Scoping Study of the Changing Landscape of Opportunities for Patient and Public Involvement in NHS Healthcare Commissioning Decision-Making

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Executive Summary

Background

Commissioning structures in the National Health Service (NHS) in England are currently in a state of transformative change, particularly in relation to the level at which health priority-setting decisions are being made for local populations. National Health Service Clinical Commissioning Groups (CCGs) have held responsibility for commissioning secondary and community care services for their local populations since April 2013. These arrangements are changing, however, with Sustainability Transformation Partnerships (STPs), created in 2016, bringing local health and care leaders together to plan around the long-term needs of local communities. It is further expected that by April 2021 every STP will become an Integrated Care System (ICS) through which NHS organisations will plan and deliver services. The ICSs will be groups of local NHS organisations working together with each other, local councils, and other partners. Existing CCGs will be merged so that each ICS will typically involve just one CCG which will be leaner and more strategic organisations that support providers to partner with local government and other community organisations.

These commissioning changes have implications for opportunities for patient and public involvement (PPI) in NHS healthcare commissioning decision-making. Although PPI is recognised as an essential and valuable resource in the development of healthcare services, improving outcomes for service users, PPI in healthcare commissioning decisions has always been a contentious issue. The way these new organisations engage with patients and the public could have significant consequences. This is particularly relevant in South London which hosts one of the country's first ICSs. Therefore, it was considered important to gain understanding of how the new CCGs, STP and ICS in South London have engaged with patients and the public during this period of transition in their commissioning responsibilities.

The scoping study presented in this report was conducted between December 2019 and April 2020 by researchers from two of the seven National Institute of Health Research (NIHR) South London Applied Research Collaboration (ARC) research themes: the PPI theme, explores PPI in health and social care; and the Public Health and Multimorbidity. The latter theme, previously (as part of the Collaborations for Leadership in Applied Health Research (CLAHRC)) undertook research with NHS CCGs, and now is looking at co-production work in local government health prevention strategies and interventions. This scoping study was envisaged as providing a platform for the development of wider projects within these two themes and potential collaborative projects between them.

The aim of the scoping study was to explore how the new CCGs, STP and ICS in South London have engaged with patients and the public during the transition period, and to deepen insight into how PPI may operate in the future.

Methods

To provide broader context and understanding of how PPI structures in South London are affected by the changing NHS commissioning landscape, we first undertook a literature review of the evidence regarding changes to NHS commissioning in England, the background to these changes, and how PPI is envisaged to fit into the new commissioning organisations.

Qualitative data collection methods were then used to explore the views and experiences of people involved in PPI including members of the public, CCG and ICS staff members, and Healthwatch representatives. Semi-structured interviews were conducted over the telephone or face to face with 13 participants to explore how PPI may have been affected during changes to NHS commissioning structures and how the future of PPI was envisaged. Interviews were approximately 30 minutes in length, recorded and transcribed verbatim. Verbal consent was obtained at the start of each interview.

Findings

Participants believed that PPI had not been effectively used in shaping the new commissioning structures in South London, rather considered only after decisions to integrate services had been taken. There appears to be a high level of concern amongst participants about the overall approach to establishing PPI in South London, albeit in combination with a recognition of the difficulties involved. A widely held belief is that PPI is a secondary concern and that other issues such as working with new partner organisations are viewed as bigger priorities. Moreover, many participants believe the new PPI structures seem to be oriented towards involving people on a short-term basis, focusing on increasing attendance at public events, rather than embedding PPI over longer, sustained periods. This situation has led to concerns regarding a reduction of scrutiny in decision-making. Some optimism remains, however, amongst some participants, about potentially greater scope for PPI in future commissioning decisions, especially in the new CCGs, with the possibility of a successful outcome if existing local PPI structures are maintained along with established relationships. It is less clear, though, how PPI in decision-making may work with the new ICSs.

Conclusion

Data collected in the current study represent a snapshot of a changing commissioning landscape. This scoping study provides understanding of PPI structures in South London and highlights specific areas of interest for the wider PPI project, including the priorities of commissioners and how these may be reflected in decision-making processes. It is envisaged that the wider PPI project will be able to learn more about the involvement of patients and the public as the commissioning system matures, and how and to what extent any possible changes to the non-statutory nature of ICSs may influence the functioning of PPI. Other issues to consider, however, include the role of Primary Care Networks and how they may fit into the developing system.

There are further developments which may affect PPI in South London, not least relating to the COVID-19 pandemic. This study was conducted during the pre- and early-phases of the pandemic, and it will be important to learn about the ways and extent to which factors relating to the pandemic impact on the wider PPI project and the Public Health and Multimorbidity research theme in terms of both approach and findings.

Chapter 1: Introduction

1.1 The changing landscape of healthcare commissioning and patient and public involvement

Commissioning structures in the National Health Service (NHS) in England are currently in a state of transformative change, particularly in relation to the level at which health priority-setting decisions are being made for local populations. NHS clinical commissioning groups (CCGs) have held responsibility for commissioning secondary and community care services for their local populations since April 2013, spending the bulk of the NHS budget in England (Checkland et al., 2016). These arrangements are changing, however, with Sustainability Transformation Partnerships (STPs), created in 2016, bringing local health and care leaders together to plan around the long-term needs of local communities. It is expected that by April 2021 every STP will become an Integrated Care System (ICS) through which NHS organisations will plan and deliver services. The ICSs will be groups of local NHS organisations working together with each other, local councils, and other partners. The CCGs will be merged so that each ICS will typically involve just one CCG which will be 'leaner and more strategic' organisations that support providers to partner with local government and other community organisations. By April 1st, 2020, 74 CCGs had completed mergers (Brennan, 2020).

In South London, the mergers were from 12 CCGs to just two: South West (SW) London CCG and South East (SE) London CCG (SW London CCG 2020, SE London CCG, 2020). With the merger of further CCGs across South London, they will become the two largest CCGs in the country (Thomas, 2019).

These commissioning changes have implications for opportunities for patient and public involvement (PPI) (Coultas et al., 2019; O'Shea et al., 2017). Broadly, this entails an increasingly individualised understanding of involvement in which patients are identified as 'integrators' of the services provided by the NHS, local government authorities, and the third sector (Exworthy et al., 2017). This is revealing a lack of structures for PPI at levels higher than CCGs.

Within both the NHS Five Year Forward View (2014) and the NHS Long Term Plan (2019), there are multiple references to commissioners working alongside the public in decision-making, as these groups are intended to work with local populations (Wellings, 2018). However, the actual role of PPI within ICSs and STPs has been unclear (Hudson, 2018). Although PPI is recognised as an essential and valuable resource in the development of healthcare services, improving outcomes for service users, PPI in healthcare commissioning decisions has always been a contentious issue (Coultas at al., 2019). The way these new organisations engage with patients and the public could have significant consequences. This is particularly relevant in South London which hosts one of the country's first ICSs in South East London (also known as 'Our Healthier South East London') (OHSEL 2020). Concerns have been raised relating to how PPI has been handled to date, with allegations that it has been tokenistic and secretive (Hudson, 2018). The situation in South West London where there is an STP (South West London Health and Care Partnership) (SWLHCP 2020) is also of interest.

Therefore, it was considered important to gain understanding of how the new CCGs, STP and ICS in South London have engaged with patients and the public during this period of transition in their commissioning responsibilities.[1]

1.2 The scoping study and the NIHR South London Applied Research Collaboration

The scoping study presented in this report was conducted between December 2019 and April 2020 by researchers from two of the seven National Institute of Health Research (NIHR) South London Applied Research Collaboration (ARC) research themes: the PPI theme, that explores PPI in health and social care decision-making within the changing landscape of NHS commissioning; and the Public Health and Multimorbidity theme, that previously (as part of the Collaborations for Leadership in Applied Health Research (CLAHRC)) undertook research with NHS CCGs, and now is looking at co-production work in local government health prevention strategies and interventions. This scoping study was envisaged as providing a platform for the development of wider projects within these two themes and potential collaborative projects between them. It seeks to explore how the new CCGs, STP and ICS in South London have engaged with patients and the public during the transition period, and to deepen insight into how PPI may operate in the future. The wider PPI project, referred to as project one, will explore how the public and patients are engaged in the new CCGs.

1.3 Scoping study aim and objectives

The aim of the scoping study was to explore how the new CCGs, STP and ICS in South London have engaged with patients and the public during the transition period, and to deepen insight into how PPI may operate in the future. Specifically, how are PPI structures affected by the changing NHS commissioning landscape?

The study objectives were to:

- Gain understanding of the new commissioning structures: Clinical Commissioning Groups, Sustainability and Transformation Partnerships, and Integrated Care Systems
- Explore plans for PPI in these new structures, and whether and how these differ from existing PPI processes
- Explore people's understanding and views of how changes to PPI will be incorporated into the new structures

[1] At the time this scoping study was undertaken, there was just one ICS in South London (SE), but since then (on 30th April 2020) South West London STP has become designated an ICS.

Chapter 2: Literature Review

2.1 Introduction

To provide broader context and understanding of how PPI structures in South London are affected by the changing NHS commissioning landscape, we undertook a literature review of the evidence regarding changes to NHS commissioning in England and in South London, the background to these changes, and how PPI is envisaged to fit into the new commissioning organisations.

2.2. Search strategy

Literature was identified through searches of electronic databases, primarily applied health research related, including Oval Medline, Applied Social Science Index and Abstracts (ASSIA) and Google Scholar. An additional manual examination of reference lists from key texts and some literature from the PPI project bid document were also included. The search of scholarly articles was narrowed using the following inclusion criteria:

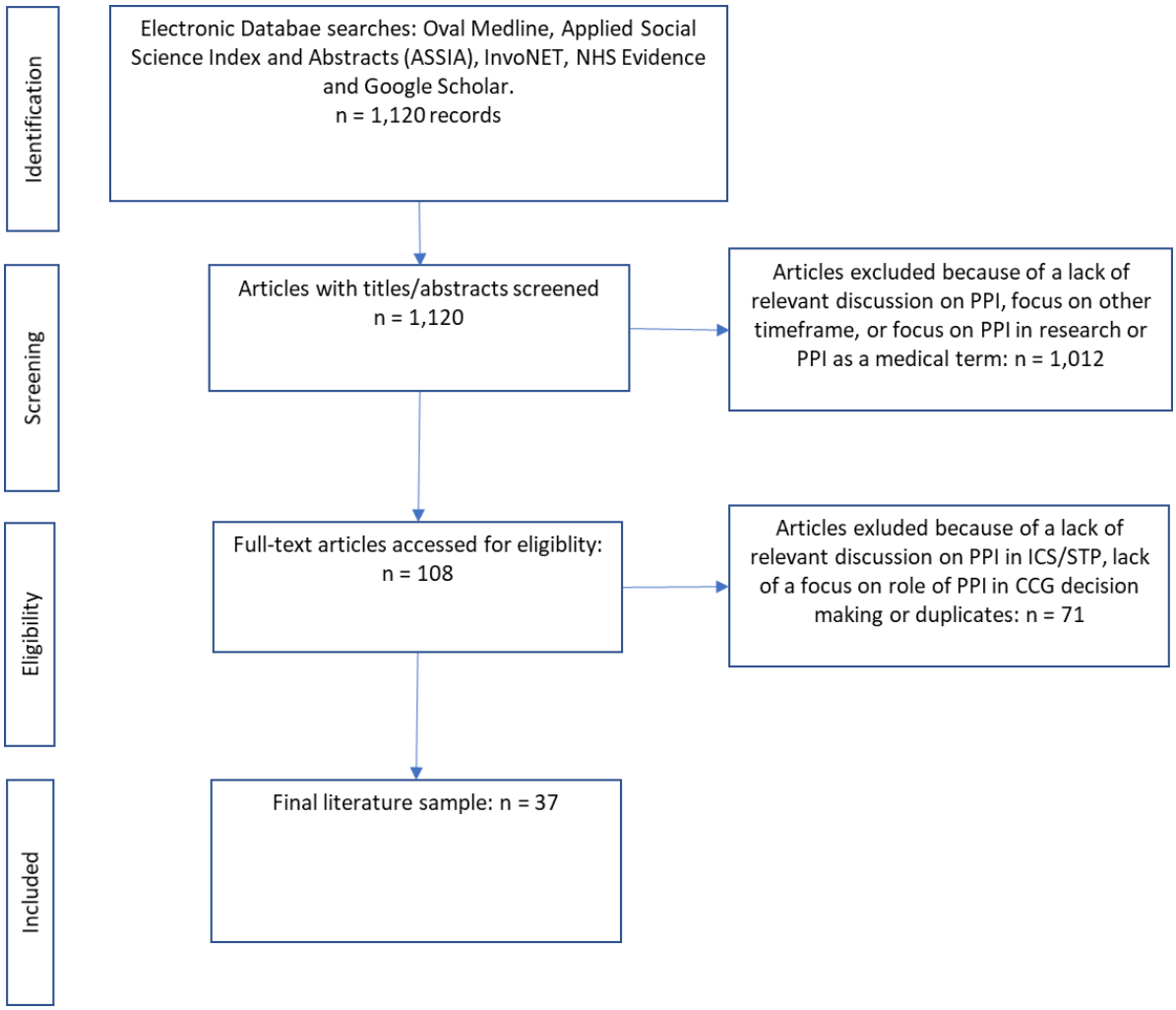
- Date of publication from 2014 to 2020
- Written in English

The reason for including literature dated from 2014 is that this is when the NHS Five Year Forward View was published, which sets out plans for the restructuring of health and social care, with literature that reflects the development of STPs and ICSs. Literature searches were initially conducted in January and February 2020, with additional searches in April 2020. Databases were also consulted for grey literature.

A variety of different terms were used to identify as many articles as possible. The same terms were used in each of the data bases.

This method initially generated a large number of articles (n=1,120), which were narrowed down by removing duplicates, checking against the criteria above and then short-listing, followed by a check of titles and abstracts (figure 1). A total of 37 papers are included in this review.

Figure 1: **Literature Review Flow Diagram**



2.2.1 Search results

The literature search included a variety of different topics, having utilised databases with papers from a range of disciplines. This ensured that there was as wide an overview of PPI as possible. All the literature was UK based, because the specific policy context does not lend itself to international data inclusion.

One of the key issues in identifying additional literature is that the area being investigated is undergoing continual change. The ICSs are new organisations and many parts of the country are still developing plans to become a designated ICS. The merging of CCGs began on April 1st 2020, with an NHS England deadline of April 1st 2021.

2.3. The NHS Five Year Forward View

The NHS Five Year Forward View (2014) began a process of developing seven new models of care which would be used in different parts of the NHS. These new models were viewed as the next steps

in changing the way that the NHS functions in a new environment in which it would not receive large funding increases year on year.

In terms of PPI, the document outlines a new way in which patients and the public would be engaged in the NHS. There are bold assertions that the NHS is "of the people, by the people and for the people" (NHS England 2014, p 9). This has led to some changes as the NHS works alongside legislation set out in the Health and Social Care Act (2012). This means that there is PPI in CCGs and some focus on PPI within the new organisations being developed under NHS structural changes.

2.3.1 The NHS Long Term Plan

The NHS Long Term Plan, 2019, outlined a new, more collaborative way for the service in England to function (NHS England 2019). The objectives of the plan are to make the service more financially sustainable to gain additional funding from the government (Ibid 2019). To achieve this goal, the NHS would undergo structural changes, developing integrated commissioning, which began with the creation of STPs (NHS Confederation 2018). The NHS Long Term Plan seeks to develop these STPs into new ICSs, non-statutory units that further integrate commissioning by bringing together a variety of providers, commissioners and local authorities to deliver health services (Ibid 2018).

2.4 Effectiveness of patient and public involvement in the NHS and social care

Patient and public involvement has historically existed in the NHS since around 1974. The involvement of patients and the public is believed to not only improve the outcomes of NHS and social care services, but also helps integrate services and lower costs (Pizzo et al., 2015). However, there is some contention around PPI relating to the ways and extent to which it is embedded within NHS organisations or accepted by NHS staff. Patient and public involvement representatives have had to strive to maintain their roles in NHS reorganisations, highlighting the campaigning nature of some forms of PPI (Piper, 2014).

2.4.1 Patient and public involvement in clinical commissioning groups

The Health and Social Care Act (2012) led to the creation of CCGs. One of the rationales for the development of CCGs was that they were believed to be more responsive to the needs of their local populations (McDemott et al., 2018). The Act mandated that patients and the public are engaged in decision-making processes. One mechanism for this is Healthwatch. The purpose of Healthwatch is to act as a consumer champion and to ensure that the voice of patients is heard with regards to matters of health and social care (Hudson, 2015). There is a central Healthwatch which has local branches to cover each CCG area (Ibid, 2015). These local units are independent and a means for local people to influence decision-making processes and governance arrangements of their local CCGs (Carter and Martin, 2016). However, they face many challenges as there is little obligation for the local CCG to follow the suggestions of Healthwatch, partly because PPI structures already exist (Ibid, 2016). There is evidence to suggest that PPI structures can be effective when there are good relationships between

key stakeholders (Coultas et al., 2019), even if their real ability to affect decisions and be involved in the process may be limited (Currie et al., 2018).

Clinical commissioning groups have a statutory responsibility to engage with both patients and the public (Hudson, 2015). There are two levels at which this is considered to take place. On one level, there is a general involvement of patients and the public where they are consulted on general issues, such as service evaluation (Currie et al., 2018). There is also, however, an obligation for PPI to be involved in decision-making within CCGs. The primary method is through public meetings and through the appointment of lay members to the governing bodies of the CCGs, who scrutinise their work (O'Shea et al., 2017). Even with statutory rules, however, there is a considerable amount of variation in how CCGs carry out PPI in practice (Currie et al., 2018). Debates around this issue exist more broadly within discussions about the effectiveness of PPI, but it is especially relevant in the context of CCGs in place since 2012 (Currie et al., 2018; Smiddy et al., 2015).

While PPI in CCGs has been a statutory requirement since 2012, it is unclear how it has been able to affect decision-making within CCGs. In many cases, PPI has not been involved in decision-making, with lay members questioning CCG commitment to real engagement (Hudson, 2018; Ruane, 2014). There are also questions whether the commitment to PPI, in theory, is replicated in practice, as many general practitioners (GPs) lack prior experience of engagement with local communities (Newbigging, 2016). What is visible in theory, therefore, may not be visible in practice. The value of PPI is significant and should be considered more carefully in a period of structural upheaval, especially with the development of the NHS Five Year Forward View outlining new care models (The King's Fund, 2014).

2.4.2. The development of Sustainability and Transformation Partnerships and Integrated Care Systems

In order to implement the NHS Five Year Forward View, NHS England and NHS Improvement developed STPs (NHS Providers 2018). The intention being more collaborative working across health and social care to tackle the challenges faced by the NHS, outlined in the Five Year Forward View (Alderwick et al., 2016; Hammond et al., 2017). There has since been opportunity for these to change into ICSs, under the NHS Long Term Plan which encourages further integration (Timmins, 2019). However, even in these more complex organisations, which have begun to engage more with the public, the structure remains difficult to comprehend; they are "almost indescribable" (Timmins, 2019, p27). This lack of clarity surrounding the structure of these new organisations also raises questions about the role of PPI, for example can PPI affect decision-making if there is a lack of clarity about how it operates and how it can affect local services?

2.4.3 Patient and public involvement in Sustainability and Transformation Partnerships and Integrated Care Systems

Under the new guidance, it was intended for patients to have a role in the development of STPs (Alderwick et al., 2016), however, evidence suggests this has not happened and that the new STPs have lacked any real accountability or transparency (Hudson, 2018). This criticism has been levelled by members of PPI groups involved in the development of an STP (Carter and Martin, 2018). These issues are exacerbated by the fact that STPs are not statutory bodies and as a result lack formal PPI

mechanisms (Coultas et al., 2019). Early evidence suggests PPI will function at the CCG level and that this may feed into the broader STP (Ibid, 2019). A contributory factor may be the relatively short period between restructures resulting in insufficient time for PPI to influence decision-making processes (Stewart et al., 2019).

This means that in any STP it is difficult to identify how PPI factors into decisions at the macro level of the STP. The early work on PPI in STPs illustrates the considerable variation of how these processes are implemented (Carter and Martin, 2018; Coultas et al., 2019). Carter and Martin (2018) found that a PPI group was involved in consultations while the STP was being developed. However, the group lacked formal status and as a result could not influence decision-making (Ibid, 2018). It was also found that the PPI group was bound to confidentiality, which left many members feeling uneasy as they could not engage with other members of the public to share STP plans (Ibid, 2018). Under the Health and Social Care Act (2012) it has been found that there is a reliance on the willingness of staff to engage and for PPI to be taken seriously (Coultas et al., 2019). These issues could be more complicated if there is further fragmentation of PPI. Under the new changes, there will be some scope for PPI in CCGs, STPs, ICSs and local providers. Fragmentation can severely limit the ability of PPI to affect decision-making (Newbigging, 2016). The current evidence suggests there are inherent tensions within the process of developing PPI (Martin et al., 2019). This will only be made more contentious as more of the transformation work of STPs takes place, with greater emphasis on moving care into the community despite concerns from PPI representatives (Carter and Martin, 2018). There are additional concerns that some PPI lay members may begin to be viewed as 'experts in laity' (Martin et al., 2019, p33). In this sense, lay members are not viewed as public representatives and thus do not conform to what PPI should be (Ibid, 2019).

The transformation of some STPs to ICSs has, however, managed to increase the involvement of local government in the decision-making process (Humphries, 2019). Local government is involved in the drafting of plans and provides extra scrutiny through local Health and Wellbeing Boards (HWBs) (Ibid, 2019). The change has enabled some of these systems to work even more closely with local government and other actors (Timmins, 2019), with better interaction between ICS leaders and HWB/local government leaders (Humphries, 2019). In cases where there has been successful collaboration, there is a noticeable tendency to involve the HWB which has become engaged with the changes of STPs to ICSs (Ibid, 2019). These more successful examples of integrated working have generally occurred in areas where there is more of a tradition of collaboration, also involving local government (Humphries, 2019; NHS Confederation 2020). Involving a 'coalition of the willing', i.e., local government, NHS staff and patients and the public appear to have had the best outcomes in local areas (NHS Confederation 2020). There is little direct discussion of how PPI may have worked within these frameworks, but there has been more significant involvement of local government and the HWB. The change to ICS has led to some additional involvement of local government because of a perception that the STP brand was 'toxic' and hence a lack of willingness for local government and the HWB to engage with them (Timmins, 2019). However, it is not yet entirely clear how this will happen and to what extent PPI affects decision-making.

2.4.4 Regional variations

In addition to the early STPs and ICSs which are considered as pioneer sites, the Greater Manchester (GM) area was given more power to commission and integrate its local health and care systems (Checkland et al., 2015). Early evidence there, could be an indicator of what shape new PPI structures

in South London might take. Greater Manchester has since formally been designated an ICS and there is still limited evidence about how and whether it has managed to achieve its objectives (Walshe et al., 2018). Under the auspices of the arrangement, the GM authority has the power to integrate health and social care services and has control over the entire budget (Ibid, 2018). Data and evidence are still being gathered and published about just how effective it has been in improving health outcomes and generating savings (Ibid, 2018). What is clear is that there has been some PPI involvement in the process (Ibid, 2018). Within the GM devolution area there appear to be two main vehicles for PPI. The first is the co-operation of local Healthwatch organisations that work together at the GM level on various boards and committees (Ibid, 2018). Local members of the public have expressed their concerns about the process and the apparent inability to become more involved, with this having been communicated at public events (Checkland et al., 2015). The second vehicle for PPI in the GM area is the involvement of the Greater Manchester Centre for Voluntary Organisations (GMCVO) which has led to an increase in members of the public becoming involved in boards related to mental health and cancer services. The ability of PPI to meaningfully affect decision-making, however, seems to be rather limited (Walshe et al., 2018).

2.5 Patient and public involvement in South London

There are two geographical areas in South London in terms of STPs and ICSs. South East London's former STP, 'Our Healthier South East London' (OHSEL 2020a), operates as an ICS. South West London's system is less developed and is considered a STP, known as the 'South West London Health and Care Partnership', although it is moving towards becoming an ICS (SWLHCP 2020). Both the SE London STP and the SW London ICS have PPI structures, and are explored in this study.

The OHSEL formally became an ICS in June 2019 and appointed a new non-executive Chair in January 2020 to provide additional support (NHS England 2020b). This suggests that NHS England is satisfied with the progress being made in SE London and that there will be further integration of health and social care. There appears to be little substantive information about how PPI influences decision-making in the ICS in SE London (OHSEL 2020a) and an apparent lack of clarity about the role of PPI more generally and how it might function within an ICS. There is only one currently existing forum for PPI members to meet (the Patient and Public Advisory Group), and this forum is being terminated, so the role of PPI will become even more difficult to discern.

In SW London there has been a less formalised development of the STP. The role of PPI, however, is a little clearer as there is a Patient and Public Engagement Steering Group (PPESG) (South West London Health and Care Partnership 2020). The purpose of the group is to provide "effective lay involvement and patient and public engagement across the Health and Care Partnership" (Ibid, 2020). The group assembles members of NHS bodies, lay members from local CCGs and representatives from Healthwatch (Ibid, 2020) and provides updates and guidance to the constituent organisations. While the SW London STP may not be as clearly defined as OHSEL, evidence suggests it has a more proactive PPI system in place.

In addition to the SW London STP and the SE London ICS areas, there are further changes in South London. The CCGs across this area are merging to create two new CCGs (one each in SE and SW London). These will encompass all the previously existing CCGs in the respective area. This is partially in response to changes relating to the NHS Long Term Plan, with commissioning being scaled up in size (NHS England 2019). In SE London, the new CCG is part of the ICS (SE London CCG 2020). In SW London,

the new CCG is not formally part of the STP but as commissioners have been collaborating for some time, a decision was taken to merge (SW London CCG 2020). The new CCGs in SE and SW London will be the largest in the country in terms of population, which could affect PPI (Thomas, 2019). While there is a statutory obligation for these organisations to have PPI structures in place, PPI could potentially become strengthened.

Across South London, however, there appears to be variation in STP and ICS structures. Further, capacity for effective PPI is placed under pressure when a primary consideration of the new organisations is to reduce financial costs. Both the STP and the ICS need to generate significant financial savings and yet continue engaging with patients and the public. There is some risk that PPI will take on a less important role during the process of consolidation (Deighton, 2020).

2.6 Summary

The overall development of PPI within STPs and ICSs has been unclear and subject to wider reforms of the health system, to local variations and dependant on a variety of other factors. A large body of literature deals with the issues connected to PPI in large scale service reorganisations. A re-emerging strand is the apparent contradiction of the strong rhetoric and verbal commitment of the authorities to PPI and the perception that much PPI is interpreted to have been tokenistic. To what extent and in what ways will PPI in the new CCGs be able to influence decision-making? At both the CCG and ICS level, there appears to be a lack of clarity about the future shape and role of local PPI structures and whether PPI can affect decision-making processes.

Chapter 3: Methods

3.1 Introduction

This is a case study of PPI in the changing NHS commissioning landscape in South London. The study uses a qualitative approach to address some of the questions highlighted in the literature review and to explore the views of people involved in PPI about the new commissioning structures.

3.2 Participant identification, recruitment, and data collection

A convenience sampling strategy was adopted for recruiting participants:

I. Participants were initially identified through online searches of websites relating to South London CCGs, the STP and the ICS. Additional individuals were identified through attending public meetings of the local ICS and HWB.

II. Key decision-makers were sent an email invitation to participate in the study.

III. As part of a snowball sampling technique, individuals who took part in an interview were invited to identify and provide details of other potential study participants who were involved in PPI/commissioning in South London.

IV. These additional individuals were subsequently contacted by members of the research team via email, inviting them to take part in a telephone interview.

A total of 13 participants were recruited to the study. Table 1 shows participant job roles and areas of responsibility.

The literature review helped inform the development of the topic guide used in interviews (see Appendix 1). Two study researchers carried out semi-structured interviews with the 13 participants. The flexibility of the approach enabled interviewers to ask participants additional questions about any new information not initially known (Gill et al., 2008). Interviews were approximately 30 minutes in length, recorded and transcribed verbatim. Verbal consent was obtained at the start of each interview.

A World Café style workshop had been planned to take place on 24th March 2020 in order to share and discuss emerging interview findings with local PPI representatives. However, due to the COVID-19 pandemic restrictions, this event was cancelled[2].

[2] Following consideration, a decision was made to not host the event online. This was for various reasons, not least relating to technological issues, from the perspectives of both researchers and participants. An online event would have required more infrastructure than was available at the time.

Table 1: **Participant job roles and areas of specialty**[3]

Participant Job Role	Number
Staff member, CCG	1
Staff Member, ICS Board	1
Lay Member, CCG	4
Patient and Public Representative	3
Healthwatch PPI Representative (Volunteer)	1
Healthwatch Staff (Employed)	3
Total:	13

3.3 Data analysis

Data were analysed using a thematic analysis approach which involves six stages of analysis (Braun and Clarke 2006). Throughout the analysis, all these stages were followed. The entire process was iterative, with feedback being considered and used throughout. Initially, the researchers who carried out the interviews familiarised themselves with the transcripts.

The initial coding process was carried out using NVivo. This generated a list of themes and subthemes, which were shared, discussed and refined over several study team meetings until agreement was reached on a final set of themes and subthemes.

[3] The areas that participants are affiliated with (SE/SW London) are excluded from Table 1 in order to protect individuals' identity.

Chapter 4: Findings

4.1 Introduction

This study seeks to explore how PPI structures are affected by changes to the NHS commissioning landscape. The findings presented here comprise main themes and subthemes that emerged during the analysis of data. These are set out in Table 2 and then described below in greater detail, drawing on participant quotes.

Table 2: Main themes and subthemes

Main Themes	Subthemes
Relationships between staff and PPI members	Working relationships between organisations Scope of PPI roles
Representativeness of PPI members	New ways of engaging the patients and the public
External Pressure – the effects of structural change	Rapid pace of reform Devolving decision-making to new 'places'
Status of the organisation	Statutory status Non-statutory status
Development of PPI structures	Decision-making of key actors Local PPI Structures
Integration of services across South London	Local differences

4.2 Relationships between staff and patient and public involvement members

The presence of strong relationships between local members of staff who are responsible for PPI appears to lead to greater clarity about local PPI structures. Where these relationships exist, participants believe that local systems will remain in place:

> *"They would like there to be conformity, however, [SW London Borough 1] and [SW London Borough 2] have dug in their heels and said no*." (Participant 1, Patient representative)

> *"But again, you know, we have been promised the current structure in [SW London Borough] will remain the same. Staff will also remain the same. So that's good."* (Participant 6, Patient representative)

"[So what will happen to the local PPI with the change to the Southwest London CCG?] Yeah, I think it looks like they've kept it similar as possible and I don't see many changes. Yeah, it's mostly black and white and looks very similar." (Participant 7, Staff member)

In both SE and SW London, many staff and PPI structures seem to have remained the same. These relationships appear to be even more important because all the new structures would fall under the communications and engagement teams at both new CCGs. These communications teams are part of the new CCGs, however they also work for their respective ICS or STP:

"The anticipation is as we move forward into our South East London CCG structure is that the central engagement team will support the ICS in developing their engagement mechanisms as well as developing the CCG engagement mechanisms …. So that central and South East London engagement team is supporting the new South East London CCG in delivering its engagement as well as the ICS." (Participant 11, Staff member)

Communications and engagement teams will oversee how new PPI structures are developed. However, there appears to be some uncertainty amongst participants about how these structures will feed into decision-making at the higher, SE or SW London level:

"I haven't thought about how those mechanisms work together as they kind of feel like they sit apart ... there is a mechanism to ensure that that kind of feedback gets in at a borough level but I don't know ... I'm not sure how it goes any higher." (Participant 5, Healthwatch staff member)

"They're trying to organise it and restructure it, but it takes a bit of working out at the moment because the organisation doesn't exist yet, it's hard to theorise it all." (Participant 7, Staff member)

Overall, the importance of good relationships was emphasised by multiple participants, mostly at the CCG level, but with some indication that this will have some influence at the ICS/STP level also.

Working relationships between organisations

Greater collaborative working is central to new NHS structural changes, with a focus on developing relationships between different organisations that have not collaborated previously. Some participants expressed concerns about how these new relationships take time to develop and the effect on PPI:

"I think there will be challenges there because of my experience working with trusts is that…well as we all our very focused on our own organisations' engagement needs and trying to do things more collaboratively across a larger geographical area could be challenging" (Participant 11, Staff member)

"I think it's a trust and working together issues as well. And that's going to have to develop, and having shared visions, shared goals that sort of thing to help us share our information." (Participant 8, Patient representative)

"The geography of the organisations and their mandates don't necessarily follow the direction of travel and that creates that... I think that the demands that that causes is drawing away capacity from… from things like patient involvement" (Participant 2, Healthwatch staff member)

However, amongst patient representatives there is also some distrust of how these new relationships may affect PPI:

"Because the role of our Trusts, is so different, until there's legislation, there is a strong possibility that Trusts, although they talk collaboration, when push comes to shove, the Trust boards may say our statutory responsibility is to this particular institution not to the greater entity and they will be legally correct, until there's legislation, so, we shall see!" (Participant 1, Patient representative)

"I think because when we're merging CCGs at least we're looking at how the NHS does things, I think when you get to an ICS the different cultures involved…I mean there's been huge culture differences between CCGs and that's all in the NHS. When you get councils and acutes [hospital Trust] and voluntary groups all with different cultures involved and different ways of doing things I think you do get challenges" (Participant 8, Patient representative)

Some participants raised concerns about how difficult it is to influence discussions between some of these organisations due to the involvement of large organisations with priorities which appear to cover a wider area than those in which participants have experience:

"It does feel remote … there are system partners around table and talking about how they work together in terms of integration, and those are not necessarily the conversations. … But not necessarily conversations that are easy to influence." (Participant 2, Healthwatch staff member)

In some cases, participants felt that it was only people in leadership or executive positions who meet and not those in other parts of the organisations:

"All the chairs and chief executives of these organisations meet all the time, but two layers down they seldom meet, and at the grassroots they never meet." (Participant 9, Patient representative)

This participant believed that due to these meeting arrangements, potential, important input was not being utilised.

4.3 Representativeness of patient and public involvement members

There is a general perception amongst participants that many members of the public who are involved in PPI tend to be homogeneous:

"And what I've noticed [borough name] has contact lists of the same old faces who always turn up at the same kind of focus groups and meetings and it's all very incestuous. All white middle class with sharp elbows who have their particular foibles" (Participant 10, Patient representative)

This appears to have led to an impetus to create new PPI structures with emphasis on making changes to consultations which may produce greater representation of the populations in South London:

"They work with MORI a market research agency to find a group of people who are truly in inverted commas representative of populations. We've been told they're looking for 26% BAME and other protected characteristics etc. And I think they will be paid to be on a sort of mailing list, a bank of people to be called in as and when." (Participant 9, Patient representative)

However, there is some apprehension about the use of the private sector to assist with making PPI groups more representative:

"They would rather research a topic with people who are paid to come to a focus group rather than have an ongoing relationship with people who start understanding how the system works….They

are going to find people who use continence product and ask them about and then they'll write a report and 6 months later they dish out this report and say we can do this better. But they won't actually have been listening to people who've been talking about this for the last 6 years." (Participant 9, Patient representative)

There is an element of frustration around this method of attempting to achieve greater public representation, relating to a perceived lack of notice taken by professionals of existing PPI in certain areas.

New ways of engaging patients and the public

Many participants reported a change in the way decision-makers have sought to engage with patients and the public, at both CCG and ICS level. Partially this appears to be in response to the perception that many people involved in PPI are not representative of their local populations. Alongside this, there appears to have been more of an emphasis on public events and less on patient and public voices being embedded in the process. Patient representatives consider there has been little clarity about these new methods:

"Although at the meeting the new director of engagement was there and s/he was talking about doing the rounds and talking to people. It's a bit late in the day about getting people's views on PPI in that all the groups are disappearing. It runs counter to 'Ten years forward' which stresses the whole thing about patients being embedded within the system at the co-design and co-production level and we're still being treated as tick boxes." (Participant 10, Patient representative)

"*They see that as the PPI of the future, it's engagement, not PPI, and they don't make the distinction*." (Participant 1, Patient representative)

Amongst staff there were different ideas which were being floated, but little clarity on what these new methods may finally be:

"Some themes that have come back on that are some people like the idea of doing more electronic engagement and to widen our reach to include younger people, or people who may not get involved traditionally. … Some people like the idea of conference, maybe one per two boroughs, because it suggests you're a delegate and have something to offer." (Participant 11, Staff member)

Some participants believe that under the new arrangements there is more of a focus on consultation and suggest that public meetings/events are more the norm when it comes to PPI:

"Patients are not one of the stakeholders … And this use of engagement rather than consultation has been a big sticking point for us. Our director allocated to SE London has been in the main the person carrying out engagement, and they are adamant that that's what they are required to do and no more. And engagement means telling you what we're going to do" (Participant 12, Patient representative)

"If it's an elderly group, they might want a fish and chip supper and they applied for the funding for the fish and chips supper with the caveat that Southwest London came and spoke to them about what their priorities were around delivering good health and social care. So we've done that twice now." (Participant 2, Healthwatch staff member)

4.4 External pressure: the effects of rapid structural change

Structural changes to NHS organisations are driven by NHS England/Department of Health with an emphasis on increasing collaborative working between NHS providers, local government, and other local service providers. Part of this focus is also making sure that these new groups can begin work as soon as possible. This has had a knock-on effect on involving patients and members of the public as the focus is on developing the new system. Participants believe that PPI seems to be considered only after these changes are beginning to take place:

> *"We all feel like we're kind of the bit of the add on, patient and public engagement often is quite difficult. They have such big priorities and so many dictats that come down directly through [um] through kind of the Department of Health and NHS England"* (Participant 5, Healthwatch staff member)

> *"What we get from CCG is 'its national'. There's no debate. That's the word that comes up always around the timescale for change, particularly PCNs [Primary Care Networks] but also this CCG merge*." (Participant 12, Patient representative)

The perceived lack of involvement appears to also extend to other groups that are involved in the work of the new structures, such as the voluntary sector and social care providers:

> *"We keep banging the drum on where's the patient in all of this…, but it appears social care, the voluntary sector and patients don't seem somehow to get a look in. So, I keep saying will you invite patients, will you invite the voluntary sector...It's called integrated care in name but very much in name only."* (Participant 9, Patient representative)

> *"The PPI representatives have expressed the same concerns that I have. That all this is being are being pushed forward at an undue haste and without a lot of common sense about how you work with groups of professionals at a local drive. Driving it from high up and remotely from the centre, it's just not going to work."* (Participant 7, Staff member)

One participant reported how concerns about changes had been raised with the 'centre' (i.e., NHS England) by local decision-makers but were dismissed, with the preference of the centre being given priority:

> *"I think the chair of CCG is being bullied. We wrote and opposed the merger … And because the CCG is a membership organisation, they have to ballot their members, the GPs. And the first ballot they opposed the merger. The ICS went spare and said we can't have this so they were told that that was an advisory ballot and it would be re-run ... And they re-ran it … and I think they voted unanimously in favour of the merger. We heard [NHS England lead name] himself had been on the phone to various people."* (Participant 9, Patient Representative)

The perception here is that power is being exercised by NHS England to ensure that the commissioning landscape aligns with national priorities. It appears to link to the notion that there is external pressure to conform and create the larger CCGs and ICS.

Rapid pace of reform

Participants raised the issue of the timeframe within which structural changes in South London are to be completed. As part of the changes, CCGs have merged a year before the NHS England deadline. The

timing of this transformation to new 'leaner' CCGs coincides with the ongoing developing of the SE London ICS, and closer working between the SW London STP and its CCG.

Both staff and patient representatives expressed concerns about how these transformations, especially given the speed at which they have developed, may affect the ability of different actors to work together effectively:

> *"If you're trying to engage with neighbouring practices and organisations, third sector and all the various people you have to engage with, it takes time. It takes a lot of time and effort to build up those relationships and yet they are being asked to do all this in a couple of months or something ridiculous."* (Participant 7, Staff member)

> *"There's bound to be a transition development period of some months as people find their feet, workout how in the world we're gonna [sic] make this work."* (Participant 1, Patient representative)

This is seen as partly a result of the effects of the centre and structural changes that are taking place:

> *"you've got the NHS long term plan [laughs] which I'm not sure if gonna change, at least in timescale it will, so the NHS Long Term Plan had some very ambitious things that it wanted to achieve."* (Participant 13, Healthwatch staff member)

This appears to have had some effect on the way in which PPI has been designed:

> "*And so we ended up without time to really properly, meaningfully engage and involve the public in the decisions in [SW London Borough], because the decision-making timeline didn't really allow it and the decision-making timeframe are SW London based*." (Participant 2, Healthwatch staff member)

Many participants feel that many decisions and deadlines have been imposed due to the structural changes:

> *"I get a sense it's being driven very much from the top and people at STP level have to react to that because they have these deadlines and they have to put things in red, amber or green codes and they have to respond to this relentless demand for change."* (Participant 7, Staff member)

> *"But as with everything within the NHS, the timescales and the delivery of change is always so ridiculously quick."* (Participant 5, Healthwatch staff member)

Some participants believe that the timeframes imposed by the centre have resulted in less involvement of patients and the public from the beginning of these structural changes:

> *"I think if there was more PPI involvement then maybe it would bring a bit more sense to it all. Being properly involved instead of just sitting on committees and commenting when it's all happening ... I think full collaboration, engagement and involvement for PPI is crucial."* (Participant 7, Staff member)

Devolving decision-making to new 'places'

The new CCGs appear to devolve most of the decision-making to the local place (i.e., borough level), however, what this will entail was unclear to participants. Concerns were expressed about new place-

based committees no longer being open to the public, and how there will no longer be any PPI members involved, creating tension around how decisions will be scrutinised:

> *"Each of those decisions are is being taken 80% locally and 20% centrally."* (Participant 2, Healthwatch staff member)

> *"The theory is that a lot will happen locally anyway*." (Participant 13, Healthwatch staff member)

> *"I understand there's kind of full delegation of finance back down to [local borough]"* (Participant 5, Healthwatch staff member)

Participants expressed concerns about there not being as much scrutiny of local decision-making:

> *"It will be replaced by an executive committee that does not meet in public as it is a subcommittee of the SW London CCG, it will not meet in public, but it will contain most of the people who are currently on the CCG GB*" (Participant 1, Patient representative)

> *"Unfortunately, that kind of board that that group that follows on from [borough] CCG, the place, it's more or less going to be a management committee which won't meet in public it'll meet in private. That's causing a bit of distress in [borough]."* (Participant 6, Patient representative)

There was some understanding that as much decision-making as possible would be devolved to borough level:

> *"So I think the public structures would be borough based as much as possible. It's not clear yet. I mean, people at the top of South West London say… She says everything that can be devolved to borough level will be. Now, if that's true, that's good, because that means we can keep the focus on PPI at borough level and can use them, the old relationships, the existing structures*." (Participant 6, Patient representative)

> "*So there has been that core group working on people from the health and social care group. Most of the activity will happen at borough level because the changes will mean a more important role for the borough health and social care group."* (Participant 6, Patient representative)

However, there was also some uncertainty:

> *"We don't know what decisions will be taken at South West London level, what decisions will be taken at place [borough] level"* (Participant 2, Healthwatch staff member)

4.5 Statutory status of organisations

The statutory status of the new CCGs means that there is a responsibility to engage patients and the public. Participants suggest this has resulted in greater emphasis on the role of PPI:

> *"The SW London CCG, there is a statutory role for PPI, none of the current lay members for PPI in the local CCGs applied for that job, they don't think it's possible to do at that level, but a lay member for Governance in one of the CCGs did apply and was appointed. So there is a PPI role at CCG level, but it will not be the same as what has been going on locally"* (Participant 1, Patient representative)

> *"We're all focused on ensuring that CCGs fulfil their kind of statutory duties to engage."* (Participant 5, Healthwatch staff member)

Some participants believe that a different approach is being taken where the ICS/STP are concerned and that the non-statutory nature generates different issues:

> *"At CCG level we have statutory duties as part of the NHS so we have to be able to assure the governing body that we have fulfilled our statutory duties. In the STP the different organisations have different duties so they may be running parallel but we have to assure our various regulators that we are carrying out what we have to do."* (Participant 8, Patient representative)

In contrast to the new CCGs, the ICS and STP do not have a statutory obligation to involve patients and the public. When created, STPs were intended to involve patients and the public in the decision-making process, but details around undertaking this were not elaborated on in the NHS Five Year Forward View or the NHS Long Term Plan. With a focus on integrating services and working with partner organisations, participants believe there has been less focus on PPI at the ICS/STP level. Participants reported not having had a good, clear feeling about how PPI has been involved:

> *"I don't get a sense that PPI representation has been involved if at all in the direction of travel … A lot of this is driven centrally from the very top. I don't think there's been much time or opportunity for PPI to be either fully aware of what's going on, or comment too much. … But sitting on the executive that's the impression I get, that they are being told things at the executive and commenting and reacting to it, so they have input in that sense."* (Participant 7, Staff member)

> *"There have been a couple of meetings where the non-executive people in the ICS, so like the acute non-executive members and the lay members from the CCG have been together but I'd say that's been a while. That hasn't been a very active group I wouldn't say at the moment."* (Participant 8, Patient representative)

There was also a perception that, by and large, PPI structures will be situated with the new larger CCGs because staff members who will interact with PPI are based there:

> *"There is a very well developed and powerful comms and engagement team at SW London, it is very competently led, it's very professional and PPI comes under comms and engagement."* (Participant 1, Patient representative)

Participants commented on how the new STP/ICS areas did not feel like viable areas to work across, and that this may pose some issues in terms of PPI:

> *"It doesn't feel like a very real thing, when you say ICS it doesn't feel very tangible here. Yeah. It's quite difficult, not that we haven't been involved, I think that I think it's probably more, more to do with the, quite gaseous, I guess, you know, hard to pin down [laugh]"* (Participant 4, Patient representative)

> *"Well I think if we are going to be an ICS, at SW London, SW London doesn't exist, it's not an entity, it's an intellectual construct, PPI happens at a local level and ideally you would build in PPI structures at local level"* (Participant 1, Patient representative)

> *"I don't think South West London is a place. I don't think it's an area that anyone recognizes."* (Participant 2, Healthwatch staff member)

4.6 Development of patient and public involvement structures

Participants reported that in some areas there would be a continuation of existing PPI structures. This would appear to rely on a good relationship with staff and a perception that such structures are robust. Patient representatives were especially clear that this was something they wanted to continue:

> *"The six boroughs have got three green rated and three green star-rated so there's a lot of talent in terms of how patient engagement is gone about in SE London. So when it comes to thinking about how we do engagement as one CCG for SE London we've started looking at what happens already and talking to the different people already involved in SE London."* (Participant 8, Patient representative)

> *"Because it's really important to a lot of communities and individuals and organisations, locally here that they stay involved, and while that... their involvement has impact, whether it's official or not, so we have a number of quite active practice patient groups (PPGs) who do all sorts of things … that will almost certainly continue, unless it's officially stopped"* (Participant 1, Patient representative)

> *"We've been told the PPI structure will remain unchanged in [SW London Borough] which is great because some got some pretty good stuff in… GP? She's the GP advice from the PPI group. Wonderful woman, really, first class. She's ... She'll be there after the change*." (Participant 6, Patient representative)

Some existing PPI structures are viewed as likely to remain in place within the new CCGs. The development of new PPI structures in the ICS, however, was perceived as a secondary consideration:

> *"The number one problem is to keep the commissioning on stream and keep to the budget. So, again, I'm really impressed that they find the time to worry about PPI, but they've been doing the best and we've been negotiating with them as to what will happen after the Big Bang, the first of April when the six CCGs merge."* (Participant 4, Patient representative)

Several concerns were raised about some PPI groups within the ICS being disbanded:

> *"There's an awful lot of experience that's just going to go to waste and I think people are feeling kind of quite bitter certainly at the PPAG group...I think they feel as though we've done all this work, and we feel we've done useful work, and it's just gone to waste."* (Participant 10, Patient representative)

Some suggestions for PPI involvement structures were thought to be under discussion at individual boroughs and consulted there. It is unclear at this stage how new PPI structures will be able to link into the decision-making processes in the new CCG from the boroughs and then into the ICS/STP:

> *"Some people like the idea of conference, maybe one per two boroughs, because it suggests you're a delegate and have something to offer… So, we've had a wide range of views including quite a level of criticisms from the more campaigning members of the public that we developed this offer without engaging them in it. And some people were seeing this as a strategy rather than a first discussion paper."* (Participant 11, Staff member)

There is also some uncertainty about how feedback from PPI structures will reach decision-makers:

> *"There is a mechanism to ensure that that kind of feedback gets in at a borough level but I don't know ... I'm not sure how it goes any higher."* (Participant 5, Healthwatch staff member)

4.7 Integration of services across South London

While there are general trends and developments, there are also variations in the transformations taking place in SW and SE London. Both areas are merging CCGs, but the ICS in SE London is more developed and is at a different stage with its PPI.

There are also differences in the amount of resources available in the two areas and whether they are perceived as being feasible areas for PPI to be delivered across. For some participants this relates to the relationship between different organisations and how they may work together:

> *"SE London is different from SW London, I know SE London fairly well, in that the Trusts there, the main one, [Name of Trust] have been keen for ages to move stuff out of the hospital and into the community and helps to focus more on the special stuff. That has not been the case in SW London, so the Trusts were leading on developing community services, that was quite different from almost everywhere else actually and that gave them a head-start and also they have also had some very active people in PPI at all sorts of levels"* (Participant 1, Patient representative)

These differences could potentially affect the way in which PPI develops in these areas due to existing local priorities and how commissioners interact with other local actors.

4.8 Summary of findings

There is generally a view that PPI was considered only after the new organisations had decided to integrate services, rather than before. Patient and public involvement is perceived by the majority of participants as having been a secondary concern within changes to commissioning structures and that other issues, such as working with new partner organisations, are viewed by professionals as a bigger priority. There are also concerns that new PPI structures seem to be focused on involving people on a shorter-term basis, i.e., increasing attendance at public events, rather than on embedding people over a longer period. The main concern is that this process could result in a reduction in scrutiny of decision-making.

Chapter 5: Discussion

5.1 Introduction

This scoping study was undertaken in order to gain understanding of how PPI structures are changing in South London during a period of structural change to NHS commissioning. The literature review explores why and how PPI is important and has been integrated into STPs and CCGs. Qualitative research findings identify some key perceived challenges and issues among staff and PPI representatives, and areas for consideration in future research. This chapter considers the study's key findings in the context of existing literature and implications for the wider PPI project.

5.2 Changes to patient and public involvement in South London

The NHS reorganisation in South London is being undertaken in a relatively short space of time. While the ICS has been in development over several years, it is an early pioneer site that is one of 14 across England (NHS England 2019). While the situation in SW London is a little less developed, the South West London Health and Care Partnership has submitted its own ICS application (SWL CCG 2019). Alongside this, in both SE and SW London, the CCGs have decided to merge in the first wave of CCG mergers under new planning guidance from NHS England. This has added an additional layer of complexity in terms of PPI, as many CCGs (12 across South London) and a variety of other partner organisations begin to work together, with the priority being to deliver integrated care.

Patient and public involvement is outlined as a valuable and important component in health and social care service development in the NHS Five Year Forward View (2014) and the NHS Long Term Plan (2019). Therefore, it would be reasonable to expect involvement of patients and the public from the outset of CCG mergers and developments of the STPs and ICSs, but this does not appear to have been the case in South London. Rather than using PPI to inform and help support the transformation process, it appears that decisions about the integration of services were taken before and without involvement from patients and the public. This may be due to the need to integrate services and generate savings. In their study of public engagement in NHS system transformation programmes, Carter and Martin (2018) found that PPI was a secondary consideration when compared to operational concerns of NHS organisations. To some extent, 'secondary considerations' of PPI could be related to the lack of clarity around guidance on how PPI should be conducted. Stewart et al (2019) report a lack of guidance from NHS England about how PPI should be carried out.

5.3 Limited patient and public involvement

Data from the current study suggest that PPI has not shaped the discussion around how the new commissioning landscape will develop. Instead, PPI appears to be considered after critical decisions are made by NHS England. Part of the justification for the development of the ICS was to have patients and the public lead on reform. However, power appears to be concentrated in the hands of NHS decision-makers. While the ICS leaders do not have statutory power to make other organisations agree to its decisions, the ICS is backed by NHS England and seems to have ability to influence others. The

distribution of power appears to be situated at the macro (NHS England) level and not at the local (borough) level. Through its ability to exert pressure, NHS England can ensure that the local decisions in the ICS reflect the ambitions of NHS England. While the creation of the ICS should ensure that there is an ability to decentralise, it appears that there is currently even greater centralisation of power and decision-making ability. The centralisation of power has implications for trust at the local level. Many participants who have been involved in the CCG structures prior to integration, express concerns about accountability and lack of clarity about what sorts of decisions will be taken at the borough level. However, despite this centralisation of decision-making, many also remain optimistic about how these new decision-making systems will work, highlighting their concerns about the financial struggles of the NHS but, for example, how collaboration may go some way towards helping provide a solution.

Some of these concerns around PPI being considered later on in the development of ICSs can be found in other work, alongside a desire to build better relationships with local communities and to deliver a feeling of 'ownership' (NHS Confederation 2018), but this is not happening at the same time that structural change is taking place. Amongst some of those who were interviewed in this study, trust appears to have been further eroded, with a distinct impression that some of the geographical areas of the STP did not make 'sense'. There is a perception that NHS England is artificially attempting to create a STP and questions about how worthwhile this development is likely to be, given that much decision-making about services is devolved back down to the new 'place' (borough). Devolution of decision-making raises questions about the purpose of the reform; if decision-making is brought back to the previous CCG area, it is not clear how PPI will fit within the dynamic of having a local place and a SE or SW based CCG. This could make it more difficult for PPI to be heard at the higher levels, which is in line with other literature (e.g., Coultas et al., 2019). These new structures also do not consider the role of the new Primary Care Networks (PCNs) as they start to operate.

Some of these issues are further compounded by the fact that engagement with patients and the public appears to be 'managed' by staff. The focus appears to be more on short term engagement and not on embedding members of the public or patients over a more extended period. This relates to how integrating services seems to be the top priority. Some participants raised concerns that PPI events taking place in South London were more about gaining views on specific issues in a one-off format. There were different views about how this occurred and whether it was a good thing, and would be worth exploring further in the wider PPI project (project one) to see if this approach becomes the norm moving forward.

A last consideration is the role that the private sector has in the development of PPI in the research area. While it may not appear to have a significant role currently, the use of private providers in engaging patients and the public will potentially change how PPI is viewed and utilised in decision-making. It is also clear that the involvement of the private sector in establishing PPI has not been publicly discussed. This is also an issue that could be further explored in project one.

5.4 Effect on decision-making

The views of participants indicate two dimensions to PPI and how it affects decision-making in South London. The first relates to PPI in decision-making around structural changes to NHS commissioning. There appears to have been very little PPI input into the new commissioning structures in the SE London ICS and the SW London STP. There was some limited input in the newly merged CCGs, with lay members being recruited and a statutory duty to engage with patients and the public which was the

case under previous CCG structures. Within the ICS and STP, there were PPI groups during the early stages of their development (the PPESG and PPAG respectively), but they do not appear to be permanent structures; there are indications they will be replaced. Further, the effect of these PPI groups on the new structures is not clearly understood. The new PPI mechanisms seem to be more closely linked to the two new CCGs, with their communications and engagement teams taking on the responsibility to develop these systems. There are some indications that these new teams have been engaging people in the previously existing CCG boroughs and conducting consultations. However, the new commissioning structures had been decided before any PPI, and needed to be implemented in a specific way. These findings correspond with other literature, where it has been argued that PPI in decision-making is a low priority in England (Stewart et al., 2019) and that decisions may already have been made before meaningful public consultation has taken place (Carter and Martin, 2018). This was further reinforced by the need for some PPI lay members in the current study to campaign for their roles to remain during the period of structural change, highlighting the precariousness of PPI when it comes to shaping new commissioning structures.

The second dimension relates to levels of PPI in commissioning decision-making, more broadly, moving forward. Within the newly merged CCGs there is clearer PPI in decision-making about commissioning decisions, due to on-going PPI structures from the previous CCGs. However, there appears to be less embeddedness of PPI in the STP and ICS and commissioning decision-making. This may, in part, be due to the non-statutory nature of these organisations. While the rhetoric around STPs and ICSs suggests that patients and the public should help shape the organisation, it is not matched by policy. Based on the perspectives of participants in this study, it appears that there will be little public input into commissioning decisions in the ICS. There is little representation of patients and the public and no dedicated group to represent them. This seems to reflect concerns expressed previously about these new commissioning structures (Hudson, 2018).

5.5 Strengths and limitations of the scoping study

This study is amongst the first studies which seek to explore PPI at the local level in an ICS. The case study approach used, enabled in-depth exploration of issues that previous literature highlights and that participants on the whole held particular views about; the semi-structured interviews yielded a substantial volume of rich data.

There are, however, some limitations to the study, for example it is small-scale, focusing on NHS commissioning in one area of London, therefore limiting the generalisability of findings. A further issue relating to generalisation is the limited variation of experience amongst participants. Despite repeated invitations to take part in interviews there were few responses from ICS board level individuals. This resulted in a majority of participants who had an affiliation with CCGs. Several individuals who were identified as potential participants were unable to commit to a time to take part in an interview, largely due to being deployed to assist NHS organisations in dealing with the COVID-19 pandemic. Ultimately fewer and less varied interviews, in terms of participants, were conducted than had been anticipated.

5.6 Conclusion

This study sought to gain an understanding of how PPI structures are being developed in the new STP and ICS in South London. The data highlight how this is a very fluid situation. While there appears to be a mixture of existing PPI structures which will continue, and the possibility of new ones which are yet to be developed, there is a lack of clarity about how PPI will be used to improve the patient experience.

At this stage of developments, approaches to PPI seem to differ between CCGs and the ICS. Patient and public involvement is more firmly embedded in some local structures in parts of South London CCGs than in the ICS. This highlights inconsistency around how PPI has been incorporated and the unclear way in which it links to decision-making in the local ICS and STP.

There was also variation in how the different organisations embedded PPI. This led to a difference in how PPI structures would influence the decision-making process in both the ICS and the new CCGs. What has become clearer through this study is that some participants remain optimistic about PPI, believing that the future relationship between staff and PPI representatives will be fruitful because staff members tend to value PPI. The issue of power dynamics, however, is an important one to be considered, with power remaining concentrated in the hands of powerful actors, namely NHS England. Many decisions appear to have been influenced by the concerns of these external actors and it will take some time to learn what decisions will be taken at a local level and which may be taken at a higher SE or SW London level.

In conclusion, there seems to be a significant level of concern amongst many participants about the overall approach to establishing PPI in South London in combination with recognition of the difficulties involved. Participants are broadly still optimistic that a successful outcome is possible if the local PPI structures are maintained along with the relationships that have already been built. As implied previously, there is understanding from participants towards staff of the newly formed NHS social care organisations and the challenges they face in implementing change and new ways of working.

5.7 Implications for project one

This scoping study provides insight into the PPI structures in South London and highlights specific areas of interest for the wider PPI project. It contributes understanding of people's perceptions of commissioners' priorities and how this may be reflected in decision-making processes. This is an area that project one may seek to gain a deeper understanding of. The study's findings highlight how many participants did not feel that they were able to affect the development of PPI structures, but instead were hopeful of affecting future commissioning decisions. There were also concerns about how PPI has been managed and engaged. Both these issues should be followed up in project one.

The data collected during this study represent a snapshot of a changing NHS commissioning landscape. Other developments may also influence how PPI is used in South London. Project one will be able to develop broader understanding of the place and role of PPI and the commissioning system as it matures, including possible changes to the non-statutory nature of ICSs. However, there are other factors also to consider. This scoping study uncovered little about the role of PCNs and how they may

fit into the developing system. Also, the COVID-19 pandemic will bring additional changes and challenges to the ways in which NHS services operate. For example, indications are that video consultations between the public and clinicians may continue after the pandemic has passed (Lind, 2020) which could create dissatisfaction amongst patients and the public. Further issues relate to the future of data-sharing amongst health organisations, in the light of restrictions having been eased in order to deal with the pandemic which may also potentially remain in place (NHSX, 2020). These matters are likely to be of concern to PPI representatives and staff.

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Appendix 1: Topic guide for interviews

Introduction

- Outline of the scoping study, background (if needed) on the nature of PPI in STPs/ICSs and why they are of interest
- Outline that this will feed into the larger Project 1 study, about attempting to understand health priority decision-making

Topics/Questions

1. Ask the individual(s) about what their involvement is with the STP/ICS to ascertain the background that they have and what knowledge they may have about the processes.
    a. This should cover any prior involvement with similar organisations/similar roles within the SE London STP.
    b. What their thoughts are on the process of integrating care and how important PPI is within that process.

2. Identify what they know of the PPI structures in the STP/ICS
    a. Explore if they are aware that the SE London ICS is seeking to abolish its Patient and Public Advisory Group (PPAG) and if they are aware of the rationale?
    b. What they may know about the roles in which the Public and Patient Voice (PPV) representatives work and how they can influence decision-making
    c. Are there any other changes to STP/ICS changes in terms of PPI?

3. Identify how PPI structures exist in the local CCG
    a. Explore if they are aware of the plans made by the new SE London CCG and how they intend to incorporate PPI in the decision-making process
    b. If they are aware of any local borough governance changes

4. Is the participant(s) able to identify the way in which changes in governance structures are being directed?
    a. Is there a process with which this is all taking place?
    b. Do they know what may happen to the PPI structures across these areas?
    c. Are they able to outline who is directing these changes?
    d. What are the demographics of these boards

5. Identify if there are differences in the way that patients are being engaged, compared to members of the public.
    a. Following in on from meetings and feedback from colleagues, there could be a difference in the ways in which commissioners and staff do engage these two key groups
    b. Does this affect the recruitment mechanisms?

6. Are there other ways for patients and the public to become engaged with the work of the STP/ICS?
    a. Currently the public meeting is held once every 2 months and questions have to be sent in in advance.
    b. Are there any other mechanisms for patients/public to offer their views?
    c. Are there many different lay members that are able to affect policy?