Organisation (WHO) definition of partnership agreed by African Partnerships for Patient Safety (APPS). (176) It is reproduced below and is equally helpful for this study since it includes ideas about trust and ethics with respect to shared accountability:

‘[a] ...collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specific goal. Partnerships involve risks as well as benefits making shared accountability critical.’ (176)

### 3.5.1 Partnerships as knowledge encounters

Having considered how partnership has been operationalised in chapters 1 and 2, it is useful to think further about how it is conceptualised. Aveling and Jovchelovitch (57) in their paper on partnerships as knowledge encounters refer to difficulties achieving equal stakeholder involvement and ownership. Mutuality is rare. Their psychosocial theory of partnerships for health and community development has parallels with PPEI for clinical commissioning. Partnership working is a practice, as in Carnwell and Carson’s ‘what we do’ idea of collaboration. (175) The practice is developmental and situated. It incorporates concepts of social representation whether knowledge is social, historical, cultural or psychological in type. This includes knowledge of self and all other stakeholders shaped by material, institutional and socio-economic contexts. (57) They define partnership as:

‘... a situated encounter between the different knowledge systems of concrete partners’ (57)

Knowledge systems are systems of meaning and understanding used by individuals (actors) to make sense of their world and the position they occupy with respect to other people, communities and contexts. What counts as appropriate knowledge at a given time and place is determined by a series of assumptions and methodological rules within that knowledge system. (177) Partnership working depends on three inter-related dimensions (57):

1. Representation of self and others which is influenced by material power such as control of resources and the source of knowledge in relation to authority, legitimacy and credibility.
2. Styles of communication that determine whether knowledge is recognised or dismissed by others. Is there consensualisation which acknowledges alternative views, identities and courses of action? Or reification where counter arguments are constructed to ensure supremacy of own view and perspective? (Castro and Batel, 2009 cited by Aveling and Jovchelovitch. (57))
3. Representational projects whereby these demonstrate a way of life, identity or cultural tradition shaped by the social conditions or institutions from which they emanate. These in turn are affected by the people who promote these identities, interests or traditions including practitioners and experts.

Aveling and Jovchelovitch (57) also suggest the dimensions can provide criteria for assessing the potential of partnerships and whether they are transformative or monologising in nature. The latter is where one partner attempts to dominate and disregard the knowledge of another. Transformative partnerships on the other hand recognise the value and perspectives of other partners and aim to work together. In their paper they illustrate this with two international case studies (57) but there are similarities with PPEI and clinical commissioning in CCGs. Partnerships are evolving as they are still relatively new (since April 2013) but the dimension of representational projects or representational systems is evident within the policies and practices of NHS England. Instrumental criteria abound for measuring and evaluating CCG performance with guidance on how patient and public participation should be enacted to encourage meaningful engagement (35, 49, 53, 178) and partnering with people and communities. (138)

Hence, my study aim was to explore what partnership meant for the participants and ask the key research question:

***What does it mean to work in partnership as clinicians and service users to commission and lead services?***

### **3.6 Concept of trust**

According to O'Neill (179), trust is distinctive in that it has to be given by someone else so what matters is *trustworthiness* of an individual or organisation. Increasing trustworthiness becomes the objective so that *trust* is then the response. (179) Characteristics of trustworthiness include being honest, competent and reliable. (179) If these characteristics are absent or diminished, the trust response is not made as opposed to it being wrongly placed and then withdrawn due to later mistrust of those characteristics or qualities.

Trust is important in partnership and relationships. It is valuable social capital and not to be squandered. (180) It is hard earned and easily dissipated. Loss of trust in health care professionals and organisations, for example, has been clearly illustrated in high profile cases such as Mid Staffordshire NHS Foundation Trust (5) and more recently Gosport Memorial Hospital. (181) However, as reported, scrutiny exposed poor systems, procedures and conditions and failure to listen to patient and carer concerns. There were opportunities to heed the warning signs but these were ignored. (7, 181)

Trust is used to explain and understand relationships and it is thought partners who trust each other will feel no need to control each other. (182) Trust is frequently mentioned as an organisational concept yet rarely subjected to empirical examination. (182) Hudson describes three types of trust and trusting as shown in **Table 3.4.**

**Table 3.4: Types of trust and trusting**

<b>Types of trust</b>	<b>Types of trusting</b>
1a) Trust as a psychological property	1b) Unconditional trust
2a) Trust as structural property	2b) Rational choice and negotiated exchange
3a) Trust as a social property	3b) Social exchange

From: Hudson, 2004 (182)

Trust as a psychological property (1a) refers to the individual characteristic of someone who depends on others in a range of circumstances. (182) It entails dispositional theories of trust whereby the individual is predisposed to trust or distrust of others based on the interaction of people's values, attitudes, emotions and moods. (182)

Trust as a structural property (2a) refers to the trust placed in organisations and institutions based on its structures and processes. (182) Written rules and contracts formalise agreements so that trust is exercised through control which Hudson describes as a deterrence-based trust. (182)

The third type (3a) is important for this practice-based study; trust as a social property in social exchange. It positions trust as a social property of the relationship and not a characteristic of individuals or features of an organisation. (182) It develops over time with repeated social interactions so that people can decide about trustworthiness. (182) Trust is a distributed social property and would be the outcome or effect of practices that interact, comply or conflict rather than the agency of individuals.

Cohn's (159) ethnographic work in UK diabetes clinics investigated trust as an emergent quality of social practice. He explored matters of trust/mistrust between patient and clinician as qualities of the relationship even if this was not explicit, for example, belief in the accuracy of self-monitoring diaries and blood sugar checks. When asked in what ways they did or did not trust the doctor they had just seen in the clinic, patients tended to recall actions or things that were said thus giving a general impression of trust which was more dispersed. Cohn (159) suggests trust is

a relational quality always done or achieved anew because it is context specific or situated. It is often indescribable and a feature of experience rather than a psychological state that can be measured. Trust practices are distributed across a range of actors and emerge from relationships between people and things. (159) In effect, the socio-material entities so that trust becomes ‘an extended property’ of a given context or situation. As my study encompasses various CCG spaces where PPEI practices for clinical commissioning take place within CoPs (**Figure 3.1**), I had further secondary or subsidiary questions that I wished to answer as a researcher:

- i. What is the nature of a trusted peer relationship?**
- ii. How can relationships be developed to demonstrate effective service user and clinician engagement?**
- iii. How might this be applied to the topic of patient and public involvement within health care professional education?**

### **3.7 Leadership- as- practice (L-A-P) movement**

In keeping with the theoretical and philosophical perspectives informing the study with respect to socio-material pedagogies of partnership, I also utilised ideas from the new leadership-as-practice (L-A-P) movement advanced by Joseph Raelin. I outline these here rather than with the other sections on practice theory and CoPs because L-A-P influenced my study once data collection and analysis had commenced. The movement has been described as both critical and radical because of its break with conventional leadership studies. (183, 184) This new paradigm does not see leadership in the traits and heroic behaviour of individuals but in the practices that constitute leading. Whilst he acknowledges that leadership has been reframed as ‘distributed’ and ‘shared’ across a range of actors and appears in recent literature with terms such as ‘collective’, ‘stewardship’, ‘empowered’ and ‘integrative’, Raelin argues that it is not based on any set of conceptual identifiers. (185) This applies to the NHS in England too where collective, followership and system leadership have all featured in the evidence base for application of new leadership models. (63, 186-188) The L-A-P line of enquiry views leadership as a social phenomenon and entails examining

routines and tacit problem-solving skills shared by a community that occur in the day-to-day experience. (184) It does not focus on the dyadic relationship between leader and followers but the social and material conditions that constitute it. (185) Thus there are similarities with both CoPs (169, 172) and Shove, Pantzar and Watson's slim-line version of practice theory. (128)

Beginning with practices as performances and as entities, Raelin (183, 184) uses Pickering's 1995 definition to examine the ontology of both. Practices are sequences of activities (performances) that may be repeated whereas practice 'refers to emergent entanglements that tend to extend and transform meaning over time.' (184) The former is about inter-action with 'inter-actors' and can be objectivist or subjectivist in nature depending on whether practices are perceived as objects, or the focus is on the interpretations of the individuals (subjects) performing the practices. (184) Practice is a more transactional mode where meaning emerges from the continual flow of processes where 'material-discursive engagements' occur. 'Pre-formed entities' such as institutions and discourses can affect the 'inter-actors' (184) which is akin to the alignment mode of identification within CoPs. (169, 172)

Practice is inter-subjective in character because it is interwoven with what takes place and the value of social interactions and connectedness. (184) L-A-P focuses on shared learning and lived experience in a community. It has a philosophy of co-development where people discover and 'unfold within themselves.' Leadership emerges so that agency is collaborative rather than focused just on the individual. Agency refers to the social forces that exert themselves on an individual such as social class and age. (177) They are influenced by structures and social conditions which emanate from the organisations themselves either through policy or more locally within teams and groups (communities). Practice theories are useful for dissipating dualisms such as structure and agency, micro and macro and process and product. (155) Agency is no longer the property of the individual but an effect of practice which should be thought of as distributed energy emerging from the flows and energies of practice. (189)

**Table 3.5: Activities consistent with the activity and relationality of leadership in complex systems. After Raelin, 2016. (185)**

<b>Leadership activity</b>	<b>Description</b>
Scanning	Identifying resources e.g. information and technology that will be useful to a new project. May help simplify or clarify a problem.
Signalling	Catching attention of other actors and mobilising for a particular project or programme. Could include imitating, building on or modifying existing programmes.
Weaving	Creating webs of interactions across existing and new networks. Building trust and a sense of shared meaning. Creating bridges between individuals and entities including the meanings attributed to certain views.
Stabilising	Providing feedback on a programme of action to evaluate effectiveness. May lead to structural and behavioural changes and learning.
<b>Inviting</b>	Ensuring everyone contributes no matter what their previous affiliations may have been or if contributions create ambiguity.
<b>Unleashing</b>	Encouraging those who have held back to participate through their ideas, energies and humanity without fear of repercussions.
<b>Reflecting</b>	Considering among self and others the meaning of past, current and future experience to learn how to meet mutual interests more effectively.

Raelin (185) identified and consolidated four specific leadership activities which he considered appropriate to the L-A-P movement. They do not belong to a particular individual or authority but he thinks they have resonance with the activity and relationality of leadership in complex systems. (185) They are included in **Table 3.5** as they are useful for identifying behaviours observed in fieldwork: scanning, signalling, weaving and stabilising. He added three other activities (emboldened)

which he described as belonging to the affective dimension as they are behaviours to support and maintain members of a team. The last one is borrowed from action learning. (190)

### **3.8 Drawing it together for a methodology**

In summary, I approached the study from a constructionist perspective in keeping with an interpretative paradigm. Holding a relativist ontological position, I believe there are multiple accounts of reality and concur with a subjectivist epistemology. (191) Knowledge and reality are co-constructed. My intention was to seek out what this might look like for partnership working and PPEI practices for clinical commissioning in two CCGs.

I have drawn on relevant social learning and practice theories to justify my research questions for the two CCG case study sites. Identifying social and material entities generated from PPEI practices should demonstrate the duality of participation and reification for social learning about partnership. In addition, the modes of identification for participants and how communities (of practice) define competence for PPEI for clinical commissioning. **Figure 3.1** shows some of the relevant CoPs where GP Leads (clinicians), service users and the public, including lay representatives, make and lead on significant decisions which shape local health and care services.

This is a unique approach to researching PPEI for clinical commissioning and has not been done before. The narrative literature review in chapter 2 reported studies informed by innovation network theory (93), Normalisation Process Theory (54), realist evaluation (19) and rational and normative ideologies of managerial control (117). There were no papers considering PPEI for clinical commissioning as a social practice or set of practices. I am assuming a different epistemological, ontological and theoretical position.

Taking forward these ideas for a conceptual and theoretical framework to inform my methodology and the analysis of my research data, I have focused on five components or aspects listed in **Table 3.6**. Each component is drawn from the earlier discussion of social learning theory and practice theories. (128, 161, 163,

169, 170, 172) The pertinent points are collated in the boxes below. The framework and its application are addressed in chapter 4 which reports the methodology and design of the study.

**Table 3.6: Conceptual and analytic framework for data analysis**

<p><b>PARTICIPATION</b></p> <p>Engagement Alignment Imagination</p>	<p><b>MATERIALITY</b></p> <p>Reification</p>	<p><b>COMPETENCE</b></p> <p>'Know how' Knowledge Skills</p>
<p><b>BOUNDARY ENCOUNTERS</b></p> <p>Past} Present} Communities of practice Future}</p>		<p><b>MEANINGS</b></p> <p>Social and symbolic</p>

## **Chapter 4: Methodology**

### **4.1 Introduction**

This chapter describes the research methodology and design of the study and provides the rationales for their selection. In the previous chapter, I discussed the theoretical perspectives informing the methodology in relation to my ontological and epistemological positioning as a qualitative researcher. I now account for how I operationalised the study using an ethnographic approach, a focused ethnography, with an instrumental case study design. The cases were two NHS organisations which commission secondary and community health and care services for populations in the South of England; an urban CCG and a rural CCG.

Data analysis and interpretation are elaborated with reference to my reflexivity as a researcher. Engaging in reflexive practice is essential in qualitative research. (192) It is more than reflecting on the research process and outcomes and instead requires the researcher to stand back and acknowledge the impact of his/her own values and background throughout (147, 192, 193), including on the co-construction of data and its interpretation. (147) It is an ongoing process and begins at the outset. Commentary is therefore provided in this methodology chapter as well as the subsequent data and discussion chapters. Reflexivity is a form of validity in qualitative research and a hallmark of quality. (194)

The chapter also shows how the study was informed by the project advisory group to ensure PPEI during the research process. It is imperative that this is transparent given the subject matter of the thesis. The narrative includes details of the research setting in the two CCGs. Appendices contain the participant information sheet, consent form and letters of ethical approval for the study and are signposted as appropriate.

### **4.2 Thinking through my theoretical perspectives and methodological choices**

Gobo (195) argues there are at least four components to a methodology in the social sciences:

1. **A pivotal cognitive mode for knowledge acquisition.** This includes observing, listening, questioning, reading, watching, and conversing to gather knowledge. One mode may be more dominant than another but often a knowledge-gathering act is part of a multisensory process. Gobo (195) uses the example of a doctor palpating a patient's body to 'see' what lies beneath the skin's surface. What the doctor finds on palpation including any tenderness, guarding or rigidity is informed by the patient's response and interaction as part of that practice activity. Similarly, clinical guidelines and policies for performing the procedure. This particular example illustrates well the 'collective socio-material enactment' (157) of the practice where material includes the body and social the policy imperatives of performing the procedure. Ethnographic methods have been favoured to uncover implicit knowledge and socio-materiality in practice. (196) 'Observation' is the dominant mode in ethnography but cannot function in isolation without 'listening', 'conversing', and 'questioning'.

2. **A theory of scientific knowledge which comprises a set of assumptions about the nature of reality, the role of the researcher, the tasks of science and the concepts of action and social actor.** This was addressed in chapter 3 in my conceptual and theoretical framework but is expanded further here. Gobo (195) elaborates on the 'tasks' of science by asking if science should just describe and explain phenomena, intervene to change phenomena or emancipate humankind. Ethnography has typically described and explained. However, Kempster and colleagues (196) explore what can be learnt from Strategy-as-Practice researchers to apply to the newer paradigm of Leadership-as-Practice (L-A-P) research. L-A-P is of interest to me as indicated in chapter 3 as it illuminates leadership as a social practice. Citing Orlikowski's summary of three modes of research, Kempster and colleagues (196) inform how these are useful for the researcher as to the orientation of the research:

a. The **empirical mode** which examines practice as a phenomenon to find out and understand what practitioners do in practice. It bridges the gap between theory and the lived experience and can generate vast quantities of

qualitative data as the researcher engages deeply with the research setting as either a participant or non-participant observer.

- b. The **theoretical mode** where practice is the perspective or lens focusing on the everyday social reality. This mode seeks to develop practice theories that can be used to study organisational activity. It is also appropriate to my study which sought to theorise PPEI practices for NHS clinical commissioning. Grounded theory and ethnography are both suitable approaches, but the challenge is what to accept as emergent practice and what to bracket out.
  - c. The **meta-theoretical mode** which sees practice as a philosophy and ontologically a social reality. Citing Schatzki (197) that social life is constituted as 'nexuses of practices and material arrangements', this mode alters the epistemology. Whereas social research draws on a representational epistemology, practice as a philosophy transforms it to a performative epistemology. The knowing comes from directly engaging with the material world.
3. **The range of solutions.** This refers to the 'tricks of the trade' or strategies that are not found in text books but are shared informally amongst fellow researchers as part of the research experience. Sometimes they are made public at conferences and in academic writing. Some are shared later in this chapter, for example, on gaining access to the research field.
  4. **The procedural steps** which tend to be what many perceive as the 'methodology'; the research design, sampling techniques, research questions, data collection and analysis which are made explicit in the research protocol. The later sections of this chapter make explicit the procedural steps I took with the study.

My conceptual and theoretical framework in the preceding chapter has already indicated my interest in social practices and practice theories. As a qualitative researcher curious about the socio-material and situated learning within communities of practice for PPEI in clinical commissioning, I was inevitably drawn to a holistic methodology such as ethnography. I was seeking to understand a

phenomenon and not a population and so desired to study participants in the places where these everyday subjective experiences took place; the CCGs. I also wanted to hear and see first-hand accounts.

A holistic methodology entails examining context and triangulating data from a range of sources including observations, interviews, documents and discourse. Practice is continually emergent and recursive, interacting with the socio-material and so theorising should aim to be plausible and practically adequate. (196) Ontological position and units of analysis must be clear. Comparative analysis is also useful by case method. In Strategy-as-Practice research, Kempster and colleagues (196) refer to two types of case method named after the researchers. The Eisenhardt (E) case method is of the post positivist paradigm and uses multiple case studies to develop theory that can be tested and generate rules. The second, which is more relevant to my research study, is the Gioia (G) case method. Usually based on a single case for what it can reveal, it is interpretative and not unlike grounded theory. It uses interviews complemented by observations and from the data analysis a process model or theory can be constructed to give an in-depth understanding of the phenomenon. I opted for two CCG case study sites and the unit of analysis was PPEI practices, that is, where patients and the public were engaged and involved in clinical commissioning processes at a strategic level.

#### **4.2.1 Ethnography; a brief history.**

Ethnography is central to anthropology and originates from the nineteenth century when the term was used for a descriptive account of a non-Western, 'primitive' culture or community. (198) Emanating from the Greek words *ethnos* for 'people' or 'tribe' and *graphia* for 'writing' it simply means 'writing about people'. (199) More specifically, *ethnos* refers to people who were non-Greeks. They were strangers, 'other' people and not like the Greeks. (199) Ethnographies were compiled by itinerant individuals such as doctors, colonial police officers, travellers and missionaries visiting distant, non-European lands at the end of the nineteenth century. Few would have had any social research training, but they could observe the 'Others' in non-Western, illiterate societies. (198, 199) The ethnographic

accounts were then used by 'armchair' anthropologists to compare and contrast the histories and origins of societies and cultures. This was known as 'ethnology' but over time the term lost favour as anthropologists began to conduct their own fieldwork. (198) Ethnography from the early twentieth century integrated both first-hand accounts and the theoretical and comparative perspectives of culture. (198) The Polish-born social anthropologist Bronislaw Malinowski, was a key figure in this development. His fieldwork in the Trobriand Islands became the template for robust ethnographic practice. It included learning the language of the community under study so as not to rely on interpreters, immersion in the culture by living within, participating in community activities and recording many field notes as well as keeping a field diary to release any emotional tensions. (199) He emphasised the importance of a theoretical paradigm and linking social theory to the data.

Positivism, as a theoretical paradigm, was popular at this time in the social sciences. British and French sociologists favoured the scientific method and empirical study to investigate society in an objective and functionalist manner. (198, 199) Modelled on the natural sciences, this entailed testing theories and hypotheses and generating scientific laws. Evolutionism and imperialism were also dominant, the former justifying the scrutiny of studying more primitive communities to compare with 'modern' society in the West. Parallels with Charles Darwin's theory of evolution in the animal kingdom encouraged comparison with learning from less complex cultures and adaptation to environment. (199) The colonisation of the Asian and African continents was also a persuasive argument for examining 'Other' 'barbaric' cultures, thus reinforcing ideas of taking control and ruling over communities or colonies.

The 'Chicago School' rose to prominence after the First World War with its distinctive urban ethnographic fieldwork. Immigration and industrialisation were transforming the North American city. Chicago was like a 'social laboratory' undergoing immense social change. (199) Two founding members of the Department of Sociology at the University of Chicago, Robert E. Park and W. I. Thomas, were influenced by the German phenomenologists Husserl and Schutz and encouraged their students to go out among the people. The 'Others' this time were the immigrants, vagrants and working class in a Western city environment.

(199) Interpretivism was the methodological lens by which theoretical frameworks were used to explore and explain social action. (199) Denzin and Lincoln's generic description of qualitative research helps elaborate:

'Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including fieldnotes [sic], interviews, conversations, photographs, recordings and memos to the self.' (191)

Interpretivism with its inherent philosophical and sociological ideas, argues that the social world cannot be explained by causal relationships and scientific laws. (198) Human action is influenced by motives, beliefs, discourse and values which all have social and cultural meanings. (198) Hence, naturalism encourages the world to be studied in its natural state so that social phenomena as opposed to physical phenomena can be observed. Data are collected with minimal disruption to the social setting. The subjective nature of this reporting has in the past called into question the rigour of ethnographic research. (198) In the 1960s, issues of representation, power and politics came to the fore. (199) How visible were the Others and how empowered were their voices? Ethnographers had not thought about their own influences on their studies and the accounts they wrote or the ethical issues, for example, obtaining consent. Many of the early twentieth century researchers were male and had not considered how subjects might respond to their gender, social class and level of education. This point is illustrated by the later publication of Malinowski's personal diaries, although they were not originally intended for public viewing. They revealed misogyny and racism towards the Trobriand Islanders. (199) Anthropologists may have been guilty of objectifying their subjects. (194)

These issues of representation marked a 'turn' in the social sciences with subjectivity, politics and representation becoming much more prominent. This has been described in various ways: the cultural turn, literary turn, post structuralist, post-modern turn. (199) Denzin and Lincoln, (191) describing eight historical moments in North American qualitative research, acknowledge what some described as the crisis of representation (1986 – 1990) and then refer to a post-modern period (1990 – 1995) and a methodologically contested present (2000 –

2010). Qualitative researchers are now confronting a methodological backlash against the evidence-based social movement. (191) Evidence-based medicine (EBM) has been prominent since the early 1990s. It comprises the linear process of asking a clinical question, searching the literature for relevant research articles, critically appraising the articles and then implementing the findings. (200, 201) Now broadened to include other health and care professionals, managers and lay people, it is often described as evidence-based health care (EBHC). (200) There have been calls to broaden its parameters to include social science methodologies. (200)

The social sciences and humanities are spaces where critical conversations should be taking place; moral discourse on topics such as class, community, nation-states, and globalisation. (191) This post structural turn also led to an increasing interest in the construction of knowledge and its theory (epistemology) and contextualisation. The modern-day social science researcher must therefore weave and assemble a patched work as in 'bricolage' - quilt making. The researcher becomes a 'bricoleur', borrowing from the many methodological practices of qualitative research. (191)

#### **4.2.2 The rising popularity of ethnographic techniques**

There has been increasing interest in ethnographic techniques to research aspects of NHS culture and behaviour. Culture is difficult to define. Silverman (202) describes it as a common set of beliefs, values and behaviours, whereas Dixon-Woods et al. (203) liken it to the phrase the 'way we do things round here'. Schein (204) says it is an abstraction; generalised concepts of culture are formulated by taking specific examples and looking for common qualities. He has written extensively about leadership in organisations and defines the culture of a group or organisation as:

'... a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.' (204)

Note within the definition the reference to learning within a group and for new members not unlike CoPs (169) and newcomers learning by LPP. (170) The culture of clinical commissioning within the NHS is evolving as CCG organisations, having implemented changes emanating from the HASCA (1), now work with the STPs and newer ICSs and ICOs. Of interest to this study is the idea of meaningful engagement, this being the second domain of the original CCG authorisation process; *meaningful engagement with patients, carers and their communities*. (4) In this study the participants are clinicians, predominantly GPs, and service users who are patients and carers and members of the public (lay representatives) from the local community. Here, community is defined by the geographical boundaries of the CCG.

Ethnographic techniques are not without their critics and debate in the journal *BMJ Quality and Safety* illustrates the tensions between the 'purists' and the 'pragmatists'. (205) Jowsey (206) commented on what she perceived as a misrepresentation of ethnography. Observational studies and descriptive statistics do not constitute ethnography. Caution is necessary to avoid separating ethnographic-like methods from the wider methodological principles of ethnography. (205, 206) The methodology requires attention to the underlying concepts including the ontological and epistemological assumptions. (205) However, it may not be possible to include the level of detail required of ethnography in a journal publication and so it could be misconstrued as method by the reader. This is also something that Strategy-as-Practice researchers commented on in relation to the 'voluminous data' not meeting journal expectations about credibility and validity. (196)

There is also increasing pressure in health services research to deliver multi-site findings to a tight time scale and so sustained participant observation typical of ethnography may not be feasible. (205) A recent systematic review on rapid ethnographies refers to the pressures on researchers to generate findings which are actionable and can be used for service improvement. (207) Thus, it creates tension for the researcher between the depth and the breadth of the data and the availability of key informants. (207) The journal editors in the case of the journal *BMJ Quality and Safety* acknowledged the criticisms and stress the importance of

being clear and consistent with labels in contemporary writing. (208) They also commented on the increasing value of close observation of organisational and clinical practices. (208) Gobo has remarked that it is as if everything has become 'ethnography' and it is highly fashionable. (195) Given its rising popularity, its broader application in the social sciences to address new contexts and theoretical perspectives since the mid twentieth century, ethnography was a methodology which could help me answer my research questions.

#### **4.2.3 Focused ethnography**

Initially, I pursued the idea of an institutional ethnography thinking that the study would be exploring and explaining PPEI for clinical commissioning as part of the NHS as an institution. Institutional ethnography is concerned with the actualities of daily lives and the social relations that form part of the institutional culture and processes tying them together – the 'ruling relations'. (147, 209) This variant of ethnography has been attributed to Canadian professor Dorothy E. Smith. Its appeal is in its ability to 'problematise' everyday practices and procedures so that researchers gain fresh insights. (147) The social relations of people's experiences are mapped to reveal the workings of the institution. (209) However, the NHS as an institution that clinically commissions health and care services appeared a somewhat daunting task to research. In addition, CCGs are complex organisations different in size and structure, in the way functions are distributed and the roles GPs take. (210) There are pressures on the researcher, not least of which is the time it takes to complete the study and the logistics of negotiating multiple geographical sites and obtaining ethical approval from separate commissioning organisations as was the case at the time of the research. Jowsey (206) refers to a typical time frame of two years but acknowledges ethnography has moved into different spaces, even local, familiar spaces as opposed to the distant Other. The tight time frame of a Doctoral study programme led me to consider focused ethnography instead. It appeared more appropriate given my research question to explore PPEI in commissioning and leading health and care services in partnership with clinicians, lay representatives and service users. The domain of practice was precise involving numerous CoPs for PPEI for clinical commissioning.

The domain is part of the larger institutional landscape of NHS CCGs post the HASCA.

Muecke (211) recognised the time constraints for health care professionals who adopt classical ethnography to answer specific questions with a clear purpose and intent. She referred to these accounts as focused ethnographies which are 'programmatically and pragmatically'. They may also be called micro-ethnographies or mini-ethnographies amongst other terms. (212) Elsewhere, medical or health ethnographies, have described relationships between cultural beliefs and health behaviours. (149) There is limited methodological guidance on focused ethnographies but researchers at the University of Alberta in Canada (149, 194, 212) have published their experiences, compared conventional, anthropological ethnography with focused ethnography and drawn on a number of studies and the expert opinions of Muecke (211) and Knoblauch. (213) Knoblauch (213) attributes the term focused ethnography to Otterbien in 1977 with reference to studying a cultural trait. **Table 4.1** characterises focused ethnography based on these publications.

More recently, a systematic review of the use of rapid ethnographies in healthcare organisation and delivery included 59 articles using the term focused ethnography. (207) This was defined as 'short-duration fieldwork balanced by data collection and analysis' as part of a typology of rapid ethnographies. (207) Some of the identified potential challenges to inform research questions included breadth versus depth and inability to pick up on changes over time, representativeness and sample size selection leading to only those informants who were available, lone researcher as opposed to multiple researchers with a range of expertise and lack of time for reflexivity of the researcher. (207) The latter is essential if the researcher is to consider how his/her presence may have influenced the collection and analysis of data.

**Table 4.1: Characteristics of focused ethnography**

1. Context-specific and focuses on a discrete community, organisation or social phenomena. The phenomena may not be new but it offers opportunity for 'deep dive' observations across multiple organisational sites. (205)
2. Precise issue or problem, maybe pre-selected with some research questions already formulated. Operates within a closed field as opposed to the open field of conventional ethnography.
3. Time limited, short-term field visits for 'events' as opposed to full immersion in the field.
4. Limited number of participants but they have specific knowledge and may not all be at one location.
5. Background knowledge outsider perspective (etic view) as opposed to insider knowledge (emic view) of researcher. (149)
6. Episodic participant observer. Observations may be intermittent or even omitted.
7. Data intensive – a lot of data generated in a short time period. Includes video and audio-recordings and photographs. Recordings as opposed to narrative writings.
8. Data session groups where researchers may gather together to view data collectively, particularly recorded data. Can provide inter-subjectivity and different perspectives as opposed to a single researcher providing a narrative.

#### **4.2.4 Case study design**

Having considered a focused ethnography as preferable I then needed to select my cases. Case study is frequently used to evaluate and research policy implementation. (74) Findings provide an indication of progress and lessons learned. The narrative review in chapter 2 and **Appendix 1** show how cases studies have been used to understand and monitor the development of CCGs. PPEI for clinical commissioning and meaningful engagement is another example of where this could be explored. I opted for two sites despite the Gioia (G) method advocating a single case. (196) By using two case study sites I could introduce some comparative analysis given that the two CCGs were different in geographical composition and size but that was not the primary aim.

My case study design was not to test a hypothesis to deduce cause and effect. There is no hypothesis to test as the study is inductive and interpretive. O'Reilly (193) cites Gary Shank who explains ethnographers use *abductive reasoning*. Make an observation, then gather further evidence from observations, not

necessarily in a linear fashion, and then perhaps advance a rule: observation, observation, rule. It is iterative as opposed to the deductive reasoning of rule, observation, result. I was interested in the CCG settings to explore and study the partnership working for PPEI for commissioning and leading health and care services. This is what Stake (214) describes as an instrumental case study as opposed to an intrinsic case study. It is a vehicle or means for studying the phenomena in question. Whereas an intrinsic case study is the case itself which is the focus and generalisations and theories are not offered. (193, 214)

The cases were a non-probability purposive sample of two CCGs; one urban and one rural. CCGs are unique with respect to their local community profiles but there are national work streams directed by NHS England guidance which all CCGs must implement. Urban CCGs have similar features and challenges and so too do rural CCGs. The CCGs were selected based on three factors; ethical approval, representativeness of CCG populations and convenience. A suitability profile (215) helped determine the two CCG case study sites in order to bound my research. The CCG case had to be:

- **Relevant to the research question** - engaging service users and the public in commissioning and leading health and care services with clinicians.
- **Significant in terms of having something important to say** – new NHS organisations which reflect the evolving commissioning landscape for health and care services design and delivery.
- **Geographically accessible location** - therefore a non-probability purposive sample.
- **Amenable to staff co-operation** – access to the research field was negotiated via the Patient and Public Engagement Leads for both organisations.

Both cases can be described and bounded but more importantly the *unit of analysis* must be defined and bounded. (215, 216) As indicated earlier, the unit of analysis was the PPEI practices to elucidate the nature of partnership working and meaningful engagement for commissioning and leading health and care services. Defining the beginning and end of the practices was challenging since various

meetings and work streams were ongoing and only snapshots were observed and discussed. There were multiple illustrations given the various meetings and work streams (CoPs) that report to the CCG GBs. (See **Figure 3.1** for a diagram of the CoPs.)

### **4.3 Research questions**

Focused ethnography, because it is aiming to describe and explain cultural aspects within a group or sub-group, tends to use the first level questions – the ‘what?’ questions. (149). Examples might be ‘What are the characteristics?’ ‘What are the shared beliefs?’ Secondary questions tend to probe further and explain; ‘what helps or constrains?’ (149) Silverman (202) refers to an open question for an exploratory study requiring less standardised research instruments. He also links the ‘what?’ and ‘how?’ questions to the constructionist model of reality. (202)

To operationalise and manage my study, I incorporated three subsidiary or secondary questions in conjunction with my primary research question. The origins of the questions were discussed in the previous chapter and are reproduced here:

***What does it mean to work in partnership as clinicians and service users to commission and lead services?***

- i. What is the nature of a trusted peer relationship?**
- ii. How can relationships be developed to demonstrate effective service user and clinician engagement?**
- iii. How might this be applied to the topic of patient and public involvement within health care professional education?**

The questions centre on exploring the experiences and practices of service users, lay representatives and clinical leaders (GP commissioners) collaborating to commission and lead health and care services. Moreover, beliefs and understanding about partnership or working as peers within the changing culture of the NHS in terms of trust relationships. The third subsidiary question was intended to reflect on what the study findings might mean for curriculum development for PPEI in commissioning and leading health and care services.

## 4.4 Research methods

The research methods must be consistent with the methodology, the theoretical perspective (social practice theory) and the epistemology (social construction). As data gathering techniques they must also align with the research questions to obtain relevant data. Findings from qualitative research within a constructionist paradigm cannot be generalised. (191) However, a sociological focused ethnography does allow a pragmatic and efficient approach to exploring cultural perspectives (social practices) within practice-based professions. (194, 212)

The methods I employed for data collection included focus groups, non-participant observations and face to face interviews. All three are part of the method tool kit for ethnographers with interviews in particular providing scope for the thick description of the participants' perspective. (198) I also included documentary analysis as this is an important part of focused ethnography (149) and practice theories with a socio-material perspective. CoPs in particular note the duality of participation and reification of situated learning. (169)

The following four sections explain what each research method entailed. The research protocol (**Appendix 2**) stipulated how many focus groups and interviews were planned in keeping with ethical approval and the time available. The protocol is entitled by the original study name.

### 4.4.1 Focus groups

O'Reilly (193) prefers to think of focus groups as planned discussions otherwise they can seem like market or government research with directed and purposeful questioning. It is better to think of it as 'asking questions' and avoid an interviewing technique which can imply power relations. Focus groups are not a 'back door route' to interview data. (147)

Whilst one advantage of focus groups might be saving researcher time and costs, a strength is their opportunity to discover why people think the way they do. (147) They allow the researcher to listen and observe conversations between participants to obtain established knowledge. (217) Thus, showing what people are prepared to share in their own words to provide 'public accounts'. (147) Discussion

might be lively with views created or changed through the course of the group interaction. (147) It is therefore important to capture this dynamic within the resultant transcript and associated field notes.

Remenyi (217) argues the academic focus group for research purposes is an ancillary technique for obtaining contextual background data and so useful at the outset of a project. It can also be used as a barometer to ensure the project is on track and at the end of a project to test out the findings. (217) The number of groups and the composition therefore assume greater significance. The 10 - 12 participants often used in market research focus groups is not appropriate for academic research and a smaller size group is recommended. (147, 217) If the group is too large it can be difficult to manage an animated discussion and keep notes whilst adhering to the prompt questions. An assistant focus group facilitator may be required. (217) Between six and eight participants is recommended (147, 217) and they should be selected on the basis of a shared experience or attribute. (147) Ideally, the participants should not know one another but this was always going to be a challenge in the two CCGs due to the compositions of the various CoPs.

The focus groups addressed the first subsidiary research question; **what is the nature of a trusted peer relationship?** They were to be held at the start of the project. Participants were exclusively service users or exclusively clinicians who had participated in engagement and involvement activities for clinical commissioning. Therefore, two focus groups for each CCG making four in total. The discrete groups were to encourage open discussion and the exchange of ideas since not everyone would be involved in the same projects and work streams. Participants, or informants in ethnographic terms, can prompt one another in discussions. (198) The term subject is avoided as it implies a power relationship reminiscent of the days when ethnographers studied distant colonies. **Table 4.2** shows how the procedure was conducted and the topic guide for the prompt questions. Each focus group was 45 minutes duration.

**Table 4.2: Procedure and conduct of focus groups**

<p><b>Focus group procedure</b></p> <ul style="list-style-type: none"><li>• Written consent to be obtained beforehand.</li><li>• 4-5 participants in room with phones switched off or on silent.</li><li>• Groups to be either service users and members of the public <u>or</u> clinicians with a commissioning role.</li><li>• Use flip charts or paper table cloths to capture ideas.</li><li>• Proceedings to be digitally recorded to assist with writing up notes.</li><li>• Outputs from focus groups to inform construction and sequencing of questions within semi-structured one to one interviews, for example, any colloquialisms and how they are used. Similarly, to inform the composition and format of observational records.</li></ul> <p><b>Focus group prompt questions</b></p> <ol style="list-style-type: none"><li>1. What is 'working in partnership' and what does it mean to you? (Definitions)</li><li>2. In what ways do patients, carers and the public work with commissioners? (Examples)</li><li>3. What would it mean to trust somebody and feel like a peer to them when discussing commissioning or changes to services? (Values)</li><li>4. How would you know if that trusted peer relationship was working or valued? (Feedback and reinforcement)</li></ol>
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Once potential informants responded either by email or telephone to indicate their interest in taking part in the study, I provided the **Participant Information Sheet** in keeping with good practice as a researcher (147) and with ethical approval, (**Appendix 3**). On the day of each focus group I allowed time beforehand to check understanding with the participants and then gained written consent with a copy of the consent form provided to the participant. (See **Consent Form** at **Appendix 4**.) The proceedings were audio-recorded using an Olympus WS-852 Digital Voice Recorder and transcribed by me thus allowing familiarity with the content. A copy of the transcript was sent to each participant for confirmation of accuracy and verification of content. I also made field notes in a research diary after the focus group to capture my thoughts on the conduct of the method. The data informed the semi-structured interview topics but also the observations in terms of what to ask or to observe.

#### **4.4.2 Observations**

Non-participant observations were also intended to provide data for the first subsidiary question; **what is the nature of a trusted peer relationship?** These were to be undertaken at CCG GB meetings or any sub-committee meetings or work streams where service users and/or public representatives were present, and their views shared or reported to clinical leaders. For practical purposes the observations were made across both CCGs according to their frequency and not conducted in a sequential manner for each case study site. The number of observations was not stipulated since the iterative nature of the study meant further observations may have been required to gather specific data. Observing with a focus is essential in ethnographic studies. (27) Observations were overt as I was not an insider/participant researcher. Field notes were recorded but this can present challenges. Participants can behave differently if note-taking is obvious (26). Recall and writing up soon after the encounter was important. Palmer (27) discusses distinct packages of material for record purposes which I attempted to collate for each observation:

- Observational notes (ON) which describe what was seen and heard.
- Theoretical notes (TN) that advance some preliminary ideas around meaning; and
- Methodological notes (MN) reflecting on the operational processes of the project plan.

#### **4.4.3 Interviews**

Interviews provide what is described as 'thick description' and are the most important data collecting technique for the ethnographer. (194) An ethnographer is attempting to learn about the participant/informant from their perspective (193) so it is the quality of the interviews that matters as opposed to the quantity. Robust ethnographic interviews require the researcher to be iterative in their approach. (198) Interviews are never just conversations but reflexive. A list of issues may be on the researcher's agenda, but the sequencing can change according to the response. The questioning mode may be directive or non-directive depending on what the interviewee or informant reveals. (198) To comply with ethical

requirements, I compiled and used a semi-structured interview schedule produced in **Table 4.3**.

**Table 4.3: Interview schedule**

<p><b>Instructions before commencing interview:</b></p> <ul style="list-style-type: none"> <li>• Written consent to be obtained beforehand.</li> <li>• Private room with phones switched off.</li> <li>• Interview to be digitally recorded and field notes taken.</li> <li>• Generic topic guide - for clinicians, service users and the public. See below.</li> </ul>
<p><b>1. Current engagement activity within the CCG (structure)</b></p> <ol style="list-style-type: none"> <li>a. Give work stream name</li> <li>b. Ask how recruited</li> <li>c. What their role is within the work stream</li> <li>d. Where they attend the work stream and the frequency of the meetings</li> </ol>
<p><b>2. Explain process and what they do – a typical activity or meeting</b></p> <ol style="list-style-type: none"> <li>a. Tell me what you do perhaps with an example of a typical meeting. <b>NB</b> Try not to mention people by name.</li> <li>b. How you convey the views of other service users / clinicians in this work stream.</li> <li>c. How you know if the meeting is going well and your views or messages are being heard.</li> <li>d. Have there been any challenging situations? Elaborate with an example if possible. <b>NB</b> Try not to mention people by name.</li> </ol>
<p><b>3. Outcomes</b></p> <ol style="list-style-type: none"> <li>a. Have you seen a work stream activity through to its conclusion? If yes, elaborate. <b>NB</b> Ascertain when – before April 2013? How does the experience prior to April 2013 compare with current activity – expand if relevant</li> <li>b. How have you been kept involved after the conclusion? For example, are you asked to review or monitor the work stream once services have been procured and implemented?</li> <li>c. How would you know if the project has improved services?</li> </ol>
<p><b>4. Conclusion</b></p> <ol style="list-style-type: none"> <li>a. Is there anything you would want to change about the engagement (work stream) activities and if so what? How can this be improved?</li> <li>b. Anything else you would want to add?</li> </ol>

It is loosely based on a Donabedian (218) quality approach of structure, process and outcome. A telephone interview was offered as an alternative where it was difficult to secure time for face-to-face interviews. There is always the risk an interviewee will tell you what he/she thinks you want to hear or be cautious about disclosure, hence, the rationale for using two other data-gathering methods - focus groups and observations – to verify or dispel data. This is integral to triangulation where various data collecting methods and multiple sources, including artefacts discussed next, provide a richer understanding of organisations and help determine the consistency of findings. (216, 217) All interviews were audio-recorded using an Olympus WS-852 Digital Voice Recorder, transcribed and anonymised. I transcribed some of the recordings but also had assistance from an administrator approved by Brighton and Sussex Medical School because of the time frame of the study. I checked the transcripts with the participants for accuracy.

#### **4.4.4 Artefacts**

Documentary sources and material artefacts such as notes and minutes of meetings together with CCG web site content were useful data sources. They are an important additional source of evidence when using ethnographic research techniques and can be used to confirm or contrast observational and interview data. (149) Focused ethnography utilises multiple visual, auditory and photographic artefacts to capture data. This was modified in my study to preserve confidentiality and maintain anonymity consistent with ethical approval of the study.

#### **4.5 Research ethics**

The study received ethical approval from the Brighton and Sussex Medical School Research Governance and Ethics Committee (BSMS RGEC) - R&D Ref No. 15/080/FER in February 2015, (**Appendix 5**). In addition, Proportionate Review with the National Research Ethics Service (NRES) under the auspices of the Health Research Authority because the screening algorithm identified two categories in the policy requirement for the research. These pertained to participants who may have been identified from past or present use of NHS

services for which the UK health departments are responsible, and similarly their carers and relatives. Prior to approval I clarified the overall number of participants, amended text on the consent form, aligned version numbers and justified why a telephone interview might be used as an alternative. The latter was to provide greater flexibility should a participant find it difficult to schedule time to attend interview between other commitments. These amendments required me to correspond directly with the proportionate review subcommittee chair and is not unusual for quality assurance purposes. The study was reviewed and given a favourable opinion by the South West Committee – Frenchay REC Ref No. 15/SW/0214 in August 2015, (**Appendix 6**).

I had helpful support and advice from a Research Governance Officer from the local Research and Development (R&D) department overseeing CCGs. It took some time to identify the correct R&D department and arrangements subsequently changed during the study. This was perhaps not surprising given that CCGs did not exist prior to April 2013. R&D responsibilities were devolved elsewhere from April 2016. When an extension for ethical approval was required for the rural CCG, due to delays gaining access to the research setting, I had to directly approach the rural CCG's governance officer. Local R&D ethical approval was granted for the two CCGs, (**Appendix 7**). I obtained Letters of Access to both CCG settings as requested including for the extension period.

Whilst the process using the Integrated Research Application System (IRAS) was protracted, it enabled me to acquire evidence for domain C (Research Governance and Organisation) of the Researcher Development Framework (219) and demonstrates methodological rigour. The latter is important for defending the quality of the research for dissemination of the findings. Please note that ethical approval was submitted under the original title of the study brief approved by the Doctoral sponsored programme.

#### **4.6 Project advisory group**

The study was designed to ensure PPEI continued throughout the research process in keeping with good research practice. (220) My own experiences of patient and public involvement work over the last 10 years in both the education

field and voluntary sector would inevitably influence the co-construction of new knowledge and theory. Experiences are not value-free and so the rigour of the research could be improved by setting up a project advisory group or reference group. This was important given the focus of the research and helped address confirmability and verification of the study findings. Project advisory group participants were invited for this purpose and comprised service users and PPEI practitioners with recent (last five years) commissioning experience. The terms of reference of the group were:

- To ensure the project remained focused on the Higher Education Academy brief;
- To provide advice on issues that affect service users and members of the public involved in commissioning processes and participating in the project;
- To provide a forum for discussion of progress including data collection methods and analysis;
- To help guide the development of recommendations and dissemination of findings.

The project advisory group had a role in assessing the rigour of the data collection and interpretation of the findings as well as checking the project remained focused on the aims of the study. Four face-to-face meetings were held during the period of data collection. Further comment on the composition of the group and its remit are included in chapter 9. All members of the group were offered reimbursement for travel and out of pocket expenses consistent with good research practice. (220)

#### **4.7 Research setting**

The setting was two NHS CCG organisations (cases) which commission secondary and community health and care services for defined populations in the South of England. Sampling was purposeful and facilitated by a member of the supervisory team who had established working relations with the CCGs. Whereas this may be perceived as a bias in selection, insider knowledge of the CCG was useful to expedite the research process. As the researcher, I had no prior knowledge of the CCGs.

The following descriptions of the cases were obtained from the 2011 UK census surveys compiled by the Office of National Statistics. There are deliberately brief to help maintain anonymity.

### Case Study 1

An urban CCG with a resident population of 273,000 people living in a geographical area of approximately 34 square miles. It had a diverse population with relatively large numbers of people aged 20 to 44 years and women aged over 85 years compared to the population of England. 19.5% of the population was from Black and Minority Ethnic (BME) groups, 15% were from Lesbian, Gay, Bisexual communities and 13% were students. There were 44 GP practices divided into three localities at the time of the study.

### Case Study 2

The second case was a relatively small CCG with a population of 164,000 people. It had a largely rural population with over 80% of residents having to travel outside of the CCG boundaries to receive hospital (secondary) services. It had an older population structure compared to England with high numbers of frail elderly. It also had higher cancer rates in the under 65s and above average numbers of young people using drugs and alcohol. There were 21 GP practices divided into two localities and three community hospitals at the time of the study.

## **4.8 Inclusion and exclusion criteria**

The participants were clinicians who were GP commissioners, service users (patients and carers) and members of the public (lay representatives). They had to meet the following inclusion criteria.

### **4.8.1 Inclusion criteria**

Clinicians, service users (patients and carers) and members of the public living and /or involved in collaborating on work stream projects to commission and lead health and care services within the CCG since April 2013. Contacting and inviting participants was facilitated by the named person within each CCG. Clinicians were

GPs who had a lead role within their CCG and were undertaking this function as a paid, formal secondment from their GP practice.

#### **4.8.2 Exclusion criteria**

Work stream projects that commenced or completed before April 2013. Some clinicians, service users and members of the public had worked on projects before April 2013 but were included because of their subsequent engagement activities after April 2013. Participants who could not speak English were not able to take part in the focus groups and interviews due to insufficient time and resources to arrange interpreters. This was to ensure the study was feasible in the time available.

#### **4.9 Gaining access to the research field**

Gaining entry to the research setting was via a named person within each CCG. The named person was the patient and public engagement manager/lead who acted as a point of reference for the study on each case study site. I met with the engagement leads in person on the CCG premises in October 2015 to explain the study, discuss the **Participant Information Sheet (PIS)** and **consent form** and answer any questions, (**Appendices 3 and 4.**) Following these meetings an email about the study, which I had prepared and submitted for ethical approval, was sent by the engagement leads to individuals likely to meet the inclusion criteria. This invited potential participants to contact me by email or by telephone. Once they had made contact I provided the PIS and followed up a few days later with a telephone call to ensure the participant was happy with the study explanation and to answer any further questions. Again, there was potential for bias as the engagement leads selected who to email but there was little choice as I had limited access to the contact details of employees or service users working with the CCGs. However, once contact was made and the focus groups set up and the observations arranged, I had access to other potential participants. This was either through recommendation from participants or direct approach by me after observing a meeting.

#### **4.10 Consent**

Full written consent was obtained from participants who took part in the focus groups and were interviewed. Permissions to observe meetings, view minutes of meetings and other documentary evidence was authorised or facilitated by the named contact person within each CCG. Some minutes of meetings were in the public domain. Any ethical issues relating to professional practice were to immediately be discussed with my study supervisors and further advice and guidance sought. As a Nursing and Midwifery Council nurse registrant abiding by a code of professional conduct I was duty bound to pursue this route.

#### **4.11 Confidentiality**

Once data collection had commenced observational field notes, digital recordings and resultant transcripts were stored in password protected electronic files on the university server with dedicated secure access for Doctoral researchers. This was in keeping with the confidentiality and good practice requirements of the Research Governance Framework within the Doctoral College and awarding academic institutions. Written consent forms were stored in a locked filing cabinet in a locked academic office on the university campus.

#### **4.12 Reflexivity**

During the 1980s, political debate on the social construction of reality brought about the reflexive turn (193) as alluded to earlier. Ethnographic fieldworkers began to look more critically at their own positioning with respect to power relations, both disciplinary and institutional, and the construction of meaning. Reflection, reflexivity and representation are key values in ethnography as the researcher will have a theoretical, ethical, political and philosophical orientation toward the research. (221) As a novice social science researcher, but with many years' experience in patient and public engagement in cancer care and in education, I was mindful of the potential for both conscious and subconscious bias. As a non-participant researcher I had an etic view, the background knowledge outsider perspective, (149) because clinical commissioning was not my area of practice as a nurse and lecturer. I had only encountered strategic commissioning

for cancer services across a larger geographical area (a cancer network) to provide feedback on behalf of a patient prostate cancer support group. Only one of the informants was known to me in this study and the GP practice where I am registered as a patient is not located in either of the CCGs where the study took place. My data interpretation and writing must acknowledge these perspectives. A common limitation in rapid ethnographies, of which focused ethnography is one of the types mentioned in a recent systematic review elucidating their purpose, methods and challenges, is their lack of reflexivity and attention to the influence of the researcher. (207) This provides further justification for the role of the project advisory group.

#### **4.13 Data analysis**

This section describes the research study findings to provide an overview of the data and how they were analysed. Pseudonyms are used for names of participants, some job and committee titles.

##### **4.13.1 Focus groups**

Three out of the planned four focus groups were completed. Participants were either exclusively service users and lay representatives or exclusively clinicians (GPs) with a leadership role in the CCG. There were eleven participants in total, (**Table 4.4**). The service users and lay representatives are denoted by participant numbers 1 – 8 and the clinicians as GP Leads 1 – 3. All had participated in engagement and involvement practices for the commissioning of health and care services since April 2013 within the two CCGs; either in the urban CCG or the rural CCG. Both CCGs had become fully operational in April 2013 with the implementation of the HASCA. (1)

Focus group 1 comprised service users and lay representatives on the CCG GB. Focus group 2 was GP Leads for the urban CCG and focus group 3 was service users and a carer in the rural CCG. Focus groups 1 and 2 in the urban CCG were conducted on CCG premises soon after commencing the study. One of the service users in the first focus group arrived 20 minutes late. His bus journey had taken him over 90 minutes, much longer than usual due to bad weather. The other focus

group participants and I agreed that when he arrived he could join the group to ensure his contribution was included. He did this with minimal disruption.

The service user group in the rural setting was held in the home of one of the service users four months after commencing the research in that CCG, and after some group observations had taken place. The venue was the preference of the participants. The delay was because I was unable to gain access to potential focus group participants until after permission was given to observe some meetings. Hilary, the service user/carer representative (**Table 4.4**) had to pull out at short notice from the third focus group on 27 June 2016 as her husband, for whom she is the main carer, had a fall at home. Her views were later included on 13 November 2016 as participants David and Hazel agreed for the anonymised transcript of the focus group discussion to be forwarded to her in confidence with the prompt questions. Hilary was consented for the study in keeping with the protocol and her contributions, plus responses to additional questions I asked for clarification via email, were disseminated to the other two other members of focus group 3. I was keen to include the views of Hilary as she was a carer and had also been involved with the procurement of community services in the rural CCG. Her perspective was therefore broader than providing feedback on experiences of health services often typical of service user and public representation. (115)

It was disappointing that the focus groups were so small. Only focus group 1 (five participants) was close to the recommended size although four to six people is viewed as manageable. (217) It proved too difficult to conduct a GP Lead focus group in the rural CCG. This was due to several factors including the geographical location of rural GP practices which, unlike the urban CCG, were some distances apart. It was not feasible for GP Leads to meet at another GP practice for a focus group given their GP patient caseloads. Nor were they able to meet collectively with me during their one day a week at CCG headquarters due to full CCG business agendas on those days. Instead, I attended and observed two GP Locality meetings; one in the north and the other in the south of the CCG. The data from these two observations were considered along with my other observations.

**Table 4.4: Focus group participants and their CCG roles**

Focus group and date of meeting	No. of people	Pseudonym and current role in CCG*	Additional roles*
<p><b>1. Urban CCG</b></p> <p><b>Service users and lay representatives</b></p> <p><b>6/11/2015</b></p>	5	<p><b>1. Edward - Lay representative</b> on GB for governance (male)</p> <p><b>2. Eddie</b> - Patient Participation Group (PPG) network representative (<b>service user</b>) (male)</p> <p><b>3. Euan - Lay representative</b> on GB for patient and public engagement (male)</p> <p><b>4. Elizabeth</b> - Volunteer representative (<b>service user</b>) with Healthwatch on 4 CCG Cancer Groups (female)</p> <p><b>5. Daniel - Lay representative</b> on Independent Funding Panel (male)</p>	<p>Deputy chair of GB. Chairs two GB committees. Member of Health &amp; Wellbeing Board</p> <p>Member of PPG</p> <p>Member of PPG. Co-chairs Communications and Engagement Committee. Deputy chair GB Quality Assurance Committee.</p> <p>Member of PPG</p>
<p><b>2. Urban CCG</b></p> <p><b>GP Leads</b></p> <p><b>7/01/2016</b></p>	3	<p><b>1. Simon - GP Lead</b> for Cardio-vascular disease work stream including stroke prevention (male)</p> <p><b>2. Ellie - GP Lead</b> for Public Health and Primary Care (female)</p> <p><b>3. Zayef - GP Lead</b> - Head of engagement and clinical leadership (male)</p>	<p>GP Practitioner. Attends PPG in own GP practice.</p> <p>GP Practitioner. Working with Local Authority</p> <p>GB member</p>
<p><b>3. Rural CCG</b></p> <p><b>Service users</b></p> <p><b>7/06/2016</b></p> <p><b>13/11/2016</b></p>	2  1	<p><b>6. David</b> - Patient delegate on CCG Quality and Performance Committee (<b>service user</b>) (male)</p> <p><b>7. Hazel</b> - Chair of Patient Representative Group (PRG) north locality and chair of joint PRG locality group meeting (<b>service user</b>) (female)</p> <p><b>8. Hilary - Service user / carer</b> representative on community services procurement (female)</p>	<p>PPG lead at own GP practice</p> <p>Member of PPG, member of Programme Board, representative on GP locality group</p> <p>PPG lead at own GP practice</p>

\*Job titles and some committee names have been altered.

The focus groups raised further questions which I wanted to investigate in the observations and interviews. This was to assist understanding of partnership working as well as the first subsidiary question:

**i. What is the nature of a trusted peer relationship?**

**Table 4.5** lists the additional questions that I compiled to prompt me as I observed, interviewed and later analysed the data. They are not in any order of importance. I wanted to capture data for an aspect of partnership that emerged from the focus groups regarding other individuals and groups key to PPEI. The study design did not include focus groups and interviews with commissioning managers and other CCG staff. The focus groups were conducted with GP Leads and lay representatives and service users. Observations, documentary sources, material artefacts and field notes would be the only opportunity to capture direct contributions from other individuals within PPEI commissioning practices.

**4.13.2 Observations, documentary sources and artefacts**

Fifteen non-participant observations were undertaken in the two CCG case study sites together with analysis of documentary sources and material artefacts. The observations were made over the course of 11 months; between November 2015 and March 2016 in the urban CCG and between April and October 2016 in the rural CCG. The meetings observed constituted the regular business of CCGs and were held every month or two months. Some are required to be held in public, for example, the GB meetings every two months.

**Tables 4.6 and 4.7** itemise the 15 observations and the associated documentary sources and material artefacts reviewed and analysed. Names of some committees have been changed to preserve confidentiality. There were meetings in both case study sites where I expected to see PPEI practices taking place. In addition to the GB meetings open to the public, I wanted to observe the GP locality member meetings, the Independent Funding Request Panel, the PPG network meetings in a locality and several other CCG internal meetings. It was not possible to view every PPEI practice for clinical commissioning in the time available and

**Table 4.5: Additional questions generated from focus groups**

No	Question	Source
1	What are the indexical behaviours (162) and expressions of the commissioning managers (and other individuals) that convey acceptance of service users in PPEI practices for clinical commissioning?	Focus group 3
2	How are the commissioning managers (and other individuals) creating conditions to impart these behaviours and expressions?	Focus group 3
3	What are the indexical behaviours and expressions of the GP Leads in these situated practices?	Focus group 2
4	Do the behaviours and expressions of the GP Leads create conditions for partnership working and a trusted peer relationship?	Focus group 2
5	Are any of the above (behaviours, expressions and conditions) characteristic of a trusted peer relationship?	Determined by study aims and focus group prompt questions 3 and 4.
6	What additional roles are the GP Leads, lay representatives and service users undertaking in meetings?	Focus groups 1, 2 and 3
7	How are these roles played out in practice?	Focus groups 1, 2 and 3
8	What do GP Leads, lay representatives and service users understand about their various roles and who and what they are representing at meetings?	Focus groups 1, 2 and 3
9	How are the GP Leads, lay representatives and service users supported and developed in their roles?	Focus groups 1, 2 and 3
10	How are skills and expertise (competences) (128) recognised and acknowledged?	Focus group prompt question 4
11	Where are the conflicts of interest and how are they described?	Focus groups 1 and 2

so those selected provided snapshots for the focused ethnography. Their selection was largely determined by the data source prompting the additional questions (Table 4.5) where informants referred to meetings they attended. In keeping with the study protocol (Appendix 2), the meetings presented opportunities where service users/lay representatives and GP Leads were present for strategic-level discussion about clinical commissioning in their respective CCGs. There was only one meeting where there was not a service user or lay representative present. This was at the GP South locality meeting in the rural CCG on 3 August 2016, (Table 4.7).

**Table 4.6: Observations carried out in urban CCG**

No.	Date	Meeting*	Duration (minutes)	Associated documents
1	24/11/15	GB Meeting	165	Minutes
2	12/01/16	Primary Care Transformation Board	120	Minutes of previous meeting Agenda and some associated papers
3	13/01/16	Communications and Engagement Committee	120	Minutes Paper – PPG toolkit Paper
4	26/01/16	Independent Funding Request Panel	75	None
5	26/01/16	GB Meeting	Viewed 35 minutes only	Minutes
6	26/01/16	Commissioning Better Patient Experience (Cancer)	120	Workshop Report
7	27/01/16	Patient Participation Groups Network Review	150	Minutes Handouts – terms of reference and PPG Network. Review slides
8	9/03/16	Communications and Engagement Committee	130	Minutes

\*Some meeting names have been altered

There was one meeting where there were no GP Leads. This was the Communications and Engagement Committee on 9 March 2016 at the urban CCG, (Table 4.6).

**Table 4.7: Observations carried out in rural CCG**

No.	Date	Meeting*	Duration (minutes)	Associated documents
9	20/04/16	Community Services Programme Board Meeting	90	Patient Engagement – sharing the learning
10	25/05/16	GB Meeting	170	Minutes PPI Update report
11	26/05/16	Joint Patient Representative Group meeting - both localities	100	Minutes Presentation from provider on Adult Community Services Presentation on Integrated Diabetes Model
12	27/07/16	GB Meeting	165	Minutes
13	28/07/16	Patient Representative Group meeting - North locality	120	
14	3/08/16	GP South locality meeting	120	Algorithm for new heart failure presentation in primary and secondary care Performance Report Activity Summary Month 2 Telephone Triage Sepsis Tool for GP/OOH
15	7/10/16	GP North locality meeting	150	Agenda

\*Some meeting names have been altered.

The observations were intended as a discrete second phase of the study but due to the delay in gaining access to the second case study site, three observations were undertaken in the rural CCG prior to the focus group at that site. As indicated earlier, the GP Lead focus group in the rural CCG proved too difficult to convene so observations of the two GP locality group meetings were undertaken instead

and included in the fifteen observations. This phase of the study was also to address the first subsidiary question: **what is the nature of a trusted peer relationship?**

Documents and artefacts were scrutinised for content relating to PPEI and if present included in the data analysis. Most were in the public domain and where these were not integral to the meetings observed, they were listed as additional artefacts, (**Table 4.8**). A total of 32 documentary sources and material artefacts were scrutinised. Some of these were collated sets of minutes, for example, GB minutes. Field notes were included to complement the data analysis and interpretation where appropriate.

**Table 4.8: Additional artefacts**

No.	Name of artefact	Originator
1	Patient and public participation strategy 2014 – 2016	Urban CCG
2	Patient and public participation annual report 2015 - 2016	Urban CCG
3	Primary Care Transformation Board minutes 16 February 2016	Urban CCG
4	2 Year Operating Plan 2014 – 2016	Urban CCG
5	Commissioning intentions 2015	Urban CCG
6	Annual Report Summary 2014/15 (web-based)	Rural CCG
7	Quality and performance report 18 May 2016	Rural CCG
8	Qualitative service evaluation for Dementia programme 2016	Rural CCG

#### 4.13.3 Interviews

Thirteen interviews were conducted in the two CCG case study sites. The interviewees were GB lay representatives, GP Leads, GP locality member Leads and GP clinical chairs of the two GBs, (**Table 4.9**). There was also one service

user representative involved with procurement of a service. This phase of the study was to address the second subsidiary question:

**ii How can relationships be developed to demonstrate effective service user and clinician engagement?**

The interviews were conducted face to face over a period of eight months between March 2016 and November 2016, predominantly on CCG premises. Three interviews were carried out in the homes of participants because it was more

**Table 4.9: Participants by date of interview, role and gender within both CCGs**

	<b>Date</b>	<b>Pseudonym</b>	<b>Interview participant</b>	<b>CCG</b>	<b>Gender</b>
<b>1</b>	9/03/2016	<b>Euan*</b>	GB lay representative for PPEI	Urban	Male
<b>2</b>	15/03/2016	<b>Hiten</b>	GP locality member Lead	Urban	Male
<b>3</b>	17/03/2016	<b>Zayef*</b>	GB Lead for engagement and clinical leadership	Urban	Male
<b>4</b>	21/03/2016	<b>Edward*</b>	GB lay representative for governance	Urban	Male
<b>5</b>	5/04/2016	<b>Natalie</b>	GP locality member Lead	Urban	Female
<b>6</b>	1/06/2016	<b>Heather</b>	GB Lead for quality	Rural	Female
<b>7</b>	3/06/2016	<b>Harriet</b>	Clinical Chair	Rural	Female
<b>8</b>	14/06/2016	<b>Lucy</b>	GP Lead for Community Services and GP Lead for Environmental and Social Sustainability	Urban	Female
<b>9</b>	15/06/16	<b>Alison</b>	Accountable Officer and Chief Clinical Officer	Urban	Female
<b>10</b>	16/06/2016	<b>Alex</b>	GP Lead for Dementia work stream	Rural	Female
<b>11</b>	17/08/2016	<b>Duncan</b>	GP locality member Lead	Rural	Male
<b>12</b>	1/09/2016	<b>Leslie</b>	Service user for diabetes service procurement	Rural	Male
<b>13</b>	8/11/ 2016	<b>Nigel</b>	GB lay representative for PPEI	Rural	Male

\* Also took part in a focus group

convenient for the participant and facilitated discussion that would have been either impossible or time-restricted 'at work'. Two of these three interviews were with GPs – one a work stream lead, the second a locality member Lead – and the third the service user representative for the diabetes service procurement. As a Doctoral researcher I followed best practice as a lone worker visiting participants' homes. On each of the three occasions, I informed one of my supervisors where I was going and then confirmed afterward that I had completed the interview.

The duration of the interviews was between 36 and 60 minutes. Total interview time was 10 hours and 25 minutes. Seven of the participants were male and six women. Of the nine GPs in a clinical Lead role, six were female and three male. Although a convenience sample this is remarkable since early reports indicated fewer women progress in GP CCG leadership roles compared to their male counterparts and are under-represented on GBs. (222) Discussion was facilitated by using a semi-structured interview schedule loosely based on a Donabedian (218) quality approach of structure, process and outcome mentioned earlier in **4.4.3**. Structure pertained to current engagement activities within the CCG, including roles undertaken as these invariably were formalised within both CCGs. Process was elaboration of the nature and flow of the activities that constitute engagement and involvement to provide a deeper description and understanding. Process and processes can be likened to the 'competence' element of practices described by Shove and colleagues (128); forms of understanding and practical knowledge that constitute actions. Elsewhere, this knowing in practice has been described as 'regimes of competence' where competence is defined by the community and includes a social dimension. (172) It is not merely an individual characteristic. Competence is recognised by members of a community of practice and can be both stable and shifting. (172) Outcome was intended to recall outputs from the engagements and therefore elicit meanings, another element of social practice, with respect to trust relationships and working in partnership. (128) Finally, there was opportunity for participants to add any further comments.

#### 4.13.4 Data management

The computer assisted/aided qualitative data analysis (CAQDAS) software package NVivo version 11 for use with Windows, enabled me to make sense of the large amount and multiple sources of text data. Produced by QSR International (223) NVivo allows data to be managed and sorted into what the software calls 'nodes' which are containers for sections of text which have been coded and categorised by the researcher. Hierarchies can be created so that parent nodes (categories) and various child nodes (subcategories) facilitate further exploration of the data. Codes can be demographic, descriptive, factual or conceptual in type. (74) They classify so that different sections of the data can be compared in a systematic way. (224)

It is crucial that codes are agreed and transparent. The definition and inclusion criteria for a container node can be recorded with the NVivo software thus allowing fellow researchers to verify valid and reliable data management. Coded content is in effect a reference to the category or subcategory. I shared codes with my supervisors to ensure I was consistently applying the criteria. Original transcripts can be re-checked against the definitions and criteria. Memos can also be added to help clarify conceptual thinking on the data. An analogy frequently used with this type of software package is the filing cabinet drawer with numerous files (codes) pertaining to the same category (node). The drawer may have dividers for the subcategories. Categories are assembled within a topic area, possibly a drawer for each, thus creating several drawers or a whole filing cabinet on a subject. After coding and arranging into categories, themes, patterns and trends should be sought. As these emerge from the data they must be explained and interpreted with reference to the existing body of knowledge.

Once the focus group transcripts were added to the software package I began with open coding. This inductive approach is considered good practice to capture the unexpected. (224) It entails labelling data which are felt relevant in any shape or form and might include behaviours, incidents, emotions or values. (224) I also used the prompt questions to make sense and organise the findings. **Table 4.10** shows the preliminary themes and subthemes using the four focus group

questions as reference points. However, I was aware that by treating the data in this manner I was in danger of confirming what I might expect to find and would likely repeat findings found elsewhere in the literature such as tokenism, single issues, the 'usual suspects' and 'too much baggage'. (118, 130)

**Table 4.10: Preliminary themes and subthemes from three focus groups**

Prompt question	Theme and CoP component* (169)	Subtheme
<b>1</b> What is 'working in partnership' and what does it mean to you?	<b>Partnership working</b> <i>PRACTICE – learning as doing*</i>	<ul style="list-style-type: none"> <li>- Hard work and complicated</li> <li>- Lip service to partnership, tick box exercise</li> <li>- Other individuals and groups key to PPEI</li> <li>- Needing feedback, seeing it from all sides</li> <li>- Out of comfort zone - learning together</li> </ul>
<b>2</b> In what ways do patients, carers and the public work with commissioners?	<b>Role in CCG</b> <i>IDENTITY – learning as becoming*</i>	<ul style="list-style-type: none"> <li>- Additional roles, past roles</li> <li>- Hours of work in CCG role</li> <li>- Recruitment and tenure\Status and how recruited to role</li> <li>- Role definition, understanding role</li> <li>- Role as a GP – understanding GP membership and locality</li> <li>- Representation – PPEI challenges and benefits</li> <li>- Muddling PPEI with patient activation</li> </ul>
<b>3</b> What would it mean to trust somebody and feel like a peer to them when discussing commissioning or changes to services?	<b>Legitimacy</b> <i>COMMUNITY – learning as belonging*</i>	<ul style="list-style-type: none"> <li>- CCG processes with SU and lay representatives</li> <li>- Power imbalance, feeling like a 'generic patient'</li> <li>- Public not understanding commissioning</li> <li>- Too much baggage</li> <li>- Wasting my time</li> <li>- Feeling part of it, new ways of working</li> </ul>
<b>4</b> How would you know if that trusted peer relationship was working or valued?	<b>What success looks like</b> <i>MEANING – learning as experience*</i>	<ul style="list-style-type: none"> <li>- Being heard - more than tokenism</li> <li>- Changes implemented by service users and lay representatives</li> <li>- Humanity and belonging</li> <li>- Not feeling valued</li> <li>- Sustainable practices</li> <li>- 'They don't know what to do with us'</li> </ul>

I needed to be true to my methodology and conceptual framework and move beyond mapping components of CoPs (169) to the four questions, (see **Table 4.10**).

The focus groups were a snapshot in time from late 2015 until mid-2016, but I began to look at the data as an ongoing relationship between participants; a socially situated learning process where I could use theory to interpret the findings. With the focused ethnography I had opportunity to observe the developing relationships as well as interview participants in the two evolving CCGs. As interview transcripts and observation notes were written up, plus key sections of documents identified (artefacts), they were added to the NVivo project file in an iterative manner. The data were coded to more than one node if appropriate. For example, an interview comment referring to the GB might also be referenced to a role in the CCG and clinical leadership. There were 148 data codes on completion of coding constituting 11 nodes or categories. They are detailed in **Table 4.11** in alphabetical order. Some nodes were influenced by the additional questions in **Table 4.5** and focus group questions.

**Table 4.11: Data nodes and final number of codes**

<b>Node</b>	<b>No. of codes</b>	<b>Influences</b>
Clinical leadership	17	Additional question 3
Development support	8	Additional questions 9,10
Governing Body (GB)	5	Additional question 8, 11
Partnership working	22	Focus group question 1 Additional question 4
Patient Participation Group (PPG)	4	Additional questions 3,4
Public engagement	6	Additional question 2
Representation	13	Focus group question 2
Role as a GP	6	Additional questions 6,7,8
Role in CCG	9	Additional questions 6,7,8
Trusting peer to peer	16	Focus group question 3 Additional question 5
What success looks like	10	Focus group question 4

Some of the 148 codes could not initially be assigned to a discrete category. On reading these isolated data again it was evident there was some duplication and overlap. They were discarded or re-assigned where relevant. In addition, the four PPG codes were merged with the representation node codes because PPGs are representing GP practice patient communities. The public engagement codes were mostly about GB activity and so were merged with this latter category. The two categories about roles were also merged leaving the 116 codes assembled in eight categories as listed in **Table 4.12**.

**Table 4.12: Eight categories of data**

<b>Node</b>
1. Clinical leadership
2. Development support
3. Governing Body
4. Partnership working
5. Representation
6. Roles
7. Trusting peer to peer
8. What success looks like

#### **4.13.5 ‘Sets of practices’ and application of the theoretical framework**

Qualitative data analysis requires immersion in the transcripts and field notes. For a focused ethnography it is important to ensure the many voices are heard, what Coffey describes as ‘polyvocality’, (1999 cited by Light (225)), and that data are situated and contextualised with reference to the wider literature and theories. This often requires returning to the original transcripts, observations, artefacts and field notes to ensure accuracy. Also, listening again to the audio recordings of the interviews and focus groups to check context is not lost. Then, constant comparison of the data to abstract and summarise. Summaries of ‘data bundles’ are sometimes employed in ethnographic research where there are a lot of data from observations and field notes that need to be condensed. (226).

As the study data were so voluminous, I grouped the data into four bundles or ‘sets of practices’. These sets were largely influenced by my research questions but what may appear a simple selection was then interpreted with reference to my

theory informed analytical framework discussed in chapter 3. The framework was applied to each set of practices. The compilation of the sets with the data categories is listed in **Table 4.13**. Note that two categories (roles and Governing Body) appear in more than one set of practices. Each set was separately analysed but if data relating to another set of practices were found during the process they were considered and reassigned to the appropriate set. During the process separate lists of social entities and material entities were collated for the sets of practices. These were helpful for ensuring I had not missed key events for reporting in the findings.

**Table 4.13: Sets of practices with data categories**

Sets of practices	Categories (numbered)
<b>TRUST</b>	<ul style="list-style-type: none"> <li>7. Trusting peer to peer</li> <li>8. What success looks like</li> </ul>
<b>LEADERSHIP</b>	<ul style="list-style-type: none"> <li>1. Clinical leadership</li> <li>3. Governing Body</li> <li>6. Roles</li> </ul>
<b>LEARNING</b>	<ul style="list-style-type: none"> <li>2. Development support</li> <li>6. Roles</li> </ul>
<b>PARTNERSHIP</b>	<ul style="list-style-type: none"> <li>5. Representation</li> <li>3. Governing Body</li> <li>4. Partnership working</li> </ul>

Once the analytic framework was applied to each set of practices I was able to elicit themes from the data using practice theory/social learning theory. I analysed the socio-material aspects of the practices within each set to interpret PPEI and partnership working activity taking place within the two CCGs. The themes from each set of practices are reproduced in **Tables 4.14 – 4.17**.

**Table 4.14: Themes for trust practices**

<b>PARTICIPATION</b>	<b>MATERIALITY</b>	<b>COMPETENCE</b>
<ul style="list-style-type: none"> <li>• Relational ways of working</li> <li>• <i>“Hear it, believe it, sign up to it”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Time                             <ul style="list-style-type: none"> <li>○ Too long</li> <li>○ Not enough</li> <li>○ Wasted</li> </ul> </li> <li>• Process reification and metrics</li> </ul>	<ul style="list-style-type: none"> <li>• Better than the PCT</li> <li>• Patients involved from the ground up</li> <li>• Being clear on engagement</li> </ul>
<b>BOUNDARY ENCOUNTERS</b>		<b>MEANINGS</b>
<ul style="list-style-type: none"> <li>• <i>“Awe-inspiring”</i> commissioners</li> <li>• Building on assets</li> </ul>		<ul style="list-style-type: none"> <li>• Feeling valued</li> </ul>

**Table 4.15: Themes for leadership practices**

<b>PARTICIPATION</b>	<b>MATERIALITY</b>	<b>COMPETENCE</b>
<ul style="list-style-type: none"> <li>• Having a track record</li> <li>• The public in engagement</li> <li>• <i>“They looked the same.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Physical spaces and artefacts</li> <li>• Reification of governing and leading processes</li> </ul>	<ul style="list-style-type: none"> <li>• Recruiting and selecting leaders</li> <li>• <i>“no-one wants to be low in ratings”</i></li> </ul>
<b>BOUNDARY ENCOUNTERS</b>		<b>MEANINGS</b>
<ul style="list-style-type: none"> <li>• Meet your Governing Body</li> <li>• Provider impact</li> <li>• Wearing old hats</li> </ul>		<ul style="list-style-type: none"> <li>• Role descriptors and status</li> <li>• Sense of community</li> </ul>

**Table 4.16: Themes for learning practices**

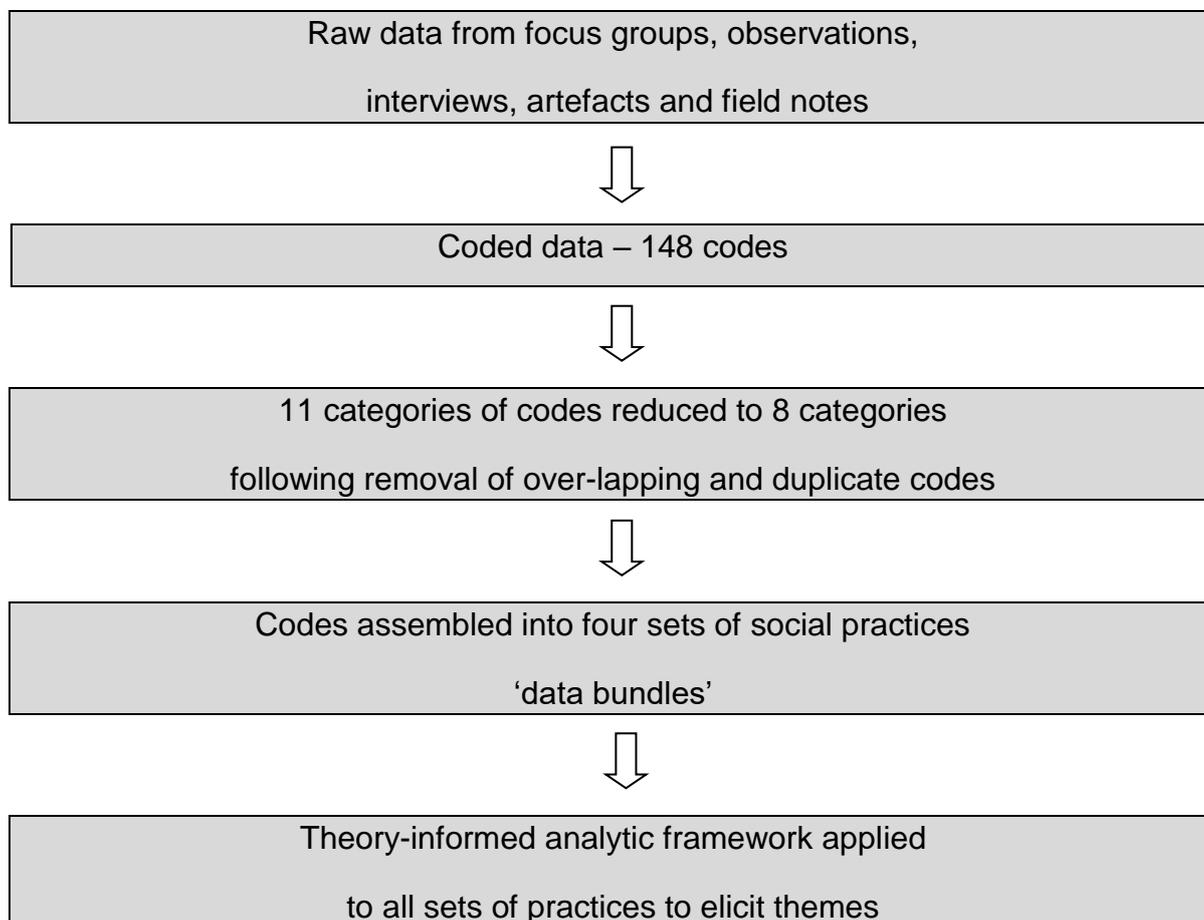
<b>PARTICIPATION</b>	<b>MATERIALITY</b>	<b>COMPETENCE</b>
<ul style="list-style-type: none"> <li>• Conforming to the model</li> <li>• Wearing lots of hats</li> </ul>	<ul style="list-style-type: none"> <li>• Formalised learning processes</li> <li>• Not enough time</li> <li>• Defined service user roles</li> </ul>	<ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Role tensions</li> <li>• Sniffing out talent</li> </ul>
<b>BOUNDARY ENCOUNTERS</b>		<b>MEANINGS</b>
<ul style="list-style-type: none"> <li>• Enablers to:               <ul style="list-style-type: none"> <li>- Communicate the message</li> <li>- Push you along</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Wanting to make things better</li> <li>• Sense of pride</li> </ul>

**Table 4.17: Themes for partnership practices**

<b>PARTICIPATION</b>	<b>MATERIALITY</b>	<b>COMPETENCE</b>
<ul style="list-style-type: none"> <li>• It “<i>doesn’t happen overnight</i>”</li> <li>• Unequal partnerships</li> <li>• Knowing what patients are thinking</li> </ul>	<ul style="list-style-type: none"> <li>• Time</li> <li>• Needing feedback</li> <li>• Financial resources</li> <li>• Reification of partnership</li> </ul>	<ul style="list-style-type: none"> <li>• Return on your contribution</li> <li>• Building confidence</li> </ul>
<b>BOUNDARY ENCOUNTERS</b>		<b>MEANINGS</b>
<ul style="list-style-type: none"> <li>• Believing in the PPEI agenda</li> <li>• Engaging multiple stakeholders</li> </ul>		<ul style="list-style-type: none"> <li>• Seeing you as a person</li> <li>• People not understanding</li> </ul>

#### 4.13.6 Summary conclusion for data analysis

A flow diagram summarises how I managed my data and its analysis.



Chapters 5 – 8 provide a narrative incorporating the thick description characteristic of ethnography together with other references to the original field data. They are assembled in the order as described above in **Table 4.13**. Commentary, contextualisation and analysis of the quotations are woven together to consider the broader significance of the findings. (225) Crystallisation of the data from all the sources helped build new knowledge and theory and is reported in the discussion chapter 9. This approach acknowledges differences and exceptions in parallel data analysis rather than the congruity of triangulation. (147) The transcript, field and observation notes are re-produced verbatim. Text has been omitted where dotted lines occur (...). This was to reduce the volume of text rather than alter any meaning or to remove direct references to people and CCG work streams that would breach confidentiality. If I have not been able to substitute a

pseudonym for an individual or organisation I have employed XXX to keep anonymity. The pseudonyms for the participants are listed in **Tables 4.4** and **4.9**.

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## Chapter 5: Socio-material practices of trust

This chapter reports the findings from the analysis of two data categories that I considered relevant to the set of trust practices. The two categories originated from the prompt questions and discussion in the focus groups and comprise evidence for social practices entitled:

- *trusting peer to peer* and
- *what success looks like*.

As described in the preceding chapter, the focus group findings were followed up with observations and interviews. New evidence was coded as appropriate including to the two above categories. The analytical framework (**Table 3.6**) was then applied to the content of the two categories.

The table below replicates **Table 4.14** in the data analysis section **4.13.5**. It lists the themes identified for trust practices for PPEI in clinical commissioning. The subsequent sections of the chapter present and explain the themes. They pertain to the character of relationships and trust as a social property developed through social and material interactions in the two CCGs.

### Themes for trust practices

PARTICIPATION	MATERIALITY	COMPETENCE
<ul style="list-style-type: none"> <li>• Relational ways of working</li> <li>• <i>“Hear it, believe it, sign up to it”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Time               <ul style="list-style-type: none"> <li>○ Too long</li> <li>○ Not enough</li> <li>○ Wasted</li> </ul> </li> <li>• Process reification and metrics</li> </ul>	<ul style="list-style-type: none"> <li>• Better than the PCT</li> <li>• Patients involved from the ground up</li> <li>• Being clear on engagement</li> </ul>
BOUNDARY ENCOUNTERS		MEANINGS
<ul style="list-style-type: none"> <li>• <i>“Awe-inspiring”</i> commissioners</li> <li>• Building on assets</li> </ul>		<ul style="list-style-type: none"> <li>• Feeling valued</li> </ul>

Some trust practices are discussed with reference to specific CoPs, for example GP locality member meetings. Others are of a more generic nature within the

domain of practice: PPEI for clinical commissioning, (Figure 3.1).

## 5.1 Participation

*Euan: I think that word trust, I think we said at the beginning, without mutual trust and respect, I don't even know if there is any point in having a conversation actually. But how do you develop that trust? Trust builds up over a very long period of time and can be lost (clicks fingers together) like that. And that is one of the difficulties, I think, is how do you build up trusting relationships with individuals and more collectively in a body where staff are changing? It is very difficult because the CCG is an institution but it is the people within it that are the institution, and then building up those relationships. I think it is really difficult because it does take a lot of time and energy.*

***[Lay representative for PPEI, urban CCG, focus group 1, 6/11/15]***

In the above focus group extract Euan describes the precarious nature of trust. He refers to individuals and highlights the temporal process of trusting relationships. Building trust can be difficult and take time and energy. Trust can be destroyed in an instant. As lay representative for PPEI in the urban CCG he had witnessed staff new into post and others leaving the organisation since the implementation of the new CCG structures in April 2013. He refers to the people that comprise the CCG as an institution, and the effect of the collective body when staff are changing.

There were two notable participatory approaches for building trust in relationships. One was to engage in relational ways of working and identify with a CoP. The second was to align with central directives to become a sustainable NHS organisation promoting patient engagement and encouraging self-management.

### 5.1.1 Relational ways of working

Several of the GP Leads in both CCGs spoke of more relational ways of working that focused on people and their experiences of services rather than an emphasis on a disease process or medical condition. The GP Lead for community services in the urban CCG (Lucy) struggled initially to articulate what she meant but recalled the time she had spent with the Memory Assessment Service. She had done this in her own time and joined some of the multi-disciplinary team meetings, patient consultations and listened in on telephone calls. It was her preferred way of

engaging despite the service having been deemed as 'failing' because it had not hit its key performance indicators.

**Lucy:** *Yes, I mean I think that we just... well... what I'm going to say is a bit vague, but I really strongly believe in human relationships and relational care and welfare and, you know, that... it really is about meeting people, getting to know them, listening to them, you know, understanding their experience of care, not just collecting bits of data, but it takes time, it takes a lot of time. So when... we did this fantastic piece of work with the Memory Assessment Service. We didn't organise it, the Memory Assessment Service did, where we really spent several weeks listening to the patients, finding out how they got into the service, whether they even wanted to be in the service and, you know, what they really wanted, not what we wanted, which was a diagnosis in dementia to put on our register but what they wanted out of it. And you learn so much, but it takes time, it takes lots of time.*

**[GP Lead, urban CCG, interview 8, 14/06/16]**

During the same interview Lucy recounted a recent experience relating to one of her younger terminally ill patients with whom she had developed a good rapport over time. She was upset by the way the relationship she had established with her patient was disregarded by the secondary care consultant who had seen her patient at the hospital. This was not so much about clinical commissioning but the relational and collaborative working practice of a GP. She referred to a book that had been recommended reading at medical school which I subsequently read. The book was written by John Berger, (227) the essayist and art critic known for his 'ways of seeing'. He shadowed a GP for three months in the Forest of Dean in the UK. The book's narrative and evocative pictures by photographer Jean Mohr portray a man immersed in his rural community, respected by community members, trusted and all knowing about his patients.

**Lucy:** *She wants to know everything. And they, you know, they're somehow dismissive of the idea, that still there are pockets where the health service does work through continuity, through getting to know another human being, you know, but they weren't even willing to hear that from the GP. So I just despair sometimes, because even if we got it going as I say, in the tiny pockets where we still believe in continuity of care, and of care. I don't know if you ever read A Fortunate Man by John Berger?*

*... An amazing book about a 1960s GP, you know, if that's what's going on in other parts of health primary.... we've got a long way to travel.*

**[GP Lead, urban CCG, interview 8, 14/06/16]**

This was not the only illustration of where a GP Lead considered his or her own knowledge and understanding had not been trusted or valued and is explained further in **5.3.1**.

I was curious about the way this GP Lead and the dementia care GP Lead in the rural CCG, (interviewees 8 and 10 respectively), operated within their work streams. Their more collaborative and social approaches within their CoPs – *“I’m in the thick of it now and I want to get it done”* (Alex, interview 10) - were not down to their past experiences of clinical commissioning. They were both relative novices when they embarked on their work streams in the post HASCA CCG landscape. I saw similar collaborative and imaginative approaches in the ‘old-timers’(170) with prior experiences of commissioning primary care services and being a GP partner. The chief clinical officer in the urban CCG (Alison), for example, had an in-depth knowledge of getting alongside and understanding community development workers. She thought that some community groups were more active than the PPGs and were trusted for the work they were doing with communities. Their community relations had developed over time and were valued for engaging with groups in the *“more deprived neighbourhoods”*.

Hilary, a service user and carer in focus group three, illustrated how she thought she was trusted and engaged in the community services procurement in the rural CCG. The minutes of meetings had captured decisions made and she was listened to at meetings she attended. Note that she says she was “chosen” to work on a procurement contract. She and her fellow patient representative both had senior NHS experience at clinical and managerial level so were familiar with the milieu. They could maintain confidentiality and so were viewed as competent and reliable. The material entities here are their professional background and years in previous job roles or past CoPs. (These are further discussed in **chapter 7** and learning practices.) Hilary had also demonstrated a track record in PPEI practices with the rural CCG thereby evidencing a relationship that was trustworthy. She appreciated having a fellow confidante with a similar former NHS identity.

**Hilary:** .....I did some work a while ago on the renewal of small contracts working in a mixed group of various clinical professionals, plus CCG representatives e.g. Finance Officer, Practice Administrator and I was the patient representative. I felt I was listened to if I had an opinion and the minutes from the meetings always noted what changes were suggested and voted on. Then I was chosen to work on the procurement of the community services contract with another Patient representative. It was really helpful that there were two of us as we could discuss elements of the submission that perhaps one of us understood more than the other and as we were unable to disclose any of the submissions to others we could not go outside for clarification from them. We were both retired from senior NHS clinical jobs so we had come through the ranks of practical and then management of our own services. Between us we had a lot of experiences and we had also previously worked with other patients on various groups e.g. PPG and Away days set up by the CCG to gain patients opinions and experiences, so we hoped we were speaking for them and not just ourselves....

**[Focus group 3, rural CCG]**

### 5.1.2 “Hear it, believe it, sign up to it”

This second theme for participation arose from the focus group with three GP Leads in the urban CCG. The focus group was held shortly after the announcement of STPs by NHS England in December 2015. (28) The GP Leads spoke about the transformation required for engagement and involvement as if they were convincing themselves about the merits of embracing this newer form of public participation with citizens and service users.

**Ellie:** And it is about knowing all the systems. Because I think it is not us doing it. It is us believing in it and hearing it and using the XXX (engagement lead) and My Life, the websites, everything that is being done because things are being ..... the self-management work stream is a significant one isn't it within the CCG and there are processes happening?

**Zayef:** Absolutely, absolutely.

**Ellie:** As individuals we have got to hear it and believe it and sign up to it.

**[GP Leads, focus group 2, urban CCG, 7/01/16]**

One of the GP Leads (Ellie) described clinicians as presuming what patients wanted but also commented on the willingness of the lay representative (Euan) to work with the GB leadership and even reduce their workload. She saw this reduction in workload as a positive feature of engagement and participation. Patients could be

“incredibly useful” and Euan was helping empower patients, but his role should be to assure representation of the public and citizens.

**Ellie:** *It was hearing ...it was experiencing meetings where patients are incredibly useful. We have got a lay member of the board [GB] who's fantastic. And really willing to not just work with us but wanting to take some of the work away from us, to empower patients to be healthy in a way that they can do best for themselves. And that makes the best sense for everybody. You know, there is evidence for it and we need to understand better as clinicians the power that the patient voice has and...*  
**[GP Leads, focus group 2, urban CCG, 7/01/16]**

A fellow GP Lead (Zayef) remarked on patient representatives at large board meetings at “the very top of making decisions” but then spoke about the self-management agenda and involving PPGs at GP practice and cluster level. (The urban CCG had divided the localities into clusters of GP practices within the same geographical vicinity.) Context appeared to switch back to getting people to change at the “very base level”. He was referring to the individual doctor-patient relationship to encourage health behaviour change rather than one based on an equal partnership with a collective patient or service user body. Self-care and patient activation measures were preoccupying the CCG at the time, so this may have influenced the response of the GP Lead to the engagement context. The muddling of context for engagement and involvement was more noticeable in the urban CCG and evident in interviews with the GP Leads as well as the GP Lead focus group. Engagement was often construed as patient engagement for self-management as illustrated below.

**Zayef:** *I think we have got to truly understand what that means because if we are going to go forward with this I think that's where the biggest benefit we might get. What do patients understand by self-management? What do the public think about that? .....*  
*..... There is a bit of information that we could share that is better and involve people at the outset. So I suspect that has changed over the period of time. It has certainly changed my view and how do we get that, how do we filter right down to cluster, to patient and practice level. Because ultimately that is where we need to get the bigger changes.*  
**[GP Leads, focus group 2, urban CCG, 7/01/16]**

It was also apparent that where participation and engagement with service users did occur it was predominantly within the strategic planning stage of the NHS commissioning cycle. PPEI for procuring services and monitoring and review was

often conducted by the commissioning teams led by the commissioning support managers. There was limited contact with GP Leads in these stages. They only saw service users contributing to a work stream at the outset. Service user representatives did not always know what happened next to complete the commissioning cycle. Some had been contacted by the commissioning team at a later stage after procurement but others not all.

## **5.2 Materiality**

The preceding section on participation has alluded to material entities that are covered elsewhere within the findings, for examples, past employment record and minutes of meetings (see **chapter 6** and leadership practices). The materiality analysis for this chapter focuses instead on two material entities affecting the development of trust relationships. The first is time as a resource. The second is reification of meeting processes and associated metrics although these did not always engender trust or success. Sometimes they had the opposite effect.

### **5.2.1 Time**

Time featured as a material resource and impacted on practices of trust in a variety of ways. Examples include the “*wasted time*” of sitting through a meeting and no-one taking your comments and contributions seriously (Elizabeth in focus group 1), and the inappropriate use of GB time to allow a member of the public to promote a Mindfulness service. The service should have been tendered in the appropriate manner as explained by one of the GP locality member Leads below. She considered other voices were not heard as a consequence of inappropriate use of time.

***Natalie:*** *We shouldn't have had to listen to that at a Governing Body meeting because if we were contracting out mental health services, it is up for retendering at the moment, then he should go through the tendering process. That was completely inappropriate use of Governing Body time. He gave out leaflets. I think we labelled him as vexatious in the end and we wrote to him as a Governing Body. But again it stopped other people having other questions necessarily. Again it makes it difficult because he turned up so he got airtime. How do you get a voice for those people who can't turn up?*

***[GP locality member Lead, urban CCG, interview 5, 5/04/16]***

GP Leads in both CCGs also spoke of how time-intensive it was to engage with multiple partners for work stream collaborations. This could be problematic when there were small VCS organisations contributing to strategic planning and/or involved in procuring and delivering services. Sometimes there was not enough time or, as Euan the lay representative for PPEI in the urban CCG clarified, “*not enough checking up*” to see if what should have been done had been done.

In other instances, PPEI processes took a long time to come to fruition. Soon after Euan was in post he wanted to change the reporting structures in the urban CCG. As lay representative he felt he could not assure PPEI and the implementation of the Patient and Public Participation Policy on behalf of the GB. This was because the participation work was a sub-committee of a sub-committee of the Quality Assurance committee.

**Euan:** ... it was like patient and public participation was an afterthought that came on at the end. And I brought it up time and time again to the Governing Body saying ‘Are you cited as to the implementation of your Patient and Public Participation Strategy?’ They just kept on looking at me blankly so in the end I said well I am not assured that the patient voice is getting into the heart of the CCG. Stuff was happening but it was all below the radar. So we agreed with this idea of setting up the Communications and Engagement Committee (CEC) [pseudonym] and we have now got a process for issues to come from the PPG up to the PPG Network up to the CEC and when Eddie (PPG Network rep) presented those issues - I asked him to do that to just cite people as to what his role is, but actually we will have a pre-meeting where we signpost the issues into the CCG, and he gets those back and he brings them back to the PPG Network. So all of that has come out of a kind of reorganisation that I spearheaded.

**[PPEI lay representative, urban CCG, interview 1, 9/03/16]**

It took a year to instigate these changes and was not helped by challenges to Euan’s authority as a leader. The Quality Assurance Committee chair effectively lost some of her responsibility, (7.4.2 in learning practices has further detail). Observing the CEC meetings, it was clear that there was a good rapport and genuineness between the participants, (observations 3 and 8). The pre-meetings comprised the lay representative for PPEI, head of CCG communications, the CCG engagement lead, GB secretary and the PPG network representative. The CEC meetings were

held every two months, so the process was resource heavy in terms of staff attendance and time including that allocated for the pre-meeting beforehand.

### **5.2.2 Process reification and metrics of success**

A source of frustration for one of the service user representatives (David) was the conduct and minuting of meetings and their outcomes. He thought the minutes of meetings he attended had been sanitised thereby removing his comments and views from the record. He attended the North GP locality member and the Quality and Performance Committee meetings.

***David:** ... But I think I am there because I need to be there or somebody representing patients need to be there. But I have had two occasions where I have had major issues which I have raised, which they have accepted as major issues, and promised all sorts of things will happen but the minutes that come out never reflect if you like the .... so my feeling at that moment is that, and I need to take it up with the secretary and the chairman, is that they are sanitising the minutes...*

**[Service users, focus group 3, rural CCG, 27/06/16]**

Following on from this focus group conversation, I attended two GP locality member group meetings in the rural CCG; one in each locality. Only the North locality had service users present and their agenda slot was limited to a few minutes because of time pressures. It was squeezed in before service providers from the new musculo-skeletal service arrived to discuss their contract, (observation 15). One of the patient representatives was apologetic and said it was their fault they did not have more to say. They should have been more organised. Talking to him after the meeting he recalled the usefulness of his own PPG in the North locality as 'helping out' at the 'Flu Jab clinics at the GP practice and raising funds from a charity cake sale. He was the chair of his PPG and had about 10 what he called 'active members.' However, David, the second patient representative who thought the minutes had been sanitised, had a different view about meetings. He was concerned by participants' pre-occupation with meeting processes and measuring the success of the meeting. He felt little was achieved as a result.

**David:** ... So I feel that there is still a big gap between what they want to do and what this group is meant to do and I think what they actually are doing. You sit round a table. There is 20 people most of whom are doctors. And they talk very loud and long about all sorts of things they are doing but I don't actually think they achieve anything. My personal view is, and I have talked to Nigel [GB lay representative for PPEI] about it, my personal view is that I should walk away from it. 'You should stay. We need you there to stir it up.' But I just feel ... their whole life seems to be focused on - their success criteria is can we have a meeting? The success criteria is holding the meeting.

... 'Oh we have finished on time.' 'Oh, we have finished five minutes early.' 'Well done, that was a good meeting.' Not what have you achieved?...

... A couple of meetings I asked when we got to the end: 'Chairman, could you just list the actions we are going to take as a result of the meeting we have had?'

**DH:** And what response did you get?

**David:** Not very good. So their whole focus is just about churning the stuff through, producing a report and then passing the report upstairs. It is not about results. It is about process. ... I think that is inevitable to some extent. I think it is part of the way bureaucracy works. It is management by numbers. And when you get a real problem like we have with XXX (name of provider service) then nobody knows what to do about it.

**[Service users, focus group 3, rural CCG, 27/06/16]**

It was disappointing to see this lack of engagement with service users having recalled the focus group discussion with the rural CCG service user representatives. The chair of the PPGs for the North Locality GP practices (Hazel) had made the case for increasing the number of patient representatives at the GP locality member group meetings. She used her past work experience in housing to defend the rationale. She would never put a single tenant on a housing board as it offered the individual little support against professional voices. It was no different with GPs and she did not want to find herself in a similar position; "*It is very hard as a patient to make your views against Drs,*" (Hazel, focus group 3). A standing agenda item was subsequently introduced to ensure there were two patients to provide a voice at the locality member group meetings. However, I witnessed only a tokenistic response in the meetings I observed.

David's comments illustrate the reification of GP locality member meetings where clinical leadership is played out as evidence of GP engagement for the CCG. The minutes are an artefact and bear witness to the activity having occurred but a GP locality member Lead in the urban CCG was equally scathing about the value of

the reporting processes to the CCG GB. She felt it was a “rubbing stamping” exercise. The GP locality member Lead later expanded on her comments about “coming from the centre”. She was not only referring to the influence of NHS England but also the pressures from secondary care in the acute NHS Trust which was impacting the work of the GP clinical commissioners.

**Natalie:** *Yes, that is overrated how much we liaise with [GP]practices. In fact, the whole democratic structure is overrated to be honest. It is still coming from the centre and coming out. It is still .....you know, we would have locality meetings every two months but really and truly they increasingly become much more rubber stamping. The CCG telling .....General Practice is really pushed. They are too busy and they can't get their heads above water to actually take on all this stuff. Actually, looking back on it they have got all the lovely structures and they can tick all the boxes but in practice ....*

**[GP locality member Lead, urban CCG, interview 5, 5/04/16]**

Both the GP Lead and David used the metaphor of taking/reporting something ‘upstairs’ consistent with ideas of alignment. However, Wenger-Trayner (172) would argue alignment is not only about submitting to authority and following a prescription as a mode of identification. For Natalie it felt as though she had no power as a GP commissioner and she wished she had learnt to be stronger from the outset.

**Natalie:** *... I think the GP commissioning was set up was so many .... it was just ... .it is a misnomer. We don't have that power. NHS England are still driving it from the centre. You know we are rubber stamping a lot of the time. We don't get that power because you will try and make some decisions and suddenly the decisions are taken upstairs. There has been a letter from NHS England saying this, that and the other. Actually, I only kind of learnt that over the three years and had I realised that when I went into it I think I would have mean much stronger, pushed a much different agenda about how we really try and commission effectively. Commission acute services effectively and hold them to account. There is always this thing ‘we can't let them fail’. ‘We have got to bail them out.’ There is lots of ‘the Acute Trust always say if they overspend they will get bailed out’. Well it doesn't happen in General Practice. Knowing what I know now I would be a lot more ‘ballsy’ – that is a rubbish word – with secondary care. And almost with trying to with NHS England. It is not GP commissioning. It is still centrally driven.*

**[GP locality member Lead, urban CCG, interview 5, 5/04/16]**

Another process measure criticised was one used for capturing patient experience. The Accountable Officer for the rural CCG had asked Hazel as a service user representative to review draft questionnaires to be sent out to patients. She was critical of the content and thought the questions did not really measure what was important to patients. It was, however, what the CCG would use to capture data for

reporting purposes as part of the monitoring and review of services.

**Hazel:** *I have done the feedback and have said exactly that. I said at no point have you - this whole process was supposed to be – it is PERM (Patient Reported Experience Measure)\* I think it is called – this process. I said at no point did you ever say to a patient ‘What was it you wanted to get out of your treatment and did you get it?’ Which is straight forward. It is a ‘yes’/‘no’. What you want isn’t obviously. It is only when you analyse those sort of issues that you find out whether the process has worked for the patient. Just saying were you able to contact your adviser on a scale of 1 to 5? You either are or you can or you can’t. So that is straight forward really.*

**[Service user representative, focus group 3, rural CCG, 27/06/16]**

\* The correct term is Patient Reported Experience Measures (PREM) which are recognised metrics for patient experience.

### 5.3 Competence

Competence is not merely an individual characteristic. It is recognised by the members of a community of practice and shapes personal experience. (172)

Competence is the know-how, skill and technique described by Shove, Pantzar and Watson (128) as one of three elements of their slim-line practice theory. In this section, three themes were identified for trust practices that illustrate how competence was perceived.

#### 5.3.1 Better than the PCT

There were several occasions when GP Leads made direct comparisons with their former PCT commissioning work. They described negative experiences of being a “*token GP*” in the PCT in a similar way to the service user representatives who said their voices were not being heard, (focus groups 1 and 3). There was a sense that things were better now for the GP Leads in the CCG with more team work and ‘open doors’ for listening and sharing ideas. This was highlighted by the GB Lead for Quality in the rural CCG when I asked her if GPs were more clinically engaged. I wanted to explore what had changed to make the GPs more trusting.

***Heather:** With other GPs? Yes, definitely. Most GPs ... there was a certain amount of cynicism I think when CCGs were set up. Mainly because we have had years of being told what was going to happen rather than being asked. And a lot of the decisions that were made you could tell it wasn't going to work because it wasn't going to work. It is General Practice. It won't work the way they say they want it to. So there was a lot of cynicism. But I think actually, now we have been going for three years. And there are still some cynics out there. There always will be. Some people just don't like change. Yeah, better engagement.*

**[GB Lead for Quality, rural CCG, interview 6, 1/06/16]**

Underlying these remarks was the attitude toward or manner by which people engaged and the communication styles used with individuals. Being told rather than asked was a negative factor for building trust relationships. Paternalistic communication was also what had incensed Lucy when the secondary care consultant discussed her terminally ill patient with her, (5.1.1). The locality member Lead for the rural CCG (Duncan) offered similar insights. Six years in the PCT and he had never seen a manager. Decisions were made at a distance and he felt he could never progress ideas. Having more GPs on the GB had made him rethink and decide he wanted to get involved with leadership in the CCG.

### **5.3.2 Patients involved from the ground up**

Communication was equally important for gaining the trust and understanding of service users and the public (citizens) in both CCGs. There were numerous artefacts, some listed in **Table 4.8**, others embedded and accompanying the minutes of meetings or available on the CCG websites. These described events and opportunities to engage and involve the public in addition to the GB meetings. They included conferences open to the public, public meetings about health and care and road shows in the larger conurbations within the CCG boundaries. The urban CCG had engaged a not for profit organisation to conduct a Kaizen improvement event for a harder to reach section of the CCG population. (Kaizen events, originating from the Japanese philosophy of continuous improvement, are typically short-term projects.) The CCG also closely liaised with community development workers on established projects to engage citizens. The rural CCG was also proud of its grass roots activities and work stream engagement which entailed attending town hall meetings and, for example, persuading villages to become dementia friendly. For

both CCGs these were public engagement events involving the communications teams and engagement leads as well as clinicians, including GP Leads, and commissioning support teams. The GP Lead for Quality in the rural CCG did reiterate that such events could lead to other service user involvement opportunities. Some are described in **7.2.3** of learning practices.

**Heather:** *I think we do a good job already to be honest in the CCG because we involve people from a very, very early stage. You don't just have it on the Programme Board. There are events at the beginning, the communication events. What you haven't mentioned, or XXX [Commissioning Support Manager] hasn't mentioned is not only have we had those specific roles, but the number of road shows and community events they did. So people have been involved right from the very beginning and then if people have been interested they can take it further.*

**[GB Lead for Quality, rural CCG, interview 6, 1/06/16]**

I observed four GB meetings, two in each CCG. In the urban CCG GB meetings there were questions from pressure groups which were considered under 'public questions' on the agenda. Given that GB meetings are meetings in public as opposed to public meetings, one of the GP locality member Leads reflected on what she thought about their public engagement processes.

**Natalie:** *The Governing Body was the usual suspects would come. Actually, I quite like the guy from the NHS Alliance, Save Our NHS ... Those guys would stand up. I think they were trying, they had a broad perspective - we might not agree with them at the time. But I think they did have a broader perspective. They had an overall perspective about the NHS, stop the privatisation -XXX didn't want to privatise any of it. They weren't a self-interest group. The ones that are tricky who are fighting a cause. I think we don't manage those people very well. We don't manage those groups very well.*

**[GP locality member Lead, urban CCG, interview 5, 5/04/16]**

The NHS Alliance and Save our NHS representatives had a broader understanding of the NHS in terms of 'know how' or competence. However, 'know how' about the NHS could work to the detriment of individuals if they could not see beyond their own service experiences and self-interest. When discussing training for service user representatives, Natalie was sceptical of what it might precipitate. She valued education level and skill (material entities for competence) but felt that the political

agenda was driving a tokenistic approach to patient engagement. It was about “ticking the boxes” and might allow someone who “shouts loudest” to influence the agenda, reiterating her earlier comments about inappropriate use of GB time. In effect, the box ticking for PPEI activities ‘from the ground up’ demonstrated CCG compliance for patient and public engagement as required by the HASCA.

### 5.3.3 Being clear on engagement

Getting the broad perspective but representing the voices of others was a recognised challenge for PPEI in both CCGs. Natalie, one of the GP locality member leads, repeated several times that the urban CCG needed to decide what exactly it was and how it should be done. She favoured a public health committee style as with citizen or deliberative approaches for commissioning decisions. By contrast the lay representative for PPEI in the rural CCG was clear about the competence required and the importance of creating the right environment and conditions.

**Nigel:** ... want people to be friendly, come to the meetings, enjoy the meetings and feel that they're dealing with people who are not talking down to them. All that. So it's creating the right environment which... where people will actually come out and... because they're intelligent people who come to these meetings. So it's just a question of helping them to get going really.

**[PPEI Lay representative, rural CCG, interview 13, 8/11/16]**

He elaborated on the qualities he thought relevant. A representative should:

- convey enthusiasm,
- be well-informed without being an expert in various diseases,
- have good knowledge of the NHS – what goes on and the issues,
- like people and want to work with them but not in an egotistical way, and
- be valued.

He described this as “pretty basic standard management stuff”. When talking about the GB where he was lay representative he said that there was a high level of trust and a good working relationship. The emphasis was on doing the work for the benefit of patients and together rather than to take any credit on a personal level.

Nigel made this clear with reference to the community services procurement which he had described as the “*big win*” for the whole community, (see 8.1.1).

***Nigel:*** *I think we've got a very good Governing Body who all work very well together and there's a high level of trust. ... so there's a very good strong working relationship and people are not interested in... in um... filling their own pockets, they're interested in getting the job done for the benefit of patients. The patient culture is strong among the other members of the Governing Body so... which makes life pretty easy for me because I don't have anything uncomfortable in terms of thinking somebody's trying to feather their own nest here, so... but if that were the case, then it's very clear that my role... I mean I'm not the only one, there's the chairman of the audit committee as well, [other GB lay representative] and others, would have to be just saying no we're not having that, and we would.*

***[PPEI Lay representative, rural CCG, interview 13, 8/11/16]***

There were other illustrations of PPEI practices where service users and lay representatives felt they were an integral part of CCG proceedings alongside clinicians and commissioning managers. A sense of commitment to the process as shown by participant 5 (Daniel) in the first focus group. He sat on the Independent Funding Request Panel (IFR) as a lay representative for the urban CCG. He spoke of CCG decisions made with lay members when considering individual patient funding requests that were outside of the negotiated service provider contract for the CCG. He thought their opinions and votes were very highly valued. In the transcript excerpt below, Daniel clearly describes his involvement and the materiality of the votes cast. The phrase the “*doctors tell us exactly what the outcome will be*” refers to the consequences of the various funding options and not what outcome the lay members must chose at the direction of the clinicians.

**Daniel:** *On the panel there will be two doctors, two lay members and four or sometimes five members of staff at managerial level and the one thing that I have noticed and I have been doing this for a number of years now, the lay members seem to have the biggest voice and they listen to everything we say. We don't refer back to anyone at all. It is just our immediate response to the case that we are dealing with. And they listen very, very carefully, the doctors do and the managers do. And they let us almost take control of the group. So we really, the two people we would be the ones that really matter as far as the awarding of finance for whatever it is going to be. We discuss the thing at a very high level. The doctors tell us exactly what the outcome will be and we have to make a decision. In the end it is done on a vote. Invariably, the two lay members usually vote together but there have been odd occasions where we have disagreed. And then it is always thrown back to another group to decide upon what is going to happen there. But they listen very, very carefully to what the lay members are saying and this is one of the things....*

**DH:** *How do you know they are very attentive and they are making their decisions based on what you say?*

**Daniel:** *They do not make a decision at all. I mean at the end of the day it is a vote. So you can see exactly what they are doing. They will then refer to what you are saying and what your views are. This is what I have found as a non-doctor, that, you know, one's opinion is considered very, very highly.*

**[Urban CCG, focus group 1, 6/11/15]**

I later observed one of these meetings to enrich my data and to see if there was bias or persuasion in the presentation of possible outcomes. Daniel was not at that meeting but a different male representative who had an established track record with the IFR panel since inception. He was also on the prescribing panel and hospital committee of another NHS service provider thereby having a 'track record.' The extract from the observation notes below demonstrates equality in the relationship between panel members with reference to an ethical framework. There was reification and alignment with the discourse against national benchmarks for the surgical procedure in question, but there was also consensus manifest in the final decision. The lay representatives were respected for their contributions which concluded with the panel seeking out further information.

*The panel considered the cost to the CCG if the missing data were obtained with further consultation. It also considered if the surgical procedure might require revision at some later date. Some of the debate centred on what constituted reliable evidence against national benchmarks as advanced by the pharmacist, but there was also a broader perspective about promoting population health. The **male lay representative** was eloquent and stated that there were two issues centring on 'moral hazard'. One was about the process and not having sufficient information to make the decision. The second was about the CCG trying to encourage healthy lifestyles and then not offering an option (such as the request for this procedure). The **female lay representative** felt more information was required.*

*The chair referred to the CCG's ethical policy for the IFR panel decision-making and thought it was timely to revisit this and make it transparent in proceedings:*

- 1. Is it rational? Use of evidence-based medicine to inform.*
- 2. Is it inclusive? Does not disadvantage sections of the community.*
- 3. Economic factors – what are the costs?*
- 4. Are decisions clear and open to scrutiny?*
- 5. Does it promote health to individuals and community?*

*The IFR GP was vocal throughout the discussion on various aspects of the case. The panel decided that the ethical framework had been followed. The consensus was that further information was required before the decision could be made. The gut feeling being that the panel was promoting health of the population.*

***[Independent Funding Panel, urban CCG, observation 4, 26/01/16]***

#### **5.4 Boundary encounters**

There were repeated references to people and their experiences, whether as a member of CCG staff or as a lay or service user representative, which impacted on informants' participation in and understanding of trust practices within a CoP. Boundaries are unavoidable within a community of practice. (172) Past CoPs, engagement with present CoP members and future CoPs all influence the experience of identity as these trajectories intersect and collide. Looking beyond the individual personalities to consider social and material entities, meanings and skills instead, the themes from this part of the analytical frame attempt to unpack two aspects of why commissioners were "awe-inspiring" and assets are important as boundary encounters.

#### 5.4.1 “Awe-inspiring” commissioners

There were numerous positive references to the commissioners or “Officers” that had taken up post in the two CCGs, many of whom were new to the organisations. These comments came from all informants; GP Leads, lay representatives, service users and featured in the focus groups and interviews. I had not planned nor had ethical approval to interview commissioning support managers, or the PPEI engagement leads, but they were clearly influencing the clinicians, service users and lay representatives. My options were therefore to observe them in meetings, look for mention of them or authorship in artefacts and listen to the responses in interviews when participants talked about commissioning officers and managers. They seemed to be brokering some of the encounters and negotiating in the various CoPs in the domain of PPEI activity for clinical commissioning. It was as if there was a new type of commissioner with a different approach and skill set. Being reliable and speaking on the same level without effect or superiority were two features of their practice.

**Nigel:** ... I think the recruiting here's been pretty good, I mean XXX [Commissioning Support Manager] a good... an excellent example actually, of how... how... there's... everybody likes XXX, everybody trusts XXX and she gets things done and she just talks the way you would want somebody to talk and that's pretty general actually, but she... she's the one, because of the Community Trust thing where it's been most obvious and I suppose most up front, and so... yes so yes it required the push, it required people to take on a different approach, but then once they did, everybody thought it was a win-win. So you'd broken the ice...

**[PPEI Lay representative, rural CCG, interview 13, 8/11/16]**

The PPEI lay representative was referring to the commissioning support manager involved with the community services contract in the rural CCG but in the urban CCG there were equally powerful illustrations. One of the GP Leads (Lucy) referred to her “awe-inspiring” commissioner with regards to setting up a dementia conference and newly commissioned dementia services for community services, reflecting both the versatility and commitment of the commissioner.

#### 5.4.2 Building on assets

Past commissioning structures were mentioned where former CoPs had functioned well or had relative merits. The clinical reference groups from PCT days

were one such example. Although many had been disbanded, one of the GP Leads (Natalie) spoke about keeping a group going when she was the diabetes Lead because of the different professionals that attended and contributed. She was referring to the diabetes nurses and the consultant diabetologists but also had a service user whom she trusted to represent the voice of patients. She described this person as “*very experienced*” and a “*rational counter balance*”. (See also **8.3.1** in partnership practices.)

There was the influence of the former strategic clinical network groups too. Voices were drawn from a broad selection of clinicians and patient groups giving credibility to the user representatives. The charity Macmillan Cancer Support, for example, were involved in the former strategic cancer network and the ‘partnership group’ and actively encouraged engagement and involvement for both commissioning and service delivery. In the urban CCG, Macmillan Cancer Support had been instrumental in using five peer researchers to gauge the experience of cancer services to inform future commissioning intentions. A cohort of volunteer community researchers were thus to be developed as a pilot for the CCG’s Patient and Public Participation strategy.

The legacies from these past CoPs were assets to be developed where appropriate. They were apparent in references to the continuing community development work in conjunction with workers and VCS organisations that were ‘tried and tested’ so therefore trusted. This was evident in both CCGs and mentioned by most informants in a variety of contexts dependent on the work stream.

For some informants past CoPs were a hinderance. The lay representative for PPEI in the urban CCG for example had found it difficult to form comfortable relationships with the clinicians in the GB. He had a good rapport with the Chief Operating Officer but she was not a clinician. Probing further the relationships with his fellow lay members on the GB, he told me that he thought he was a threat to them and so it was difficult to establish a rapport. He had been keen to have additional meetings and discuss their strategy as lay members, but time was never made. The independent clinical members were there to fulfil their obligations to the

GB but were not seeking additional work outside of their busy schedules. Time, as a material entity, was a factor but the fear of threat is important to the construct of trust as a social property. Partners who trust each other will not feel the need to control one another (182) but Euan was prevented from taking his ideas forward.

**Euan:** *No, I think the problem was ... the history, they had been together since the formation of the CCG. Then I came in and I thought they would naturally be my allies and that I could be very open with them. But of course, I think they took it you know more personal that they hadn't been doing their job properly. I think they felt very threatened by me. I would say I have got a stronger relationship with most members of staff more than with the lay members which I completely and utterly didn't expect to happen.*

*... Yes. You got the independent clinician, the independent nurse, and the lay member for governance and the very fact that we never meet up as a group of lay members. ... I probably have the better relationship with Edward (Lay member for Governance). There is no discussion about issues. I thought we would be discussing issues. I brought it up at the first meeting so that we can draw some strategies up together. Why do you want strategies Euan? What are you trying to do here? We have got the vision and we are just working towards that. So I said maybe that is not the right way. They didn't feel comfortable with that at all and we have never met up in 18 months we have never met up as the four of us.*

**[Lay representative for PPEI, urban CCG, interview 1, 09/03/16]**

For Euan there appeared to be a boundary between him and the other lay members based on their respective past CoPs. The lay members who were clinicians were more established within the CCG and functioned in their GB roles to comply with the remit of the CCG constitution. Similarly, the GB Lay member for governance had held a number of NHS roles in primary care. He commenced as a non-executive director for a PCT in 2006. Subsequent roles included being audit chair for various NHS organisations as his previous employment had “*been a Finance Director of a public company for many years*”. Reification of the urban CCG roles as evidenced by minutes of GB meetings and minutes of sub-committees where they might be expected to chair meetings was sufficient for these lay members. It was consistently aligned with the NHS commissioning agenda whereas the lay representative for PPEI was used to working in a more participative way. His past CoPs were predominantly from the VCS where he expected to co-produce or work in partnership with other team members. He was

negotiating a new CoP with the other GB lay members almost as if he was the apprentice. (170)

## 5.5 Meanings

An important manifestation of trust practices and what trust means to the individual or a group (CoP) was feeling valued. Mutual trust and respect were fundamental if belonging to a CoP was to create a sense of purpose or meaning and legitimate identity. One of the lay representatives for PPEI (Euan) described it as “*generally a kind of warming*” when relationships are going well and have purpose.

### 5.5.1 Feeling valued

An illustration from the rural CCG focus group entailed identifying cues that made service user and carer Hilary and her fellow service user representative feel trusted and part of proceedings at a procurement meeting for the community services work stream. She identified the sharing of jokes, taking refreshments together with the CCG staff and being respected for maintaining confidentiality. She also likened it to the camaraderie experienced in a job role.

**Hilary:** ... think we did build up a trust with those people we worked so closely with for that period of time and everyone respected the confidentiality of the work. The outcomes will prove if it was all worthwhile. That now has to be monitored and kept in line so that the services are there for the patients who need them.

**DH:** What were the cues that made you feel you were both trusted?

**Hilary:** The whole group spoke quite freely in front of us and we were included in any jokes or e.g. extra teas and coffees or cakes from the shops, as you are when you work alongside people in your job. Some of the discussions were financial and sometimes might have been about individuals or the particular problems in an area, so we were trusted not to discuss those outside the room, which we didn't.....

**[Rural CCG, focus group 3, e-mail 13/11/16]**

These social aspects of what I originally labelled as a subtheme entitled *feeling part of it* (Table 4.10) were apparent elsewhere within the data. A service user within the urban CCG (Elizabeth) described similar experiences when comparing the groups she participated in as a representative. The social aspects of the PPEI activity included being remembered as a person and by name, engaged in conversation before and after meetings with other CCG staff and asked about your ideas and

views with opportunity for follow up. The informality ran counter to what she sometimes experienced as a “*them and us*” situation where she felt the CCG viewed service users as “*a little bit of a thorn in their side*”.

**Elizabeth:** *Sometimes it is the informality of these formal events and meetings and things. And I find, to ask me that specific question. The difference that I have between the one group that I have a problem with and the three that I don't - the difference is ... I feel that they know me personally, they always remember my name. It is not sort of like you have to wear a badge because they don't remember your name or they don't know who you are. And they will always talk to you before the meeting, after the meeting and if you have raised something they may come up to you at the end and sort of say actually 'Yeah, are you interested in..' 'Give me your email and I will have a look at this'...' 'Have you seen this document' or something. And I think it is being informal just having a chat as though they are not an alien being, they are just a human being like you are, all working for the same team as it were rather than all trying to work against each other. I think sometimes there tends to be a bit of 'them and us' sort of feel. And I do sometimes think, as I said at the beginning, they feel that we are a little bit of a thorn in their side.*

**[Urban CCG, focus group 1, 6/11/15]**

It was not just service user and lay representatives that needed to feel valued. The lay representative for PPEI in the rural CCG (Nigel) pointed out that it was important for the commissioning managers to know that they are valued by the patients and “*that it flows in both directions.*” Earlier in the chapter (5.1.1) the need to feel valued and trusted was reported in relation to GP Leads. A need to get alongside and experience the human and care relationships rather than focusing on the “*technical bureaucratic processes and referrals*”, (interview 8).

Inevitably, there were some negative experiences of ‘feeling valued’. One service user, anonymous for this illustration, felt the CCG clinicians were grateful for service user contributions but remuneration for travel expenses told a different story. Recompense or remuneration is a standard part of PPEI policies and certainly for research (220, 228), and should be considered as another material entity. On this occasion it created a potential division between the service users and CCG staff. Whilst the informant referred to voting on an “*equal footing*” which could be viewed as a successful trust practice, she highlighted inequality over reimbursement. In subsequent discussion with the informant she acknowledged that the system or policy constrained the remuneration. The commissioning managers could only permit the recommended reimbursement.

*XXX: ..... We both felt that we had been able to contribute to discussions and the outcomes and it was remarked on that they were grateful to have us there as we did often have an alternative opinion to the officers. We were involved in discussions and the voting on an equal footing with clinicians and officers. The only thing we both felt slightly unhappy with was that the officers were there as part of their job and were paid a reasonably good salary but we were only given a small sum for each session we attended. We felt we were not paid in respect of our expertise as they were. Not that I did it for the money but because I was interested and wanted to be involved, to try and achieve a good outcome.*

**[Focus Group]**

## **5.6 Concluding thoughts on socio-material practices of trust**

Hudson argues that empirical examinations of trust are still rare and suggests there should be a focus on developing measures of inter-organisational and inter-professional trust. (182) Whilst this study was not examining trust between organisations per se it was examining trust between the different representatives (clinicians, lay representatives and service users) for PPEI for clinical commissioning. Some of the questions Hudson asks are relevant here such as how can trust be promoted and then sustained. (182) Good clinical leadership impacts on trust practices and so it is to this aspect the next chapter turns with respect to the study findings.

## Chapter 6: Socio-material practices of leadership

Findings from analysis of the three data categories considered relevant for the practices of leadership are reported in this chapter. It incorporates data from the various CCG communities where PPEI activity occurred or should take place, for example, GB and GP locality member meetings. There are also data from PPG meetings where leadership skills were coded. The data categories were:

- *Clinical leadership,*
- *Governing Body and*
- *Roles*

There were 17 codes for *clinical leadership* which included both strategic and operational functions of the CCG. The 11 codes for the *Governing Body* category included codes re-assigned from a former public engagement category and *roles* had 15 codes. *Roles* included those performed within the CCG by all participants and the role of the GP as both a member and Lead in the CCG. The data spoke clearly about identity and belonging, ‘modes of belonging’ being the term used by Wenger in his earlier work on CoPs. (169)

The analytic framework (**Table 3.6**) was applied across all three categories of the social practice data. The table below replicates **Table 4.15**. It lists the themes identified for leadership practices which are then presented and explained.

### Themes for leadership practices

PARTICIPATION	MATERIALITY	COMPETENCE
<ul style="list-style-type: none"> <li>• Having a track record</li> <li>• The public in engagement</li> <li>• “They looked the same.”</li> </ul>	<ul style="list-style-type: none"> <li>• Physical spaces and artefacts</li> <li>• Reification of leading and governing processes</li> </ul>	<ul style="list-style-type: none"> <li>• Recruiting and selecting leaders</li> <li>• “no-one wants to be low in [the] ratings”</li> </ul>
BOUNDARY ENCOUNTERS		MEANINGS
<ul style="list-style-type: none"> <li>• Meet your Governing Body</li> <li>• Provider impact</li> <li>• Wearing old hats</li> </ul>		<ul style="list-style-type: none"> <li>• Role descriptors and status</li> <li>• Sense of community</li> </ul>

## 6.1 Participation

### 6.1.1. Having a track record

Consistent with earlier studies of emerging CCGs (17, 229) my findings showed appointments into clinical leadership roles were initially taken up by clinicians (GPs) with prior experience of working in practice-based commissioning and Primary Care Trusts (PCTs). This also applied to the lay representatives.

The GB Lead for engagement and clinical leadership in the urban CCG (Zayef) had always been involved with some form of commissioning. He was previously locality chair for practice-based commissioning and wanted to ensure the collective GP voice was heard to improve care for patients. He had looked forward to engaging more with his clinical colleagues in secondary care as well as General Practice. For other GP Leads, participation was more about using their prior experience to address current need. Someone needed to do the job if GPs were to be clinically engaged and embrace the new model of NHS clinical commissioning. This was not always met with overwhelming enthusiasm as the following excerpts illustrate.

**Heather:** ... So I had been working with the PCT and practice-based commissioning for a number of years. I started off doing the prescribing lead and then when the CCG started, because I had already been working as the prescribing lead and in practice-based commissioning, it was asked for interest. And I didn't stand back quick enough. (Laughs) So that is basically ....it started off when the CCG first set up, I started off just doing the prescribing and then all the roles were re-jigged and it sort of morphed into something quite a lot bigger. (Laughs)

**[GB Lead for quality, rural CCG, interview 6 – 01/06/16]**

**Natalie:** ...I think it was just the last man to leave the room. There certainly wasn't a huge queue for obvious reasons if you are a full time GP leading your partnership. I think only one other person expressed an interest and they were not a doctor and it was meant to be GP led I just thought well ... I probably should do it because I just felt if we are going to try and make this work we have to give it a go. But I certainly, it wasn't something that I kind of planned really.

**[GP locality member Lead, urban CCG, interview 5 - 05/04/16]**

GP locality member Lead Natalie had extensive experience within a pathfinder CCG and practice-based commissioning. She had also been the GP Lead for diabetes and later became the locality member Lead. Her track record was significant although she did take the view that roles were time-limited. If you stayed too long you lost your effectiveness.

A track record of engaging and aligning with the NHS agenda was also evident with the lay representative for governance in the urban CCG. Edward had accrued 10 years of NHS experience having first become a PCT non-executive director in 2006. He was well known locally and had been involved in the winding up of PCTs as they transitioned into CCGs. He had little difficulty securing his role as a lay member.

**Edward:** *We signed off all the closures of all the organisations at the same time. Handed over to the CCGs and I was thinking I was going to wave goodbye and disappear into the sunset when the CCG approached me and forced me to join them. I am not joking. They did a little arm twisting. I was reasonably willing anyway. I was surprised they wanted me to join them so I did join them as their lay member for governance and so I came in.*

**[GB Lay representative for governance, urban CCG, interview 4 – 21/03/16]**

Edward's fellow lay representative for patient and public involvement in the same CCG (Euan) had also worked with the PCT in a past role as regional director for a voluntary sector organisation. Similarly, the lay representative for patient and public involvement in the rural CCG (Nigel) first became involved with patient groups for a national voluntary sector organisation in 2004. He had since occupied several patient representative roles at both local and national level and was chair of one of the Local Involvement Network groups (LINKs). LINKs were the predecessors of Healthwatch, the consumer champion for users of health and care services in England. (230) He took up post in 2012 prior to CCG authorisation and since then had created an impression of a capable leader with the GP Leads, GB members and service user representatives alike commenting on his participation.

*Harriet: ... everybody on the Governing Body has done development, you know the PPI Lead, he's been on a lot of development, although he's very self-driven, he drives a lot of what he does, but he is... we're lucky to have him, he is amazing and he certainly leads by example, ...*

**[Clinical Chair, rural CCG, interview 7, 03/06/16]**

### 6.1.2 The public in engagement

I attended four GB meetings during the study period, two in each CCG. Between 14 and 18 GB members were present at the meetings and the chair person was always a GP. The deputy or vice-chair was the lay representative for governance in both CCGs. The composition of the core membership was usually:

- Chief Operating Officer (see **Glossary**)
- Five or six clinicians comprising GP Clinical Chair, GP locality Leads and GP Leads responsible for quality or leadership or clinical engagement,
- Two independent members; nurse and secondary care clinician. The independent nurse was not present at one meeting,
- Finance director,
- Public Health Consultant,
- Two lay representatives although at one meeting only the lay representative for governance was present,
- GB minutes secretary (in attendance)

The urban CCG also had a lead nurse responsible for clinical quality and patient safety and the local authority Director of Adult Social Care as GB members.

A striking feature was the lack of public attendance despite high profile media coverage of one agenda item that affected both CCGs. The rural CCG had fewer public attendees. At one meeting in the rural CCG I was the only audience member after members of the public had departed following the public questions. A TV journalist and his colleague appeared at another of the meetings. The colleague attempted to record the discussion on a hand-held device but was quickly asked to refrain. There were notices with the agenda and minutes of the meetings and on the CCG websites to say recording of proceedings was not permissible, both illustrating reified policy for public conduct at GB meetings.

A second impression was the nature of leading a CCG meeting in public as opposed to it being a public meeting. It felt contrived at times and particularly for the public questions which were taken at the beginning of the meetings in both CCGs. The conduct of the GB meeting is such that public questions must be submitted in advance in writing. The urban CCG requested this be done at least six working days in advance and in the rural CCG it was three working days. Speaking rights are reserved for the GB members and the public are only allowed to contribute at the allotted time.

In the urban CCG, public questions appeared as the second item on the agenda after the welcome and apologies. There were no introductions of the GB members, but their first names were used during the public questions when a member was asked to respond. (At a previous meeting in July 2015 attended in preparation for the study, but not during the period of study, I had witnessed a member of the public ask the GB to introduce themselves.) In the rural CCG, the public questions item was not included on the main agenda but there was a statement to say questions would be heard. It was only after the public questions in the rural CCG that the welcome to the meeting occurred implying the main business was about to commence.

As for the record of GB meetings, the rural CCG noted the questions at the beginning of the minutes. Both CCGs included the public questions in the minutes of the meetings and appended the questions from the public and the responses from the CCG with names included. The following extract from observation notes illustrates stage-managed proceedings imbued with mostly material entities which appeared to constrain rather than enhance. The member of the public who raised the question was offered further discussion outside of the meeting with the CCG's Head of Finance. He had also asked about lack of information regarding the integration of health and social care and was directed to the website of the local authority overseeing the process, because it was not the CCG who was taking the lead on this project. The GB meeting was in effect conveying a message of go and find out yourself as your question is not the remit of the CCG; that belongs to a different system.

*After the meeting I spoke to the member of the public who had raised the public questions..... I asked him if he had expected his answers to be handled this way. He replied yes he did. He had received a phone call from the Associate Director of Operations asking him whether he wanted the responses read out verbatim at the GB meeting. No he did not and he did not know the TV reporters would be there. I explained what I was doing there – researching. He stressed that PPI should be all about asking the patient. He didn't feel that had happened with the XXX Service. The criteria had been altered but maybe not communicated. He had just finished working for a charity for older people and knew these things because people used to phone about the criteria. He came to the meeting because the CCG is the lead CCG dealing with the XXX contract. No personal involvement. He feels strongly that you need to ask people for their views. He travelled to the meeting from a town about 16 miles away and used the train to travel.*

***[GB meeting, rural CCG, observation 12, 27/07/16]***

### **6.1.3 “They looked the same.”**

I observed GP locality meetings in the north and south of the rural CCG in conjunction with examination of the relevant documentary sources and artefacts for these meetings. I purposefully sought these meetings out as I was unable to conduct a focus group with the rural GP Leads due to time and distance constraints for the participants. The meetings took place every two months and was for GP members representing their GP practices in each locality. Practice managers usually attended as well as the Lead locality GP practice nurse. Meetings were held at lunch time so food was a central feature. In the South locality it appeared more of a shared social endeavour with the Chair and Business Manager for the GP practice bringing sandwiches and drinks to the meeting purchased earlier from the local supermarket.

At the North locality meeting there were 20 attendees including three GB members. The location was a community hospital. All attendees had to travel to the site and three GPs were late. The locality encompassed 12 GP practices. The food was provided by pharmaceutical representatives. Perhaps not uncommon except for how one representative responded to the patients present, thinking they were GPs:

*The meeting room was in use on arrival so along with the two Patient Representative Group members, the pharmaceutical representatives and a practice manager, I waited outside in the corridor. The patient representatives were both men and looked as if they could be around retirement age. The pharmaceutical representatives thought they were GPs and handed them company information. Later, before the main meeting they realised they were patient representatives and asked for their materials and business cards to be handed back. I heard one of the pharmaceutical reps whisper 'they looked the same' by which she meant the same as the GPs. The pharmaceutical reps did not want the patients to sign the register of attendance for their companies.*

**[GP North locality meeting, rural CCG, observation 15, 7/10/16]**

When the pharmaceutical representative realised the two Patient Representative Group members were patients, she was concerned about them retaining the drug information and distorting the attendance figures as they were not prescribing clinicians. After the meeting I spoke with the two Patient Representative Group members, one of whom was David (participant 6) from my focus groups. He raised the issue of having to return the materials to the pharmaceutical representatives. I sensed he was frustrated by this action. In addition, the meeting agenda had indicated a slot for 'patient group feedback' but this amounted to no more than two minutes confirming that David was the new chairperson for the North locality Patient Representative Groups. It was squeezed in before the service providers for the new musculo-skeletal service arrived to discuss their contract.

There did not appear to be any concerns about patients participating in the North locality meeting, and they were not treated in any special way by those present other than the pharmaceutical representative. It was as if the meeting would carry on regardless as a series of clinical and business discussions. The co-chairs of the meeting (the GP North locality Lead and the Practice Manager Lead North locality) commenced the meeting without introductions. New individuals or guest attendees may not have been able to differentiate who was who; a point confirmed with a new female GP sitting next to me who did not know everyone in the room. An agenda slot where the invited consultant diabetologist was explaining the new Community Diabetes Service he was leading on behalf of the service providers, contained graphic images of an infected and gangrenous diabetic foot without any warning. However, questions were invited and one of the patient representatives (David) asked the diabetologist: "Are you going to deliver?" He had been taking

notes on the different levels of the service and referred to 'lots of promises' that are not always delivered. The consultant referred him to the Key Performance Indicators (KPIs) against which the service was to be measured and highlighted the email address for further information. The patient representative noted the email address. This was a further illustration of reification (169) of performance; the KPIs being the approved tool for demonstrating if patient outcomes for the Community Diabetes Service in the CCG had been met. They formed part of the broader agenda, influenced by the Government's mandate to NHS England, and objectives set for obesity, diabetes and prevention. (231)

## **6.2 Materiality**

The conduct of GB meetings was affected by the physical spaces occupied and the work products of CCG governance. Likewise, with the locality member meetings which tended to be held over lunch periods when there would be less impact on patient consultation sessions. The following elaborates on some of the material entities that constituted leadership practices.

### **6.2.1 Physical spaces and artefacts**

The arrangement of the physical spaces for the GB meetings entailed assembling large board-room style tables in a C shape so that GB members faced out toward their audience but could still see each other and maintain eye contact for discussion. Name cards were used at both CCG GB meetings and generally were visible to the public sat in front. In the rural CCG, after the welcome, each member briefly stated their job title during the introductions. The audience may therefore not have known the role of the GB members answering earlier public questions before the main business of the meeting commenced. The urban CCG used microphones to improve audibility, but this was problematic at times with people not speaking close enough to the microphone. The public seating, given the large capacity of the venue for the urban CCG, was positioned approximately 10 metres away from the GB members. The venue was always the same; a centrally located community hub well known to the urban population and used by a variety of community groups. In the rural CCG the seats were closer giving a slightly more

intimate milieu. The venue did alter because of the geographical spread of the rural population. Civic community centres in the larger towns were selected where there was supposedly public transport links and/or car parking nearby. On one of the days I attended there were major roadworks in the town making access difficult and causing delays to travel. This may have impacted attendance as the roadworks continued over many weeks. Nearby businesses in the main street had expressed concern the reduced 'footfall' was affecting their trade.

The artefacts from the GB meetings were remarkable in terms of the volume of information released to the public one week ahead of each meeting. For example, the rural CCG released 34 papers before one meeting, and the combined papers for the second meeting attended contained 273 pages or nine megabytes of data when downloaded from the CCG website. The urban CCG was no different with around 200 pages in the GB papers collating all the ongoing work including reports from committees and work streams, and financial information contained within performance reports. Paper copies were available, but it is difficult to see how this could be assimilated and followed at the time of the meeting if the content was not familiar to the reader. Some members of the public flicked through the papers which could be taken away. Downloading the data to a personal computer or mobile device or reading online ahead of the meetings would be another option but time consuming. Printing off papers would not be practical or environmentally friendly. I chose to download the papers to a mobile device rather than read online at the time of the meetings as WiFi connections were not always available.

### **6.2.2 Reification of leading and governing processes**

GB agendas followed a set structure which addressed common features of the meetings including: declaration of interests, minutes of last meeting and matters arising, governance, quality and performance, delivery and strategy, reports and minutes from sub-committees. The rural CCG also had agenda items for the Chair and Chief Officer reports. Most of the content was for noting rather than discussion. In the rural CCG, discussion of the items to note, primarily minutes of the sub-committees, had to be arranged by request. The emphasis was on procedure to process and report the work of the CCG rather than decision-making,

a comment that was also made by one of the lay representatives with respect to locality member meetings as well, (5.2.2).

The many activities of the CCGs were captured within GB documents using a standardised template for consistency and transparency. Reporting 'patient and public engagement' on the template, the urban CCG used phrases such as:

*"Patient representatives were engaged throughout the procurement exercise and formed part of the evaluation team. They have been consulted on the service model."*

***[Reporting outcome of procurement for a community service, urban CCG]***

*"Individual risks on the risk register may impact on Patient and Public Engagement."*

***[GB Corporate Risk Report, urban CCG]***

*"Nil – however this will be a meeting held in public."*

***[Report for revision of terms of reference of a commissioning committee, urban CCG]***

In the rural CCG, the template contained similar impersonal phrases as illustrated below:

*"Not applicable."*

***[Annual CCG Report and annual audit letter, rural CCG]***

*"Individual risks may have potential impact for patient and public engagement."*

***[Quality Report, rural CCG]***

*"Information to be detailed in verbal reports where applicable."*

***[Reporting from sub-committee chairs and leads, rural CCG]***

The rural CCG revealed less detail which was also noticeable in the minutes of the GB meetings. Discussion points were not attributed to individual GB members other than when an agenda item was first introduced. Collective phrases such as "It was reported", "It was advised" and "the Governing Body discussed" were used

whereas the urban CCG used the initials of GB members to record where they had contributed to the discussion. This gave the impression of greater ownership of the activities in the urban CCG thus reinforcing the shared repertoire of the participants.

### 6.3 Competence

#### 6.3.1 Recruiting and selecting leaders

With respect to recruitment processes, the GP Leads appeared to 'play down' the roles they occupied in terms of the material aspects of selection such as a job description, application form and interview. These were absent and sometimes there was no competitive selection or formalised interview for the clinicians as can be seen in the following accounts from both CCGs. It was a case of someone having to do the job and willingness to participate based on their experience of leadership and GP clinical engagement.

*Alex: So I am the Dementia Clinical Lead for XXX CCG and that really evolved from the beginning not knowing where it was going to take me, to be perfectly honest. I was asked by Harriet, who's the Clinical Lead (Chair), to come and have a conversation. I sort of met her during a locum session that I'd done at her surgery and she said oh yeah come and have a chat..... And I said well what do you really... what do you want me to do? And she said well I just want you to go and see what's going on in this area and come back and let me know. And I said oh OK then, so I didn't know that I'd sort of got the job and I went away and I thought about it and I sent her an email and said well it sounds quite interesting, what do I have to do to apply for it. And she said no, no, you've got it...laughs... the role is yours. And I said fine OK and that was how I sort of got into it and it's grown from nothing to quite a big... well a big project really.*

**[GP Lead, rural CCG, interview 10,16/06/16]**

Lucy held two GP Lead roles, but her hours were cut back to align with the other Leads in the urban CCG working one day a week. She led on both the community services work stream and what she called environmental and social sustainability. The second work stream was about reducing the carbon footprint rather than focusing purely on saving money. The word 'sustainability' tended to be seen as addressing one of the three gaps identified for improvement in 5YFV; the financial sustainability gap.(8) She was keen that the environment and carbon production were not overlooked because of the focus on financial sustainability. Ironically,

reducing her hours in her CCG role potentially made some financial savings but her portfolio was extensive.

**Lucy:** *So I didn't apply for that in the same way and... which wasn't helpful to me in a way because it meant that I was given it ... I never had a job specification. I asked several times for an induction and I never got one. I asked several times for some sort of specification and the most I've got, from my own research is looking at other Leads' specifications and seeing.... And when I took the job, the person doing it before me was a nurse by background and she did two days a week, whereas mine was dropped to one day a week, so it was definitely a role that changed as I took it over, so that hasn't been helpful for me I have to say.*

*... Well I think austerity was probably what drove the drop in hours. And the feeling that, I think most of the other Leads are only one day a week and that was the feeling that... why did this need two days a week. I mean it is an enormous portfolio compared to some of the others, so I suppose that's why and actually what I do is... so my two roles together make a day and a half and... and I probably do two days and I don't specifically set time aside for one or the other so they are getting more out of me than the day because I try and be flexible.*

**[GP Lead, urban CCG, interview 8, 14/06/16]**

Once again time as a resource is noted and recurs across the other sets of practices as a significant material entity. However, the emphasis in this section is on competence and how the CoPs, especially the Governing Bodies and locality member meetings, determined suitability to participate in a leadership capacity. Both GB lay representatives for PPEI described completing an application form, submitting curriculum vitae (CVs), seeing a job description and being interviewed by a panel of people before the decision to appoint was made. The reification of this selection process added legitimacy and identification with the respective CoPs in the two CCGs yet both individuals had extensive track records in the field of PPEI practice.

The selection of the lay representative for PPEI in the urban CCG was particularly rigorous with two interview panels conducted on the same day. The first was with GB members and the second included voluntary sector and PPG representatives. Euan was interviewed alongside two other applicants.

**Euan:** ... so I was known within the organisation, but absolutely not connected to that, there was a recruitment process and it was stipulated that you could apply for the post but you had to be a PPG member. So that was the stipulation...

... So there was an open recruitment process. An advert went out. A number of people applied. They were shortlisted. So it was an application process. There was an interview. In fact, two interviews on the same day. One was with the Governing Body members. So that was with the chair was there, the chief nurse was there, a member of Healthwatch was there and, ...the Independent Nurse who is like a lay member XXX (first name) was also part of that interview. There was a presentation about the CCG and some of the issues it might be facing. And then eight or so questions.

And then after that, so there were three people who were shortlisted, so we went to that interview, and then after that we all three of us had to come back together and be interviewed by a patients' panel which was observed by the CCG. So there were two members of staff of the CCG who sat in the room but the panel was I think five or six people, of which I think three were PPG network members, I think the other two were voluntary sector people – Age UK and somebody else. ... there were then questions put to the three of us and you took it in turns. So I think there were three questions and each time you led on a question. Each time you were in the middle. Each time you were at the end. And then there was a discussion. So it was quite fair like that. There were discussions around the issues that they asked. .... So it was very well chaired.

**[GB Lay representative for PPEI, urban CCG, interview 1, 09/03/16]**

### **6.3.2 “No-one wants to be low in [the] ratings.”**

Activity summary sheets are tools used to authenticate various processes and outcomes associated with clinical commissioning. They are part of the knowledge management of CCGs to provide meaning and show the value of activity in its broadest sense. They can also indicate competence in terms of whether the CCG and its member GP practices are achieving activity targets. They are also another example of reification (169) within a community of practice being a product of work and learning. Wenger talks of 'local' and 'global' where reification of activities is for 'exportable interpretation' but notes content and context can get lost by giving a broad view. (169) Here 'local' could be perceived as locality level or by GP practice. This in turn informs the rural CCG GB as the local organisation. On a 'global' level the data is 'exported' to inform NHS England where it will be interpreted as part of the annual performance assessment of CCGs. (131)

The activity summary sheets for all the GP practices were shared in the locality member meetings I observed in the rural CCG. There was complete transparency in that the North and the South GP practices could see each other's activity. At the South locality meeting, the attendees had paper copies and viewed the same data on a projection screen. In the North locality, the meeting had paper copies only but there were insufficient for the number of people attending. There was no suggestion the Patient Representative Group members should hand back the reports which contained sensitive data on expenditure, non-elective hospital admissions and Accident and Emergency attendances. The GP members at both locality meetings keenly studied these artefacts. Small snatches of conversations started up at various points in the review of the activity as the members compared their GP practices. After the meeting in the North locality I mentioned this to the GP locality Lead. His reply was: *"no-one wants to be low in ratings."*

In the South locality member meeting there was discussion about how cost savings might be realised across 'clusters' of GP practices to show benefit. Clustering of GP practices was emerging during the second phase of the study when the observations were undertaken. It was a collaborative endeavour rather than individual GP businesses thinking about their own financial position. There was an acknowledgement of the lower socio-economic status of patients in the locality compared to the North locality and the pressures this might bring on expenditure. However, in a separate agenda item one of the GP members in the South locality raised that better performing GP practices may get less money and the performance statistics would not look so good. This is an illustration of where conflict of interests can occur between GP practices as businesses and the CCG wanting what is best for a locality population.

Performance data were clearly driving the leadership but one of the GP Leads in the urban CCG wanted to break away from the reification of performance embedded in KPIs. She referred to it as *"counting beans"* but what mattered to her was listening to the patient experience, the qualitative data. She wanted to use **patient reported outcomes measures (PROMS)** to assess quality of life which she considered of greater importance.

*Lucy: ... so obviously we have our key performance indicators, but again, that's something I'm trying to challenge. I'm not the only one, but working with XXX [name of female commissioner] in particular around the dementia we really want to stop using beans, counting beans and actually start using... you know there's lot's quality of life PROMS that you can use, you know, for dementia, and similarly for some of the other community services, you know, stop measuring activity and actually start measuring something much more important, so you know, from that basis the patients and service users will become much more important. You know at the moment we collect our beans and then we have a few comments from patients, but that's all, whereas with PROMS, they're going to be absolutely key to...*

*[GP Lead, urban CCG, interview 8, 14/06/16]*

## **6.4 Boundary encounters**

### **6.4.1 Meet your Governing Body**

The urban CCG GB held 'Meet your Governing Body' sessions ahead of some of the formal meetings. One of these sessions took place when five GP surgeries were threatened with closure. There were no questions on the topic. However, the GB chair did agree to take a verbal question in the public questions' section of the meeting even though submitted late. It was not related to the closure. A member of the public (male) seen on previous occasions at the meetings asked about tendering for a fund of money. The GB did not seem to be clear about what was being asked and the Finance Officer said only GPs could apply for the fund in question and not the CCG. The questioner followed up with a variation on the question four more times. The answer on each occasion was that the fund could only be accessed by GPs. Eventually, it was agreed the point would be discussed outside of the meeting. The matter was politely handled without the board being dismissive.

Asking one of the GP locality member Leads about the *Meet your Governing Body* events she described how they were forced to be compliant with the CCG constitution and statutory requirements. There were tensions between having a statutory agenda when a political agenda may be what the public want to address, for example, the illustration above about who can access funds. It was also about

who should have the voice, choice and be empowered (73) as a participant and representative and how this should be done.

**Natalie:** *We did try and extend that a couple of times. We had an extended question time starting an hour earlier, extended where people had an open mic session so they didn't have to submit a question in advance. Again it was quite forced really. It was because we had to do it. It felt like that, it really did. It felt like we can go through, there is a limited time for questions. We were doing the job constitutionally we were doing as we had been told. I know we did try and break free of that a couple of times to have that kind of open mic.*

*... We would say next time come at one and we will just do a kind of informal question and answer session rather than a formal question and answer. I mean it is difficult isn't it? Because if you have got a political agenda, it is difficult to accommodate that political agenda when you have been given a statutory agenda. It comes back to this who is deciding where the resources are going? Who has got that overview and who should have that overview? And should it be down to individual patients or individual groups with their own agendas? Or should it be again some kind of public health committee type system that allocates resources according to need?*

**[GP locality member Lead, urban CCG, interview 5, 05/04/16]**

#### 6.4.2 Provider impact

Both CCGs had been challenged by the failing performances of secondary care providers and the joint enterprise was about how to deal with this and ensure services were not jeopardised for the respective CCG populations. At the time of the study, several secondary care providers required improvement following inspections by the Care Quality Commission, or they were about to receive feedback on recent visits from the regulator. As the study progressed and I attended more meetings I began to appreciate the impact of these inspection outcomes. It had delayed some of the transformational work to integrate health and care and examine new ways of working. One of the secondary care providers had asked the urban CCG to effectively 'take the pressure off them' and look for capacity elsewhere as they dealt with their performance issues.

Clinician engagement as both a member and Lead in the CCG was evident in the locality meetings observed. In the North locality meeting of the rural CCG six members of the musculo-skeletal service provider arrived 'en force' to field questions from the GP locality members. The GPs were seeking answers

regarding aspects of care with which they were dissatisfied. The provider's main spokesperson was a GP himself with a specialist interest but there were also two extended scope practitioners, a physiotherapist, an improvement manager and a manager who took questions. The GP member taking the lead for the locality commented "*we are generalists*". "*Pathways need to be simple*". Their main concern was the patient could be sent back and forth between themselves and the provider wasting time. It was about what was reasonable in primary care and specialist tests were not the everyday domain of the GP to be able to interpret the results. He asked why send the patient back to the GP with the results? There was frustration from the CCG locality GP who talked about getting "*out of my box*" to raise these issues. Some solutions were offered on the part of the provider to facilitate and better manage patient referral and pathway progression but lack of time curtailed discussion.

#### **6.4.3 Wearing old hats**

Several of the informants referred to past roles which either enhanced what they brought to CCG discussions or caused them to reflect on why something did not work so well. Leslie was involved in the diabetes service procurement but had previously worked in the purchase of computer systems, both the hardware and software. This was not NHS employment but he was well-acquainted with specifications and their complexity. He was one of several service user representatives as the successful service provider would be providing patient care for the residents of two CCGs. He had not met the patient representatives who were from the other CCG and did not see the GP Lead during the procurement process. Asking him about his experience of the process he confirmed there was plenty of reading as four tenders had been received but he was critical of the CCG's competence. He thought the CCG had probably not encountered such a large contract before and did not have adequate IT support. He was acutely aware of the interface between IT systems and importance of patient data security. He said he "*... really left the patient's voice and was helping the office ...*"

I probed him about the challenges of this experience until he reminded me that he had signed a non-disclosure agreement. However, he had given me enough

insight to realise that this boundary encounter caused him to take on more of a leadership role than he had anticipated, including altering the draft contract.

**Leslie:** Well “shall” is a mandatory thing and “will” is a future item and the original document they gave me, this is just one trivial facet of it, was very, very weak and it was my experience that any aggressive contractor could have driven coach and horses through that and it was so weak as to be dangerous.

**DH:** And ... did you give that in the form of verbal feedback at the meetings?

**Leslie:** No, I altered the drafts.

**DH:** And how... how was that received by the other members in the group, when you contributed that expertise?

**Leslie:** Well at first they were quite surprised, because it... that is a little example, but there were many others and... but perhaps it's because it's relating to mandatory items in a contract, you have to be niggly if you like, and they came to... very quickly came to see the danger of not taking that quite seriously... the wording.

**DH:** Were you surprised, looking at the documentation, that it wasn't tighter?

**Leslie:** Surprised is one word... horrified really, because having dealt over a number of years with much bigger contracts than that, and having seen industry, they... and worked in industry, they will take advantage of a weakness in that.

**[SU representative for diabetes service procurement, rural CCG, interview  
12, 01/09/16]**

Several of the GP Leads also spoke of other employment experiences, either before studying medicine or when taking a career break. They highlighted the emphases on presenting a NHS process but not always seeing this through to completion to get services up and running. Alex said that it could mean losing your job in her former world echoing what David had said about his leadership experience in industry, (see **8.3.1**).

**Alex:** ... in the NHS I've found that people are really good at talking about things and really good at writing things on a piece of paper and presenting them. However, they don't always close the cycle and actually get the services up and running. Now if I had my old XXX's hat on ... if I didn't get something done and we didn't win a deal or... we didn't get done what we were being paid to do or that worked for the team, we'd just lose our jobs, it's a completely different understanding... and that's my background,

**[Rural CCG, GP Lead - 16/06/16]**

## 6.5 Meanings

### 6.5.1 Role descriptors and status

Early in the study during the first focus group, my attention was drawn to the status of a service user especially when there was a formal role definition and recruitment process. One of the service user representatives (Elizabeth) referred to this as something that made a difference when Eddie became the PPG network representative. It was as if he had almost become an employee consistent with ideas of being and feeling valued and able to demonstrate a track record.

**Elizabeth:** ... sometimes things I am involved with I have come to by accident basically. Somebody knew me and invited me along. That is how it has come about apart from the Healthwatch. I have had an interview for the Healthwatch role that I do. But I just wonder if that's the difference because it is almost as if you are more important, no that is not the right word....

**DH:** Is it about status?

**Elizabeth:** Official. Status, yes. More official. Because you have officially.... not employed but been employed if you know what I mean.

**[Urban CCG, focus group 1, 6/11/15]**

To further illustrate, Daniel who was also part of the first focus group, brought along the advertisement for his lay representative role on the Independent Funding Request panel (IFR). An IFR panel discusses funding requests for procedures and treatments that are outside the normal CCG funding cycle. The case must be made for the funding on a named patient basis although the name of the patient is not known to the panel. Daniel had retained the advertisement from the local newspaper and expounded the skills required to the focus group. Prior to that, in a telephone briefing for the study, he informed me he was a retired headmaster and had been a lay member for the Royal College of Physicians and involved with NHS complaints procedures. He shared this 15-year background with the focus group reiterating his status and track record.

**Daniel:** .... I am on two national bodies at the Royal College of Physicians and I worked for the PMETB for three years – the post graduate medical training board. So like a 15 year period this was my background.

**[Urban CCG, focus group 1, 6/11/15]]**

Service users and lay representatives had experiences or histories of engagement and leadership relevant to their current roles. Some of the service user representatives drew attention to their lack of status and recognition, a point well-illustrated in the rural CCG focus group by Hazel when comparing patient representatives to the lay representatives on the GB, for example, the nurse representative. They brought a wealth of expertise valued by their peers on the GB. Hazel, who chaired the PPGs in the North locality, said it was as if patients (service users) were only seen as “*generic*” and were not considered for the skills and expertise they brought from their daily lives.

The rural CCG focus group participants were from the more affluent of the two CCG localities. Some had held professional roles in their working lives with leadership responsibilities prior to retirement. Hazel spoke about her PPG and how the patients set the agenda. GP practice staff could attend if they wished as they had skills the patients could use! She was trying to encourage diversity in the group. There had been a representative from the youth service who attended a couple of times. More recently a young woman who was taking her AS levels and wanted a career in medicine had come along to the group. Hazel had led a PPG project to gauge young peoples’ attitudes on sexual health. They had carried out other surveys, but she could not recall if the findings had been presented elsewhere in the locality or CCG other than in her GP practice. Time and effort had gone into these initiatives, but it appeared the information was not seen as contributing to commissioning decisions. This may reflect the status of the PPG and how it was perceived by the CCG.

**Hazel:** *We always have a practice manager there and we have very often a GP there. We set the agenda. At the beginning they were setting the agenda and I stopped that. (Laughs.) If they are going to have a patient group they are going to have one who decides its own agenda. They are very welcome to come along. They are very welcome participants because they bring skills that we need but you know it is our meeting. The committee of our practice is quite large now – it is about 10 or 12 people who meet on ....*

**DH:** *So having set the agenda, you said that's what you told the practice you wanted to do, are they things that affect the practice?*

**Hazel:** *... They encourage us, they can't insist, they encourage us to do some survey work on them on a fairly regular basis. So we have done a survey about young peoples' sexual needs. And we got the local community college to do that. They did it themselves and set up a survey of what young patients needed. And then we fed that back to the practice. And we talked about that and that has influenced some of the things they are doing. We have recently done one on maternity and mothers and babies and whether they are getting enough support. Particularly whether there is enough support for women after pregnancy. So that's the second one. We do ones on quality every now and then like how often are the telephones answered? That has led to a lot more people going on the telephones.*

**[Service user representative, focus group 3, rural CCG, 27/06/16]**

Patient representation was not evident at the rural CCG South locality meeting on the day I attended. The Patient Representative Group member had been seriously ill, and another deputising representative was unable to attend. There was an agenda item for 'Patient Stories' which seemed to be for feedback on particular issues and the learning that had occurred from the episodes. There was no specific patient story on the day that I attended. Accounts were not directly spoken by the patient but appeared to be mediated by a member of staff from the GP practices – the practice managers. This seems tokenistic but as examples were not available it is difficult to comment other than representation did not seem to be well-defined with respect to its purpose at the meeting observed. The GP locality Lead described the patient representative as a "*helpful contributor*". Maguire and Britten (129) in their discussion on representation differentiate between 'acting for' and 'standing for'. It would be difficult to categorise the Patient Stories other than an 'imaginative act' and putting yourself in someone's shoes and presenting a case but it would still have been mediated or filtered by a practice manager.

The Primary Care Transformation Board in the urban CCG had a remit to bring together stakeholders for the changing commissioning interface. Work streams

addressed included co-commissioning, workforce, collaboration of GP practices and locally commissioned services. The board was chaired by the lay representative for governance (Edward) and held at the urban CCG headquarters. Examining the terms of reference, the membership comprised 23 mostly senior staff from the CCG, nine of whom were GB members. The local Healthwatch were part of the membership with their position described as 'patient representative'. This formal mechanism for CCG accountability was therefore seen as the 'public' contribution.

At the meeting the chair adeptly steered his way through a 13-item agenda to finish on time after one hour. Each agenda item had a set time (in minutes) allocated to the topic. There were 17 people sat around the board room style table with three others set back a little as there was insufficient space at the table, including myself as a non-participant observer. There were three GB members on the day I observed including the chair. Participants were generally engaged and attentive throughout the meeting which moved at pace. Pressures were apparent on work streams due to several factors; tight deadlines to use NHS England money for capital projects such as premises, a private contractor withdrawing as provider of some GP practices which could mean closures and/or amalgamations, and the trajectory towards the federation of GP practice. There was camaraderie and laughter but also a lot of jargon was used.

At one point, the patient representative remarked on proceedings relating to a business case and challenged the costs as well as commenting there was no service user feedback. The person presenting the business case, who was sitting next to me, said in an aside that she did not know service user involvement was required. Surprised at the confidence of the patient representative, I spoke with him after the meeting. He had extensive NHS experience (16 years) having previously been a chief executive of two NHS Trusts and led a GP fund-holding practice. He was not perturbed with the use of acronyms and the business jargon and felt he knew more than others in the room. As the Healthwatch representative he was fulfilling the 'accountable representation' conceptualisation described by Maguire and Britten (129) within the 'acting for' type. His contributions had not

gone unnoticed by one of the GP local member Leads who described him as “*fantastic*”. He had no difficulty in holding his ground and fulfilling his status as the patient representative to provide the ‘public contribution’.

**Natalie:** *Some people are fantastic. You get some members of Healthwatch who are fantastic. We had a great chap ...*  
**[GP locality member Lead, urban CCG, interview 5, 05/04/16]**

### 6.5.2 Sense of community

There were times when informants showed they were prepared to take risks and move “*out of [their] comfort zones*”, but there was also the “*humanity and belonging*” and “*sense of community*” reported in my initial analysis from the focus group data, (Table 4.10). Participants wanted to make things work with the new clinical commissioning arrangements and so sometimes it was a case of a project or venture being “*less successful*” rather than described as failing. It takes time, energy and persistence to lead and take people with you whether that is your fellow GP clinicians or the wider community and its public and service user representatives.

Whilst analysing the data for the set of leadership practices I was cognisant of the Leadership-As-Practice (L-A-P) movement described in chapter 3 focusing on shared learning and lived experience. The philosophy of co-development in a community where people discover and ‘unfold within themselves’ was evident as leaders found meaning in the events they described. The following extracts illustrate the scanning, signalling, weaving and stabilising activities highlighted by Raelin. (185) In addition, the affective activities (social entities) of collaborative agency such as inviting, unleashing and reflecting with self and others which sustain a team or CoP and illustrate leadership-as-practice. (185)

Noticeable is the use of “we” as collective ownership and there being no F word (failure) but something “*less successful*”. The Clinical Chair of the rural CCG described how she mobilised and catalysed others (signalling) and created interactions across new and established networks (weaving) so that there was a

sense of shared meaning and increasing trust. (185) There was engagement and imagination too which are described as modes of identification within CoPs. (172) She was inviting everyone to participate no matter what their allegiance or alignment. (185)

**Harriet:** *We had a XXX million deficit and this area has never had financial balance before. So it wasn't looking good. We had the SHA telling us we lacked capacity and capability, which at the time we probably did because we, you know, had never done it before. But actually we were so motivated to do it, and we had a lot of early meeting with our local GPs and actually with our patients, and we were out there, we were at the XXX Town Hall annual general meeting. We were up at the Council meeting all our councillors, we were meeting our local Trusts, we were meeting our Mental Health trusts, we were meeting everyone basically and building those relationships which I think are crucial to the whole thing. That's the only way you can change culture, is by actually getting people to come along with you.*

*... NHS XXX then gave us a manager, and to start with we were saying ah we're not having him, because they just want to control us and... but then we realised that he was all about engaging with people and building those relationships and that he was actually himself taking quite a risk because he didn't know if this was going to work or not. He'd never worked at the Chief Officer level before, so for him it was a risk as well.*

*But we then recruited a management team who share our kind of... we all share this similar let's just get the vision done, you know, we've got to do this, we've got to make things better for patients. So the management team are a very talented, but innovative bunch who again are prepared to take risks, working outside their box. You know, we don't use the F word here, there's no such thing as a failure, it's something that's been less successful.*

**[Clinical Chair, rural CCG, interview 7, 03/06/16]**

Harriet was also identifying resources that could contribute to new ways of working and help make sense (scanning) (185) of the new NHS CCG landscape. She was 'unleashing' (185) by encouraging those who had perhaps been reticent in the past to participate and bring new ideas without fear of repercussion.

**Harriet:** ... to start with there was me and a practice manager and that was it. I had no previous commissioning experience at all. And a very... a lack of engagement by the GPs understandably because they said well the PCT never did anything for us, you know, and they were completely cynical and completely switched off. So I managed to get them to come to a King's Fund thing with me about the changes and the 2012 Bill and to start with they were saying why are you here and they just said 'oh because Harriet told us we had to come' (laughs). But by the end they were like wow, there are some real opportunities here, and in our patch we've got XXX community hospitals and they really were underused and so there was massive opportunity to grow those and actually make them the central community hubs and bring as much out to the community as we possibly could.

**[Clinical Chair, rural CCG, interview 7, 03/06/16]**

In the urban CCG, the Accountable Officer (Alison) who was also a GP, engaged and identified with different facets of CCG business at various levels of the organisation through her knowledgeability. She did not always need to be the subject expert. She too was indicating signalling and weaving activities in response to my question about patient and public involvement on work streams, either locally or NHS England directed. Her reference to Sustainability and Transformation Plan predates the change of term from plan to 'partnerships'.

**Alison:** So I do do quite a lot of the sort of public facing engagement, so obviously I'm on the Governing Body.... we obviously have public questions, but we also do have more informal Governing Body sessions on particular topics. We usually take commissioners with us and clinical leads with us, but if it's something a little bit more high level, like the Sustainability and Transformation Plan or something like that, then XXX (Chair of CCG) and I will tend to front that and Zayef [GP Lead for engagement and clinical leadership] \* perhaps as the sort of Governing Body clinical people.

On quite a lot of the engagement events I would be there for at least part of those events to introduce the topic even if I wasn't like being the subject expert, I'd be there sort of talking to people, whether that's with the third sector, with other partners or with the public directly. I certainly have been to talk with the facilitators of the work that we do with our more difficult to engage with, or hard to reach groups, so I haven't talked to those groups directly since I stopped being a clinical lead, although I encourage the clinical leads to do that, but I have talked with the third sector organisations that sort of try and move that for us. So yeah, quite sort of... quite involved really.

**[Accountable Officer & Chief Clinical Officer, urban CCG, interview 9, 15/06/16]**

\*Not real job title

One of the GP clinicians reflected on initiating the dementia work stream where she had taken the lead on inviting stakeholders to participate and provide

feedback; the unleashing which Raelin describes but also the weaving and signalling activities. (185)

**Alex:** *Yes, so the engagement aspect came before the pilot was even put together. What I had to do was I had to engage with all the different local people in terms of patients and their carers, in terms of GP practices, in terms of the secondary care group. There are lots of voluntary organisations that have an interest in older age and in dementia, there are lots of carers associations, and each one of those groups, and things like the dementia advisors... each one of those groups comes with their own agenda and comes with their own... a complexity in terms of their understanding of where they fit into the bigger picture. Sometimes they don't have any understanding of that at all. And my job really was to go and meet those people individually and then try and bring them together as a group.*

**[GP Lead, rural CCG, interview 10,16/06/16]**

Other illustrations have been used elsewhere in the findings, for example, David setting up the PPG meeting (7.3.1), and Euan changing the PPEI assurance with the creation of the Communications and Engagement Committee (7.4.2). Both wanted to create a more cohesive sense of community.

## **6.6 Concluding comments**

Having explored the socio-material entities of leadership practices in this chapter by applying the analytical framework to the three data categories, the next step is to look at how social learning takes place. Chapter 7 focuses attention on learning practices and how they are manifested or enacted in the domain of PPEI for clinical commissioning.

## Chapter 7: Socio-material practices of learning

This chapter focuses on situated learning for both partnership working and clinical engagement for leading and commissioning health and care services. It includes 'learning as an organisation' about PPEI in partnership working as well as learning to take on leadership roles and be clinically engaged. The intention is to convey what the learning comprised; the how, what, when and by whom.

The table below replicates **Table 4.16** from the data analysis section in **4.13.5**. It lists the themes identified for learning practices. The themes were extracted by applying the analytical framework to the two data categories *development support* and *roles*. Eleven codes were assigned to *development support* which included acquiring new skills, learning by doing and training for committee roles as well as more formalised learning processes. There were 15 codes for *roles* combining *role in CCG* and *role as a GP*. The category encompassed aspects such as undertaking additional roles, past roles, recruitment to and understanding the role. The subsequent sections of this chapter present and explain the themes.

### Themes for learning practices

PARTICIPATION	MATERIALITY	COMPETENCE
<ul style="list-style-type: none"> <li>• Conforming to the model</li> <li>• Wearing lots of hats</li> </ul>	<ul style="list-style-type: none"> <li>• Formalised learning processes</li> <li>• Not enough time</li> <li>• Defined service user roles</li> </ul>	<ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Role tensions</li> <li>• Sniffing out talent</li> </ul>
BOUNDARY ENCOUNTERS		MEANINGS
<ul style="list-style-type: none"> <li>• Enablers to:               <ul style="list-style-type: none"> <li>- Communicate the message</li> <li>- Push you along</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Wanting to make things better</li> <li>• Sense of pride</li> </ul>

## 7.1 Participation

### 7.1.1 Conforming to the model

Learning to participate often manifested in reporting how new groups and partnerships were functioning within the clinical commissioning landscape. In both CCGs there were references to CoPs as a form of engagement and preferred way of working aligned to good practice. The rural CCG was endeavouring to embrace CoPs within all its work practices and work streams. In addition, CoPs were being adopted at the time of the research by some of the provider organisations as well as the broader NHS. The following extract from the minutes disseminated to all the PPG representatives in the two localities of the rural CCG illustrates by example. It includes an explanation by the adult community services provider invited to the joint locality patient representatives group meeting. The meeting of both localities was described as “*very rare*” by Leslie, a service user representative and chairperson of one of the PPGs. He said meetings were usually called for “*a special task*”. The minutes were written by the secretary of one of the locality patient representative groups. There is a reference to the contemporary movement ‘What matters to you?’ originating from the 2012 paper on shared-decision making (232) and an explanation of what this would mean for patient care.

*XXX explained the Communities of Practice model, emphasising the care is around establishing “what matters to you” rather than “what is the matter with you”. They aimed to provide greater links between services available; a stronger multi-disciplinary team; fewer barriers; more sharing assessments and personalising patient treatment.*

***[Minute extract, joint locality patient representative group meeting, rural CCG, observation 11 artefact, 26/05/16]***

Similarly, at locality member meetings, CoPs featured in discussions with clinical GP Leads referring to the model as a way of working. It was evident too in annual reports available from the CCG web sites and GB meetings. More so in the rural CCG where it was further established and structured in nature. It was as if CoPs were a panacea for partnership working but there was limited evidence of the

patient or service user being included on an equal basis. It was something the professionals or multi-disciplinary teams were learning to do to manage their work load.

*... the CCG Lead for urgent and emergency care spoke about CCG plans for MIAMI – minor injuries and acute medicine..... He explained the nature of the multi-agency hub and that it would address extended hours. It would be co-located with the Out of Hours service. The present capacity in the GP workforce would make it difficult for GPs to rotate in. He queried whether it might offer ‘same day service’. A ‘community of practice’ would be established. The Patient Participation Friends were mentioned plus the Community Transport bus which the CCG had organised for rural patients who found it difficult to get to appointments, admissions, etc.*

***[GP South locality meeting, rural CCG, observation 14, 3/09/16]***

*Deliver services for local people through communities of practice which would see clusters of GP practices supported by a range of professionals, including district nurses, therapists and mental health and social care practitioners.*

***[Annual Report Summary 2014/15, rural CCG web site, artefact No. 6]***

*The South Locality chair referred to public engagement and the Communities of Practice event that had taken place with the new community services provider.*

***[GB meeting, rural CCG, observation 12, 27/07/16]***

During the field work for the research, draft Sustainability and Transformation Plans were being compiled and submitted to NHS England. The timescale was tight as the new STP footprints were announced in December 2015 for the financial year 2015/16. (28) Some of the discussions at CCG meetings concerned how this might impact public engagement, especially when further guidance was issued from NHS England on place-based care and CCG alliances. There was new terminology “*hot off the press*” to learn, apply and align with central requirements, that is, NHS England. It affected how the CCGs participated and understood the new landscape. The secondary care physician in the rural CCG was concerned it might compound or “*trip us up*” in pursuing the CCG’s objectives. The STP plan needed to move into the public domain for feedback illustrating again the influence of NHS England over the CCGs.

### 7.1.2 Wearing lots of hats

Lay representatives and service user representatives often had several roles to fulfil. Roles entailed attendance at a number of CCG meetings in keeping with organisational and legislative requirements, for example, the two lay member roles for governance and assurance which are integral to the constitution of a CCG. (144) Euan co-chaired the Patient Participation Group Network meeting and the Communication and Engagement Committee (pseudonym) for the GB in his capacity as lay representative for PPEI in the urban CCG. He was also required to attend the CCG's Audit Committee, Remuneration and Nominations Committee and was deputy chair of the Quality Assurance Committee. In addition, he was an active member of the PPG where he was registered as a patient with a GP practice. The lay representative for governance (Edward) in the urban CCG, was deputy chair of the GB and occupied other roles as chair of the Audit Committee, Primary Care Transformation Board, Remuneration and Nominations Committee, Performance and Governance Committee. He was also one of the five members of the CCG GB on the local authority Health and Wellbeing Board and made a point of attending the GP locality member meetings. Asking Edward how many hours he worked for the CCG he told me he never counted them but was contracted to work one day a week. The roles he was undertaking and the meetings he attended far exceeded his contractual hours.

The picture was similar for the GP Leads as they juggled roles and responsibilities. Alex had taken on the GP Lead for dementia in the rural CCG. She had turned down an additional Lead role for mental health as she considered the workload would be excessive. Alex described it as having a split personality as well as a working week. She was a locum for some sessions and a salaried GP at other sessions. She had to put her work with the judiciary on hold because her role as a GP Lead had been all consuming. Similarly, Heather held several roles related to the GB in the same organisation. She too was continuing to practise as a GP and see patients.

**Heather:** My title for the record is Chief of Clinical Quality and Performance so really I am involved in looking at the quality of the services our patients receive. So part of my role is attending the quality reference groups at the hospitals which looks at their waiting lists, and their infection rates, and their serious incidents. Say for XXX [name of urban area] A&E times, CQC reports and looking at it from a quality point of view. So that is the main part of the role. I am also the Safeguarding Lead so if there's any issues with adult or children safeguarding that comes through to me as an executive member of the Board. And I am also the Caldicott Guardian.

**DH:** ... so quite a number of roles there.

**Heather:** I have also been involved (laughs) with the Community Services re-procurement. **[GB Lead for Quality, rural CCG, interview 6, 1/06/16]**

There were other illustrations across both CCGs. The absence of a clear definition of work role was noticeable among the clinicians. Sometimes this was due to reconfiguration in the CCGs and new GPs taking up leadership roles. At the time of data collection, three years had elapsed since CCG authorisation under the HASCA and some GB members and GP Leads were considering whether to pursue another three-year term of office. Hiten, a GP locality member Lead in the urban CCG, had been in post for less than six months, his predecessor having moved on to pursue another project within the CCG. He had not received a formal handover but had sought advice from another experienced GP locality member Lead (Natalie) in the same CCG. He was still adjusting to the role and learning what that entailed with regards to committees and meetings he was expected to attend. He described the role descriptor as being "very loose".

**Hiten:** It is very loose. It is about engagement, communication and sitting on the Governing Body. But which committees exactly that I was expected to sit on was not on the job description. I think it is still unclear. .... QAC which is Quality and Compliance. I sit on the .... let me have a look in my diary. I am on the Clinical Strategy Group. If I look at my web-based storage – that's the other thing I find it difficult to remember what the acronyms are. So there is Locality Member Group, there's Performance and Governance, there is Primary Care Transformation, there's Quality and Compliance, and the Governing Body and Clinical Strategy Group.

**DH:** When you were looking at this role what did you think it would entail? Just Governing Body?

**Hiten:** Governing Body and LMG (locality member group) really. It wasn't clear that it had all these other things there.

**[GP locality member Lead, urban CCG, interview 2, 15/03/16]**

Hiten, used the phrase “checks and balances” several times with reference to his role in the CCG. He saw himself as principally a conduit for information flowing between the locality member GP practices and the GB. Patient engagement was something that happened via other mechanisms within the locality.

**Hiten:** *It is still a role that I am coming to terms with in terms of what that means. So it is to provide oversight of the Governing Body’s decisions. Again checks and balances. Again to represent the XXX locality here but as well as to represent XXX locality’s practices I guess we are also representing XXX locality’s patients as well. That bit the patient engagement through the locality leads doesn’t really... I don’t think it really works that well. ... Those views are probably fed through the Patient Representative Groups. I very much represent the practices directly and actually indirectly the practices and even more indirectly the patients. So it is reliant a great deal on my integrity to represent the views of others.*

**[GP locality member Lead, urban CCG, interview 2, 15/03/16]**

## 7.2 Materiality

### 7.2.1 Formalised learning processes

Formal learning as evidence of material entities for learning practices were present in both CCGs and took various formats. Harriet, the clinical chair for the rural CCG, remarked that everyone on the GB had done development. She had been on NHS Leadership Academy courses and media training. The GB members had since asked for presentation and media skills training. She took pride in ensuring she conducted their appraisals. In addition, she considered 360 degree reviews a worthwhile investment. Each GP clinical Lead also had a sponsor on the GB and was perceived as an investment for the future.

**Harriet:** *...what I’m doing this year is doing 360s for all the Board [GB] and the clinical leads and that is quite a big financial investment, but I think it’s really helpful because they’re the next generation and I’ve got two of my GPs going, doing... one of these, they’re doing aspiring Chief Exec/Chair things with... I think it’s with the NHS Leadership Foundation, I can’t remember. And I do appraisals with all the Governing Body and each clinical lead has got a sponsor on the Governing Body.*

**[Clinical Chair, rural CCG, interview 7, 3/01/16]**

Alex had attended a leadership programme run by the medical school and a course on dementia to help her with the learning for her GP Lead role. Both were beneficial especially being able to converse with other clinical leads including from

other CCGs. It helped her to think differently about her work stream, how to engage with peers and partners to transform the project. She had found it difficult to engage GP colleagues at a local level even though dementia was high profile at national level.

**Alex:** *And at the same time all this was going on, I was doing some... a leadership programme at the CCG and also I was involved in the Dementia Fellowship, which was really helpful, really helpful, not only in terms of bringing me up to speed with new developments in dementia, because I had the training from medical school, but also setting up that group, you know this peer group which is great, and also some of the speakers that came in who had been involved in other transformation projects, came in and it... the penny dropped that you couldn't just tinker, if you were going to do it, it was going to be a bigger... a bigger thing. Because I had different ideas on pieces of paper about how we could move things around and... it wasn't really coming together, but it was this idea... it was from the Fellowship that you... you could change it and save money and actually, by spending the money and not giving a good service was just a waste of money anyway, let alone a waste of patient involvement and not getting good patient care, it was all of those things, but I don't think I'd really put it into my mind how big it could be and I didn't ever plan it to be that big but... so that's how all that came together. So engagement was fundamental.*

*...I found that really beneficial and I also found that was a really good environment to get to know the other clinical leads, and where... what they were doing and what they were scoping and...*

**[GP Lead, rural CCG, interview 10, 16/06/16]**

In the urban CCG there was less mention of leadership programmes for the clinicians although Hiten spoke of coaching he was going to have for his role and a series of inductions he had attended. He was also pleased to have “*bagged a chance to get onto a clinical leadership course which was interesting*”. He was referring to a Masters degree programme at the medical school. Euan, the lay representative for PPEI, had been coached for his role by an external facilitator paid for by the CCG. He had also undergone some training on conflicts of interest which centred on CCGs being able to co-commission primary medical care services from April 2016. His counterpart lay representative for governance in the urban CCG (Edward) spoke of a 360 degree review he had undergone alongside his other non-executive lay representatives. He had found the process “*quite powerful*” and approached 10 or 11 reviewers including the local Healthwatch and

a representative from the urban local authority. He had also been appraised on a yearly basis.

Some service user and public representatives in the urban CCG had undergone a formal training programme specifically on clinical commissioning. The CCG had contracted a local engagement training provider to run a course over seven or eight weeks for representatives involved in some of the work streams. One of the GP Leads in focus group 2 was surprised when he encountered a patient at his own PPG who had undertaken the course. The patient he was referring to was also a local councillor and so understood the commissioning landscape. He acknowledged:

**Simon:** "... a lot of the patients know quite a lot and they are actually very motivated some of them to get quite heavily involved."

**[GP Leads, focus group 2, urban CCG, 7/01/16]**

By contrast, Nigel the PPEI Lay representative in the rural CCG, whilst he had personally undertaken a lot of development as a GB member, spoke of limited resources for the service user representatives. Much of the training for the roles was done by providing information.

**Nigel:** We didn't... we had meetings where we effectively were doing training by giving information, but we didn't give training in terms of this is how you... you must act at a meeting with GPs or whatever. No we didn't. Um... frankly we didn't have the resource. We were... we were really... we've done all this on very thin resources actually, so it's been a question largely of... you've also got... it's hard to get patients to engage, that's the other thing that needs to be said.

**[PPEI Lay representative, rural CCG, interview 13, 8/11/16]**

The GB Lead for Quality in the same CCG referred to some formalised training that service user representatives had undergone to learn about procurement. She described it as quite complicated to learn all the rules and regulations in a half day.

**Heather:** ... I think it was half a day or something. It was quite a complicated - I don't understand it completely... all the rules and regulations you have to hit. You know, it is not like going out and buying a new car. You have got actually to be fair and transparent. You have got to give .... and then you have all the stages you have got to go through.

**[GB Lead for Quality, rural CCG, interview 6, 1/06/16]**

The content for the half day was elaborated by one of the commissioning support managers in an earlier encounter. She explained it was an introduction to procurement alongside how to evaluate. The session was facilitated by one of the CCG's procurement specialists. The CCG had also offered an introduction to community services to the patient representatives. The community services contract was to be awarded by competitive dialogue<sup>1</sup>. The service users and clinicians needed to understand the process but were briefed separately from the GP Leads.

Both CCGs had other learning opportunities that embraced the wider CCG community. The rural CCG held Protected Learning Events also known as 'practice learning time'. Similarly, in the urban CCG informants described the training seminars for the GB held every other month in between the formal GB meetings in public. Edward, the governance Lay representative, described them as informal and non decision-making whether "*being trained about things or we are debating things that we need to debate.*"

### 7.2.2 Not enough time

**Ellie:** ... But actually, one of the challenges is time. It's capacity. I don't know if that comes into this specifically. Most people [GP Leads] are doing one day a week. How quickly can you learn a role? ....

**[GP Leads, focus group 2, urban CCG, 7/01/16]**

Time as a material entity or resource was mentioned on numerous occasions by informants across all data collection methods in both CCGs. Service user representatives and GP Leads all felt they had insufficient time for the tasks and roles they were required to carry out. Leslie, the lay representative for the diabetes service procurement in the rural CCG, spoke of weekly meetings and a lot of background reading. Hilary, part of the third focus group, remarking on her experience with the community services procurement, referred to having to skim other parts of the contract if they were not relevant due to lack of time. However, she received good advice from a commissioning support manager who assisted

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<sup>1</sup> The process that allows the contracting authority to discuss different options with bidders with a view to identifying the best solution(s) to meet its needs, on which it then invites final tenders.

<https://www.procurementportal.com/glossary/#C>

her and her fellow service user with managing the information. The “Officers” in the extract below refers to the commissioning support manager and Director of Strategy in the CCG.

**Hilary:** *Time was the element that really controlled what we could do, as there was hours of reading for each submission and then interviews and presentations to attend. There were several steps in the contracting process to reduce it to the final contender. At each level we were able to offer our thoughts and ideas and we were given equal opportunity to question the candidates alongside everyone else. There were representatives of all the services involved as well as the Officers at each level.*

*... Yes, we were warned. It was pretty intensive as it all had to be completed in a short time frame. We both agreed it was too much reading to do more than skim the other parts of the contract that we were not directly commenting on, unless we had a particular interest in something. XXX [Commissioning Support Manager] was exceptionally organised about giving us good guidance and support so that we could complete our work in time.*

**[Service user representative, focus group 3, rural CCG, 13/11/16]**

Hazel, also in the third focus group, was precise about her role and the time commitment required as a service user. She conceded she could not fulfil the commitment but was not prepared to relinquish responsibility for ensuring contract outcomes were achieved. She opted instead to take on a role in a group that met less frequently so that she could stay in touch.

When asking Hiten how he felt about his various commitments, he commented on the time required for reading and attending to CCG emails. This occupied another three hours or so on top of his allocated one day a week to the urban CCG as a GP locality member Lead; “*So considering I am contracted 9 to 5, I am already doing 40% more.*” It might mean saying no to something new, but he hoped technology would improve access to information sent in electronic format. He had been frustrated by some of the web-based storage which entailed moving documents from one place to another which he considered was not good use of his time.

The lack of time for various organisational requirements associated with the CCG clinical leadership roles had brought about changes in the way the GP clinical Leads functioned to retain their sense of identity and engagement.

- Three of the nine GB GP Leads interviewed had given up their GP partnerships, reduced their clinical hours as a GP and chosen to work elsewhere in either another GP practice as a salaried GP or as a locum.
  - Two were working as locums and one as a salaried GP. One of the locum GPs was also working as a salaried GP.
- Four had retained their GP principal roles, including the Clinical Chair for the rural CCG, but had reduced their number of GP consultation sessions.

Salaried GP roles are not unusual now in 2018 given the pressures on GP recruitment and retention (68) and the move to GP Federations. At the time of the interviews, participants were describing working practices that had developed over the previous three years since CCG authorisation. There were tensions relating to their identity, what Wenger originally called modes of belonging (169), and role requirements.

**Alison:** Yes so I was wrongly sold the role as something you could do three days a week. Ha ha – I laugh at the very concept. So I thought I could... and accepted the role knowing I could stay two days a week in practice, I was doing four sessions. I quickly became clear that wasn't tenable, so I've been doing two sessions in clinical practice which I do on a Monday, which is our busiest day in General Practice so I still see lots of patients, so I still see, you know, probably, have contact with between 60 patients, you know, 50/60 patients a week so... which keeps my feet on the ground.

**DH:** And that was in your old practice...?

**Alison:** No, I changed practice because becoming more part time is very difficult when you've got patients who are used to you more full time, and I just felt it was better to move to a different practice. And actually I changed then... when I went down to one day a week, the practice actually didn't like that, so I actually moved again in order to do that, not because... out of my choice, but because the practice really wanted someone for more sessions.

**[Accountable Officer and Chief Clinical Officer, urban CCG, interview 15/06/16]**

### 7.2.3 Defined service user roles

The two CCGs had established strategies for public engagement and PPEI for clinical commissioning. There were lead appointments to implement and work with PPEI strategy although the rural CCG shared this post with two other CCGs at the commencement of the study. The rural CCG appointed its own Engagement Officer

half way through the research study.

A striking feature of learning how to engage for PPEI and partnership working in the rural CCG was the service user roles and how people were recruited. During the interview with Harriet, the Clinical Chair of the rural CCG, we discussed what seemed to be well-defined roles for service users and the public within the CoPs. I wanted to know how the roles had come about and how they had learnt as a CCG to deliver this 'bottom-up' approach to participation and whether it was a model that permeated their PPEI agenda. Below she explains in detail how she envisages PPEI at every level throughout the CCG because there are "*different types of patients.*"

**Harriet:** ... I think it's always been bottom up, it's about really looking at what is the problem we've got here and who are the best people to find the solutions. So we'll have patients on every level through, so you've got the patient participation groups in the individual practices that we quite often call on. Then we've got the locality patient reference groups, then we've got our Governing Body lay representative for PPI ... and they're all sort of coordinated by the communications team and then, for instance, with XXX (GP Lead) when she was doing the Community Services, and XXX who's the senior manager, they decided what, you know, which type of patient we needed on which group. Because there are different types of patients. You've got the good citizen patients that are coming along for the greater good that want to make things better for everybody, and then you've sort of got the experiential patients who are here because they've had a disease and they've either been very happy or very unhappy with the way it's gone. So they're sort of bringing their own personal experience, but they can't... sometimes can't necessarily do the strategic... so if you're on a strategy group, say for Community Services, you need your good citizen patient who can think strategically, but if you want someone to bang the drum for, you know, this is my experience, and this didn't work or this was brilliant, you need a very different sort of person.

**[Clinical Chair, rural CCG, interview 7, 3/06/16]**

The geography of the rural CCG and the higher socio-economic status of the population living in the North locality seemed to generate active PPGs. They were keen to stay in touch across the GP practices and be part of the PPEI agenda. This was done via the locality patient reference groups to which Harriet referred. Hazel, the chair of the North locality groups, spoke of the PPGs as "*very highly involved*" in "*strong practices*".

In addition to the PPGs engaging with their CCG locality business, the defined service user roles were observed in the community services procurement. The community services CoP was one of the first in the CCG and included three separate roles for patient engagement. The role descriptors as material entities spelt out what was required with the first being more strategic and aligned with national guidance to integrate health and care. The third descriptor was more operational:

1. Member of the Programme Board providing recommendations to the GB. Attendance once a month.
2. Procurement participant including dialogue process and evaluation to recommend preferred bidder.
3. Reference group member to discuss service development ideas in small groups.

Recruitment to these roles followed public engagement events where people were invited to express an interest, attend a CCG briefing, submit a CV and then have an individual meeting to further discuss the role of interest. These prescriptive roles were matched to the applicants by the commissioning support team. When I asked Leslie about his role in procurement he told me he did not have a job title as a volunteer. He was asked to get involved in a different work stream because of his interest in and having diabetes himself. Role and job titles featured in leadership practices (6.5.1) and sparked some interesting debate about legitimacy and belonging to a CoP, especially in the urban CCG.

*Leslie: No, I forget exactly how... but there was a call for help and it was the community care ... that process was going forward, that's new and they... I volunteered for that and they didn't want me, but the diabetes ...did.... I think I met them and the... the main thing was background reading and it was during that process that I discovered that I could be of real help to them.*

***[Service user, diabetes service procurement, rural CCG, interview 12, 1/09/16]***

The idea of being matched and 'forwarded' to where the rural CCG thought the service users could be of greatest benefit was also mentioned by Hazel. She sat on the Programme Board for Community Services but her talents as chair of her GP practice PPG saw her 'forwarded' on to be chair of the North locality in the CCG.

## 7.3 Competence

### 7.3.1 Learning by doing

A comment from one of the commissioning support managers early in the study focused on the experience of working and learning. It was in relation to determining competence within the CoP for the community services contract.

Competence is the knowing in practice that includes a social dimension; not an individual characteristic but it shapes personal experience and vice versa. (172)

The commissioning support manager had remarked:

*“Everything is different about this contract that is why it is brilliant to work on.”*

***[Field notes for pre-meeting observation 9, rural CCG, 20/04/16]***

There were other comments about ways of working and relationships between GP Leads and managers being different compared to what had previously occurred. Heather, the GB Lead for quality in the rural CCG, thought relationships were much better in the CCG compared to PCT days. She said “... *it’s much closer than any other thing has ever been*” but thought it could be daunting for some GPs who were not used to speaking to senior managers. Heather was a point of reference for the community services GP Lead. The ‘point of reference’ on the GB was so that GPs would feel more comfortable speaking to another GP rather than a senior manager. The Clinical Chair in the rural CCG referred to this function as a GB “*sponsor*” for the GP Leads.

There were some negative experiences though. The Chief Clinical Officer (Alison) in the urban CCG, was particularly candid when reflecting on the failing secondary care provider and how this may have impacted on her ability to speak up for the CCG. She spoke of getting “*air cover*” and using certain “*buzzwords*” to “*keep the minister off your back*” although she had chosen not to pursue that course of action. Life for her as a clinician was about complexity and “*coming at it from a bit more of a disruptive place and I don’t think that’s done us any favours as a CCG.*” She was referring to her two roles as Chief Clinical Officer and Accountable Officer. Separating them into a clinical role and a managerial role with the legal duties would have been her preferred option which is what the CCG opted for at a later

stage. She was a clinician at heart, not a leader, and commented on her many years of training to be a doctor and her reluctance to be dragged along a management trajectory.

***Alison:**.... but I haven't used the right buzzwords, I don't think I've been good at saying what they needed to hear when they needed to hear it, and I've seen other people, not in as a difficult situation with their acute trust as we're in, so maybe I could not have done it, I might be being hard on myself, but I do think I've seen other leaders manage to get air cover for their commissioning groups by using certain buzzwords, having a phrase, using that, you know, it's a couple of sentences probably you need to... and then they get it. Whereas I come at it from a clinician, accepting that the world is complicated, the complexity is what we do, that a buzzword doesn't solve anything. You know, I come from a very different place, whereas what they need is something simple to feed up the line to keep the minister off your back.*

**[Accountable Officer & Chief Clinical Officer, urban CCG, interview 9, 15/06/16]**

Another negative learning experience was described by David and Hazel, service user representatives in the North locality of the rural CCG. They were frustrated with trying to organise an open meeting for patients from one of the PPGs. David led the initiative accessing some charitable funds affiliated with the GP practice to set up the meeting. He was pleased when close on 250 patients arrived at the venue. The GP practice had approximately 3,500 patients. His frustration was with the lack of preparedness and competence of the GPs and practice staff. Although an illustration from a PPG meeting, David struggled with the idea of representation generally and within a CCG locality. He wanted the PPGs to network and be supported in that learning which he perceived as a function of quality. Both he and Hazel acknowledged it was a cultural shift requiring time but the lack of preparedness on this occasion conveyed to them it was an exercise that was not valued by the GP practice and its staff. An alternative explanation might be that the staff and GPs did not feel adequately equipped to enter in to that dialogue due to insufficient time or lack of PPEI training.

**David:** *They all turned up. The Doctors all turned up. All the practice Doctors turned up. The surgery staff most of them turned up. They just couldn't believe it. Because they turned up with nothing to say. That's what annoyed me. They turned up. 'Dr XXX you are going to speak.' And he stood up in his jeans and his T shirt and he just rambled on. And he said 'Oh let me introduce you to someone else' and she stood up and rambled on.*

**Hazel:** *They didn't really use the occasion to really get through to people. Doctors themselves are not great communicators. As we know they are not great on a single one to one level. And some of them, for instance, the head of practice ... Lovely, lovely man, adored Doctor was so nervous to stand up in front of patients that he just begged me that he didn't have to do it.*

**[Service users, focus group 3, rural CCG, 27/06/16]**

### 7.3.2 Role tension

As alluded to earlier with respect to not enough time, there were role tensions and potential conflicts of interest. Some GP Leads spoke of financial ramifications and learning how to negotiate the territory if you are a GP partner and take on a GP Lead role with the CCG. Alison had chosen to become a salaried GP because of her responsibilities as Accountable Officer in the urban CCG. She thought it untenable to have any kind of pecuniary interest in the profits of General Practice. This showed the importance she placed on becoming a salaried GP as a mechanism for remaining competent as a leader within the CCG commissioning landscape of practice. Natalie talked of being an independent contractor (as a GP partner) and the work not stopping at the end of seeing patients on a session list. Work was more bounded for a salaried GP. She related how it had been difficult to work out the impact on her pension, tax and seniority. Whereas, she was not likely to lose out financially and was not seeking an incentive, it had been “tricky”.

**Natalie:** *It is complicated because as Clinical Leads you can still be paid as a kind of locum, paid to the (GP) practice, but if you are an officer of the CCG because of the HMRC regulations you have to have a salaried appointment.*

**[GP locality member Lead, urban CCG, interview 5, 5/04/16]**

The GB Lead for engagement and clinical leadership in the urban CCG spoke of the expertise required of a GP clinical Lead. It was a learning curve for many but

required knowledge and experience to demonstrate competence as a GP clinical Lead.

**Zayef:** ... and I think there is a learning curve for clinical leads too. I am not just sitting here as a GP. I am sitting here with GP knowledge but I have got to understand what public health is about. I have got to understand what patient need is about. But actually, I have got to understand a little bit about what the financial background is too. So you have got to develop it. It is good to have a mix. It is good to have leads with slightly different perspectives, but we have got to come together as a collective haven't we and make that decision?

**[GB Lead for engagement and clinical leadership, urban CCG, interview 3, 17/03/16]**

Zayef considered the collective decision-making important to GP Lead commissioning roles in the CCG but one of the GP locality member Leads in the rural CCG commented on how long it takes to make decisions. Duncan referred to GP Leads going “*native*”, becoming institutionalised, attending committee meetings and not making decisions. He referred to the speed of decision-making as “*glacial*”. Whilst it is not possible to compare the two CCGs, and Duncan did acknowledge the CCG was “*a much better system than the old PCT*”, it had not lived up to his expectations. He had been a GP partner, was retired from his own practice and continuing to practise as a locum. He had a long-standing interest in GP groups in primary care commissioning so could legitimately make comparisons between the GP commissioning models.

The role tensions were evident among the service user and lay representatives too. The first focus group recounted informants' own experiences and the observations they had noted since the urban CCG had come into operation. For example, Euan, the lay representative for PPEI, mentioned GPs referring to the CCG as if it were an external body and they were not part of it; “*Oh that is something to do with the CCG*” when an issue was raised at a PPG meeting. He thought it was harder to engage the GPs with the CCG and the idea of locality than it was the patients. He also recounted how he had to often remind people that he was not **the** patient or public representative. His lay representative role as a member of the GB was to assure PPEI was happening in all the places or CoPs where commissioning should be occurring in partnership with patients and the public. Euan also revealed during

interview that his role as a carer was not effectively heard at the PPG meetings where he was registered as a patient. This was because the practice manager, the GP who attended the meetings and the chair of the PPG saw him only as the lay representative on the GB. It was a source of frustration to him.

### 7.3.3 Sniffing out talent

Spotting competence or potential in others was something that the Clinical Chair Harriet spoke about as part of her role to “*sniff out talent*” in the rural CCG. Alex was working as a locum GP in her practice and she suggested to her that she had time on her hands and liked a challenge. Alex’s account confirmed this informal way she was approached to take on the GP Lead role for the dementia work stream. By her own admission, Alex had little understanding at the beginning but did like complexity and was sufficiently curious to pursue the invitation. She recounted how she responded after some thought and was then surprised to be told the role was hers. There was no formal application process. She had got the job!

**Alex:** *So I went along really not knowing anything about the structure of the CCG and this whole clinical leadership concept. And she started to talk about their vision, you know, how she thought that there were certain areas that were very strategic, and if we could get those areas right we would do big things for our patients effectively who because you could offer them better care and more joined up care, and you’d also do right by the CCG in terms of resource allocation, in terms of people working together and... and I really didn’t know what all of that meant and she sort of gave me this structure chart and I could see how it was all... her vision... but there wasn’t a lot more at that time.*

**[GP Lead for dementia, rural CCG, interview 10, 16/06/16]**

Other informants described people they saw as skilled or expert who they could learn from or invite to be part of their CoP because of their experience. Alex described a carer who looked after his mother until she died and then continued with the dementia work stream in a voluntary capacity. She found his contribution invaluable and commented that he had “*become more professional in the input*” and was now an established part of the group. She wanted to call him a “*learned carer*”.

Lucy, who had two GP Lead roles in the urban CCG, frequently referred to relational ways of working and human relationships. She picked out several people whom she considered were good role models. For instance, she commented on

the lay representatives on the GB and their ability to listen and recall your name as illustrated in the following extract.

**Lucy:** *Their knowledge, their experience. The way they interact. The way... you know, because it's very clever, interacting in a way that is measured. They never get passionate. They listen a lot and then they come out with some really important comments. They **know** you. Oh my God, from two minutes in the CCG they would say hello Lucy, how are you getting on, how's that?*

**[GP Lead for Community Services and Environmental and Social Sustainability, urban CCG, interview 8, 14/06/16.]**

Lucy had spent some time out of medicine and described the NHS as “a bit of a behemoth” and something you cannot really push or move. She had made a point of finding out some details from one of her commissioning managers about the service users who contributed to her work streams prior to me interviewing her. She was shocked when she discovered they were not paid given their expertise. She felt she and her fellow Clinical Leads were “slightly amateurs” in terms of how to commission and looked to one of the service users as a mentor.

**Lucy:** *So one of them, she's obviously worked at the Council before, she knows everything. She comes up with really incisive questions that we... the rest of us, hadn't thought of. One of the others is very much a sort of service users' champion, but in a really positive and creative way, so I mean those two really do stand out as...*

*.... And this woman with the knowledge and expertise is able to really steer us and say well you know, what about this, you can't, you mustn't forget that. Oh, you know, you need to take that to the legal board, you need to...*

**DH:** *So they've got good insider knowledge?*

**Lucy:** *Very good insider knowledge... one of them feels almost a bit like a mentor sometimes, you know, in asking the questions.*

**[GP Lead for Community Services and Environmental and Social Sustainability, urban CCG, interview 8, 14/06/16.]**

## **7.4 Boundary encounters**

### **7.4.1 Enablers to communicate the message**

Boundaries between CoPs are viewed as learning assets because they can offer new insights for learning. Boundary objects which include practitioners and their

activities can be a focus point for engaging multiple perspectives. (172) Thus far in this chapter there have been illustrations of individuals brokering relationships. They are operating across boundaries between groups or CoPs within the domain of practice; the domain being PPEI for clinical commissioning. The commissioning support manager for example who helped Hilary and her fellow service user representative negotiate the procurement documentation for the community services contract in the rural CCG, (7.2.2). And the mentor that Lucy referred to in the previous section guiding the incisive questioning. One of the GP locality member Leads (Natalie) spoke of the Healthwatch representative in the urban CCG who was *“fantastic and really gets it.”* She wondered whether that way of engaging for the *“bigger picture”* was trainable and remarked that the organisation, the CCG, needed to be clear about what it was seeking for PPEI. However, there were other examples of enabling for PPEI; learning how it can be done for partnership working and clinical engagement for leading and commissioning health and care services.

Alex, as the GP Lead for dementia in the rural CCG, strongly felt she had to go in person to communicate the messages about the pilot project she initiated. She thought she was the only person that could explain about the project because of her clinical background and the vulnerability of the patients and their carers. She did not want them to be inconvenienced and so preferred to be present to answer questions. She could cross boundaries and spoke about engaging with different groups or communities and finding a way to get heard by identifying those who held power or *“sway”*. Much of this was about recognising and acknowledging the different perspectives and then sheer persistence. She described herself as being seen as *“it’s that woman again”* and often having to ask GPs twice to engage them in the project.

**Alex:** *I think you have to target certain individuals, because they always hold sway, whether that be within a CCG, so some of them are on the Governing Body. Some of them are more influential in their (GP) practices, you know, some people want to engage with you. Well sometimes people have got to the stage where they're just sticking their heads in the sand and really they're just overwhelmed and they just don't want any more, they just want to do what they want to do. And sometimes that's a generational thing, sometimes it's just a personality thing. And I think you have to try and find like-minded people, not only in terms of... it might not be dementia that they're like-minded, but in terms of... GP services have to change. We can't sit there and just be told what to do. I think we have to be those leaders, locally, and we have to do things differently for our patients. It's not about our workload, it's about our patients, and I think you can engage with colleagues on that level. That's how I've found the most successful outcomes.*

**[GP Lead for dementia, rural CCG, interview 10, 16/06/16]**

In the same CCG, several of the PPG representatives from the North locality commented on the absence of the lay representative for PPEI on the GB. When Nigel was present they felt he always worked hard to keep information flowing between the CCG and the locality patient representative groups. They thought his background and experience of PPEI over the years was an asset that could not be matched even with a temporary replacement. His absence was sorely missed and there was great relief when he returned to his post.

Other boundary encounters included opportunities for formal learning and research with organisations not embedded within the domain of practice. The “GP tutor” from the medical school was mentioned in the context of being able to access funding to take forward the dementia pilot project. There was also another member of university academic staff helping with evaluation of services where the CCG was working with the not for profit sector. Lucy was impressed by this work and it helped her think differently about evaluation of outcomes. Methods that broke away from the formal measurement expected of CCGs. It was radical, and she enjoyed it.

**Lucy:** *So she's helping us to do most significant change analysis of stuff, unbelievably exciting stuff. So I mean yes, the stuff that I'm doing, that isn't hide-bound by all the structures, you know, again, because the way we're doing evaluations is radical.*

**[GP Lead for Community Services and Environmental and Social Sustainability, urban CCG, interview 8, 14/06/16]**

Lucy also commented on the GP social enterprise contracting primary care services with the urban CCG. The enterprise was willing to learn how other people and organisations were doing things. She described them as “*light on their feet*” and thought the CCG could learn from the way they operated.

#### **7.4.2 Enablers to push you along**

Two illustrations show how boundary encounters can help push you along on the learning journey. They are a source of encouragement and a confidence booster. Euan, the lay representative for PPEI in the urban CCG, had a good working relationship with the Chief Operating Officer who subsequently doubled his contractual hours for each month to 30 hours. This was to address the lack of time to fulfil his role. There had been two lay representatives for PPEI in the former PCT and Euan felt he just could not attend all the committee meetings. He had also been challenged about his leadership role on the recently formed Communications and Engagement Committee by the nurse representative on the GB who chaired the Quality Assurance Committee. (The Communications and Engagement Committee became a sub-committee of the Quality Assurance Committee.) The Chief Operating Officer was insistent he pursue the committee leadership role. Euan had identified that not assuring the PPEI work in a more visible way would be detrimental to the CCG’s public engagement strategy.

***Euan:*** *And we got into some really ridiculous conversations about terms of reference but I knew XXX (Chief Operating Officer) was supporting me through that. Sometimes overtly, sometimes just there pushing me along. “This is the right thing to do Euan. We need you in a leadership role.”*  
**[PPEI lay representative, urban CCG, interview 1, 9/03/16]**

He also volunteered for an additional 30 hours. He said it was “*the oxygen that keeps me alive when I am out there*” and prevented him from getting sucked into the system and overtaken by numerous committees. The volunteering was allied to his PPEI work and included attending community events, interacting with other CCGs and NHS England. It brought him joy as well as new learning.

The second illustration is from Lucy’s account of working with two of her community services commissioners. They had a lot of prior experience from other

CCGs (past CoPs) and she described good working relationships. Consequently, she had learned from them as she had gone along as they drew her into the commissioning processes. She felt that with them they could effect change in the nursing home sector for the local community. She was excited by the opportunity and had pledged to make that difference with one of the commissioners.

**Lucy:** ...I have these two wonderful commissioners that I do most of my work with and I feel so privileged that I have the possibility of shaping services, of doing radical things, to make things better for the people, .... With one of them we've made a pledge, me and the commissioner, that we're going to transform care homes and I... I just think well... how did I get the chance to drive something like that?

**[GP Lead for Community Services and Environmental and Social Sustainability, urban CCG, interview 8, 14/06/16]**

## **7.5 Meanings**

Two main themes emerged from the learning practices data with respect to the meanings of taking on leadership roles and partnership working for PPEI for clinical commissioning in a CCG. These were aligned to the social aspects of learning in practice. (169) The social and symbolic significance of participation at any one moment as an element of practice. (128) The first was about wanting to make things better and the second was the sense of pride in the achievements so far. The focus groups and interviews allowed the informants to reflect on their learning. In effect, these two research methods became a learning activity for the participants, a point made by Lucy and her GP Lead colleagues in the urban CCG who were part of the second focus group.

### **7.5.1 Wanting to make things better**

In addition to comments about wanting to transform care homes (Lucy) and Euan's delight to be engaged with communities in a voluntary capacity for his own learning, there were other motivations for continuing to work at partnerships and leading them. The clinical chair in the rural CCG said it was not about ego and awards although her organisation had been recognised for some of their innovative projects. It was bringing about whole system change and working in

more relational and caring ways. This permeated both CCGs, GP Leads, lay representatives and service users alike.

David spoke about enabling an elderly lady to have her medicines delivered to her home by the local pharmacist. It resulted from the PPG being able to contact patients on the GP practice list in the rural CCG by newsletter. He was disappointed that the patient had not been informed how to organise this in the village. He was also frustrated that it had taken him three years to contact some patients as their PPG representative and chairperson. This was because of the data protection regulations preventing release of personal information. Similarly, Hazel wanted to change the way patient experience was captured. She was asked as chair of the North locality PPGs to comment on questions for Patient Reported Experience Measures that the CCG were compiling for a survey. She thought the questions were not the sort of things that patients would prioritise to report back but there had not been patient input into the design, (see 5.2.2).

### 7.5.2 Sense of pride

*Harriet: ... I think we've got something very special here and our staff, I mean the staff survey is amazing, you know, they're in the top, you know, best places to work in the NHS and I think that's because it's such a "can do" feel and they say they wouldn't feel it anywhere else, and I often say well yeah and I'm not sure I would chair another CCG because part of it is the ownership of doing it for your population and taking a band of people with you. So it is about being close to your population, whereas if I was going to suddenly work in XXX (name of a different county) I wouldn't have the same connection.*

***[Clinical Chair, rural CCG, interview 7, 3/06/16]***

The sense of pride had different emphases in the two CCGs although both related to community and place. For the clinical chair in the rural CCG it was about bringing the staff along with her and learning how to lead for clinical commissioning. She was proud of her 16 clinical leads and their individual projects and that she had recruited them into these roles. She spoke about the importance of having sufficient "manpower". The above extract demonstrates this in relation to staff survey satisfaction.

For the Chief Clinical Officer in the urban CCG it was about pride in the commissioning teams and improving mental health outcomes. The old PCT previously had some of the worst mental health outcomes in the country. She was pleased that the CCG was working well with public health and the local authority and commented that “*we have moved that dial*”. She used the phrase “*proud of*” on several occasions in response to my question about what had worked well for the CCG. I had asked her what stood out for her since April 2013. She also praised the locality member practices and their understanding of resource allocation given the demographic profiles. She said GPs often get a bad press about their General Medical Services contract; “*being really jobsworthy .... nobody’s touching my GMS contract*”. The commissioning teams had worked hard with the locality members with the clustering of GP practices. She thought this was why there was a better understanding of the resource allocation model for the CCG.

## 7.6 Conclusion

**Euan:** *I think we are all a little bit out of our comfort zone and I think that we have to sort of accept, accept that as patients and as managers people are learning together. I think that is an important part of the collaboration is to get managers out of that feeling that they should know. Because I think we are all in the unknown actually.*

**[Lay representative for PPEI, urban CCG, focus group 1, 6/11/15]**

The above comment, made in the very first focus group, sums up this chapter in terms of learning practices for both partnership working and clinical engagement for leading and commissioning health and care services. The socio-material learning for PPEI for clinical commissioning was new for most participants. It was entering the unknown and so both past CoPs and new CoPs could contribute to the collaborative processes of learning together as an organisation to take on leadership roles and be clinically engaged. Participants had to be willing to accept that they may not know the ‘answers’ or the way but if true partnership working was to be forged the route had to be taken. The next chapter, which is the final one reporting my findings, addresses partnership practices and once again used my conceptual framework for analysing and interpreting the socio-material entities.

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## Chapter 8: Socio-material practices of partnership

In this chapter the findings from analysis of the three data categories constituting what I perceived to be partnership practices are reported. The categories contained evidence of social practices relating to:

- *the Governing Body,*
- *partnership working, and*
- *representation.*

The *representation* category had 13 codes which included data on PPGs. The PPGs were more significant than first anticipated which may have been affected by the clusterin' of GP practices within CCG localities at that time. Not only did PPGs provide feedback on GP services to their respective GP practice partners, they were also part of a network of PPGs within a cluster or locality. This enabled feedback to be collated for the CCG as an engagement strategy for the collective service user voice. It was cited as such within the patient and public participation strategy of one of the CCGs, (**Table 4.8**, additional artefact 1). GP practices are the “*gateway to NHS care*” and so can therefore become “*involved in wider discussions and work around locality.*” The PPG networks or reference groups were evident in both CCG research settings.

There were 22 codes for *partnership working* within the data and 11 codes for the *Governing Body* category. Public engagement codes were combined with the GB category as previously indicated. The analytic framework was applied across all three categories of the social practice data. As explained earlier in the methodology, if data were found elsewhere relating to partnership, that is, in another set of practices, they were considered alongside and included here if relevant. The table below, reproduced from the **Table 4.17** in the data analysis section **4.13.5**, lists the themes identified for partnership practices. The subsequent sections of this chapter present and explain the themes.

## Themes for partnership practices

PARTICIPATION	MATERIALITY	COMPETENCE
<ul style="list-style-type: none"> <li>• It “<i>doesn’t happen overnight</i>”</li> <li>• Unequal partnerships</li> <li>• Knowing what patients are thinking</li> </ul>	<ul style="list-style-type: none"> <li>• Time</li> <li>• Needing feedback</li> <li>• Financial resources</li> <li>• Reification of partnership</li> </ul>	<ul style="list-style-type: none"> <li>• Return on your contribution</li> <li>• Building confidence</li> </ul>
BOUNDARY ENCOUNTERS		MEANINGS
<ul style="list-style-type: none"> <li>• Believing in the PPEI agenda</li> <li>• Engaging multiple stakeholders</li> </ul>		<ul style="list-style-type: none"> <li>• Seeing you as a person</li> <li>• People not understanding</li> </ul>

### 8.1 Participation

**Edward:** *The CCG has got some very successful partnerships working particularly with the local authority for example ... That hasn’t just come around about overnight. It has taken a long time to get there. There have had to be a lot of barriers to be overcome, lots of understanding created amongst the participants so that they can partner well.*

**[Lay representative for governance, urban CCG, focus group 1, 6/11/15]**

#### 8.1.1 It “doesn’t happen overnight.”

There was acknowledgement in both CCGs that changes in the clinical commissioning landscape to take forward partnership working were not achieved overnight. The phrase was repeated by several of the informants. It took a lot of hard work to bring stakeholders together. The GB Lead for engagement and clinical leadership in the urban CCG (Zayef) said the biggest culture change, and most difficult to instigate, was bringing together stakeholders for the transformation of services to ensure quality and safety for patients. He had worked with the medical directors of the provider organisations so that his GP clinical Leads could understand more about risk and what patients wanted. He wanted “*true clinical engagement*” and “*true clinical working*” across all the

providers and thought some of the big decisions could not be taken by the CCG alone as commissioners.

This point was well illustrated by the GP clinical Lead for dementia (Alex) in the rural CCG. She had submersed herself in a project that was multi-faceted across primary and secondary care as well as the local authority and the VCS sectors. The clinical chair of the CCG described this as a “*deep dive*”. It was something she wanted all clinical leads to do to uncover the detail of their work stream projects. Alex talked of having to have stamina, spending many hours with various stakeholders and the discrepancy between national and local agendas. It was difficult to engage GP colleagues where local practice was not aligned with the NHS England discourse.

**Alex:** *Yeah, there were some really tricky bits. First of all the hardest thing was that dementia was just not what people were interested in. It may have been at a national level but at a local level people just were not interested in those patients. And that was GPs ....*

*... So that was one challenge and secondly, I think the other thing was, this whole idea of integration between social care and any kind of medical service, and again it was very much at a national level, they were all talking about integration and how it's happening. The reality is, it is not happening.*

*And we were going to adult social care and would speak to them about the most complex of patients or group and inform them that we were all not doing the best thing for them and how... could we get our heads together to work together as we should be. And they would sort of say oh yeah, yeah we will come to your workflow and then they would pull out, and if they came along they would only want to malign aspects and they were a constant challenge. And I think because they were under a lot of burden as well, I think there were lots of changes going on, in social care too, and it didn't... we would try or I would try and go to the top, I would try and go to people who were working day to day and it would always be the same thing.*

*They have come to the table a little bit more and they are engaged a little bit more, but it is an ongoing issue. And to me, unless you can get all of that stuff right, I sometimes feel that all our good work can just fall apart.*

**[GP Lead, rural CCG, interview 10, 16/06/16]**

The work stream project Alex was leading resulted in successful outcomes acknowledged at national level, but it was her persistence and that of her commissioning support manager and team that brought it to fruition. They were

determined to have all parties at the table including the different support groups for patients and carers as well as voluntary organisations. She wanted everyone to have a voice. Alex spent a day in secondary care and held monthly meetings over four or five months with all parties to determine gaps in services. This latterly included community service colleagues. The commissioning team wanted to ensure that the patients and carers were more than the sets of medical records which Alex as GP Lead had reviewed for a dementia diagnosis. The team “*always had them in the room*”. Her view was that you can be innovative in the CCG, and show imagination, but you cannot do this unless you truly know what is going on.

Hard work and persistence were clearly important and could deter individuals from engaging further. Given their persistence, I asked the service user representatives David and Hazel in the rural CCG (third focus group) if they would be continuing their locality lead roles for PPG meetings and other CCG committees. Hazel wanted to stand down as she thought the roles were time-limited, but she was concerned it might go “*downhill*”. She was keen to keep her foot in the door for the people coming behind her amidst a “*huge cultural change going on*”. She had chaired the PPG in her own GP practice for about three years before moving onto chair the North locality PPGs. She had therefore experienced working with the PCT structures as well as the newer CCG communities. Similarly, David thought it was not yet a going concern and wanted it to become a “*self-winding mechanism*” so that the alliance of PPGs and the locality work would stand the test of time and others could take it forward.

***David:*** *I actually think if I stood down it might carry on or it might fail. It is like getting something to a stage where you say well it is a going concern. It is not a going concern at the moment. It is only happening because one or two people are putting in an exceptional effort in to it to make something happen. The clock won't wind itself at the moment. So therefore, I feel a little bit if I step down what will happen? I would like to get it to a stage where it is a self-winding mechanism if you like.*

***[Service users, focus group 3, rural CCG, 27/06/16]***

Both David and Hazel had a strong allegiance to the engagement agenda and spoke of the hard work required to sustain a partnership. One area where this had come to a successful conclusion in the rural CCG was the procurement of the community services contract. Hazel sat on the Programme Board for that work

stream. The lay representative for PPEI (Nigel) described it as a “*big win*” having “*moved this whole relationship*” so that patients were at the centre. People were now happy with the outcome talking about a whole community working together instead of separating out the doctors, patients and managers. However, some partnership working was decidedly unequal or “*loose*” for some informants.

### **8.1.2 Unequal partnerships**

During the focus group conversations David and Hazel both described arguments or disagreements they had had with the clinicians. Hazel called it a “*loose partnership*” saying that if the CCG wanted them to be true partners they should be recognised for the skills they bring. She compared the way lay representatives on the GB were co-opted because of their skills whereas the service user representatives were often seen as “*generic patients*”.

**Hazel:** ...When they ask us to come along they simply see us as generic patients. Like ‘a person in the street’ but most of us have skills. We have skills in jobs that we have done and they may be skills that they could very much learn from and would help them. And we want to be true partners and give that kind of skill. They haven’t understood that we are not sort of just generic patient people.

**[Service users, focus group 3, rural CCG, 27/06/16]**

She provided other illustrations including where she had asked the clinical chair if there would be a replacement for the lay representative for PPEI whilst he was on sick leave. This was not forthcoming in the short term and she was told the CCG GB did not have time to help. When someone was eventually given the temporary post, Hazel was not permitted to give the name of the appointee to other PPG locality members. She found the constraint on what she could say a source of frustration having held a senior role in the housing sector in her professional life before retirement. She described this approach and lack of trust as “*not a proper partnership*”. David too spoke of “*sanitising the minutes*” where he considered details of discussions at meetings were omitted or reported sparingly.

As reported in chapter 7 (learning practices), the rural CCG had defined service user roles and individuals were recruited to these roles. The clinical chair Harriet spoke of the “*triumvirate*” of providers, patients, GPs and the managers around the table together when a new service was designed. She described the essence or

features of working differently in partnerships as taking a blank sheet of paper without the dissenting voices of old saying why things could not be done. She recounted how they first decide what the problem is, what the 'gold standard design' should be, research it and then decide if they can afford it. If the CCG cannot afford it, they decide what is acceptable as second best. However, one of the GP locality member Leads in the same CCG suggested the CCG knew who they wanted in those roles.

**Duncan:** *Oh, I think the managers at the CCG tend to know people who they think will make a valuable contribution to the discussion, or who have an understanding of the health services, yeah, so I don't think it's a sort of straightforward patient voice.*  
**[GP locality member Lead, rural CCG, interview 11, 17/08/16]**

This was further expounded by David who thought as service users they had been imposed on the CCG for PPEI practices and not integrated within the organisation.

**David:** *They have not embraced us and said look this is an opportunity to improve what we are doing. It is 'well we have got to listen to what they say. If they say something really important we will see if we can do something.' We are imposed on them rather than integrated.*  
**[Service users, focus group 3, rural CCG, 27/06/16]**

He felt the rural CCG was still coming to terms with what to do with patient representatives in the 21<sup>st</sup> century whilst Hazel remarked they still "don't know what to do with us." The experience was similar for Elizabeth in the urban CCG confirming patient representation was required but her own input had been ignored. Elizabeth had a long history of PPEI with the urban CCG and its predecessor PCT. She was a volunteer representative for Healthwatch and a member of four CCG cancer groups.

**Elizabeth:** *.... It is almost as though it is a tick box exercise. We **have** [emphasis] to have patient representation and we are doing that because we have somebody sitting on this group for example. But I do come away from meeting, in fact it has just happened this week actually, I do come away sometimes from a meeting thinking what have I wasted two hours for because quite honestly, I really feel ...They have taken on board what I have said and then totally ignored it really.*  
**[Service users & lay representatives, urban CCG, focus group 1, 6/11/15]**

Both lay representatives for PPEI on the GB referred to the unequal power relationships between patients and clinicians. Euan, the urban CCG lay representative, provided a powerful illustration of the complicated dynamics of relationships in partnerships. You could be at an important CCG meeting with GPs and managers when *“five minutes earlier you have been lying on the couch and they have been examining you”*.

### **8.1.3 Knowing what patients are thinking**

This theme arose in relation to enabling a representative and participative patient voice for PPGs and partnership working. With regards to PPG representation, several of the GPs described difficulties with forming and sustaining a PPG. A few of the GP practices in both CCGs had tried virtual groups to broaden the appeal to different demographics, particularly younger patients, and others continued with face to face meetings. At the time of data collection some GP practices still did not have a PPG. Nigel, the lay representative for PPEI in the rural CCG, thought this was sometimes because patients were happy with their village GP practice and did not want change. Merging GP practices and setting up GP federations would be a threat to the status quo particularly in the more affluent areas within the localities.

In the urban CCG, GPs Natalie and Alison spoke of patients feeling sorry for them and worrying about their welfare. The patients would turn up for some meetings and then *“kind of slowly fade away.”* Natalie said most people have busy lives and PPGs were part of the Conservative party *“misplaced Big Society idea”* to volunteer, take part and give back. She tended to ask the most junior GP partner in her practice to attend PPG meetings as after a 12-hour day, seven or eight hours which may be consulting with patients, *“you haven’t got any head space left.”*

Harriet was clear that agendas must not veer into GP practice business matters. Her PPG in the rural CCG would be reminded of their terms of reference if they started talking about business issues instead of improving the patient experience. Another GP Lead (Heather) in the rural CCG, differentiated between patients who attended because *“they had an axe to grind”* and others who were being the good citizen and

had more of a strategic interest in making improvements. This was consistent with attendance and experience at her own GP practice PPG. She stopped going to the meetings after a few months when she felt she was no longer required. Asking her what she meant by *"I wasn't needed"* Heather replied that PPGs had morphed into the latter purpose with her group able to run things for themselves and network with other PPGs. This PPG was in the more affluent North locality of the rural CCG where patients chairing the meetings had held professional roles in their working lives. Whilst I did observe some of the PPG network meetings and comment on them next with respect to partnership working, it is important to note again David's frustration about not being able to contact patients in his own GP practice in the rural CCG. As recounted in **7.5.1** he found it difficult to reach other patients on the GP practice lists because of data control and so felt he was not representing what others were thinking.

I observed three patient representative/PPG network meetings to see how service user representatives engaged and got involved with CCG strategic business and clinical commissioners/lay representatives. The first observation was a PPG network meeting (observation 7) chaired by Euan the lay representative for PPEI in the urban CCG. It was a meeting to review the progress of the network for all PPGs (43 at the time), and how the new CCG structures with GP practice clusters might impact on the work of the PPGs and the support they required.

The second was a Patient Representative Group meeting for the combined North and South localities' PPGs (observation 11) in the rural CCG held at CCG headquarters in the early evening. The third was a Patient Representative Group meeting for the North locality PPGs (observation 13) in the rural CCG held in the early evening at a community hospital. Both rural Patient Representative Group meetings were chaired by Hazel. David and Hilary were also present with Hilary taking and writing up the minutes of the meeting for the North locality PPG meeting. All three were informants from the third focus group. The early evening meeting time allowed PPG members to attend after a day at work or if they were reliant on another family member to return home for caring/parenting duties.

The additional questions in **Table 4.5** were instrumental in guiding my observations with regards to participation for partnership working. I wanted to see how the commissioning managers functioned at these meetings as well as the engagement leads and other partner organisations working with the CCGs. I have used the urban CCG PPG network review meeting (observation 7) as an illustrative snapshot here. The meeting was held at a central, easy to access community hub in the afternoon. There were 25 people present including:

- Lay representative for PPEI (chair),
- CCG Head of Engagement,
- Representatives from 13 GP practices (10 female, 6 male)
- Local health and wellbeing centre representative,
- Local community development project representative,
- Local third sector community development organisation representative,
- Local community development project representative (in attendance),
- Engagement lead for urban voluntary and community sector organisation (in attendance)
- Engagement and Communication Co-ordinator for Healthwatch (in attendance)
- CCG minute secretary (in attendance)

At least two members from each PPG were encouraged to attend for companionship and support at such a large meeting, but also in case one person was unable to attend. Apologies were received from 11 network group members who represented a further four GP practices and a local councillor for one of the electoral wards. The size of the meeting, especially if all the members had been present, presented some material challenges for the chair and CCG organisers. The room was just large enough with sufficient chairs. All members could see the chair at the front. No-one commented on not being able to hear but one cannot assume the experience was audible for everyone present.

As an exemplar of a CoP principally comprising PPG representatives for the GP practices in the urban CCG, it was clear other local community organisations had a vested interest in what the representatives were reporting back. This was especially relevant for one agenda item where the CCG Head of Engagement explained the new GP practice clusters and NHS plans for population-based commissioning. She wanted to establish cluster PPGs, as part of the wider

community, in the vicinity of adjacent GP practices that had formed a cluster. This could mean the same representatives do not attend both the PPG meeting for their own GP practice and the cluster PPG meeting. There were concerns including how it might impact on a PPG and what the GPs might think about the new arrangements. The Head of Engagement confirmed support would be in place to help the cluster PPGs develop. Examples of support included a community development worker from the VCS, access to small grants and cascade newsletters to grass roots. Recorded in the minutes (observation 7 artefact) was the comment: *“There are no rules, it is what works for the practice.”* The measures were designed to further explore what patients were thinking and maintain engagement.

## **8.2 Materiality**

### **8.2.1 Time**

Unsurprisingly, time featured as a material and necessary resource for partnership working and has already been highlighted in the previous section on participation. There were references to established partnerships and relationships with community development workers that had taken years to establish. Here again, in the transcript excerpt below, it specifically refers to lack of time and short time scales for reading large volumes of CCG papers before meetings. The CCG work was encroaching on personal time if the GP Lead was to keep up to speed with the requirements of the leadership role and participate in strategy meetings for partnership working. The lay representative for governance in the urban CCG (Edward) thought the time factor was one reason why it was difficult to recruit GPs to the GB.

**Lucy:** *There's acres of paperwork, you know, this afternoon we've got the Clinical Strategy Group meeting and ... five days before you get sort of a hundred page document to read, you know, so yes I do a lot in the evenings and around the edges.*

**[GP Lead, urban CCG, interview 8, 14/06/16]**

### 8.2.2 Needing feedback

Despite the numerous ways CCG performance is monitored at both local and national level for NHS England, there were frequent references to the need for more feedback. CCGs can be compared via the [My NHS](#) website and also undergo an annual assessment as part of the CCG Improvement and Assessment Framework. (131) However, informants were suggesting more and clearer feedback that went beyond the materiality of quantitative KPIs was required. Lay representatives and service users said they wanted to know what difference their contributions had made to partnership working. Service users also wanted a greater understanding of what can and cannot be done.

**Elizabeth:** *No-one actually comes back to you and says the reason we **didn't** [emphasis] do it this way was because, because of the system, or because we couldn't, or because of funding, or because of there just isn't the capacity to do it that way or you know, so you just sort of think well I said that but no one is taking the slightest bit of notice of that and I don't know why.*  
**[Service user representative, urban CCG, focus group 1, 6/11/15]**

One GP Lead thought the real challenge was getting information to and feedback from the 'grassroots', from the actual patients. The GP Leads in the urban CCG (focus group 2) also discussed feedback beyond KPIs but this was a desire for more objective and quantitative measures about interventions. "We did this, and we put this in, what outcomes?" Closer questioning ascertained that GP Leads did not participate in the monitoring and review stage of the commissioning cycle for a work stream. That data was invariably collected and collated by the commissioning managers and support teams.

### 8.2.3 Financial resources

David, as well as being the lead for his PPG in the North locality, also sat on the rural CCG's Quality and Performance Committee. He thought financial resources should be available to support the development of the PPG work. He perceived this to be a quality issue and support would enhance and encourage the groups.

**David:** *These patient groups are not going to run on love....  
...I think the role of patients and representative role of patients' needs to be changed. It needs to be seen to be a quality job. It needs to be seen to be supported in some way. It is not someone doing it on their kitchen table all the time. There is some support in the system to encourage. I am not talking about paying people to do the work but possibly paying people to support the work might be the thing.*

**[Service user, focus group 3, rural CCG, 27/06/16]**

He wanted money for administrative support rather than remuneration. In his own PPG he had been able to access charitable funds aligned with the GP practice, but this was for the room hire when 250 patients turned up. It was not for the day to day costs. (See 7.3.1, learning practices). His challenge had been finding the contact details of the patients. In contrast, the urban CCG had awarded small grants to help PPGs with publicity, developing newsletters and running information events. A PPG had to apply and make the case for the grant.

One of the service users commented on the poor level of remuneration for attending procurement meetings in the rural CCG set against the salaried staff who were there because it was their job. She felt she and her fellow service user colleague were not valued for their expertise but acknowledged the staff were adhering to policy on reimbursement and fees. (See 5.5.1, trust practices.) Similar findings were evident in the urban CCG. Lucy was shocked when her commissioning support manager in the urban CCG said the service users attending her work streams were not paid.

**Lucy:** *...Because one of them is so much an expert on the... what we're doing, and he said oh we don't pay them, and I'm like 'My God!' what a resource!*

**[GP Lead, urban CCG, interview 8, 14/06/16]**

#### 8.2.4 Reification of partnership

**CCG strategic objective:**

*Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care.*

**[Patient and Public Participation Annual Report, 2015 – 2016, urban CCG, additional artefact 2]**

There were numerous examples of reified engagement and involvement activity some of which I describe here to further illustrate the materiality of partnership. Much was contained within artefact evidence whether it be CCG strategy with reference to NHS England guidance on PPEI, annual reports on progress with the PPEI strategy, web materials to explain CCG objectives for involving citizens and patients, minutes of meetings, PPG toolkits, terms of reference for meetings, documents to capture patient and carer pathways or products generated from meetings. At the time of the research NHS England was using the guidance for NHS clinical commissioners entitled 'Transforming Participation in Health and Care' which addressed individual participation, public participation and insight and feedback. (49)

Continuing with the example of the PPG network review meeting (observation 7) mentioned in **8.1.3**, the following recounts the generation of an artefact that reifies partnership working. The meeting had a clear agenda with allocated time slots for each of the six agenda items. As mentioned earlier, one item was a recap of the urban CCG structures for the PPG network and how these aligned with governance requirements. The CCG Head of Engagement conveyed part of this explanation with a Powerpoint presentation showing information flows between the PPGs, the PPG Network meetings, the Communications and Engagement Committee and the GB. Paper copies with a diagram of the process were available at the meeting and participants were invited to comment. The diagram captured the role of the recently formed Communications and Engagement Committee that had become a mechanism for the PPG Network to report to the GB via a representative. This one representative (Eddie in my first focus group) was the voice of the 43 GP practices so had to ensure he attended the PPG Network meetings or was aware of the discussions that took place. He would then attend and report to the Communications and Engagement Committee who in turn would liaise with the CCG GB.

At the PPG network review meeting the members of the PPGs were divided into two groups and spent 15 minutes exploring how the PPGs could be a source of information from the wider patient population. The cluster PPGs could facilitate access to a broader community than just that of individual GP practices, but it was

important to find out what support would be required for this development. The minutes of the meeting recorded the amendments to the diagram suggested by the participants thereby creating a modified artefact or product. The minutes were clear and captured the discussion attributing both questions and responses to individuals by name. There was no evidence of jargon and terms were explained. The modified diagram generated from the (community of) PPGs captured what Wenger (169) describes as the duality of participation and reification. It helped the participants negotiate the meaning and purpose of the PPG Network.

### **8.3 Competence**

#### **8.3.1 Return on your contribution**

In the previous section, feedback was reported as a material entity of partnership. Informants also spoke of wanting to know what difference their contributions had made. However, this feedback was more as a measure of competence within a community and knowing that other members valued your contribution or participation in practice. Euan (lay representative for PPEI in the urban CCG), for example, referred to things getting done or actioned by others after meetings he chaired. For him, these were signs that his competence was recognised by the community of practice in which he was participating. Elizabeth also referred to receiving follow-up contacts or emails after meetings because this meant people were interested in her ideas and what she had to say. Conversely, Hazel's frustration at not being allowed to give the name of the temporary replacement for the lay representative for PPEI in the rural CCG and being perceived as one of the "*generic patients*", caused her to reflect that her skills were not valued.

The idea of a return for your contribution was raised by Edward, lay representative for governance in the urban CCG. During the first focus group in the urban CCG, he and Eddie, the PPG Network representative, spoke of the need for two-way communication on an equal basis for partnership working.

**Edward:** *There is a thing about people have to learn how to work in partnership. It is not easy. People are used to working in hierarchies and you know higher up people ordering lower people round and organising the work and so on. Working in partnership is a much more complicated thing to do. And people have to learn certain skills and they have to, if you like, get over your activation energy and also employ some methods that encourage people to participate well.*

**So there has to be a return for your contribution.** *[My emphasis] To something you have to know. As you say, what's changed as a result of my contribution? Or why couldn't things change and will there be a possibility to change them later and these sort of questions need to be addressed and answered satisfactorily. I think we get much better partnership when we, involvement when we make sure that there is - your point Eddie - 'two way communication' - so feedback, back to people who can then sort of go round the loop again and say that wasn't such a good idea but this makes me think well there might be another good idea or whatever. It then begins to work a lot better.*

**[Lay representative for governance, urban CCG, focus group 1, 6/11/15]**

Hilary, a service user representative from the rural CCG, also spoke about the two-way exchange of information and ideas for partnership working. For Hilary, expecting to be listened to required listening to others in response if relationships were to flourish. However, her fellow representative David was critical of the CCG not listening to him. Generally, he thought the CCG was competent but should recognise when they are not for specific issues. This was in relation to a high-profile issue in the CCG which had caught the media's attention. He was referring to a CCG Quality and Performance Committee meeting he attended as a service user representative.

**David:** *And they were dealing with a contract that they didn't understand. I sort of got quite annoyed about it. And they all said 'oh yes, oh yes.' When you see the minutes there is none of that in there at all. There was no report back. I was promised a report back personally about what they were doing but that has not happened. So I feel that there is still a big gap between what they want to do and what this group is meant to do and I think what they actually are doing.*

**[Service user representative, focus group 3, rural CCG, 27/06/16]**

I noticed David had added the initials of a UK honours award to some correspondence. The award is given to an individual for a major local role in an area such as a business, the public sector or a charity. On searching the online UK honours record, I discovered David had been chief executive of a national association in an industry for which he was awarded the honour. The work of the

association was akin to the issue of concern in the CCG and the advisory group he used to manage before he retired comprised 500 staff. It appeared his expertise and skills from prior membership and competence in another CoP were not recognised within the context of the CCG meetings he described.

**David:** *I just feel .... I am frustrated because my background you know - if I worked like that I wouldn't have survived a week.*

**[Service user representative, focus group 3, rural CCG, 27/06/16]**

David did not believe the CCG fully understood the enormity of the issue and advised expertise should be sought from elsewhere. The minute record did not capture that passionate belief or his competence and desire for the CCG to be appropriately advised on the matter. A few months after our focus group discussion the rural CCG, as the lead CCG on the procurement of this high-profile issue, agreed a mutual termination of the provider contract. The provider had not met the contractual requirements and the populations served within the affected CCGs voiced their disquiet publicly in local and national news media.

Being competent with a return on your contribution did raise other issues about measuring competence and preparation for participating in a community of practice. Alison, Chief Clinical Officer and Accountable Officer in the urban CCG drew attention to the challenges and the need “*to work as a system*” to ensure patient safety. This being integral to good partnership working and the competence of the CCG. She was speaking about the sole secondary care provider for the CCG who, along with several other secondary care providers in the South of England at the time of the study, had been put into special measures by the Care Quality Commission. Working as a system was one way of demonstrating competence to peers and stakeholders alike, but rapid change to offer a service elsewhere was challenging in making sure all the right questions had been asked for meeting the needs of the people affected.

**Alison:** *So that's why it's really important we work as a system. Healthwatch are often very helpful in say actually going in, they have a sort of enter and view right, so then they can go and actually talk to people in those services, you know, how is it for you, is this change a good thing for you?*

*...and they'll be oh we've talked to so and so and then, which is often the interest group, and you have to go yeah, but they're not representing everybody, so again ... we have to be quite challenging around engagement, even though it's very fast moving, even though it's about safety, so you can't say no necessarily to that change, but you have to... where... where the system is so challenged and I think this comes back to the STP discussion, the health service is trying to react quickly to keep people safe, medically safe, within a very stressed environment, and so decisions are being made quickly and so our challenge has to be yes but how... how have you talked to people about this, how do you know this change is genuinely going to keep people safe?*

**[Accountable Officer and Chief Clinical Officer, urban CCG, interview 9, 15/06/16]**

Natalie, a fellow GP in the urban CCG, was more cynical about measures (of competence) for demonstrating PPEI for partnership working. She described it as “*bureaucratised*” and just ticking boxes for the political agenda. She was not convinced patient engagement put patients at the centre of their care journey when there were patient interest groups, the ‘usual suspects’, monopolising CCG meetings with their own agendas. Nor was she clear about why patient engagement was needed unless people understood the strategic picture and what commissioning was trying to achieve for a population. Her comments were influenced by her own experience leading the diabetes works stream to reconfigure services. She was happy with the patient she put forward as a service user representative and whom she described as:

**Natalie:** *... very experienced and ... a rational counter balance really and could actually bring quite a lot to the table in terms of strategic and pathway point of view following a patient going through that pathway.*

**[GP locality member Lead, urban CCG, interview 5, 5/04/16]**

However, she thought the representative selected by the secondary care diabetologist, although supposedly an ‘expert patient’ having worked with the charity Diabetes UK, was pro-hospital care and reluctant to change anything in the pathway. Natalie would have preferred to have seen a public health type committee that contributed to the decision-making process but the preparation for such a role requires consideration. The GP Lead for quality in the rural CCG (Heather) raised

this point during her interview as well. Service user representatives must learn how to function in meetings if they are to feel comfortable in such environments and not be overwhelmed by others (GPs, managers, lay and other service user representatives) more familiar with the style and function of the CoP.

### 8.3.2 Building confidence

Building the confidence of individuals participating in partnership working meetings happened at different speeds. This point, made by the lay representative for PPEI in the rural CCG, applied to GP Leads as well as service user representatives. It was important to have all the willing voices at the table and for him as lay representative to reassure people that he was on the side of patients and the public. He thought it would take longer for PPG representatives in the South locality to operate in the same autonomous way as the North locality PPGs. This was due to the socio-economic profile of the South locality where there was more deprivation and fewer service users willing to participate.

Similarly, GPs were not confident when CCGs came into being with the HASCA. They were used to running their own GP practices as small businesses and had little corporate experience. Edward spoke of this in terms of the support and guidance he offered the GP Leads in the urban CCG. He was like the 'old-timer'(170) using his extensive experience to mentor and model competence. Lucy, a GP Lead in the same CCG, described both lay representatives on the GB (Edward and Euan) as clever and measured in their interactions. They never got passionate, *"they listen a lot and then come out with some really important comments"*. She was drawing comparisons with the clinical strategy group where she described GPs as *"impassioned"* and *"we jump up and down"*.

**Edward:** *I try and provide some feed back to them [clinicians] if I can if there is something I can say that I think will help. Because they know I am going from a different world, and a different point of view. If there is something I can say to support, help or whatever it is then I will try and do that. It is a kind of informal meetings as well. Generally in the meetings, particularly initially, the clinicians were less willing to contribute in public particularly. I think because they recognised their lack of experience. I think that has changed over time. That has been a very positive development. I think now they feel much more confident about expressing their view... [Lay representative for governance, urban CCG, interview 4, 21/03/16]*

## 8.4 Boundary encounters

### 8.4.1 Believing in the PPEI agenda

*Hazel: They are some officers, two particularly I am thinking of at the moment, XXX and XXX [commissioning managers] who really do believe in the agenda. I think they do believe it very strongly and they do everything they can to facilitate it.*

*Hilary: I feel that the Officers within the CCG find it easier to accept patients and their ideas more easily than the clinical members.*

**[Service user representative, focus group 3, rural CCG, 27/06/16]**

The service user representatives in the rural CCG spoke highly of the commissioning ‘Officers’, acknowledging that they understood the patient perspective and were committed to PPEI as integral to the commissioning process. They were also praised by the GP Leads. In the urban CCG too, the commissioning managers and the engagement lead were mentioned numerous times as facilitating and enabling PPEI work. These comments appeared at the initial focus groups and were mapped to the first prompt question in **Table 4.10** as *other individuals and groups key to PPEI*. As the ‘Officers’ were not included in the research protocol to be interviewed, I was alert to when they were mentioned or discussed and noted their behaviours and interactions during observations. When they were mentioned at interview by other informants I explored their connections and encounters within the various CoPs. I wanted to look beyond the individuals and establish what it was they were doing to attract such high praise. The clinical chair in the rural CCG described the commissioning managers and some of the practice managers as “*very talented*”. Several of the GP Leads also remarked that they were not like the faceless managers rarely seen in the old PCTs. They would go that extra mile to keep people up to date with work stream developments.

The commissioning managers were warm and engaging, interested in people and believing in the agenda to work with patients and the public. There was no sense of hierarchy or lack of time. All people were treated with respect. One of the commissioners had helped me when I was finding it difficult to gain entry to the rural CCG for this research study. The commissioner was empathetic and genuine which is what the informants were seeing too. She invited me to observe a

community services programme board meeting in the rural CCG from where I was able to identify further possible informants.

In the rural CCG there was a GP business practice manager who sat on the GB as the practice manager lead for the South locality. She was described as “*outstandingly good*” by Nigel the PPEI lay representative. I observed her at GB meetings and a locality member meeting. She was efficient and practical and ensured all the food and refreshments were organised and set out for the latter meeting which I observed in August 2016 (observation 14). Attendees, comprising five GPs including the locality member Lead and CCG Lead for emergency and urgent care, four practice managers, locality lead nurse, pharmacist and a GP trainee, were made to feel welcome including myself as an observer. We each introduced ourselves before the business of the meeting commenced. These social niceties or entities were important for the ambience and conveyed a human connection. Nigel, who was not at that locality member meeting, had commented on how the practice manager lead had been instrumental in establishing patient engagement in the South locality. Her enthusiasm had encouraged and built up the confidence of participants who were initially reluctant to get involved. On the day I attended there was no service user representation as the patient from the locality PPGs had sadly died. The GP locality member Lead spoke highly of the representative. Together with the practice manager lead this conveyed a commitment to and belief in the PPEI agenda.

#### **8.4.2 Engaging multiple stakeholders**

*Ellie: I think as clinicians we have to listen to the other people in the organisation who know how to do this well and XXX (engagement lead) has been doing it for years and I trust her understanding of communities. I think GPs are quite keen on saying ‘Oh, I know this tiny group.’ Or ‘I know this’. We often think we do know stuff when actually there are more expert people who we have to listen to.*

***[GP Lead, focus group 2, urban CCG, 7/01/16]***

The above transcript extract from the GP Leads focus group in the urban CCG acknowledges the expertise of the engagement lead; her experience and understanding of the various communities that made up the urban footprint of the CCG. She had been employed with the former PCT, since the first few years into

the new millennium, and was the Patient Advice and Liaison Service manager before later becoming head of engagement. She had also handled complaints for the PCT.

Most of my observations of the CCG engagement leads took place in the urban CCG. (The rural engagement lead was not appointed until part way through my research study and was then undergoing his induction.) A striking feature of the encounters and conversations observed was the strength and depth that came from networking with *other individuals and groups key to PPEI*. The urban engagement lead had good working relationships with the local Healthwatch and VCS and the latter's umbrella organisation, all CoPs in their own right. In fact, the umbrella organisation had been commissioned by the urban CCG to undertake some public engagement projects and to work with and develop the PPGs. The engagement lead had good knowledge of the community development projects and had also worked with Macmillan Cancer Care when they used peer researchers to collate patient cancer experience. Her networking skills to engage multiple stakeholders had not gone unnoticed by the GP Leads. Lucy drew comparisons between the poor recruiting strategy for the PPG where she was a GP and the calibre of the service user representatives for CCG work streams. She described the engagement lead as having "*feelers*" to locate service user voices that impacted the commissioning process. Lucy had also carried out a lot of the ground work for her own projects and described working with the local authority and Citizens Advice Bureau. Her approach had been: "*I just make partnerships where I can really.*" Alex, the GP Lead for dementia in the rural CCG, had taken the same approach with her "*deep dive*" to unearth what was going on with her work stream and to include all the voices at the table, (8.1.1). Working with staff who had expertise from other present and past CoPs did facilitate a broader range of stakeholders for the commissioning process.

## **8.5 Meanings**

Two dominant meanings emanated from the data identified as partnership practices. The first entailed being seen as a person and not just a service user or GP clinician. The second related to the frustrations within 'the system' and having

to work amidst constant change, central directives, financial constraints and failing service providers. Members of some CoPs perceived that the public on whose behalf the CCGs were working, that is, local communities and neighbourhoods, did not understand commissioning at a population level.

### 8.5.1 Seeing you as a person

**Elizabeth:** *I just think sometimes they talk about this partnership and they bang on about how it is the way forward and all this but I don't think in practice. They still need a bit of a nudge to sort of say actually you know this really is important and you need to be listening to the people that are on the receiving end of the services as well as. It is all very well coming up with all these hair-brained schemes and throwing it all out there and saying this is marvellous. Yes, it is marvellous but actually putting it into practice is different.*

**[Service user representative, urban CCG, focus group 1, 6/11/15]**

Both Elizabeth in the urban CCG and Hazel in the rural CCG spoke of needing to be viewed as people instead of “generic patients” that tick the checklist box for the CCG. The extract above reiterates the earlier points about two-way communication and listening, (see **section 8.3.1**). There were similar experiences for the GP clinicians in their commissioning roles about not feeling valued or being spoken down to in a paternalistic sense. However, this theme conveyed the sense that something was different about partnership working in the new clinical commissioning landscape. Heather, GP and GB Lead for quality compared her experiences of practice-based commissioning in the PCT with the new way of working. She described how she felt she was the token GP in the old system.

**Heather:** *... I was there for the patients. I am not certain the managers were there for the patients. They were there to earn money or save money or whatever with money. But I don't think they were there .... It is possibly not entirely fair and not true for everybody. But I think the reason was to balance the books rather than actually improve patient care...*

*...you were the token GP. They weren't actually interested. The managers weren't interested in what you said or what you did. It wasn't clinically led. It was managerially led with a bit of clinical input rather than the other way round.*

**[GB Lead for Quality, rural CCG, interview 6, 1/06/16]**

Now, commissioning was for the right reasons and putting patients at the heart of care. She illustrated further with an example of where the commissioning managers waited until she had arrived before starting the meeting. They made it clear that it

was the clinical input that was required, and she and her GP colleagues were central to the discussion. It could not be done without them. This new attitude initially surprised Heather her but she welcomed the openness and more relational way of working on a commissioning work stream or project.

### **8.5.2 People not understanding**

As mentioned earlier, the sole secondary care provider for the urban CCG was deemed as 'inadequate overall' by the Care Quality Commission at the time of the research. The provider asked the CCG to take some of the pressure off their services whilst they worked on rectifying the issues. This inevitably impacted how the CCG could commission for their population and so patients had the choice to go elsewhere, maybe outside of area or use a private provider paid for by the NHS. Alison, Chief Clinical Officer, spoke candidly about how some of these knock-on effects were affecting the CCG plans.

**Alison:** *(Sigh) I think the quality and performance issues within secondary care at the moment, are causing so much dysfunction, that we have to put a lot of energy into that. I know the solutions lie in primary care, secondary care, mental health, and reforming those services and we absolutely have to have a focus there as well, but there has been... there are massive problems within our hospital and systemic large problems that we have been trying to help them with since I came into the role. We're only now getting full clarity honesty from them about those... the depth and the breadth of those problems and we have to put some energy into helping them fix it. ... because we spend so much money there, a problem there, and a dysfunction there, quickly gets out of hand and dominates all the discussion.*

*...we've got our sort of vision for how we want to move forward, which is that kind of assets based approach, building resilience in communities and the services within those communities very locally, and being much more pro-active about what we do in preventative care, we absolutely are committed to that, but at the moment, just now, you know, my colleagues in primary care and myself, are spending between 8 and 10% of their time supporting people who can't get to the service they need in secondary care, that has to be fixed quickly, because otherwise there isn't enough capacity in primary care to do the new stuff.*

**[Accountable Office and Chief Clinical Officer, urban CCG, interview 9, 15/06/16]**

There was also a sense of frustration among GP Leads that there were no levers to call the provider to account. It had ramifications if patients were not prepared to travel out of area and waiting times for procedures further increased. Similarly, if

patients were not prepared to use a private provider this also increased waiting times. The patient safety risk lay with the CCG yet, as one of the locality member Leads had said, the voice of General Practice and the CCG seems to be diminishing. Compounding the situation was a local survey that was being conducted to 'stop the NHS from being privatised'. The campaigners running the survey thought this would be an inevitable consequence of the HASCA and so were attempting to gauge public opinion. I asked Alison about the survey and its effect on how the CCG was viewed as a commissioning organisation. She felt there was a lack of understanding about the complexity of public sector issues affecting health and care. The CCG was collaborating with its partners and trying to help the provider address its difficulties, but some members of the public only saw the public provision as the good option.

**Alison:** *It certainly isn't done scientifically laughs...*

*"Do you think the NHS should be privatised? Or... you don't think the NHS should be privatised, do you?" ...*

*...is really difficult so when, you know, people are doing these surveys, you kind of think you're not understanding what's going on in the public sector. You're not understanding the depth of the problems that are developing locally and you're not understanding what they are... because they kind of are portraying it as though, you know, we're doing our local hospital out of business and, you know, this is going to be harmful for the NHS, where we're saying we want to refer locally, we want a really good local hospital, they're asking us to take pressure off them so they can improve. They can't improve under this amount of pressure, so they're asking us to do it, we're working in collaboration with them, but you know, where you've got this kind of, you know, like I say, public good and private bad, kind of approach that we get a lot at board meetings as well, it's very difficult, it's really difficult to have those conversations, people aren't just understanding.*

**[Accountable Office and Chief Clinical Officer, urban CCG, interview 9, 15/06/16]**

## 8.6 Conclusion

This draws to conclusion the findings from the four 'sets of practices' where my unique analytical framework has been applied to the data. Further interpretation with reference to the theory and existing body of knowledge is necessary to convey and comprehend what this might mean for the domain of practice PPEI for

clinical commissioning. This is addressed in the final chapter where discussion includes recommendations for practitioners, educators and researchers.

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## Chapter 9: Discussion

### 9.1 Introduction

In this chapter I begin with an exposition of developing a conceptual model from my findings. I then discuss the model in relation to the domain of practice, that is PPEI for clinical commissioning, and show how using social learning theory and practice theories has provided a unique perspective on PPEI as a practice entity. In addition, what this might mean for leading health and care services in partnership. By scrutinising the various **performances** of PPEI for clinical commissioning within the four sets of practices (chapters 5 – 8), I have exposed their socio-materialities through the focused ethnography. This includes not only the meanings (social entities) and materials but also the competences comprising multiple forms of understanding and practical knowledgeability. Shove and colleagues (128) describe these as the ‘elements of practices’. It makes visible how PPEI practice has been constructed across the landscape of clinical commissioning within the various CoPs during the period of the research and in so doing answers my key research question:

***What does it mean to work in partnership as clinicians and service users to commission and lead services?***

**Figure 3.1** shows the different CoPs where PPEI practices for clinical commissioning may take place.

Following on from this exposition I debate the pedagogical utility of the model by applying the model to the four practices in performance of PPEI for clinical commissioning with illustrations from my data; that is, ‘performing’ trust, leadership, learning and partnership. In so doing I address my subsidiary research questions offering recommendations from the study. Finally, I comment on the conduct of the study and its limitations as well as my reflexivity as a qualitative researcher, concluding with suggestions for further research.

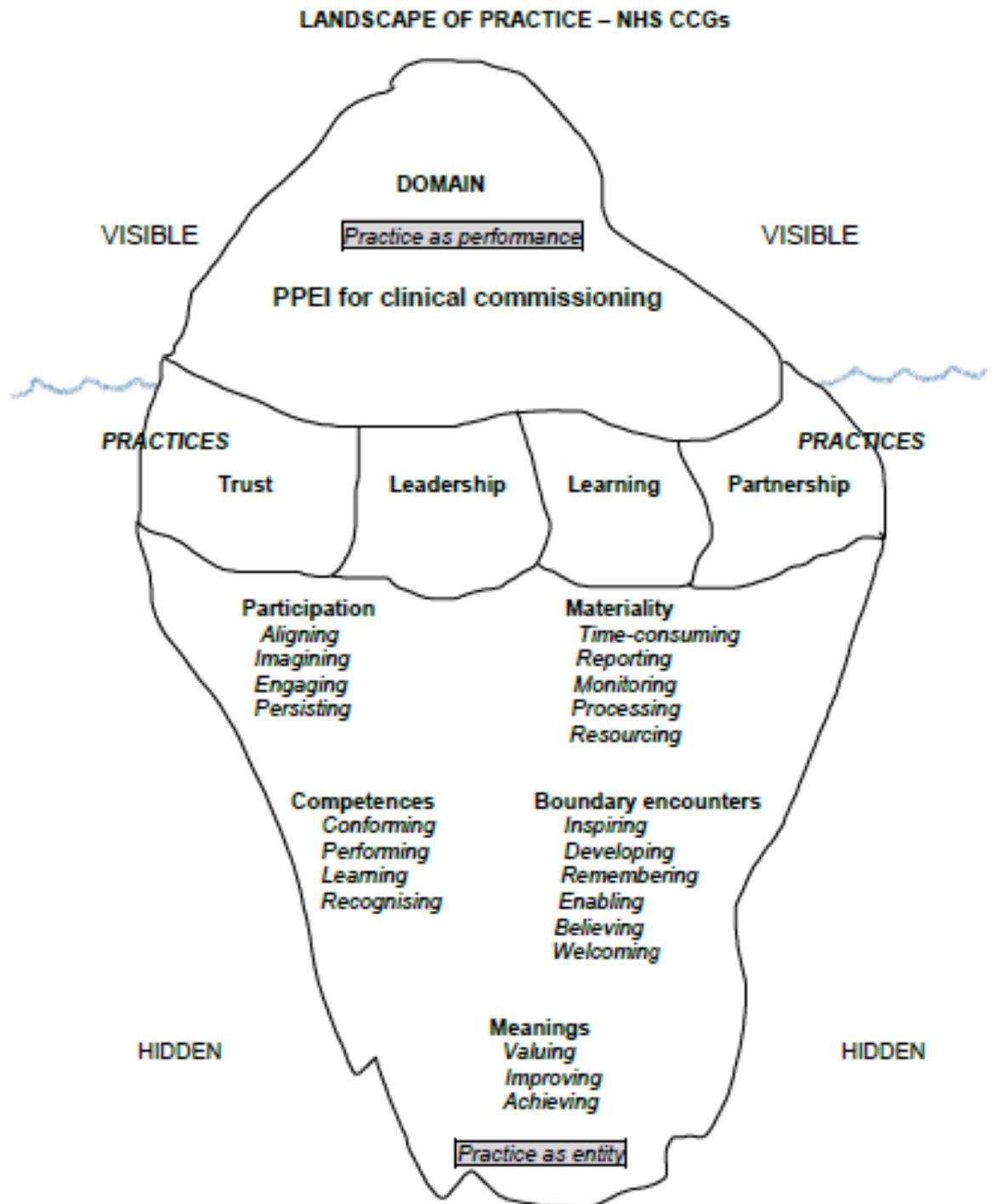
## 9.2 Developing a conceptual model of PPEI practices for clinical commissioning

Identifying the socio-materialities generated from PPEI practice is important for understanding the meaning of participation within a CoP and its implications for partnership and learning. Using this theoretical lens, PPEI for clinical commissioning can be re-imagined, and moves beyond the dominant cognitivist and realist accounts. It becomes not just a product, or outcome to be measured for impact. That is not to say evaluation does not have a place if the right tool is utilised. Commissioners will always be concerned about cost-effectiveness of the process and whether outcomes are improved, just as researchers are too with PPI and research. (233, 234) However, the focus on the technical and methodological aspects of PPEI/PPI has been to the detriment of a deeper understanding of practices. (235)

I see PPEI as a process made up of practices that are constantly interacting, colliding and reforming depending on the locations (within CoPs), materials and competences and to what extent practitioners are permitted to participate as a competent member. PPEI practice for clinical commissioning is like the tip of an iceberg with multiple practice performances that lie below the surface. Some are just visible, others hidden below the surface. **Figure 9.1** illustrates what I have called the 'iceberg model of PPEI practices for clinical commissioning'. The practice iceberg has been reported elsewhere to explain practices as visible forms of behaviour; what people do in 'practice as performance'. (236, 237) 'Practice as entity' is what lies below the surface; the knowledge and skills, the materials and infrastructures and socially shared meanings and tastes. (236) I have used these ideas to think differently about my data and its relevance.

In chapters 5 – 8, I have reported the themes of my findings. Themes are used by qualitative researchers to communicate meaningful patterns in their data but these are often descriptive. (238) A focused ethnography aims to describe and explain cultural aspects within a group or sub-group. (149) An interpretative approach

Figure 9.1: Conceptual iceberg model of PPEI practices for clinical commissioning



requires the researcher to identify the underlying concepts and model the relationships between them using the core patterns in the data that have informed the themes. (238) Beyond the thematic analysis, I was seeing the four sets of

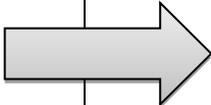
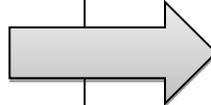
practices as more than just data bundles for ethnographic research. (226) I was conceptualising them as sets of practices since loose-knit patterns of practices are described as bundles based on their co-location and co-existence. (128) Perhaps even the stickier and integrated combinations of practices described as complexes (128) because of their interdependence, for example, trust and partnership.

Having moved across the data to identify four separate practices, in developing this model, I then reapplied the analytical framework (**Table 3.6**) to see how these four practices intersect and to see how these were distributed geographically across the domain of practice that constituted my study as shown in **Figure 3.1**. I did this by combining the findings (**Tables 4.14 – 4.17**) for all four sets of practices. I now discuss each component of the iceberg diagram in **Figure 9.1** with reference to the extant literature. By returning to the literature in the domain of practice and social practice theory, I was able to enrich the qualitative analysis and interpretation. This assisted with the exploration of ideas and how they fit with what has gone before. (239) I begin first with participation and then proceed to materiality, competence, boundary encounters and meanings. Following on from this, in **section 9.3**, I explore the application of this model to exemplars from my data in some of the CoPs in **Figure 3.1**.

### **9.2.1 Participation**

**Figure 9.2** shows the combined findings for participation across all four sets of practices in the left-hand column. These have been attributed to the three modes of identification described by Wenger-Trayner (172) because identification is how members participate or belong to a CoP. All three modes of identification were present in the data, where community members were practising PPEI for clinical commissioning. A CoP might have just one mode, for example, alignment with NHS England directives but another might have all three in a new work stream; alignment, engagement and imagination. In the right-hand column the themes are shown as to how they might appear in practice. An activity or behaviour in a CoP might be described as aligning or imagining or engaging.

**Figure 9.2: Participation across all sets of practices**

Themes	Practising is
<p><b>ALIGNMENT:</b>  <i>"Hear it, believe it, sign up to it"</i>            Conforming to the model            The public in engagement            Having a track record</p>	 <p>ALIGNING</p>
<p><b>IMAGINATION:</b>            Relational ways of working            It <i>"doesn't happen overnight"</i>            Knowing what patients are thinking</p>	 <p>IMAGINING PERSISTING</p>
<p><b>ENGAGEMENT:</b>            Unequal partnerships  <i>"They looked the same."</i>            Wearing lots of hats</p>	 <p>ENGAGING</p>

In my study there were times when participation was clearly being driven by NHS England or other commissioning directives. Wenger originally acknowledged that alignment can control and direct practice and therefore concerns power relations within a CoP. (172) This is important for functioning in a broader system such as a CCG or the NHS where performance is monitored and assessed. The discourse drives alignment so that local actions fit the broader framework generating artefacts that can be shared elsewhere as evidence of participation. Wenger's later work on landscapes of practice suggests alignment is not all about compliance or passive acquiescence. (172) It should be a two-way process but there were clearly set ways of doing things, determined by the CCG constitution and legislation (HASCA), and for responding to NHS England directives. For example, participating in a tightly scripted GB meeting in public, implementing CoPs for the CCG work streams and addressing medicines management for cost containment at locality member meetings. This centrally-directed control has been reported elsewhere in case studies on the early development of CCGs. (54, 111) More recently Reidy et al. (116) demonstrated how local voices were mostly absent for

self-management support commissioning as national drivers and incentives such as the Quality Outcomes Framework (132) determined performance management.

CCG clinical leaders were generally the 'usual suspects' (66), that is, GPs with prior experience of working in practice-based commissioning and PCTs. This too is alignment since the GB must be accountable to both its public within the CCG geographical boundary and to NHS England. It must demonstrate it has the appropriate governance structures and committees in place with capable leaders. Some of these committees were highlighted as CoPs for PPEI in **Figure 3.1** (orange-coloured circles) as they inevitably have a PPEI function, for example, the Communications and Engagement Committee in the urban CCG or the PPG Network Group (mauve-coloured circle). Such public involvement structures are not uncommon and have been reported elsewhere. (117) The GB lay representative usually chairs the CCG PPEI group and will often have an established managerial background as was the case in my study. Croft et al. (117) found that identifying with CCG management structures and aligning with managerial processes was important for the credibility of the lay representative.

The above illustrations are examples of how the CCGs were influenced by the central agenda from NHS England and so politically and constitutionally they were **aligning** with policy. NHS England is responsible for the performance management of CCGs. (19) This alignment was more evident in the GB and locality member meetings akin to leadership practices and so has been included as part of my conceptual model to account for PPEI practices for commissioning.

Imagination as a form of participation and mode of identification was manifest in wanting to think differently about ways of working and to not rely on "*counting the beans*" as with the KPIs. These more relational approaches took a considerable amount of time and energy involving a whole team approach. Noticeable among the individuals who perceived a new way of working, or reconfiguration of a service model or pathway, was their persistence for seeing something through. This applied to the GP work stream Leads, for example, Alex and the dementia work stream in the rural CCG and Lucy and the community services works stream in the urban CCG. Similarly, with Euan setting up the Communications and

Engagement Committee in the urban CCG and Hilary and her fellow service user representatives working with community services procurement in the rural CCG. The activities were invariably partnership and leadership practices and so **persisting** alongside imagining has been added to practising participation in **Figure 9.2**.

Engagement is about the everyday in the moment lived experience of participation. (172) The data themes revealed that informants were wearing multiple hats for various roles in PPEI and/or leading in the CCG. Wearing more than one hat added to workload pressures including the capacity to assimilate minutes, reports and other reified products associated with the roles occupied. This applied to all informants; GP Leads who were partners in a GP practice, a salaried GP or locum who was a work stream Lead; GB lay representatives who by the CCG constitution were required to chair, deputise or sit on various committees; service users who were often leading a PPG, part of a locality or CCG PPG network and a patient representative for a work stream. The latter could be at operational level, for procurement or at strategic (programme board) level. The GP Leads were noticeable by their absence in the buying services and monitoring and assuring stages of the NHS commissioning cycle, (**Figure 1.1**). As engagement was all encompassing in the CoPs and central to Wenger -Trayner's modes of identification (172) **engaging** has been included as part of the conceptual model for the participation component.

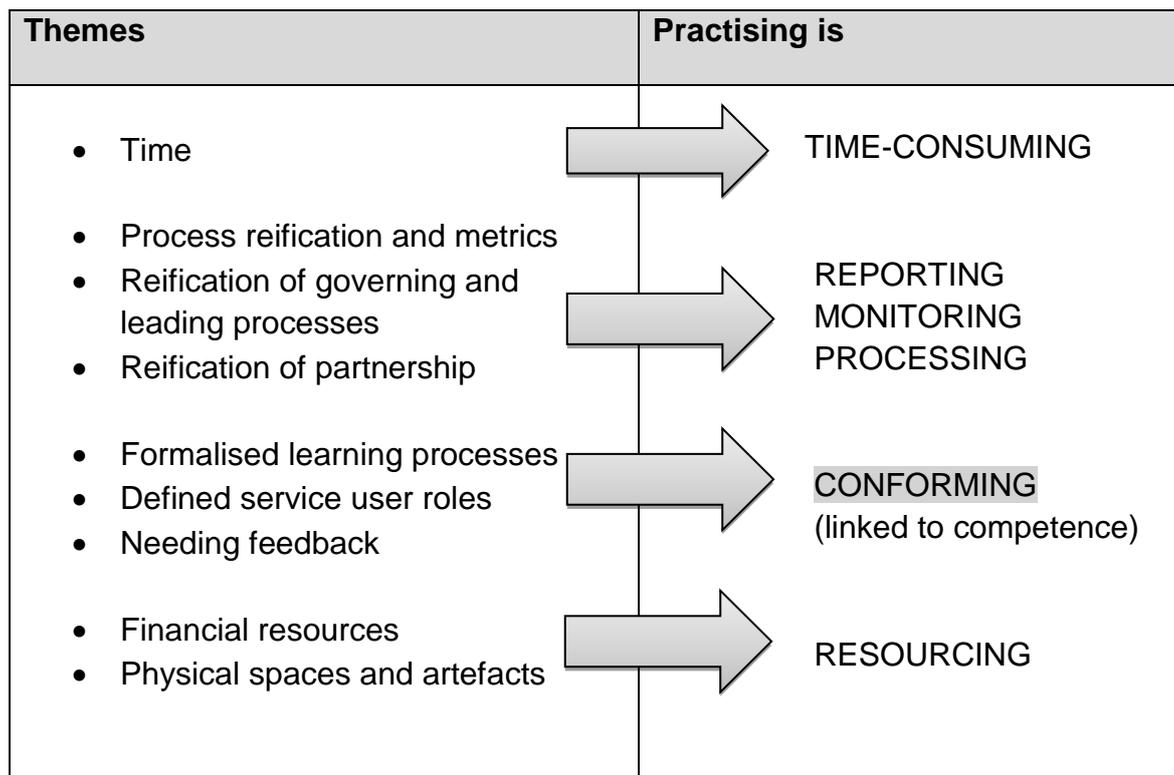
What should be noted at this point is that the modes of identification for participation do not necessarily convey how well they are deployed; only that they are occurring across all four sets of practices (trust, leadership, learning and partnership) and result in practising (or performance) that is **aligning, imagining, persisting** and **engaging** in **Figure 9.2**. These are also shown on the conceptual iceberg model at **Figure 9.1**.

### **9.2.2 Materiality**

Material entities are important for social learning and go hand in hand with participation. The experienced practitioner can demonstrate or guide the novice for example in how to use a piece of equipment, a database or a checklist. Materials

matter and can often be implicated in relation to patient safety (157) if the learner or practitioner has not paid sufficient attention, for example, adhered to a guideline or followed a procedural checklist. **Figure 9.3** illustrates how the materialities in the data contribute to the conceptual model of PPEI practices. It is a busy image but there was a considerable amount of reification to make transparent the work of both CCGs (rural and urban) as accountable organisations.

**Figure 9.3: Materiality across all four sets of practices**



The materialities reported in chapters 5 – 8 impacted on PPEI practices for commissioning in many ways. CCGs must ensure the timeliness of interventions and treatments for patient safety and assimilate patient experience feedback. Alison, the Accountable Officer in the urban CCG, commented on this in relation to the failing secondary care provider (8.3.1). Hazel was critical of the Patient Reported Experience Measures (5.2.2) and as a service user representative wanted to ensure feedback was appropriate and meaningful to patients.

Time was an important material resource. Many respondents referred to having insufficient time or taking a long time to establish a work steam. This was

especially relevant where informants had other roles. Reading minutes and papers for meetings was time-consuming given the quantity provided only a short time in advance including for the GB meetings in public. It would be overwhelming, perhaps inaccessible if only available online. For the 'naïve member of the public', described by Reidy et al. (116), wishing to attend a CCG GB meeting and raise a public question it may even deter participation. Hence, **time-consuming** has been added to the conceptual model of practices.

Wenger refers to the complementarity of participation and reification; one compensates for the other. (169) If participation (the doing reported in **9.2.1**) prevails there is insufficient material to anchor the specifics of a process and its products. Reification therefore 'congeals' the human experience and the practice generating artefacts such as minutes, procedures, protocols for a concrete record of material entities. There can be over reification of process which in turn limits participation or makes it tightly controlled. An example of this was David, the service user representative in the rural CCG, who was frustrated by meetings where the success criteria were more to do with the conduct of the meetings (the process) than the outcomes of decisions made, (**5.2.2**). Focusing on processes and actions has been reported in other research exploring PPEI for commissioning at strategic level. Measurement against nationally driven financial incentives for commissioning organisations prevailed over locally determined need from engaging with patients and the public. (116, 240) Therefore, materiality has a significant role in **reporting, monitoring** and **processing**.

The voluminous paperwork for the GB and procurement meetings are further examples of reification. Information demands upon CCGs and what has been described as excessive tendering and procurement may be because CCGs are concerned about being subject to judicial review. (13) They need to be transparent and fair in their contracting but also in demonstrating meaningful engagement with patients and the public.

The defined service user roles, although an illustration of materiality, are discussed in the next section as the content of the role descriptors makes explicit the competences required for the roles. It also illustrates the entangled nature of

practices and the interdependence of the elements of practice. I see the defined roles as an illustration of **conforming** which is better positioned as part of competence (know-how and skills) within the model.

Finally, **resourcing** has been included as separate to time as a resource. This is because providing the most appropriate venue and ensuring the structure and use of that space can be important for the success of PPEI meetings. Financial resources for administrative purposes and remuneration of out of pocket expenses for service users were also mentioned in the data. They too have a bearing on the valuing of PPEI practices for both individual participants, and the CCGs as NHS organisations engaging with patients and the public in a co-productive partnership for commissioning.

### **9.2.3 Competence**

Competence as the dimension of knowing is negotiated and defined within a single CoP by the community members. (172) It is a learning partnership and members bring skills and knowledge from past CoPs that become important for present and future CoPs. These histories form trajectories within and across CoPs. Practices collide and entangle so that practitioners either perpetuate and sustain what has gone before or make/perform something new. The 'threading through' (155) idea is partly dependent on practitioners as 'carriers' (128, 155) and whether there are 'materials' at the new destination, that is another CoP, which can be utilised in conjunction with their knowledge and skills. An example for PPEI practice might be the initial public engagement events run in the rural CCG and the ability to replicate them in a different work stream with a different group of service users and clinicians at a different venue. The 'carrier' might be the CCG engagement lead or commissioning support managers. The meaning of a practice may alter in the new destination because of the different context and cultural norms. Note, that 'practitioners' refers to the people performing the practice and not exclusively the clinicians. A practitioner could be a GB lay representative, a service user as well as a GP Lead.

Individuals can belong to a number of CoPs (multi-membership) that are in turn likely to be part of a broader constellation or landscape of interconnected

practices. (169) Hence, my preference for calling the domain of practice PPEI for clinical commissioning and the diagram at **Figure 3.1** showing these constellations of interconnected practices. An individual can participate competently in a few CoPs but for some CoPs will only be on the periphery. As previously argued, time as a material resource may be one factor preventing full participation. This is why it is important for a leader to demonstrate knowledgeable ability. (172) A leader does not have to be the subject expert or fully participating in every CoP, a point made by Alison as chief clinical officer in the urban CCG, (6.5.2).

**Figure 9.4** shows how competence should be across all four sets of practices for PPEI practices for clinical commissioning. Once again present participles are used as practices are constantly in motion and changing (practising) but the community determines competence. (169) Hence, some of the GP Leads commented on their willingness to become clinically engaged compared to past experiences in the PCT. They were no longer a 'token GP' but engaged alongside managers. The CCG roles enabled them to participate in a different but more rewarding way. Similarly, patients were perceived as being involved right at the grass roots from the PPGs to the locality Patient Reference Groups (rural CCG) to the PPG Network meetings (urban CCG). This is labelled as **performing** but also noticeable in the data was the requirement to conform to the role specifications.

The role descriptors for the service user representatives and the rigorous recruitment process for the GB lay representative for PPEI in the urban CCG are examples of materiality that was explained earlier. However, they have criteria which culminate in the role occupants **conforming** to the requirements of the CCG to confirm their competence. The service user representatives talked about being selected, recruited or forwarded to the roles. The commissioning managers determined who should occupy the roles and directed subsequent participation. Other studies have reported similar findings where members of a CCG reference group 'had to jump through hoops' (115) for selection, or the appointees were 'not very lay' (116) and the commissioners selected who they would approach. (116, 117)

**Figure 9.4: Competence across all four sets of practices.**

Themes	Practising is
<ul style="list-style-type: none"> <li>• Better than the PCT</li> <li>• Patients involved from the ground up</li> <li>• Being clear on engagement</li> </ul>	 <p style="text-align: right;">PERFORMING</p>
<ul style="list-style-type: none"> <li>• Recruiting and selecting leaders</li> <li>• <i>“no-one wants to be low in ratings”</i></li> </ul>	 <p style="text-align: right;">CONFORMING (linked with materiality)</p>
<ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Role tensions</li> <li>• Sniffing out talent</li> </ul>	 <p style="text-align: right;">LEARNING</p>
<ul style="list-style-type: none"> <li>• Return on your contribution</li> <li>• Building confidence</li> </ul>	 <p style="text-align: right;">RECOGNISING</p>

Formalised learning processes were also apparent in the materiality component as they are concrete entities. They were complemented by the theme of ‘learning by doing’ which appears above in **Figure 9.4**. As **learning** in CoPs is key to social learning theory it is included here as part of the competence component of the conceptual model. This is ‘learning as becoming’ which Wenger argues is about identity and how learning changes who we are as described in **3.4**. (169)

Recognition of competence in a CoP was important to informants. Hence, the theme ‘return on your contribution’ and **recognising** in the conceptual model. Coupled with ‘needing feedback’ on your contribution (materiality), service user representatives and lay representatives in both CCGs acknowledged it was important and helpful to know the consequences of their participation. Again, this is evident in other research where service user and lay representatives wanted more feedback on their contributions and if it had influenced decision-making for strategic commissioning. (115) Some studies have shown PPEI processes have had little impact on final commissioning decisions. Managerial priorities

determined what should be commissioned because of how CCGs were judged against outcomes. (54, 115, 117) There was little evidence of partnership working.

#### 9.2.4 Boundary encounters

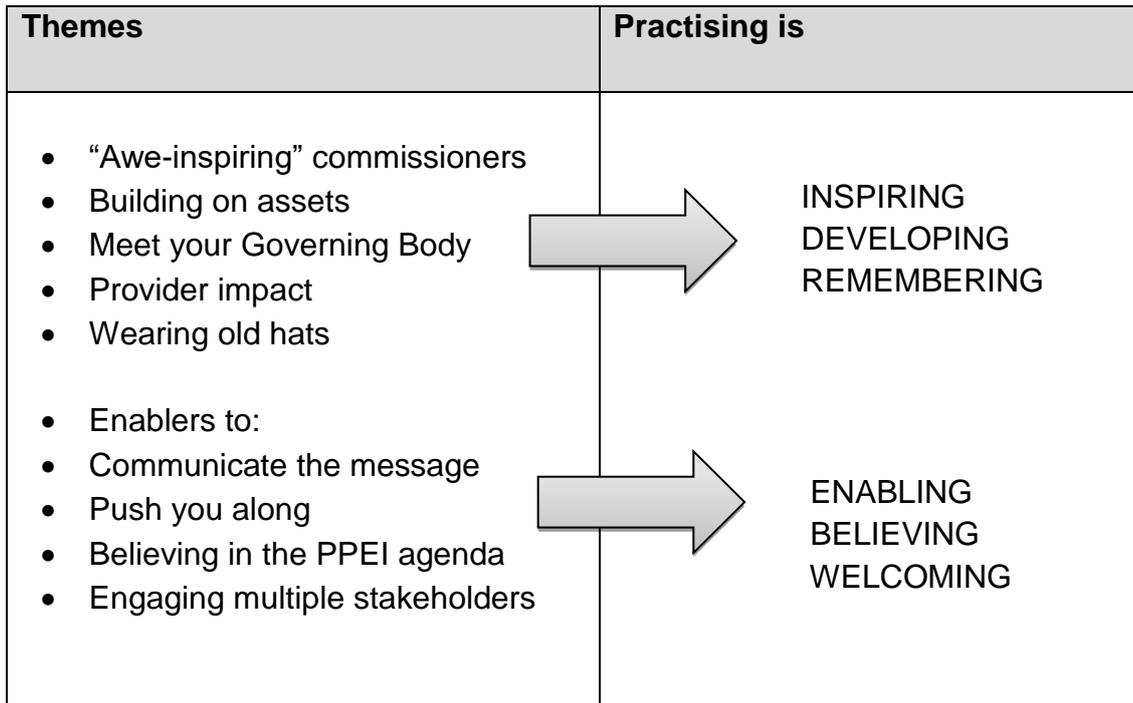
Boundaries between different CoPs can create some discontinuity (169) which is why boundary encounters were included as part of the analytic framework.

Wenger refers to boundary objects, a phrase attributed to the sociologist Leigh Star (169, 241), which enable continuity so that communities can function in a more productive manner. A boundary object might be an artefact brought from another CoP that facilitates a new practice.

This component of the framework revealed some interesting and unexpected findings as reported in the methodology chapter (4.13.1) and findings chapters. Several informants described the commissioning support managers and Director of Strategy (in the rural CCG) as **believing** in the PPEI agenda. They were **enabling** and **inspiring** whilst being **welcoming** and receptive without passing judgement on the many stakeholders they encountered, (Figure 9.5). The engagement lead in the urban CCG was also highly praised for her ability to work with different stakeholders across the CCG localities and community groups. This demonstrated the **developing** nature of engagement. Hence, these doing words, as with the emboldened words in the other components, have been included in the model so that they can be sought, observed and mapped in scenarios where PPEI for clinical commissioning occurs. (See more on the synthesis and application in 9.3.) They are also shown on the conceptual iceberg model in Figure 9.1.

**Remembering** has also been included in the model to accommodate the times when CoP members put on old hats to address specific issues. They brought know-how and previously acquired skills (competence) that could be re-kindled and used. Leslie and the computer system procurement in the rural CCG is one example, (6.4.3). He referred to leaving “... *the patient’s voice and was helping the office ...*”. It provides a further illustration of the inter-connected nature of practices as his competence in a past CoP functioned as a boundary encounter.

**Figure 9.5: Boundary encounters across all four sets of practices**



### 9.2.5 Meanings

Earlier in chapter 3 the social aspects of practices were considered in terms of what Wenger saw as the tacit knowing. (169) The meanings component of my analytic framework was intended to uncover some of that knowing and reveal the social and symbolic aspects of PPEI practices whether related to what was said or left unsaid. **Valuing** community members, especially the contributions of service user representatives, emanated from the data where roles and role descriptors were discussed by the service user representatives. This was linked to practices of trust and being viewed as credible and competent. In addition, the desire to improve and achieve transformational change in the CCGs although this had more resonance with the GP Leads and leadership practices as they had targets to consider. **Figure 9.6** illustrates how meanings contribute to the conceptual model in practising PPEI for clinical commissioning. **Improving** and **achieving** are also listed. Note that the “*people not understanding*” theme is not a deviant case. (74) That was the genuine view considered by the GP Leads and is well documented in the literature. Patients are seen as not understanding the NHS for PPEI purposes because it is so complex. (117) It can be a source of frustration to managers and

clinicians when explanations of CCG business for a work stream are repeatedly clarified at meetings.

**Figure 9.6: Meanings across all four sets of practices.**

Themes	Practising is
<ul style="list-style-type: none"> <li>• Feeling valued</li> <li>• Seeing you as a person</li> <li>• Role descriptors and status</li> </ul>	 <p style="text-align: right;">VALUING</p>
<ul style="list-style-type: none"> <li>• “We don’t use the ‘F’ word here</li> <li>• Wanting to make things better</li> <li>• Sense of pride</li> </ul>	 <p style="text-align: right;">IMPROVING ACHIEVING</p>
<ul style="list-style-type: none"> <li>• People not understanding</li> </ul>	

### 9.2.6 Creating a conceptual map from the iceberg model of PPEI practices for clinical commissioning

For the iceberg model to have utility beyond an explanatory level in social learning, it must be comprehensible and easily applied. I now explain how this can be done but begin with a précis of the earlier sections in this chapter. **Figure 9.1** illustrates the iceberg model of PPEI practices for clinical commissioning showing:

1. All five components of my analytic framework that are elements in any given practice. These include the three ‘elements’ defined by Shove and colleagues (128): competences, materials and meanings. Participation and boundary encounters are two components (elements) that I have added.
2. Four sets of practices as entities; trust, leadership, learning and partnership.
3. Trust, leadership, learning and partnership are **performed** as practices in conjunction with the five components. Each component has a list of doing words, the present participles of verbs derived from my data. The doing

creates a continuity with ongoing practices.

4. Together these illustrate the practising of PPEI for clinical commissioning as an entity.

**Figure 9.7** is a map of the model which can be used to trace PPEI for clinical commissioning as a practice entity for individual CoPs. It reveals the hidden practices that are often not overt in performance because they do not appear in the portion of the iceberg that is visible above the surface, (**Figure 9.1**). The five components of the analytical framework compiled from the four sets of practices (trust, leadership, learning and partnership) are included in the map. They are arranged in columns running left to right together with the ‘practising’ words for each. To show the variations across all four practices against the five components of the theory and analytical framework the map can be shaded. It is possible to have more than one shaded box in a column, for example, a CoP may have material entities for reporting, monitoring and processing.

**Figure 9.7: Conceptual map for PPEI practices in clinical commissioning**

<b>Participation (P)</b>	<b>Materiality (Mat)</b>	<b>Competence (C)</b>	<b>Boundary encounters (BE)</b>	<b>Meanings (M)</b>
Aligning	Time-consuming	Conforming	Inspiring	Valuing
Imagining	Reporting	Performing	Developing	Improving
Persisting	Monitoring	Learning	Remembering	Achieving
Engaging	Processing	Recognising	Enabling	
	Resourcing		Believing	
			Welcoming	

The conceptual map can be used either as a one-off exercise in a CoP or repeated during a work stream. Who performs the mapping exercise will depend on the consensus in the CoP. It does not have to be the work stream Lead. Reidy et al. (116) used service user researchers to inform their data providing supplementary materials highlighting good and bad PPEI practice. Given the evolving nature of practices and the complexity of some patient pathways/service

redesigns, the map may change over the course of time as community members accustom themselves to the work stream and gain confidence.

### **9.3 Synthesis and application of the conceptual model/map to all four sets of practices**

I will now apply the iceberg model/map to show the constitution, variation and distributed nature of PPEI and clinical commissioning across some of the CoPs within the domain of practice as envisaged in **Figure 3.1**. To demonstrate how the map can be used, I have taken exemplars from each of my four sets of practices. It is not possible to produce maps for every CoP as space does not permit. However, the illustrations provide insight into the performances of trust, leadership, learning and partnership practices. I have selected these exemplars because they are either a good example of PPEI for clinical commissioning and partnership working, or because it was more difficult to illustrate where PPEI was evident in the CoP. By using the map practices become visible together with their socio-materialities. If there are parts of the map where performance could be improved, it provides opportunity for exploring what can be changed within the CoP to make that improvement.

The letters denoting the columns in the map are included in brackets in **Figure 9.7**. Replication of the map in the following sections shows the columns labelled by the letters only.

#### **9.3.1 Trust practices**

**Figure 9.8** is the map of the community services procurement CoP that involved Hilary in the rural CCG. I did not witness these meetings other than a programme board meeting so am reliant on her account. However, there were other service users, commissioning support managers and GP Leads that verified Hilary's version of events.

Noticeable on the map is the aligning (P) and time-consuming (Mat) nature of the work. The contract was completed through competitive dialogue. Hilary was recruited into her role under the direction of the commissioning support manager (BE). Her competence was agreed as conforming (C) to the requirements of the

CCG. However, she was learning (C) during the process having attended a half day training session. She also said that the commissioning support manager had talked her and her fellow service user colleague through the process. There were multiple documents because of the number of tenders and so she had to learn what she must read and what she could skip over. Hilary was very complimentary about the commissioning support manager and felt valued (M) because the manger believed in the PPEI agenda for clinical commissioning.

**Figure 9.8** is helpful for answering my first subsidiary question:

**i. What is the nature of a trusted peer relationship?**

The map in **Figure 9.8** illustrates the distributed nature of trust as a social property. Trust emerges as a quality from composite relationships between people, physical objects and the environment in situated practices as described above. Trust is not a bankable resource located inside the head or body of an individual. (159) Nor is it a feature of an organisation but a social property in social exchange. (182) It shows

**Figure 9.8: TRUST PRACTICES - Community services procurement (CoP) in rural CCG – Hilary**

<b>P</b>	<b>Mat</b>	<b>C</b>	<b>BE</b>	<b>M</b>
Aligning	Time-consuming	Conforming	Inspiring	Valuing
Imagining	Reporting	Performing	Developing	Improving
Persisting	Monitoring	Learning	Remembering	Achieving
Engaging	Processing	Recognising	Enabling	
	Resourcing		Believing	
			Welcoming	

the composite relationships and the outcome or effect of the practices associated with participation, materiality, competence, boundary encounters and meanings as they interact, collide and conflict. Trust is not reliant on the agency of individuals although the commissioning support manager was a catalyst for moving the trust relationship on with her enabling and believing practices. This does challenge the

appropriateness of the word ‘peer’ in the question. The research question should have perhaps read ‘what is the nature of a trust relationship’?

### 9.3.2 Leadership practices

The exemplar for leadership practices is the GB CoP. **Figure 9.9** is a map of the two GB meetings attended during the research study in the urban CCG. The map shows the heavy reification (Mat) associated with holding meetings in public that are predominantly for rubber-stamping the business of the CCG. The volume of papers and data were highlighted in **6.2.1**. There was much aligning within participation practices (P) as these frequently addressed central directives from NHS England or the operational plans of the CCG, especially with the secondary care provider in special measures. Competence (C) in the CoP was about conforming to GB roles. Boundary encounters (BE) was for developing the work streams and initiatives, for example, reporting PPG clustering to the GB via the engagement lead. Remembering encompassed co-opting others to work with the GB membership because of experiences from past CoPs or calling up past events and initiatives, for example, around public health. (The public health consultant was a member of the GB in the urban CCG.) The practices associated with meanings (M) were mostly about improving commissioned services for the CCG population and improving the quality of GP services, both of which are the legal duty of the CCG. (17)

**Figure 9.9: LEADERSHIP PRACTICES - GB (CoP) meetings in the urban CCG**

<b>P</b>	<b>Mat</b>	<b>C</b>	<b>BE</b>	<b>M</b>
Aligning	Time-consuming	Conforming	Inspiring	Valuing
Imagining	Reporting	Performing	Developing	Improving
Persisting	Monitoring	Learning	Remembering	Achieving
Engaging	Processing	Recognising	Enabling	
	Resourcing		Believing	
			Welcoming	

The GB meetings were not the best examples of PPEI for clinical commissioning within a CoP. They did not convey where patients and the public had engaged in

partnership to commission and lead services. Proceedings were controlled by the GB chair and the agendas were largely scripted in that members would have an allocated slot. Public questions were handled in a formulaic manner as reported in **6.1.2**. Both GB lay representatives for PPEI (Euan and Nigel) had leadership and managerial track records. Nigel was prepared to challenge the clinicians more in the rural CCG whereas Euan, when he had suggested how the GB lay representatives could work together, was discouraged from doing so by them. This might have been due to lack of confidence as he was encouraged by the Chief Operating Officer to pursue the leadership role as "*it was the right thing to do*". However, Euan may not have wanted to create too much conflict and upset.

One of the challenges with envisaging PPEI for clinical commissioning as a domain of practice is that not all the CoPs depicted in **Figure 3.1** are formed through choice. They are not informal, self-selecting and self-organising (242) since every CCG must have a GB with a largely pre-determined membership. To address the second subsidiary research question, it is therefore helpful to refer to other leadership practices from the data where participation practices were more engaging and imagining. Competence too was about learning and recognising within a CoP.

## **ii. How can relationships be developed to demonstrate effective service user and clinician engagement?**

Lucy described it as a privilege to have the opportunity to change services as a GP Lead in the urban CCG. Ideas about joy and meaning in work are not lost on leadership commentators who refer to joy as something to be pursued to ensure the happiness and retention of the workforce. (243) It has become the fourth constituent of the quadruple aim for service improvement and cost-effective health care (244) and something to address within reflective processes for professional development. Batalden (245), in a recent essay rethinking his 2007 work on quality improvement, adds professional development as a previously missing element of his taxonomy. Co-production is about working as 'whole people' and so the professional that uses the experiences of individuals, as well as science informed practice and their own knowledge and skills does make themselves vulnerable.

(245) However, working in this more relational and imaginative way can create a sense of trustworthiness. Lucy's example of the young terminally ill patient illustrates this point, (5.1.1). She had created a trusting and effective interpersonal relationship with her patient but her participatory and imaginative approach was also evident in her work streams. See the next **section 9.3.3** for learning practices. This illustration shows how the clinician (GP Lead) can develop their co-producing relationships but it is equally applicable to service users and lay representatives who need space and permission to be vulnerable. Continuous learning is not just the hallmark of the 'professionals'. (245) Using the conceptual map of the iceberg model of PPEI for clinical commissioning would be helpful to reveal more clearly the characteristics of the practices within a CoP, and to identify where improvements can be made to work in a more relational way.

### **9.3.3 Learning practices**

Novice GP Leads Alex and Lucy spoke of engaging with their work streams and going out to local services and communities to find out about the patient experience and whether services were fit for purpose. They also learnt from the commissioning support managers and the lay representatives. **Figure 9.10** is an illustration from Lucy's work stream (CoP) for community services reported in 7.4.1. Although it was time-consuming (Mat) and reported to the CCG through formal processes (for example, the Clinical Strategy Group) she imagined what her team would be able to do. She spent time engaged with the service providers and patients and listened in on consultations so was persisting with her vision. (P) She thought the GB lay representatives and service user representatives inspiring, and together with her commissioning support manager (BE) they could improve services and value the voice of patients and carers. (M)

A comparison of the two case study sites was not the primary purpose of the study; but there were a few initial observations. The rural CCG appeared to focus on developing the GP Leads. More informal processes were employed for preparation of the service user representatives as elaborated by Nigel in 7.2.1. Whereas the urban CCG, which was larger with more GP practices, invested in

developing the PPG representatives through the PPG network meetings, workshops and conferences.

**Figure 9.10: LEARNING PRACTICES - Community services (CoP) work stream in urban CCG - Lucy**

<b>P</b>	<b>Mat</b>	<b>C</b>	<b>BE</b>	<b>M</b>
Aligning	Time-consuming	Conforming	Inspiring	Valuing
Imagining	Reporting	Performing	Developing	Improving
Persisting	Monitoring	Learning	Remembering	Achieving
Engaging	Processing	Recognising	Enabling	
	Resourcing		Believing	
			Welcoming	

Experiential learning and shadowing clinical commissioners have a place in the training and preparation of recently qualified doctors. (246) Sabey and Hardy’s study (246) highlights the theme of readiness versus reluctance with respondents saying they lacked understanding of roles and skills required for commissioning. Although the study data were collected between 2007 and 2010 (246), before the current iteration of clinical commissioning, respondents wanted first to learn to be a good GP. Then they could turn their attention to becoming a commissioner. Insight taster sessions to foster a positive discourse and local education provision by way of preparation were suggested as a solution. (246) Lucy and Alex did not have the benefit of shadowing as their roles were part of the new commissioning landscape post the HASCA. They had to get out and get on with the job but learnt along the way from other members of their respective CoPs. Alex did undertake some formal learning and was able to meet other commissioners as part of that learning process.

### 9.3.4 Partnership practices

**Figure 9.11** provides an illustration of partnership practices mapped to the iceberg model. Alex’s work stream was for dementia services in the rural CCG. As with Lucy in the learning practices exemplar, she spent a considerable amount of time learning about her role and undertaking the “*deep dive*” suggested by the clinical

chair Harriet. She also had to work hard at developing the partnership with the various stakeholders as recounted in 8.1.1. It was not something that was going to happen overnight. She also found some of her GP colleagues resistant to change. The map shows her imagining and persisting skills of participation (P) plus the time-consuming work associated with processing a new work stream, (Mat). She was learning on the job (C) but also had great confidence in her commissioning support manager (BE). The meanings (M) attached to the CoP entailed valuing the voices of the service users and carers as she “*always had them in the room*”, improving and achieving the services which she was determined to see through to the conclusion.

**Figure 9.11: PARTNERSHIP PRACTICES - Work stream (CoP) for dementia in rural CCG – Alex**

<b>P</b>	<b>Mat</b>	<b>C</b>	<b>BE</b>	<b>M</b>
Aligning	Time-consuming	Conforming	Inspiring	Valuing
Imagining	Reporting	Performing	Developing	Improving
Persisting	Monitoring	Learning	Remembering	Achieving
Engaging	Processing	Recognising	Enabling	
	Resourcing		Believing	
			Welcoming	

At the time of the data collection in late 2015 and 2016, the definitions of partnership took on a new meaning with the announcement of STPs. CCGs were already attempting to further partnership working with local authorities in the public sector and not-for-profit organisations in the VCS. Some of these partnerships and relationships had long histories originating from the days of practice-based commissioning and PCTs. There was also an increased emphasis on engaging patients to work in partnership with clinicians for person-centred care (247) and shared decision-making. (248) In addition, using patient activation measures (PAMs) especially for long term conditions to encourage patient engagement and self-management on an individual basis. (249) I note this here as, despite my questions focusing on strategic PPEI for clinical commissioning, the responses were at times inevitably influenced by what was capturing the attention of the CCG

around partnership working. The collective voice of the service user was sometimes overlooked. Informants, especially the GP Leads, provided me with responses they thought I wanted to hear around partnership working and self-management. However, the exemplar provided above was a good illustration of partnership practices with strong evidence of PPEI for clinical commissioning, even if some of the service user roles were prescriptive and defined by the managers.

My key research question focused on partnership between clinicians and service users to commission and lead services:

***What does it mean to work in partnership as clinicians and service users to commission and lead services?***

The mapping of partnership practices with the iceberg model of PPEI for clinical commissioning provides insight but snapshots of CoPs do not convey the complete picture over time. **Figure 9.11** exposes partnership practices as a practice entity and reveals the complex nature and hard work at that time. The practices were not only performed by Alex the GP Lead. Other team members brought skills and knowledge that contributed to the meanings; the valuing, improving and achieving of the partnership. Some of this know-how was related to the trajectory of CoPs and the learning that changes community members because of past experiences or CoPs. A memorable recollection was Alex referring to her “*learned carer*” and recognising that the community member had much to contribute from his life experience and the death of his mother from dementia, (7.3.3). There are parallels here with the professionalised service user (130) and educative role that a public involvement group can undertake. (117)

**9.4 Developing the conceptual model / map for PPEI practices for clinical commissioning and partnership working**

To consider the development and use of my conceptual model I now reflect on the distance travelled so far. I have used social learning theory and practice theory as a conceptual and theoretical framework to inform my methodology, data analysis and interpretation. Specifically, I have taken the CoP theory (169, 172) and applied

it to a novel situation; PPEI for clinical commissioning as a domain of practice. I have re-imagined how the various CCG committees and work streams might be functioning as separate CoPs but are part of a broader landscape of clinical commissioning in the English NHS. In addition, I have used Wenger-Trayner's idea of 'plug and play' (173) to examine my data with other practice theories, namely Shove, Pantzar and Watson (128) and Raelin's L-A-P movement. (183, 185) Wenger-Trayner acknowledges the evolution of his social learning theory and invites others to apply it to new situations. (172) Given the criticisms of his CoP theory outlined in **3.4.3** and its lack of attention to power relations, I was keen to use the slim-line practice theory expounded by Shove and colleagues (128) which has vast potential for understanding complex change and challenges and could influence public policy, as has already been seen with public health and sustainability issues. (164, 236, 250)

In terms of using the iceberg model and conceptual map for examining PPEI practices, there are some further points to consider. An immediate observation is the tendency toward the positive. There is the assumption that community members will participate but Wenger acknowledged that non-participation is just as much about identity as participation. (169) It might be to do with power or even as a strategy to disrupt. The community member could be positioned on the periphery of the CoP or restricted from participating as an outsider. (169)

Ideas for further development and application include consideration of the following:

- How do you evaluate how practices are performed when they are relational, emergent, entangled, changing and dependent on the other elements present?
- Can the five components or elements (participation, materiality, competence, boundary encounters and meanings) be assessed or compared by building a portfolio of real cases over time? That is, with evidence of trust, leadership, learning and partnership practices from CoPs within CCGs, or their successor commissioning organisations, including STPs and ICSs.

- Some CoPs constrain by purpose, for example, the GB and its heavy reification due to performance assessment against national standards for CCGs. (131) How can these materialities be made less cumbersome for all partners, including service users, GP Leads and lay representatives so that voices and choices are not overlooked in commissioning decisions?
- Importance of 'remembering' what community members bring to the table and valuing those contributions on an equal footing. Meanings of PPEI practices for clinical commissioning can then focus on improving and achieving trusting relationships for partnership working.

## 9.5 Project advisory group

In keeping with good research practice (220), and because the PhD topic area was PPEI, it was important that the advisory group/steering committee for the study included people with clinical commissioning experience representing service users and the wider public. Clinician membership of the group was counted as supervisory involvement although my supervisors were not present on every occasion. The three service user members were individuals with current or recent PPEI work for CCGs including someone who was a patient representative on a GP locality member group in a different CCG to the two cases study sites. Another had been a lay member during the commissioning of a memory assessment service and out of hours service prior to my study commencing. The third member of the group was involved with the original bid for the Doctoral funds and so instrumental in the study proposal and its subsequent development with one of my supervisors. She had an extensive PPEI background including running training programmes for local Healthwatch organisations, CCGs and lecturing to postgraduate students at the medical school.

As indicated in the methodology chapter, the group was set up and four meetings were held with me as the chairperson. The first meeting was just after ethical approval of the study. Terms of reference for the group (4.6) were agreed and the participant information sheet and consent form shared with the members. The research aims, study protocol and research questions were also discussed. Subsequent meetings included review of the anonymised focus group transcripts

and preliminary coding for categories using the NVivo software for data management. The group did also advise on concerns from two focus group participants who were worried they would be identified in the research. I did not want to lose the richness of the data in the transcripts, so we agreed I would reassure the participants that their data would be anonymised. The participants confirmed they were happy with my reassurances. All members of the project advisory group were offered reimbursements for travel costs, car parking spaces when meeting on the university campus and provided with refreshments.

Six months after convening the project advisory group, one of the members was asked to be a temporary replacement for the GB PPEI lay representative in one of the CCG study sites because of long term absence. This meant she could no longer participate in an advisory capacity as it would compromise her neutrality. In addition, the patient representative who was part of a GP locality member group informed me he had resigned his position. The consensus from the locality member group was that it was difficult to implement change and drive innovation when the CCG was continually having to respond to NHS England directives. My advisory group member therefore decided he did not want to pursue that line of representation as he was heavily involved with other PPEI initiatives and VCS work, including as chair of a prostate cancer support charity in the south of England. (I have connections with this charity as I have run one of its support groups for 16 years on a voluntary basis.) Fortunately, he was willing to continue as a project advisory group member and has since attended a seminar where I presented my research to my peers and supervisors. I am in regular contact with him through the charity's work and have had the benefit of his expertise. His experience helped validate my study findings around alignment as a form of participation where NHS England were ruling what should and should not be done to effect commissioning practice.

The third member with the extensive training background has remained as part of the advisory group and helped recruit a replacement for the person who took up the temporary GB lay representative role. We have reconvened on one occasion. My intention is to follow up with another meeting so that we can discuss the results and conclusions in more detail and consider dissemination of the findings. It is

disappointing that this will not be completed by the time of my thesis submission but does provide scope for ongoing work. One of the advisory group members has already co-authored a publication on research into cancer services commissioning at the time of the strategic clinical networks. (251) Further writing with acknowledgement of the project advisory group is something that I wish to see through to complete the research study.

## **9.6 Reflections on the research methodology and my reflexivity as a researcher**

As a qualitative researcher and ethnographer, I need to fully engage with the reflexive process to assure the reader, and scientific community, that my research is authentic and trustworthy as possible. (192) This requires addressing my own subjectivity as inevitably my values and experiences will influence how I look at my data, interpret it, and reflect on my methodology and research methods. However, as a social constructionist with a relativist view of the world, I am not seeking objectivity to reduce bias. Bias is an 'epidemiological construct' according to Egger, Smith and Altman cited by Greenhalgh, Thorne and Malterud. (109) I am not making an objective comparison between two groups or more. I am attempting to provide an interpretation of the findings with reference to theory whilst acknowledging how I may have affected the research process and its evaluation.

Considering the conduct of the research and the methods employed, there were times when I wondered how I would manage all the data and 'pin it' down. The project felt over ambitious for one researcher when there were CCG case study examples (17, 54, 116, 117, 252) with whole research teams. I perhaps should have adhered to the single case as advocated by the Gioia (G) case method for understanding practice as perspective. (196) However, carrying out a focused ethnography means you cannot include everything. One must be selective and discerning to capture the snapshot of the case or, with my research, two cases (CCGs). There was more that I could have included on the evolution of PPGs and PPG networks for example, but for brevity have had to exclude some of this data.

There was so much data from using the four methods; focus groups, observations, interviews and artefacts. Employing the different methods ensured crystallisation

of the data and confirmability of the findings. (149, 194) This was aided too by the project advisory group. I was taking an etic view and so did allow the data to largely guide me as to where I carried out my observations. As a researcher on the ground I was also aware of adapting my methods to explore the data.

Methodologically, this is consistent with the idea of following a hunch and abductive reasoning. (193) For example, a focused ethnography does not rely on observations, but I felt more comfortable observing and looking in. I could not use photographs and images because of preserving anonymity of the informants and the confidentiality of some CCG documents. The observations enabled me to contextualise my findings chapters because I had immersed myself in the detail in the field (149) which was previously unfamiliar to me.

The iterative nature of the data analysis was assisted by using NVivo but I would have saved myself time if I had made better use of some of the software features for categorising my data and generating my themes. Assimilating the artefacts was also a challenge as I used web-based materials as well as hard copies of minutes and reports. I was searching for mention of PPEI policy, strategy and process. If I were to repeat a similar exercise I could focus on the content analysis and take a more structured approach to collating the detail.

One consequence of using NVivo to categorise my data and an oversight on my part, is that I minimised the style and flow of the focus group exchanges and lost some of the synergy that shaped the views of participants. The focus groups were small as already mentioned in **section 4.13.1**, but the animated discussions that I have referred to with over 30 focus group transcript extracts in chapters 5 to 8, do not always do justice to the chain of ideas that helped me gain a better understanding and interesting insights. (217)

It was a privilege to have been the researcher for this project. I gained clear insights into the world of clinical commissioning through my informants being so willing and honest to share their experiences. I wondered if this was sometimes due to the 'label' I carried as a research student from the medical school which seemed to endorse the project as much as the ethical approval. It reminded me of

Gobo's range of solutions for a social science methodology. (195) I was able to take advantage of the access it provided.

In terms of the impact of my thesis, I have begun to impart the experiences of clinicians and service users/public in the practice and performances of PPEI for clinical commissioning. This has been through oral and poster conference presentations, (one primary care focused, one pedagogic research and another PPI focused for healthcare courses). I have done this in a unique and original way by drawing on practice theory to make transparent what I see as Communities of Practice for PPEI for clinical commissioning within the landscape of NHS CCGs in England, (**Figure 3.1**). This was one of my intentions indicated in chapter 1 but continues to be relevant in the evolution of STPs, ICSs and ICOs. The knowledge gained is transferable and contributes to what is a relatively new and unexplored aspect of healthcare commissioning with limited good quality research papers. Publications will be required to share this learning.

A project advisory group member, sharing his views about people and about power, argued the case for public bodies letting go and doing things differently when it comes to PPEI. People as participants in this process also need to think differently about their health and care which requires trust and will, that is, trust as a social property (182) of the partnership. However, to believe this can be done in new ways participants often want to see the evidence. Another of my aims was that new knowledge and understanding could inform practice as well as education curricula for health care professionals, especially where there would be a focus on leadership and commissioning. My conceptual iceberg model and map of PPEI practices for clinical commissioning (**Figures 9.1** and **9.7**) have been developed from empirical data. They offer a way to examine the underpinning dynamics of social learning when new conceptual tools are required for practice theory to make a difference. However, they must be able to account for power. (140) If by application and testing involving the public and engaging communities was shown to be 'meaningful', the conceptual model and map could be more persuasive for both practitioners and academics alike.

## 9.7 Recommendations from the study

My recommendations are informed by three audiences; educators, practitioners and researchers. Beginning with the educators as this addresses my third subsidiary research question in relation to the study findings:

### iii How might this be applied to the topic of patient and public involvement within health care professional education?

#### 1. Educators

- a. Learners to consider shadowing clinical commissioners (GP Leads) as recommended by Sabey and Hardy for newly qualified GPs. (246)  
Equally relevant for students with a management background learning about commissioning. Could also have a place in pre-registration medical education for final year students.
- b. Spend time at a procurement, monitoring and review meeting to understand PPEI practice. Role of GP Leads and commissioning support managers to be witnessed first-hand by the novice – ‘protected learning time’ permitting.
- c. **Figure 3.1** to help explain PPEI commissioning landscape as CoPs. Develop this as an interactive tool to grasp the complexity of the landscape of practice.
- d. Iceberg model and map to develop skills and knowledge of PPEI as a practice entity together with the entanglement of trust, leadership, learning and partnership practices. Learners to map own practice and use as a teaching tool.

#### 2. Practitioners

- a. **1 a** and **b** are important for the practitioner especially in a mentoring capacity as an ‘old timer’ supporting a newcomer. (170)
- b. ‘Protected learning time’ to think about ‘joy’ in work for deepening understanding of relational ways of working for PPEI in partnerships and leading for clinical commissioning. (245)

- c. If a GP member, ensure fully cognisant of CCG PPEI policy and strategy and consider where CoPs together with L-A-P may have a role for leading health and care services.

### 3. Research

- a. Further ethnographic case study research. Interview patient engagement leads and commissioning support managers.
- b. Consider using L-A-P for mapping leadership skills in the data and discover how leaders 'unfold within themselves'. (185)

## 9.8 Limitations of the study

As an ethnography focusing on specific cases, two CCG communities, the findings cannot be generalised to other CCGs. It was a snapshot for a point in time, and CCGs have evolved since the data collection in 2015 and 2016. The data are now old given the current landscape of clinical commissioning with a move toward more centralised control and scaling up with merged CCGs, GP federations, STPs, ICSs and ICOs. However, PPEI for clinical commissioning decisions and ideas on co-produced service improvement in partnership with various stakeholders, including patients and the public, is unlikely to disappear. It remains part of NHS policy (39) and system leadership.

The study focused on GP Leads, lay representatives and service users commissioning and leading health and care services. The role of the commissioning support managers and CCG engagement leads was underestimated with respect to PPEI for clinical commissioning. It would have been helpful to have interviewed them to better understand the complexities of PPEI practices. In addition, to ascertain to what extent PPEI practice impacted on commissioning decisions as other studies have included in their results. (116, 117)

## **Glossary**

These are the terms and acronyms used in my thesis that require further explanation. I have either adopted a definition from a trusted and identified source where I think it offers the best explanation or described and defined my own understanding of the term as applies in 2018.

### **Accountable Officer**

The Accountable Officer is legally accountable for the activities of the CCG as a statutory body. This person can be a clinician but is invariably a professional manager. If the Accountable Officer is a clinician, the appointee should be supported by a senior manager. The Chair of a CCG can be either clinical or non-clinical.

### **Better Care Fund**

'The Better Care Fund (BCF) is a programme spanning both the NHS and local government. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life.'

**Source:** NHS England website; Oct 2016

The BCF was announced in June 2013 with an initial £3.8 billion to drive the transformation of local services and integrate care and support. This meant pooled budgets between local government authorities and CCGs.

**Source:** Department of Health and Department for Communities and Local Government. Better Care Fund Policy Framework; 2014

### **Care Quality Commission**

This is the independent regulator of all adult and social care in England. The role of the commission is to ensure health and social care services provide people with safe, effective, compassionate, high-quality care.

## **Clinical Commissioning**

Commissioning is the process by which health and care services are planned, purchased and monitored. The idea was introduced into the NHS in the early 1990s when the purchasing of services was separated from their delivery thereby creating an 'internal market'. It was thought that making providers compete for resources would result in greater efficiency and innovation and make them more responsive.

**Source:** Wenzel L. What is commissioning and how is it changing? London: The King's Fund; 2017. (14)

## **Clinical Commissioning Groups (CCGs)**

'A Clinical Commissioning Group is a group of GP practices in a geographical area that work together to plan and design local health services. Each CCG receives a budget from NHS England to spend on a wide range of services that include hospital care, rehabilitation and community-based care. Many CCGs now also commission primary care. A local CCG should work with the local authority and local community groups to ensure that the needs of local people are being met.'

**Source:** Local Government Association and NHS Clinical Commissioners. Integrated Commissioning for Better Outcomes: a Commissioning Framework (ICBO); April 2018

## **Chief Operating Officer**

This is a senior CCG manager who can support an Accountable Officer who is a clinician.

## **Culture**

'A set of basic tacit assumptions about how the world is and ought to be that a group of people share and that determines their perceptions, thoughts, feelings,

and, to some degree, their overt behaviour'; 'it arises through shared experiences of success.'

**Source:** Schein, 1996:11,12. Cited in HEA and Council of Deans. *Developing and sustaining a culture of innovation in health higher education - literature review*. July 2014.

Business organisational culture - a living phenomenon in which members create shared meaning, group norms and espoused values - **Bergson et al. 2008** cited in above publication – p. 14.

'the collection of overt and covert rules, values, and principles that guide organizational behaviour and have been strongly influenced by history, custom and practice' or 'the way we do things around here' (**Burke and Litwin, 1989, p.74 cited by Hurley, 1995**) Publication as above – p. 15.

'A common set of beliefs, values and behaviours.' **Silverman; 2013.** (202)

'shared basic assumptions, norms, and values and repeated behaviours of particular groups into which new members are socialised, to the extent that culture becomes 'the way things are done round here.' **Dixon-Woods et al. 2013.** (203)

### **Communities of practice (CoP)**

'... **community of practice**, which we define as a learning partnership among people who find it useful to learn from and with each other about a particular **domain**. They use each other's experience of practice as a learning resource. And they join forces in making sense of and addressing challenges they face individually or collectively.'

**Source:** Wenger, E, B Traynor and M de Laat. Promoting and assessing value creation in communities and networks: a conceptual framework. Ruud de Moor Centrum, Open Universiteit; 2011

The key elements of a CoP are:

**'The domain:** members are brought together by a learning need they share (whether this shared learning need is explicit or not and whether learning is the motivation for their coming together or a by-product of it)

**'The community:** their collective learning becomes a bond among them over time (experienced in various ways and thus not a source of homogeneity)

**'The practice:** their interactions produce resources that affect their practice (whether they engage in actual practice together or separately)'

**Source:** Team BE. FAQ What is a community of practice? 2011. Available at: <http://wenger-trayner.com/resources/what-is-a-community-of-practice/>

## **Co-production**

'Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.'

**Source:** Boyle D, Harris M. The Challenge of Co-production. London: Nesta; 2009

'Co-production' involves sharing responsibilities and knowledge – of both service design and delivery – between professionals and users, and sometimes with the user's family and neighbours. A co-production approach recognises that everyone has assets that need to be engaged to make society work. This approach requires a relationship of reciprocity and partnership between commissioners, providers and users that recognises each has a vital role to play in achieving the best outcomes.'

**Source:** Ryan-Collins J, Sanfilippo L, Spratt S. Unintended consequences: How the efficiency agenda erodes local public services and a new public benefit model to restore them. London: New Economics Foundation; 2007.

## Healthwatch

Healthwatch is the consumer champion for health and care in England. Its vision to work towards a society in which people's health and social care needs are heard, understood and met.

'Achieving this vision will mean that:

- People shape health and social care delivery
- People influence the services they receive personally
- People hold services to account"

The values of the organisation are

- Inclusive
- Influential
- Independent
- Credible
- Collaborative'

**Source:** NHS England website. <http://www.healthwatch.co.uk/>

## Involvement

'one emerge (s) from the humanistic perspective and the other from the bureaucratic view of consumerism based on controlling costs, outcome and efficiency' - from Cahill, J (1998) cited in **Bellows et al. 2015** (133)

## Partnership

'collaborative relationship between two or more parties based on trust, equality and mutual understanding for the achievement of a specified goal. Partnerships involve risk as well as benefits, making shared accountability critical.'

**Source:** Taken from WHO definition. Cited in **Bellows et al. 2015** (133)

## **Patient and public engagement and involvement (PPEI)**

Peckham et al. (54) use the abbreviation PPEI – patient and public engagement and involvement; the rationale being that you cannot involve people unless you first engage with them. Whilst other publications and organisations, including INVOLVE, prefer to transpose the words engagement and involvement to read PPIE, my favoured description is PPEI.

## **Patient Participation Group (PPG)**

Each GP practice must have a PPG made up of representative members on the practice register. Previously PPGs were known as Patient Reference Groups (PRGs).

## **Patient Representative Group**

This term was used in the rural CCG for describing the collective group of PPGs. There was a Patient Representative Group for the North locality, one for the South locality and a combined one for both localities.

## **Pedagogy (ies)**

‘the principle, practice or profession of teaching.’

**Source:** The Collins Dictionary and Thesaurus; 1987.

## **Primary care**

The ultimate goal of primary health care is better health for all. **WHO** has identified five key elements to achieving that goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- increasing stakeholder participation.

**Source:** WHO website; [Accessed 2016 Aug 1]

**Primary health care** provides the first point of contact in the health care system. In the NHS, the main source of primary health care is General Practice.

The aim is to provide an easily accessible route to care, whatever the patient's problem. Primary health care is based on caring for people rather than specific diseases. This means that professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social problems, rather than specialists in any particular disease area.

**Source:** University of Bristol website - Centre for Primary Academic Care. [Accessed 2016 Aug 1]

Full definition of ***primary care***

1. : health care provided by a medical professional (as a general practitioner, pediatrician, or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist —often used attributively <a *primary care physician*> —called also *primary health care* — compare [secondary care](#), [tertiary care](#)

**Source:** Merriam Webster website -<http://www.merriam-webster.com/> An Encyclopedia Britannica company; 2016

## **Proactive Care**

This is NHS England's proactive care programme for avoiding hospital admissions of vulnerable adult patients. It is an enhanced service within Clinical Commissioning Groups where GP practices identify a cohort of patients with more complex needs and then design care to meet those individual needs. The cohort should be at least two per cent of registered patients over the age of 18 and includes mental health as well as physical health. An accountable, named GP oversees the programme.

## **Public involvement in commissioning**

'Public involvement in commissioning is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services. ... the term 'patients and the public' includes everyone who uses services or may do so in the future, including carers and families.

'The term 'involvement' is used interchangeably with 'engagement', 'participation', 'consultation' and 'patient or public voice' and there are many different ways to involve patients and the public, ... Different approaches will be appropriate, depending on the nature of the commissioning activity and the needs of different groups of people.'

**Source:** NHS England. Patient and public participation in health and care: statutory guidance for clinical commissioning groups and NHS England. April 2017:9

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## **Appendix 1: Early reading on CCGs**

Two qualitative case studies used as key reference points for clinical commissioning.

<b>1. PRUComm – principal investigator Dr Kath Checkland, University of Manchester.</b>
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The project was funded by the Department of Health Policy Research Unit for Commissioning and the Healthcare System (PRUComm). The research team is affiliated to the University of Manchester, the London School of Hygiene and Tropical Medicine and University of Kent. An initial review of the evidence for clinical engagement in primary care-led commissioning informed this study. (253) The researchers investigated the early experiences of eight Pathfinder CCGs and collected data between September 2011 and May/June 2012 for the first part of a longitudinal project, the report being published in September 2012. (252) The case study sites were selected to represent a wide range within a set of characteristics such as size of the CCG, socio-demographic profile, structure of local health economy and links with local government institutions. (229) Qualitative data methods comprised interviews with 96 GPs and managers, observation of 146 meetings, and study of available documents, for example, governing board minutes. There were also two national web surveys and 38 telephone interviews.

The second phase of the study explored the ongoing development and impact of CCGs, particularly the 'added value' that GPs bring to clinical commissioning. The report was published in April 2014 (229) and focused on 42 interviews in seven of the CCG sites. Data were collected between July 2013 and January 2014. There have been subsequent publications from this project appearing in peer-reviewed journals. (24, 27, 96, 152, 222, 254-256)

## **2. The King's Fund and Nuffield Trust**

**Project title - The evolution of clinical commissioning; learning from local experience.**

The King's Fund project team is led by Ruth Robertson, Shipla Ross, Chris Naylor and Laura Bennett. See project website:

<http://www.kingsfund.org.uk/projects/evolution-clinical-commissioning-learning-local-experience>

The Nuffield Trust project team is led by Natasha Curry, Holly Holder and Dr Louise Marshall. Advisors are Dr Judith Smith and Dr Rebecca Rosen. See project website:

<http://www.nuffieldtrust.org.uk/our-work/projects/evolution-clinical-commissioning-learning-local-experience>

The King's Fund and Nuffield Trust are two independent charities working to improve the health and quality of care in the UK population. They have been following six CCG case study sites since 2012. The case study sites were selected at random using a stratified approach to represent the mix of CCGs whether large, small, urban, rural, high or low level of deprivation in all four regions of NHS England: London, Midlands and East, North and South. The project, which is being conducted over a three-year period, is researching the nature of relationships within the CCGs. Particularly how the CCGs are functioning as membership organisations and supporting the development of primary care in their local areas. The three research questions focus on how involved GPs are with the CCG leadership, how CCGs are developing quality improvement in General Practice, and what structures and processes are developing to enable these aspects. The project's first report focuses on the time before CCGs were fully authorised in March 2013. (17) The field work included 74 interviews, 18 observations and 232 responses from an online survey to all the GPs in the six case study sites.

Data for the second report were collected between January and March 2014 and comprised 279 responses to a GP online survey, 70 interviews with GP leaders

and managers and a review of board papers. (76) Dr Kath Checkland is an external advisory group member for the report.

In addition to the two reports, some study data have been uploaded onto the Nuffield Trust and King's Fund website in the form of project presentations. These include findings from the first year survey on member engagement (257) and data from a membership survey on co-commissioning. (75)

## Appendix 2: Study Protocol

**Title:** A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians

Supervised by Professor Gordon Ferns<sup>1</sup> (GF), Ms Breda Flaherty <sup>1</sup>(BF) and Dr Kay Aranda<sup>2</sup>

1. Brighton and Sussex Medical School
2. School of Health Sciences, University of Brighton

### Background:

Despite current policy drivers to place patients and carers (service users) at the centre of care (1) and high-profile examples of failing to listen to service users (2), there is limited research on the impact of service user involvement in commissioning and leading health and social care services (3, 4). The field is muddled in terms of process and outcomes despite models of involvement and engagement having been described and advocated in practice. The evidence base is weak or emergent and concepts of service user engagement theory remain contested (5-8). The literature describes the service user as a 'consumer' and a 'citizen' with arguments for and against a consumerist choice free-market place in health and social care, and a democratic rights-based citizenship with entitlement (4, 9, 10).

The National Health Service (NHS) in England has undergone extensive reform since 2010. Changes brought about by the Health and Social Care Act 2012 required all 8,000 General Practitioner (GP) practices to become members of a local Clinical Commissioning Group (CCG) by April 2013. These new and developing organisations place clinicians at the heart of commissioning and leading integrated health and social care services. This has been accompanied by a much greater emphasis on public involvement within commissioning processes (11). The language of involvement has changed too with the word 'engagement' now prominently featuring in both the literature and policy documents (1, 12, 13)

There are 211 CCGs in England each serving an average population size of 226,000. They are responsible for expenditure of approximately 60% of the total NHS budget. In 2013/14 this equated to £65 billion. (14, 15) A CCG has two distinct roles:

- to commission secondary and community care services, and
- to support quality improvement in general practice (14).

Prior to the formation of CCGs, clinically-led commissioning was in the guise of 'GP-led commissioning' with some GP practices being 'fund holders' during the 1990s, and practice-based commissioning from 2005 onwards (14). Despite a 20-year history of clinically focused commissioning for patients, research does not show this has led to increased public and service user involvement. Evaluation and effectiveness of service user involvement presents methodological challenges and evidence is sparse where commissioning and leading services are concerned (16). Research findings from a recent National Institute for Health Research study using case study design in three emerging CCGs refer to a 'peripheralization' of patient and public engagement and involvement (PPEI). (13) Peckham et al. (13) offer clear implications for future practice from their research and include a number of recommendations. They stress the urgent need for further research and suggest use of similar methods because of their participative and iterative value in case study design (13). Case study is frequently used to evaluate and research policy implementation (17).

The Engagement Cycle (5) is seen as a contemporary process approach for determining how services should be developed, procured, monitored and improved in conjunction with service users and the public in CCG communities. Originally developed by InHealth Associates on behalf of the Department of Health and Croydon Primary Care Trust, the Engagement Cycle is a resource to help commissioners demonstrate one of the six domains and associated competences required of CCGs (1). This is the second domain; *meaningful engagement with patients, carers and their communities*. It was assessed as part of the CCG authorisation process and, along with the other domains, will continue to be monitored following changes implemented under the Health and Social Care Act

2012(5, 11). Clinicians and service users must collaboratively engage when deciding how resources should be spent.

There is an imperative for determining the nature and impact of service user engagement given escalating health and social care needs in an aging UK population and finite resources. The recent Five Year Forward View (18) refers to a “more engaged relationship with patients, carers and citizens in order to promote wellbeing and prevent ill-health” (p.3). An argument being that this will lead to better use of funds if service users are engaged and can collaborate on a ‘trusted peer’ basis. This aligns with current leadership and management theory espoused in the public sector which is now seen to be more ‘relational’ (19). Much of the literature entails a radical re-think of leadership culture with terms such as ‘distributive’, ‘collective’ and ‘followership’ entering the language. These are supported with published theories such as Rittel and Webber’s 1973 typology of ‘wicked’ and ‘tame’ problems paraphrased by Grint and Holt (20). Wicked problems are often intractable and not solved easily by ‘command and control managers’. Emphasis is on engaging staff and service users to address the pressing health and social care requirements of the 21<sup>st</sup> century such as more people with long term conditions and increasing technological advances.

It is therefore timely to examine current approaches to engagement in CCG commissioning and to better understand the processes and impact. Can clinicians and service users be trusted peers and work in partnership? What is the reality and is it *meaningful*? How is the relationship or partnership constructed against the backdrop of a changing culture within the NHS? These questions shape the focus of this study and it is anticipated findings will inform both the theory and practice of PPEI for future healthcare curricula.

#### **Study aims:**

This is a Higher Education Academy funded study. Research intentions are to contribute new knowledge to the evidence base with respect to:

- i. How to develop an effective peer/partner approach between clinicians and service users in commissioning and leading health and social care services.
- ii. How to identify and measure the essential features of effective models of service user - clinician engagement as peers in commissioning and leading.
- iii. The impact of the emerging research findings on the curriculum design for student and postgraduate health professionals on the topic of patient and public involvement.

**Research questions:**

The key research question centres on exploring the experience and practices of service users and clinical leaders collaborating to commission health and social care services. In particular, their beliefs and understanding of partnership within the changing culture of the NHS. There are also three supplementary questions to inform the aims of the study.

*What does it mean to work in partnership as clinicians and service users to commission and lead services?*

- i. What is the nature of a 'trusted peer' relationship?
- ii. How can relationships be developed to demonstrate effective service user and clinician engagement?
- iii. How might this be applied to the topic of patient and public involvement within health care professional education?

**Research outcomes:**

- i. To identify and share on a national basis how commissioners, leaders and members of the public can engage as trusted peers in making significant decisions which shape local health and social care services, and
- ii. To inform curriculum design on partnership, public engagement, and clinical leadership for students and postgraduate health professionals.

### **Study design:**

A case study design with an ethnographic approach will be used to focus on engagement activities within two local CCGs. The study has an interpretivist orientation concerned with the knowledge, beliefs and practices of the participants and how this is constructed to have meaning and purpose within the changing culture of the NHS. Barbour (21) refers to this type of ethnography as *institutional ethnography* and the levels of data that need to be collated, drawing comparisons with discourse analysis. These are easily aligned to research methods and can be viewed as discrete studies informing each case.

Engagement activities will be determined by current work streams directed to the CCGs by NHS England and be studied across the various stages of the Engagement Cycle (5):

Stage 1 – Working with communities to identify needs and aspirations.

Stage 2 – Working with the public to plan and transform services.

Stage 3 – Working with patients and carers to improve quality and safety.

Stage 4 – Working with patients and the public to procure services.

Stage 5 – Working with patients and carers to monitor services.

The Engagement Cycle was refreshed and updated in August 2014 so that it better aligned with current policy thinking on engagement (1). All five stages now include the phrase 'working with'. It may not be possible to study a work stream though all the stages of the Engagement Cycle within a CCG or study the same work stream in both CCGs:

### **Study 1 – Focus Groups**

The focus groups address the first supplementary research question; *what is the nature of a 'trusted peer' relationship?*

To inform the project it is necessary to elicit what service users and clinicians understand by 'trusted peer relationship'. Can they suggest what this looks like and give examples? Do they know what a good or a bad relationship might be when working in partnership to commission and lead health and social care

services? This is not intended to be anecdotal but instead yield data to initially inform the semi-structured interview topics. The focus groups will be conducted so that participants are exclusively service users or exclusively clinicians who have participated in engagement activities for commissioning. They will be held for both case study sites so a total of four focus groups are anticipated.

### **Study 2 – Observations at meetings**

Non-participant observations are intended to also provide data for the first supplementary question; *what is the nature of a 'trusted peer' relationship?* These may be undertaken at governance meetings, CCG board meetings or work stream sub-committee meetings and preferably where service user and/or public representatives are present. For practical purposes the observations will be across both CCGs according to their frequency and not conducted in a sequential manner for each case study site. Field notes will be recorded to complement the observations. Question templates help guide observational records (21) and it is envisaged a template can be generated from the earlier focus group work. Notes and minutes of meetings together with video recordings or webcasts of proceedings available to the public or accessible subject to ethical approval will also enrich the data. There may be other field artefacts which assist the observational notes, for example, a real or virtual notice board, the latter being a social media platform to encourage contributions from all parties in the commissioning process. See project plan for proposed eight-week observation period.

### **Study 3 – Interviewing.**

This research method will elucidate data for the second research question; *how to identify and measure the essential features of effective models of service-user engagement as peers in commissioning and leading.* Five or six semi-structured interviews within a CCG work stream will be conducted using a topic guide generated from the focus groups in Study 1 and further refined from the observations in Study 2. All interviews will be digitally recorded and transcribed with NVivo software or similar to assist presentation and organisation of data. Participants will be CCG Commissioning Leads for a work stream and a patient or

service user lead for the same work stream. A total of 10 – 12 face to face interviews will be completed and field notes recorded. A telephone interview could be included as an alternative if it is exceptionally difficult to secure time for face to face interviews. See project plan for proposed interview period but in reality this will be determined by availability of the study participants within each CCG.

### **Setting:**

The study will be conducted in two local Clinical Commissioning Groups (CCGs). It should be noted CCGs are developing organisations and subsequent manifestations may vary in composition and name. For the purposes of this research, the setting will be two organisations (cases) which commission secondary and community health and social care services for defined populations in the South of England. Brief details of case profiles follow:

Sampling is purposeful and has been facilitated by a member of the supervisory team (BF) who has established working relations with the CCGs. BF is course leader for a BSMS postgraduate course in commissioning and leadership.

### Case Study 1

XXX and XXX CCG has a resident population of 273,000 people living in a geographical area of approximately 34 square miles. It is an urban CCG. According to the 2011 census, Brighton and Hove has a diverse population with relatively large numbers of people aged 20 to 44 years and women aged over 85 years, compared to the population of England. 19.5% of the population is from Black and Minority Ethnic (BME) groups, 15% are from Lesbian, Gay, Bisexual communities and 13% are students. There are 46 GP practices in the city. (Demographics taken from XXX and XXX Clinical Commissioning Group 5 Year Plan 2014 – 2019.)

### Case Study 2

XXX XXX Havens is a relatively small CCG with a population 164,000 people. It is a largely rural population with over 80% of residents having to travel outside of East Sussex to receive hospital (secondary) services. It has an older population

structure compared to England with high numbers of frail elderly. It also has higher cancer rates in the under 65s and above average numbers of young people using drugs and alcohol. There are 21 GP practices and three community hospitals.

(Data from XXX XXX Clinical Commissioning Group Business Plan 2014 – 16)

Participants will be accessed via a 'named person' within each CCG, the Patient and Public Engagement manager / lead or nominee, who will act as a point of reference for the study. Individuals must meet the inclusion criteria and will be selected on availability and willingness to participate in the study.

**Inclusion criteria:**

Clinicians, service users (patients and carers) and members of the public living and /or involved in collaborating on work stream projects to commission and lead health and social care services within the CCG since April 2013. Contacting and inviting participants in the stages of the Engagement Cycle (5) for these work streams will be facilitated by the named person within each CCG. Clinicians are likely to be General Practitioners who have a lead role for projects within their CCG and are undertaking this as a paid, formal secondment from practice.

**Exclusion criteria:**

Work stream projects which have commenced or completed before April 2013. Some clinicians, service users and members of the public will have worked on projects before April 2013 but still be included because of their subsequent or current engagement activities. If included, it will be important to ensure their responses differentiate between the work stream activities so contamination is minimised. See topic guide for interviews. Participants who cannot speak English will not be able to take part in Studies 1 and 3 due to insufficient time and resources to arrange interpreters. This is to ensure the study is feasible in the time available. Study 2 could include participants who do not speak English if they are attending meetings with interpreters arranged by the respective CCGs.

**Procedure:**

Orientation to the study settings and fact finding will include meeting relevant CCG staff who can facilitate access and permissions. Participants will be invited and briefed in advance at a face to face event within each CCG. See project plan timetable. Study information sheets for participants will be prepared in advance and distributed in written or electronic form. Opportunity for questions and clarification will be facilitated by the face to face briefing events and provision of my contact details on the information sheets. The name of my supervisor (BF) and her contact details will also be included with this information as a further point of reference.

**Consent:**

Full written consent will be obtained for participants who are interviewed. Permissions to observe meetings and view minutes of meetings and other documentary analysis will be authorised or facilitated by the named contact person within each CCG. Some minutes of meetings are in the public domain.

**Confidentiality:**

Once data collection has commenced observational field notes and digital recordings with resultant transcripts will be stored in a secure, locked filing cabinet and/or password protected electronic file as appropriate. The filing cabinet will be within one of the offices in the Division of Medical Education at BSMS. The electronic files will be stored on the *My files* drive which is part of the secured University of Brighton intranet. This is in keeping with the confidentiality and good practice requirements of the Research Governance Framework. Any ethical issues arising that impact on professional practice will immediately be discussed with my supervisors and further advice and guidance sought.

**Timescales:**

It is anticipated the data will be collected and analysed over six to eight months ideally commencing in Autumn 2015 subject to ethical approval.

### **Analysis:**

Qualitative data from each of the three studies will be separately analysed using a thematic approach which requires immersion in the transcripts and field notes.

The data will be coded by hand and with the assistance of transcribing software to help organise, identify categories and sub categories. Summaries of 'data bundles' are sometimes employed in ethnographic research where there are a lot of data from observations and field notes and this needs to be condensed. (22) Study 1 is likely to be a deductive analysis to address the first supplementary question: *what is the nature of a 'trusted peer' relationship?*

Studies 2 and 3 will be more inductive in nature and here it could be useful to move beyond descriptive themes and employ a framework approach or matrix for analysis which is often used in healthcare research (17). This could be an existing framework or emanate from the emergent literature. Peckham et al. (13) used an existing well-respected framework but stressed the importance of the iterative nature of data collection and analysis and comparison between cases. It is not unusual to have both deductive and inductive approaches to case study design. (23) This will depend on the orientation of the researcher and their reflexivity with both the data and research process. As an interpretivist researcher I will want to see how the beliefs and experiences of participants co-construct the culture and practices of PPEI in these two CCGs (NHS institutions). This will help me answer the second supplementary question; *how to identify and measure the essential features of effective models of service-user engagement as peers in commissioning and leading.*

Crystallization of the data from all three studies will help build new knowledge and theory. This approach acknowledges differences and exceptions in parallel data analysis rather than the congruity of triangulation (21). An existing framework or an emergent one based on new applications of practice theories within the social sciences and health will assist this process. Practice theory is a type of cultural theory concerned with the everyday social practices of life. It is not concerned with structure and agency but the tacit knowledge or 'know how' and the social relations within day to day practices. Shove et al. (24) advance a slim line version

of practice theory and argue it has vast potential for understanding complex change and challenges. They suggest that understanding these transformations could influence public policy. An ethnographic approach to the case study design therefore seems justified and the resultant findings should inform the third supplementary question; *how might this be applied to the topic of patient and public involvement within health care professional education?*

The project advisory group will have a role in assessing the rigour of the data collection and interpretation of the findings as well as checking the project remains focused on the aims of the study. Where practical participants will also have opportunity to verify data for its authenticity, sometimes referred to as respondent validation (17).

#### **Dissemination:**

Preliminary findings will be made available and disseminated as appropriate in a variety of formats, e.g. poster presentation, conference presentation, taught sessions on BSMS courses and publication. This includes to all stakeholders; CCGs who have participated, research community at BSMS and the studentship sponsor – Higher Education Academy.

Target journals for subsequent publication following completion of the study or parts thereof are: *Health Expectations*, *British Journal of General Practice*, *Journal of Education and Training*, *Medical Teacher* and selected Higher Education Academy publications.

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## **Appendix 3: Participant Information Sheet**

### **A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians**

I would like to invite you to take part in a research study. But before you decide to take part, it is important that you understand why the research is being carried out and what it will involve for you. Please take your time to carefully read the following information.

Do ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

#### **1. What is the purpose of the study?**

The study aims to investigate how patients, carers and members of the public work together with clinicians to decide what health and social care services are needed for local communities. This is part of a process that is termed 'clinical commissioning' which is an important process in the new arrangements for the National Health Service since April 2013. The clinicians involved are usually general practitioners (GPs) who have an extra role to commission for their local community area. This community area is called a clinical commissioning group (CCG).

The study will explore what is effective about this type of partnership working and how it can be taught to students who are learning about clinical commissioning.

#### **2. Who is organising and funding this study?**

This is a PhD study funded by the Higher Education Academy. The academy is a national organisation aiming to improve learning and teaching in universities. This includes the learning and teaching of doctors, nurses and other health care staff.

### **3. Why have I been invited?**

You have been invited because you have been, or are currently, involved in clinical commissioning work for your local CCG. You may be in this role because you are a patient, carer, representative of the local community or a clinician. Your involvement must have taken place since April 2013 to be eligible for inclusion in this study.

### **4. Do I have to take part?**

No. It is entirely up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. Your decision not to participate will have no negative impact upon your role or position with the CCG.

### **5. What will I have to do?**

There are three elements to this project: focus groups, face-to-face interviews and observations. You can take part in all three elements or just one or two.

#### *Focus group*

You will take part in a small group (four to five people maximum) to discuss what you think 'working in partnership' should be like within the new arrangements for clinical commissioning. You will either be in the focus group for clinicians or the focus group for patients, carers and the public. The focus group will be of no more than 45 minutes duration and will take place on CCG premises. It will be audio-recorded and transcribed later. I will also take notes during the discussions and as a group we may decide to write notes on flip chart paper. The transcript (a written version of my questions and your answers) and all the notes will not identify you by name. Reimbursement for travel expenses will be available where applicable but you will need to provide evidence of the cost, for example, a bus ticket.

### *Interviews*

You will be interviewed face-to-face about your experiences of clinical commissioning and working in partnership. This will be an individual interview conducted in a private space. The interview will be audio-recorded and transcribed together with any notes I make during this time. The interview should be no longer than one hour and will take place on CCG or university premises according to your preference. Reimbursement for travel expenses will be available where applicable as above.

If it is difficult to arrange a date and time for a face to face interview an alternative is a telephone interview which will be audio-recorded and transcribed afterwards.

### *Observations*

You may be attending meetings where I am observing the proceedings. You will not have to do anything other than take part in the meeting as you normally do. I will be taking notes and later transcribing them. You will not be identified by name in the transcript.

## **6. What are the possible benefits of taking part?**

There is no benefit to taking part, however you will have the opportunity to talk about your experiences and what it means to work in partnership for commissioning health and social care services in your local community. This will potentially inform the training of doctors and other health professionals in the future.

## **7. Are there any possible disadvantages or risks of taking part?**

It will take time out of your day, but every effort will be made to minimise the inconvenience and ensure your comfort in the interview process. It will be possible to take a break or stop at any point during the interview.

## **8. What about confidentiality?**

All the information about you taking part in this study and all information collected during the course of the research will be kept strictly confidential. The consent forms, notes from the focus groups including flip chart jottings, observations and interviews plus the audio-recordings and transcripts will be stored securely in a lockable filing cabinet and/or electronically on password protected computer files at the university. You will not be identified by your real name on the files. A participant number will be used instead. Anonymous quotes will be used in the published report.

## **9. What will happen if I don't want to carry on with the study?**

You are free to withdraw at any time and without giving a reason. If you do withdraw all information collected up to that point will be retained and used in the study. These would still be kept in a confidential manner as described above. The transcripts are de-identified and anonymous so no-one other than the researcher will know your identity.

## **10. What if there is a problem?**

If you have any concerns about any aspect of this study or complaints about the way you have been treated during the study, please speak to my research supervisor. Her contact details are provided at the end of this sheet. In addition, you can speak with the study sponsor at the University of Sussex. Please contact Ms Isla-Kate Morris, Research Governance Officer. Her telephone number is 01273 872748 and email address [i.morris@sussex.ac.uk](mailto:i.morris@sussex.ac.uk) Alternatively, you can raise your concerns using the NHS England complaints procedures. The information can be found at this web page: <http://www.england.nhs.uk/contact-us/complaint/>

## **11. What will happen to the results of the research study?**

The results of the study will be written up for my PhD thesis. Parts of the study may also be submitted for publication in a journal or presentation at a conference. An additional short report of the research findings will be provided

for distribution to participants. This may also include a presentation to CCG members which you will be invited to attend.

## 12. Who has approved this study?

This study has received ethical approval from the Brighton and Sussex Medical School Research Governance and Ethics Committee (BSMS RGEC) - R&D Ref No. 15/080/FER. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the South West Committee – Frenchay REC Ref No. 15/SW/0214.

Thank you for taking the time to read this information sheet.

## 13. Contact Details:

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PhD student, Division of Medical Education

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## Appendix 4: Consent Form

### Title of Project:

**A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians**

**Name of Researcher: Debbie Hatfield**

**Please initial  
box**

I confirm that I have read and understood the information sheet dated 27 July 2015, version 3 for :

**A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians**

I have had the chance to read the information and ask questions about the study and am satisfied with the answers I have been given.

I understand that my participation in this study is voluntary and that I am free to stop at any time, and I do not have to give a reason for doing so.

Occasionally an external regulator or funding body may ask to look at the data for this study to check that it is being run correctly. I give permission for those organisations to access my study data for monitoring purposes.

I understand that the focus group I take part in will be audio- recorded.

I understand that my interview will be audio- recorded.

I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*Researcher to complete:*

- I have explained the information in this document and encouraged the participant to ask questions and provided adequate time to answer them.

_____	_____	_____
Name of Researcher or Person Seeking Consent (If different from researcher)	Date	Signature

When completed: 1 copy for the participant; 1 copy for the researcher site file;

Version 3, 27 July 2015

## Appendix 5: Brighton and Sussex Medical School ethical approval

**BSMS Research Governance & Ethics Committee (RGEC)**  
Chair: Professor Kevin Davies  
Deputy Chair: Professor Bobbie Farsides  
Secretary: Miss Caroline Brooks  
Tel: 01273 872855 [c.e.brooks@bsms.ac.uk](mailto:c.e.brooks@bsms.ac.uk)  
Applications and general enquiries: [rgec@bsms.ac.uk](mailto:rgec@bsms.ac.uk)



26/02/2015

Professor Gordon Ferns  
Brighton and Sussex University Hospitals NHS Trust  
Royal Sussex County Hospital  
Eastern Road  
Brighton  
BN2 5BE

Brighton and Sussex Medical School  
Medical Teaching Building  
University of Sussex  
Falmer  
Brighton  
BN1 9PX

Dear Professor Ferns

**Full Study Title:** A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians

**R&D Ref No. :** 15/080/FER

I am writing to inform you that the Brighton and Sussex Medical School Research Governance and Ethics Committee (RGEC) Sub-Panel which met on **Monday 23<sup>rd</sup> February 2015** has now assessed your application and granted **Research Governance Approval** to proceed with the above named project.

This letter acknowledges that you have the necessary internal regulatory approvals. **Please note, formal approval from all the respective CCGs will be required to access service user representatives and members of the public participating in commissioning processes, as well as Patient and Public Engagement leads / their nominees and attendance at CCG governance and board meetings. Please could evidence of approval be sent to this Committee for our records once obtained.**

### Conditions of Approval

The approval covers the period stated in the Research Governance & Ethics Committee (RGEC) application and will be extended in line with any amendments agreed by the RGEC. Research must commence within 12 months of the issue date of this letter. Any delay beyond this may require a new review of the project resources.

### Amendments

Project amendment details dated after the issue of this approval letter should be submitted to RGEC for review and formal approval. Please submit your application for an amendment to the Committee (via [rgec@bsms.ac.uk](mailto:rgec@bsms.ac.uk)) using the 'Request for an Amendment Form'.

### Monitoring

The Medical School has a duty to ensure that all research is conducted in accordance with the University's Research Governance Code of Practice. In order to ensure compliance the department undertakes random audits. If your project is selected for audit you will be given 4 weeks notice to prepare all documentation for inspection.

It is your responsibility to inform me in the event of early termination of the project or if you fail to complete the work. I wish you luck with your project.

Yours sincerely

A handwritten signature in black ink, appearing to read "Kevin Davies", is written over a light blue horizontal line.

Professor Kevin Davies  
Chair of the BSMS Research Governance and Ethics Committee

## Appendix 6: Health Research Authority ethical approval



### **Health Research Authority**

**NRES Committee South West - Frenchay**

Level 3, Block B  
Whitefriars  
Lewins Mead,  
Bristol BS1 2NT

Email: [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net)

10 August 2015

Miss Deborah A Hatfield  
MPhil/PhD candidate  
N/A - full time student  
Division of Medical Education, Brighton and Sussex Medical School  
Room 344b Mayfield House  
Falmer, Brighton  
BN1 9PH

Dear Miss Hatfield

**Study title:** A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians

**REC reference:** 15/SW/0214

**IRAS project ID:** 180633

Thank you for your response to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Naazneen Nathoo, [nrescommittee.southwest-frenchay@nhs.net](mailto:nrescommittee.southwest-frenchay@nhs.net). Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### **Conditions of the favourable opinion**

A Research Ethics Committee established by the Health Research Authority

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” above).

#### **Approved documents**

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [DAHatfield letter to PRS 27 July 2015]	1	27 July 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Employer's Liability Certificate for University of Sussex]		16 September 2014
Interview schedules or topic guides for participants [Topic guide for focus groups and interviews]	2	28 May 2015
IRAS Checklist XML [Checklist_10072015]		10 July 2015
IRAS Checklist XML [Checklist_14072015]		14 July 2015
IRAS Checklist XML [Checklist_14072015]		14 July 2015
IRAS Checklist XML [Checklist_29072015]		29 July 2015
IRAS Checklist XML [Checklist_03082015]		03 August 2015
IRAS Checklist XML [Checklist_04082015]		04 August 2015
Letters of invitation to participant [E-mail to participate v 2]	1	28 May 2015
Other [CV for B Flaherty]	1	16 June 2015
Other [Public Liability Certificate University of Sussex]		16 September 2014
Other [Professional Negligence Insurance University of Sussex]		16 September 2014
Participant consent form [Participant Consent Form v 2]	2	12 April 2015
Participant consent form [ICF 27 July15 v 3 with track changes]	3	27 July 2015
Participant information sheet (PIS) [Participant Information Sheet V2]	2	15 April 2015
Participant information sheet (PIS) [PIS 27July v 3 with track changes]	3	27 July 2015
REC Application Form [REC_Form_14072015]		14 July 2015
Research protocol or project proposal [Study Protocol version 5 for IRAS]	5	25 June 2015
Summary CV for Chief Investigator (CI) [CV Document for IRAS DAH]	1	09 April 2015
Summary CV for supervisor (student research)		28 May 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Project Plan for DH v 2]	2	25 June 2015

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

A Research Ethics Committee established by the Health Research Authority

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

**15/SW/0214**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



**Pp Mr Peter Jones Chair**

Enclosures: *"After ethical review – guidance for researchers" [SL-AR2]*

Copy to: *Professor Kevin Davies*

*Ms Helen Vaughan, Sussex NHS Research Consortium*

## Appendix 7: Local research ethical approval for CCGs



### Sussex NHS Research Consortium

Research Consortium Office  
Worthing Hospital  
Lyndhurst Road  
Worthing  
West Sussex  
BN11 2DH

Miss Deborah Hatfield  
PhD Student  
Division of Medical Education  
Brighton and Sussex Medical School  
Room 344b Mayfield House  
Falmer, Brighton  
BN1 9PH

Tel: 01903 285027  
Fax: 01903 209884  
www.sxrc.nhs.uk

14/08/2015

Dear Miss Hatfield,

**Our ID: 1621/NOCI/2015**

**TITLE: A study of the impact of service user engagement as peers and partners in commissioning and leading health and social care services with clinicians.**

Thank you for your application to the Sussex NHS Research Consortium for research governance approval of the above named study.

I am pleased to inform you that the study has been approved, and so may proceed. This approval is valid in the following Organisations:

#### **Name of CCGs removed**

The final list of documents reviewed and approved is as follows:

- IRAS NHS REC form (signed and dated 14/07/2015: 180633/815745/1/461)
- IRAS NHS R&D form (unsigned and undated: submission code 180633/829747/14/743)
- Study Proposal – RGEN application form (no version control, dated 27/01/2015)
- Participant Information Sheet (version 3, dated 27/07/2015)
- Consent Form (version 3, dated 27/07/2015)
- CV for D. Hatfield (signed and dated 09/04/2015)
- Evidence of University of Surrey Indemnity (valid until 31/07/2015)
- NRES Committee South West – Frenchay favourable opinion letter (signed and dated 10/08/2015)

**Please note these additional conditions of approval:**

- **You must obtain written authorisation from the appropriate person at each CCG prior to commencing any research activity and forward it to the Consortium Office for our records.**
- **You must be in receipt of a Letter of Access issued by the Consortium prior to commencing any research activity on CCG premises.**

Your research governance approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application.
2. You notify the Consortium Office should you deviate or make changes to the approved documents.

3. You alert the Consortium Office by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.

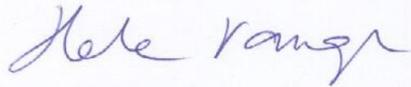
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of research governance approval.

5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Good luck with your work.

Yours sincerely,



**Mrs Helen Vaughan**  
Assistant Research Governance Manager

Email: [helen.vaughan@wsht.nhs.uk](mailto:helen.vaughan@wsht.nhs.uk)  
Tel: 01903 285222 x 84190  
Fax: 01903 209884

