Understanding Democratic Governance: an inductive analysis of collective co-production in the NHS in England

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Declaration

I Thomas Kerridge hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: _____ Date:

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Abstract

This thesis explores the role of collective co-production in facilitating democratic governance in the National Health Service (NHS) in England. Democratic governance offers citizens a role in constructing their communities and institutions. It is a model of governance that is contingent on equality of decision-making between different citizens. However, in the NHS this form of administration has been atypical. Over the past 30 years NHS governance has been based on neo-liberal ethics and latterly institutionalised networks. These models have been imposed through compliance processes that strengthen managerialism and reduce the capacity of the service user.

Recently, a number of contemporary governance scholars have critiqued the notion that governance is simply imposed on institutions. Decentred theorists argue that organisations are inherently complex and cannot be understood through ideal models. Instead, they propose that governance is produced through the actions and beliefs of those who operate within institutions. Crucially for this thesis, this approach means that democratic governance can be generated by staff members, patients and other stakeholder communities.

In this thesis I study one route through which individuals organise and participate in democratic governance in the NHS. This is ‘collective co-production’: a form of decision-making that enables communities to work together and produce outcomes. To do this I have created an inductive framework that examines how the implementation of collective co-production is influenced by exogenous, institutional and departmental traditions; and which studies how actors participate within collective co-production and engage in equal decision-making.

List of Abbreviations

NHS-National Health Service

NPM-New public management

OPM-Old public management

DT-Decentred theory

JUG-Joined-up governance

KBP-Knowledge based practice

GT-Grounded theory

HCP-Healthcare professional

SU-Service user

PROMS-Patient recorded outcome measures

PREMS-Patient recorded experience measures

EPP-Expert patient programme

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Introduction

In this thesis I consider possibilities for democratic governance in the National Health Service (NHS) in England. I ask how democratic governance arises within an institution that is often considered to be beset by the ethics of paternalism or the market. My focus is, therefore, one of discovery. I employ an inductive analytical framework to explore how stakeholders of NHS services implement and participate in collective co-production. This is a form of group decision-making that involves service users and providers (Brudney and England, 1983). Furthermore, I investigate how this process contributes to the generation of democratic governance. From this investigation I create a theory of democratic governance in the NHS in England.

My research is rooted in the governance literature. This is a form of inquiry that provides an understanding of institutional organisation (Kettl, 2015, pp. 25-26). Governance researchers suggest that administrations are no longer dominated by the state. Rather, administrations assume many of the underlying assumptions that orient the study of policy networks (Bevir, 2013, pp.90-93). These networks are constituted by arrangements of state, market, civil and citizen actors. The governance literature offers different ways of understanding these relationships. On one side it highlights positivist analysis and on the other an interpretivist approach (McAnulla, 2006). The former projects the value of objective typologies like New Public Management. By contrast, the latter valorises inductive analysis as a means of understanding how individuals shape governance.

In my thesis I employ an interpretivist approach. In doing this I eschew the notion that objective models of governance provide meaningful accounts of organisation. These models conceive of governance as constituted by theories such as that of rational choice (Bevir, 2013, p.4). As such, positivists suggest that institutions can be changed and explained through the application of these theories. In this sense positivist approaches to governance offer few opportunities to study the role of the individual in constructing administration. They divorce understanding of the institution from the historical contexts against which individuals operate. In this way interpretivist theorists propose that positivists hold a reified and essentialist vision of governance (Ibid; Bevir and Rhodes, 2008).

In rejecting the positivist perspective, I build on the work of decentred theorists like Mark Bevir (2002, 2006 and 2013) and examine how governance is produced through the beliefs of those who operate in institutions. These actors possess situated agency: a concept that suggests that actors negotiate between different traditions and undertake practices that inform governance. In applying a decentred approach, I explore how democratic governance emerges within the NHS. I suggest that a number of high-status professional and lay actors are capable of organising processes of collective co-production. Furthermore, I argue that a wide cross-section of stakeholders participate in collective co-production and, subsequently, influence the direction of NHS services.

The interpretivist orientation of my thesis means that I consider governance from the perspective of those with experiences of collective co-production in the NHS in England. To do this I have employed a research design that has enabled me to study lived experiences. This is Knowledge Based Practice: a methodological guide that provides researchers with a set of principles for inductive investigation (Glasby and Beresford, 2006). These principles highlight the value of lived experience, proximity to the subject and an understanding of perspectives. I then realised the principled stance of knowledge based practice through a methodology called Grounded Theory (Glaser and Strauss, 1967; Corbin and Strauss, 1990). As such, I continuously sampled and analysed the experiences of actors who have organised and taken part in processes of collective co-production (Draucker, Martsolf, Ross and Rusk, 2007). From this I have constructed an inductive framework of collective co-production as a mode of democratic governance.

Thesis organisation and claims

My thesis is arranged in to a number of chapters. In *Chapter 1: Literature review*, I provide the background to my research. In *section 1.1* I introduce the topic of governance. I discuss different modes of institutional organisation and epistemological inquiry and locate my research within the interpretivist governance tradition. This positioning requires me to conduct a decentred exploration of the traditions that interact to influence decision-making within institutions. In *1.2* I

discuss co-production. I examine typologies of co-production from authors like Bovaird and Loeffler (2013) and Nabatchi, Sancino and Sicillia (2017). Furthermore, I consider co-production as a normative process. In *1.3* I examine collective co-production and consider how it is used to create democratic governance. Finally, in *1.4* I discuss the implementation of collective co-production in public services and suggest that successful implementation is contingent on the employment of numerous supplementary processes.

In *Chapter 2: Methodology*, I outline the design of my research. In *section 2.1* I explore how I integrated the interpretivist approach of Decentred Theory with my research design. In doing this I introduce a methodological guide called knowledge based practice. This is a collection of methodological principles that emphasises investigation through in-depth and comparative examinations of lived experiences. In using this guide I conform to the interpretivist methodology of decentred theory by examining how individuals play a role in the construction of their environment. In *2.2* I highlight my use of an exploratory questionnaire to appreciate expertise and select a sample of participants. In *2.3* I delineate how I interviewed participants and show how I addressed ethical issues, conducted interviews and transcribed testimony. Finally, in *2.4* I illustrate how I employed grounded theory to concurrently collect, sample and analyse interviews.

Chapter 3: The normative definition of collective co-production represents the beginning of my framework. In *section 3.1* I outline how interviewees conceive of collective co-production as a process that is founded on a vision of equality. This is a vision that corresponds to notions of positive liberty that are embedded within the literature on democratic governance (Bevir, 2013). In *3.2* I show how interviewees consider the variables of representation, accessibility, solidarity and openness to be facets of equality. Interviewees suggest that these variables improve the normative quality of collective co-production by empowering a range of stakeholders to participate in governance. As such, the normative definition of collective co-production embedded in this chapter is employed as a prism through which to study the remaining chapters of my thesis. This chapter should be understood to:

- Provide understanding as to the normative variables that constitute collective co-production in the NHS in England.

- Link the overall normative ideal delineated in this chapter to the generation of democratic governance.

In *Chapter 4: The conditions for collective co-production*, I discuss how a number of different conditional layers impact on the generation of collective co-production. In *section 4.1* I examine external conditions such as political economy and government legislation aimed at increasing public participation. In *4.2* I explore institutional conditions in English healthcare and study priorities related to efficiency and productivity, power diffusion between strategic and operational NHS actors and notions of service user capability. Subsequently, in *4.3* I investigate the department as a conditional level and suggest that operational actors are influenced by norms and procedures that define environments like intensive care units and emergency departments. Finally, in *4.4* I examine organisers of collective co-production in NHS services and introduce two types of organising actor, the entrepreneur and standing group. This chapter contributes to an understanding of:

- The traditions that influence the situated agency of organisers of collective co-production.
- The importance of the organising actor as the instigator of collective co-production. For example, I show that high-status actors who engage in learning play a vital role in overcoming barriers to organisation.
- The potential for alternative organising actors. I display how organisers do not have to be professionals. Rather, organisation often arises from lay groups.

In *Chapter 5: Preparing for collective co-production*, I discuss how organisers engage in numerous preparatory phases that support the manifestation of equal and empowering collective co-production. In *section 5.1* I explore how organisers realise representation within decision-making. In this section I suggest that organisers' prior exposure to communities is important in facilitating representative recruitment. In *5.2* I turn to the design of collective co-production wherein I explore how processes of co-design empower stakeholders to shape the methodology and meaning of collective co-production. Finally, in *5.3* I explore preparation. In this section I study how organisers engage in activities that increase accessibility and solidarity. This

occurs through a study of preparation processes which increase the capability and efficacy of participants and promote notions of a collective. In this chapter I conclude that:

- Representation is often contingent on how organising actors understand the inherent complexity embedded within communities of stakeholders.
- The institution of co-design enables stakeholders to engage in the construction of meaning and influence the principles on which collective co-production processes are founded.
- Preparation phases are not only necessary to increase the capacity of citizens but are also important in promoting collective purpose and partnership.

In *Chapter 6: Interaction and outcomes*, I describe how communities come together to collectively co-produce. In *section 6.1* I delineate the importance of initial supplementary processes in promoting open interactions between stakeholders. In asserting this I also speak to the value of facilitation in supporting participants to overcome grievances and clinical inequalities. In *6.2* I introduce a process that I call follow through. This is a stage of collective co-production wherein participants and non-participating stakeholders receive opportunities to intellectually and/or physically realise public outcomes such as service improvements. Finally, In *6.3* I examine outcomes. I provide a typology of outcomes by delineating how public and private products occur within the NHS. From this I examine how private outcomes contribute to democratisation. In this chapter I determine that:

- The quality of interaction in collective co-production often depends on participants' reflexive understanding of the space in which they are engaging.
- Facilitation is a vital aspect of collective co-production as it enables people to overcome grievances and inequalities.
- Follow through is a significant phase in the generation of public outcomes. This is because outcomes are amalgamated with the realities of the institution.
- Private outcomes contribute to the reproduction of democratic governance within the NHS in England. This is because private outcomes like changes in understanding of the self and the service often coalesce to form a greater appreciation of co-production.

In *Discussion: Conclusions for the organisation of collective co-production*, I reflect on the implications of my findings. Firstly, I examine how entrepreneurs experience organisation and suggest that research should explore the diffusion of entrepreneurial opportunities within services. Furthermore, I assert that status is an important variable in understanding how professional actors become entrepreneurs. Secondly, I explore how standing groups implement collective co-production within services. In doing this I claim that understanding of time and the stigmatisation of service users are important variables in studying how standing groups organise. Thirdly, I study the outcomes of collective co-production. I promote the idea that one should understand collective co-production as contributing towards incremental systemic change. In this way democratic governance is slowly embedded through the reproduction of private outcomes such as changes in understanding of the self, others and the institution.

Chapter 1: Literature review

The study of governance asks researchers to examine the actors and regimes that organise the state and its institutions. In doing this researchers have created objective models of governance that describe transitions between paternal public management, neo-liberal governance and notions of the networked regime. However, it is suggested that these models are overly prescriptive. Critics argue that institutions are complex and cannot be understood through the application of objective frameworks. Consequently, interpretivist theorists like Bevir (2006, 2013) advocate for the employment of decentred theories of governance. This is a form of investigation that examines the traditions and beliefs of those who operate within institutions.

Decentred theory suggests that governance is the product of traditions. These traditions exist within particular environments and shape the beliefs of actors. Individuals subsequently use these beliefs to interpret and make sense of their environment. Bevir (2006, 2013) calls this situated agency. Decentred theorists, thus, assert that democratic governance arises from the influence of traditions that impose on the situated agency of actors within institutions. These are traditions that promote a vision of equality which eschews essentialist notions of identity and demands that each person play a part in decision-making.

Democratic governance can be realised through collective co-production. This is because collective co-production enables providers and citizens to engage with one another and make decisions (Bovaird, Van Ryzin, Loeffler and Parrado, 2015). In the literature scholars discuss how collective co-production is used to reorganise and reform organisations and institutions (Ostrom, 1996; Denters and Klok, 2010; Jo and Nabatchi, in Brandsen, Steen and Verschuere, 2018). In doing this they demonstrate that collective co-production processes are employed to commission, assess and design services (Nabatchi et al, 2017; Bovaird and Loeffler, 2013).

Furthermore, scholars have examined collective co-production as a normative process. Academics like Cahn and Gray (in Pestoff, Brandsen and Verschuere, 2013) and Leach (2006) have presented a number of norms and assumptions that define collective co-production. These definitions often portray collective co-production as

a process that empowers actors to share their understanding and experiences within decision-making. Thus, collective co-production is characterised as a process through which participants engage in the construction of governance.

I begin this literature review by examining governance. In *section 1.1*: *Governance and the NHS: a history of organisation*, I consider how governance has evolved as both a theoretical topic and a practical tool for organisation. In doing this I highlight the value of decentred theory when exploring democratic governance. In *1.2: Creating democratic governance: an analysis of co-production*, I examine how co-production is used to implement democratic governance. In this section I delineate how co-production relates to different service activities and discuss the normative history of the process.

In *1.3: Levels of co-production: moving from individual to collective*, I discuss how co-production occurs across different levels: the individual, group and collective. From this I focus on collective co-production and provide an analysis of how this process offers empowered participation. Finally in *1.4: Implementing co-production*, I review how co-production is realised within service environments. As such, I explore barriers to implementation relating to professional autonomy and power, as well as ways in which individuals are empowered to participate.

1.1: Governance and the NHS: a history of organisation

To understand governance one first needs to appreciate the nature of the state. States are huge and complex (Fung and Wright, 2003, p.4). Their governments are responsible for myriad societal issues such as health, social care and education. Moreover, their legitimacy as sovereign actors is frequently questioned (Rhodes, 1996, pp.8-14). As such, governments necessarily, and perhaps gladly, relinquish power to a number of external actors. These may be private organisations or civil society groups (Pierre, 2002, pp.3-4). Widely accepted positivist definitions of governance are reflective of this plurality. They view the study of governance as a means of co-ordinating organisation between different sectoral actors (Rhodes, in Rhodes, 2017, pp.7-11; Fung and Wright, 2003, p.5). In doing this positivist scholars

base their models of governance on what are perceived to be ‘objective social facts about people’ (Bevir, 2013, pp.16-18).

Positivist accounts of NHS governance

Such an understanding of governance has not always existed. State orientated administration was dominant in the post-war period. This administrative mode has been called old public management (OPM) and speaks to the necessity to centralise and expand welfare services to meet public need (Osborne, 2010, p.3). In the UK OPM developed from a desire to harness the revolutionary potential of the Second World War (Timmins, 2017). This desire was realised through the adoption of a policy of national social insurance that was founded on family allowances, a national health service and the maintenance of employment (Beveridge, 1942). The policy’s author, William Beveridge, considered that national social insurance would halt the spread of the five giant evils of want, disease, ignorance, squalor and idleness that had plagued the nation in the previous decades (Lowe, 1998, pp.130-134).

William Beveridge’s eponymous report is broadly conceived as the foundation upon which the United Kingdom’s National Health Service (NHS) was berthed (Ibid; Timmins, 2017). In its pages Beveridge (1942) recommended the establishment of a comprehensive and inclusive healthcare system ‘without a charge for treatment’. This proposition was duly advanced by politicians like Aneurin Bevan who, perhaps apocryphally, proclaimed that ‘the sound of every dropped bedpan in Tredegar will reverberate around the Palace of Westminster’ (as cited in Glasby, Peck, Ham and Dickinson, 2007, p.2). In stating this Bevan was conforming to the notion that healthcare should be free to all, irrespective of identity (Powell, 2019). This perspective was, subsequently, ratified through legislation that centralised healthcare authority, thereby giving government control over the design and delivery of services. In the NHS this transpired through empowering Regional Hospital Boards and the Ministry of Health to assume responsibility for the administration of care (Gorsky, 2008).

However, this centralisation of administration occurred alongside the preservation of clinical autonomy and practitioner power (Bevir and Rhodes, 2007). Unnerved by

the prospect of solely relying on the state for their income, healthcare professionals (HCPs) fought to retain particular elements of their clinical and administrative authority such as the capacity to engage in private practice (Lowe, 1998). From this HCPs were empowered to act as quasi policy-makers within their respective departments and practices (Ibid). Moreover, the collective power of their two trade unions, the British Medical Association and the Royal College of Surgeons, enabled HCPs to temper the ambitions of policymakers and administrators (Lowe, 1998, p.170; Gorsky, 2008, pp.441-444). This meant that HCPs were able to influence how resources were distributed: allocating their dispersal 'in accordance with the relative prestige of different branches of medicine' (Powell, 2019, p.44).

This notion of the authoritative professional actor is reflected in the governance literature. Academic accounts suggest that the status of professional expertise within national politics enabled professionals to hold significant powers within public institutions (Bevir, 2011, pp.6-8). This is because professionals were viewed to have the capacity to interpret the demands of political actors (Ibid). In the NHS this meant that HCPs were capable of eschewing everyday concerns regarding the administration of hospitals and pursuing clinical work within what was described as a 'smoothly functioning environment' (Gorsky, 2008, p.443). In this way OPM is characterised as an interrelated and bipartite system of centralised bureaucracy and professional autonomy (Ibid; Powell, 2019).

Of course, the notion that government and its respective bureaucracies create a 'smoothly functioning environment' has been critiqued. In the 1970s concerns grew about the role of government in the maintenance and provision of services. This was because governments were viewed to be incapable of acting in the long-term and their officials of ignoring self-interest. Thus, public institutions were deemed to be unwieldy and administrators to be irrational (Majone, 2001, pp.60-61). 'Neo-liberal' theorists like Majone (2001), thus, asserted that the legitimacy of public institutions could be restored through processes that moved them away from majority rule and beyond the administration of government. In this way government failures could be avoided and improved outcomes could be achieved (Ibid, pp.60-61).

Through this focus there grew a vision of administration that renounced the role of government in services (Lynn Jnr, in Osborne, 2010, p.110). This was New Public Management (NPM): a form of organisation that promoted methods of control that ran counter to state orientated bureaucracy. Its proponents argued for the introduction of 'market like incentives' within services as tools through which to increase effectiveness and improve accountability and legitimacy (Lynn Jnr, 2006, pp.142-144). In many cases, these incentives were advanced by the introduction of managerialism within institutions.

The 1983 Griffiths Report and the 1990 Community and Care Act, amongst other acts of government, introduced and increased management structures within the NHS (Ferlie, Fitzgerald and Pettigrew, 1996, p.43). The Griffiths Report recommended the introduction of a system of 'general management' that enabled NHS services to engage in 'accountability reviews and value-for-money initiatives' (Ibid). Furthermore, the Community and Care Act 'paved the way for the introduction of a quasi-market in the NHS' (Ibid, p.59). In response to these dictates NHS services employed larger numbers of managers to improve their effectiveness. These changes were informed by neo-liberal values and acted as methods through which to locate accountability as a product of service outcomes (Bevir, 2013, p.16).

These changes did not occur on their own. Rather, parallel alterations to the values that pervaded the NHS were also required. These were alterations to the autonomy of professionals and their relations with the macro concerns of management (Harrison, 1999, pp.50-53). For example, increased competition meant that NHS managers became 'hands-on': defining professional freedoms by restricting budgets and limiting time (Dent and Barry, in Chandler, 2017). Furthermore, clinicians were given managerial positions. This altered professional understanding by asking them to consider and address administerial concerns related to finance (Ibid).

NPM was not the only form of governance that redefined the NHS. The institutionalist model of governance introduced a new framework through which to understand and alter the institution. This model stresses that there are objective facts about actors and the communities from which they originate. These facts are related to the institution and are, thus, rooted in the norms and rules that give it meaning

(Bevir, 2013, pp.17-23). In this way each actor has a particular type of expertise that can be amalgamated within a network. This proposition conflicts with the neo-liberal thesis. The focus on embeddedness deviates from the notion that the introduction of a foreign market ethic improves outcomes. Rather, institutionalist arrangements acknowledge and harness embedded structures (Ibid).

In this sense the institutionalist model of governance is a critique of the Neo-liberal framework. Its proponents suggest that neo-liberal reforms were limited because they ignored the innate place of actors and communities within institutions. They argue that attempts to alter the identities of actors through the imposition of managerialism neglect the notion that social actors are limited by path dependency (Bevir, 2013). This supposition means that actors are intrinsically tied to the institution through the stories that they share with one another (Turnbull, 2011; Lowndes and Roberts, 2013).

However, institutionalists also admit that the growth of managerialism in the NHS promoted an environment in which new forms of governance could be imagined (Bevir, 2010). To them the reforms of the 1980s and 90s produced the unintended consequence of increasing the involvement of actors from the private, third and civil sectors (Lowndes and Roberts, 2013). From this there were promoted new ways of organising the NHS that emphasised the value of harnessing the expertise of different actors through creating and maintaining horizontal and flat networks (Powell and Exworthy, 2001).

It is suggested that the New Labour government of the late 1990s and 2000s organised the NHS around these networks (Bevir, 2006). To achieve this the government employed an organisational model called Joined Up Governance (JUG): a form of organisation that emphasises the value of local partnerships between governmental, market and civil society actors (Davies, 2009). This is demonstrated in a 1999 White Paper called ‘Saving Lives: our healthier nation’ that set out the Labour government’s ambition for an ‘integrated approach’ to health:

> This is our new contract for health. Our new approach, based on our three-way partnership between people, local communities and the Government, adopts a new way of tackling poor health which is both inclusive and integrated, comprehensive and coherent.
>
> (UK government, 1999, paragraph 139)

This passage shows that institutionalists sought to manifest changes in the NHS by drawing on and strengthening networks that included providers, citizens and actors from alternative sectors. In these networks state, market and civil society actors collaborated in the design and delivery of services (Bevir, 2006).

Both neo-liberal and institutionalist theses have been used to structure the NHS. Their promise to explain the 'how' and 'why' of institutions has meant that they have been considered as objective models for institutional arrangements (Bevir and Rhodes, 2007, p.83).[1] However, the application of these ideal models has been hampered by the innate complexity of service institutions. Interpretivist academics suggest that attempts to apply objective theories have been damaged by the situated agency of actors who operate in institutions (Bevir, 2006, 2013; Bevir and Rhodes, 2007). These actors draw upon traditions as a means of interpreting the social world around them. This agency empowers individuals to create unique forms of governance that do not conform to the rigid philosophies of NPM or JUG (Bevir, 2013, p.107).

Building a decentred theory of NHS governance

Decentred theory (DT) represents a radical departure from positivist theories of governance. Unlike the neo-liberal and institutionalist models, DT asks researchers to explore the experiences and understanding of those who operate in institutions (Bevir, 2010, pp.85-87). In doing this DT accepts that individuals are not wholly defined by the communities from which they are deemed to be institutionally relevant. This proposition means that NHS patients are not simply actors who require services. Equally, it means that HCPs are not solely providers of services. Rather,

[1] The notion of the rational market actor or appeals to path dependency act as explanatory devices in NPM and institutionalist theories respectively.

DT proposes that traditions related to the social contexts against which actors exist impose on the identities of individuals by influencing their beliefs and subsequent actions (Ibid).

DT builds analyses of governance as constituted by traditions. These are social and institutional traditions, or 'contexts', that form the backdrops against which actors are socialised (Bevir, 2013, p.44). These traditions influence beliefs and are, subsequently, used to interpret and solve dilemmas that occur within institutions (Bevir, 2006). In DT, dilemmas relate to the generation of new beliefs that conflict with existing traditions. These dilemmas arise as products of exogenous or endogenous changes to an environment. Actors then negotiate between established beliefs and dilemmas by using their 'situated agency' (Bevir, 2013). This notion implies that any course of action is contingent on individuals choosing to behave in a particular way. Governance should, therefore, be considered to be a product of reflexive and internal negotiations:

> Crucially, decentred theory allows the researcher to examine how the various actors involved in policy networks mediate their environment, and thereby to understand the everyday production and reproduction of political power.
>
> (Ibid, pp.103-104)

To understand governance researchers must examine the traditions that influence the beliefs of actors within institutions (Bevir and Rhodes, 2007, p.79). In the NHS traditions occur as a result of a number of factors. For example, Speed (in Bevir and Waring, 2018, p.192) proposes that traditions originate from notions of an NHS ethos. This ethos is delineated within a 1944 White paper regarding the wartime government's desire to create a national health service. In this paper the government asserted that the service was to be free at the point of use, available to all and publicly funded (Ministry of Health and Department of Health for Scotland, 1944). Delamothe (2008) suggests that notions of an NHS ethos should, therefore, reflect these principles. As such, he asserts that the NHS is characterised by values of universalism and collectivism. These principles may, consequently, be powerful

explanatory factors when analysing contemporary NHS governance (Speed, in Bevir and Waring, 2018, pp.194-200).

This hypothesis is supported when examining the NHS reforms of the 1980s and 90s. As discussed, these reforms attempted to introduce internal market competition within the service. However, Hardy and Rhodes (in Fleming, 2017) argue that the reforms did not fundamentally alter the normative foundations upon which the institution was founded. Rather, they argue that the strength of the NHS ethos tempered reform (Ibid). The 'jewel like status' of the NHS as a universal and collective good may, therefore, be a powerful factor in maintaining the inclusivity demanded in documents such as the Beveridge report (Bevir and Rhodes, 2007, pp.132-133).

However, understanding of this tradition is contingent on a variety of contemporary factors. These are factors that conflict with notions of an NHS ethos, thereby creating dilemmas for NHS operatives. For instance, the ethos promoted in the 1944 White Paper may be altered by variables related to the economy, as well as political factors such as changes in class solidarity (Davies, 2008). Furthermore, it is argued that the recent political focus on austerity has played a role in changing understanding of the institution. Speed (in Bevir and Waring, 2018) discusses how the 2012 Health and Social Care Act produced an understanding of the NHS as a more parsimonious entity. This means that notions of cost and value have impinged on the ontologies of actors who work within and use the NHS (Ibid, p.198).

Beyond notions of an NHS ethos, the literature shows that traditions regarding the status of HCPs also impose on the beliefs of institutional actors. As discussed, the NHS has long provided practitioners with the autonomy to act as policy-makers within their respective environments. This is because of the collective power of practitioners in moderating attempts to create an NHS bureaucracy controlled from the centre (Bevir and Rhodes, 2007). However, Klein (in Marmor and Klein, 2012, pp.406-409) proposes that HCP power is also supported by the valorisation of clinical and technical expertise. Glasby and Beresford (2006) suggest that this tradition is a product of the value attributed to objective understanding and evidence-based knowledge within the NHS.

Like the NHS ethos, it appears that the strength of this tradition is fluid. It is argued that the value ascribed to HCP expertise is often 'outmoded' in respect of contemporary issues that define NHS services (Klein, in Marmor and Klein. 2012). For example, it has been suggested that professional expertise is increasingly porous as a result of improved citizen access to medical information (Rowe and Sheperd, 2002). Furthermore, the NHS is increasingly having to deal with challenges that require normative judgements (Klein, in Marmor and Klein. 2012). These judgements relate to issues such as the rationing of care (Bevir and Rhodes, 2007).

Of course, the preceding examples do not represent an exhaustive list of traditions and dilemmas. This is because traditions and dilemmas are conditional. They relate to the locations in which actors are socialised and operate (Bevir, 2013). Thus, actors within particular constituencies, services and departments are likely to be influenced by divergent sets of factors. As such, decentred theorists suggest that examinations of governance require in-depth, and perhaps narrative-based, explorations of individual experiences (Davies, 2008). This research design enables researchers to examine how individuals understand and are affected by traditions and dilemmas (Ibid; Bevir and Rhodes, in Finlayson, 2004).[2] In doing this one may explore how conditionally specific traditions and dilemmas affect the manufacture of democratic governance (Bevir and Rhodes, 2007, pp.86-89).

Democratic governance

As discussed, DT proposes that administration is influenced by traditions that exist within social and institutional locations. Thus, governance is a product of situated agents who interpret local traditions and use them to inform their actions (Bevir, 2013, pp.173-174). Democratic governance may, therefore, occur when situated agents want to promote greater participation in decision-making (Bevir, 2006, pp.429-430). These are individuals who do not wish to discriminate against or diminish the participative capacity of actors. Rather, they seek to facilitate the

[2] I examine the value of interpretive and narrative based research designs in facilitating understanding of governance in *section 2.1*.

engagement of different stakeholders within decision-making forums (Bevir, 2006, p.430).

Such participative desire is reminiscent of involvement processes considered in republican theories of democracy.[3] As this is a thesis on governance I cannot speak to the complexities of republican theory in the same way as a student of political analysis. Nevertheless, I suggest that there is value in briefly delineating aspects of republican theory and illustrating how it is defined by notions of ethical self-government (Sandel, 1996). This is because an appreciation of republican theory promotes an understanding of democratic governance (Bevir, 2006, pp.429-431). For example, the republican notion of positive liberty is a theoretical crutch, upon which rests democratic governance. Positive liberty is a concept that describes how, in certain circumstances, each person has the capacity to participate in the construction of government (Pettit, 2012). This capacity for government is achieved through reducing inequalities that are based within society such as those related to a person's class, ethnicity or gender. In reducing these inequalities individuals are empowered to engage with one another and participate in shaping decision-making (Sandel, 1996).

In this way democratic governance requires participation to be built on a normative framework that facilitates the sharing of experiences irrespective of the identity of the person taking part. This framework empowers individuals to 'make their own freedom through their participation in self-governing practices' and share their 'local experience' and 'local reasoning' and 'make changes through sharing (their) stories' (Bevir, 2013, pp.174-175; Haque, 2016, p.345). Processes of participation must, therefore:

- Provide access to participation that is free from inequalities which exist within society, thereby enabling the sharing of lived and local understanding.
- Provide access to the generation of outcomes in a way that empowers people to play a role in the production of change.

[3] This means that democratic governance is, perhaps, contingent on the creation of forums for participation akin to those idealised versions of the early American town halls. See Sandel (1996) or latterly Rakove (in Niederberger, 2013) for comparable, yet distinct, elucidations of this.

Democratic governance should, thus, be understood to be linked to participative processes that empower actors to engage in the construction of the decision-making process itself, as well as in the creation of outcomes (Bevir, Needham and Waring, 2018).[4]

This type of empowered participation is not often used within the NHS (Hudson, 2018). In recent years participative opportunities have frequently been founded on values akin to those espoused by advocates of NPM. Rowe and Sheperd (2002) assert that this has often occurred through the provision of feedback. From this citizen experiences are interpreted and used to generate improvements to services. In this way outcomes such as citizen empowerment are ignored, whilst the 'strategic and operational needs of healthcare providers' are met (Ibid, p.280).

Public participation in the NHS may, therefore, be characterised as increasingly passive. This notion is supported by Marmor and Klein (2012). In their work they discuss the democratic vitality of Foundation Trust governor elections. They suggest that this process acts as a form of feedback wherein citizens express their frustrations regarding the state of their local service. However, they argue that this is only a 'symbolic nod' to accountability, rather than an explicit attempt to increase the contributions of citizens (Ibid, p.404; Hudson, 2018). In this way it is argued that there is a lack of empowered involvement within the NHS (Alderwick, Dunn, Mckenna, Walsh and Ham, 2016).

However, NHS decision-making authority is not only enjoyed by Foundation Trust governors and other strategic authority figures (Bevir, 2011). Rather, decentred theorists suggest that myriad stakeholders are capable of participating in governance (Bevir, 2013; Davies, 2008). Research in to democratic governance should, therefore, examine how individuals organise and participate in empowering involvement processes by considering how they are influenced by traditions that occur within their social and institutional environments. Accordingly, researchers should study the experiences of situated agents as a means of capturing and

[4] See my examination of co-production and collective co-production for a delineation of how these processes enable actors to engage in governance. This is found in sections *1.2*, *1.3*, and *1.4*.

understanding the environmental factors that precipitate subsequent participative desires.

The capacity for change: the limits of decentred theory

As suggested, democratic governance requires a normative framework akin to that of republican democracy. This is made possible as a product of the bottom-up institution of democratic governance (Bevir, 2013, p.185). Rather than relying on the organisational capacity of elite decision-makers in services or government, democratic governance occurs as a product of individuals. This means that democratic governance is an organic expression of participatory democratic desires.

Furthermore, democratic governance is a function of 'the impetus given to policy makers to reflect on their activity' and 'the opportunity to reimagine democracy' (Ibid, pp.32-33). This assertion suggests that democratic governance is not simply a product of normative understanding regarding the value of equal and empowering participation. Rather, it is a product of the capacity of the organising actor to engage in activities that produce such understanding. These may be learning processes that demonstrate the value of empowered participation.

However, Bevir (Ibid) admits that actors may find it difficult to engage in learning processes:

> Equally, however, social scientists should remain aware of the ways in which markets and networks often embed inequalities and impose identities upon people

This extract indicates that the continuing influence of neo-liberal and institutionalist forms of governance have manifested what could be called sticky identities. Actors are, therefore, subject to the imposition of essentialist identities within environments that have been defined by particular forms of organisation. For example, citizens may be understood as consumers within locations affected by NPM, whilst healthcare professionals might be viewed in relation to their particular specialisms. These forms of identity influence the extent to which actors have agency within their

environment: characterising them in a way that defines their capability and interests (Ibid). Accordingly, the capacity to engage in processes of reflection and learning may be influenced by the amount of agency that an actor enjoys within their local environment.

This notion promotes a set of critical propositions within my analysis of DT:

- If we are to accept that democratic governance is the product of the situated agents who desire forms of participation that are akin to notions associated with republican democracy, then we must assume that these actors have gained this perspective from somewhere.
- Furthermore, if we are to accept that situated agency is restricted as a product of the essentialist logics that pervade institutions, then we must also assume that those who attain such understanding have greater agency than others.

These points are noticed by Speed (in Bevir and Waring, 2018). In his work critiquing DT as a form of macro-analysis Speed argues that Bevir does not provide a framework through which to understand the origins of new beliefs. He claims that 'Bevir is more interested in how the individual responds to the newcomer (i.e. whether this provokes an individual dilemma or not) rather than where the new element has come from.' (Ibid, p.193). This statement suggests that DT is concerned with capturing and examining interactions between traditions. DT is, therefore, presented as an approach that does not enable researchers to analyse the social conditions from which traditions emerge (Bevir and Rhodes, 2008).

One way of responding to this issue is to adhere to a form of structural analysis. This is achieved through the inclusion of notions of hegemony within decentred theory (Glynos and Howarth, 2008). By including hegemony one appreciates how power structures constrain the practices of actors, thereby limiting their situated agency to concepts and notions that are 'normal' to them. Moreover, we may begin to understand how certain actors are capable of 'reimagining democracy' as a result of the fact that they reside within privileged institutional positions (Ibid, p.165). This suggests that an actor's capacity to engage in the creation of change is contingent on our appreciation of the actor as tied to particular social structures.

Of course, Bevir and Rhodes argue that their conceptualisation of situated agency already incorporates the perspective of Glynos and Howarth (2018). They purport that their thesis encompasses the reproduction of power within particular environments. To them power and hegemony are aspects of the background from which individuals inherit their traditions (Bevir and Rhodes, 2008). Their analysis, thus, implies that actors are agents to different degrees. Individual agency is subject to the constricting impact of a person's background. Some are capable of interpreting their environment and constructing new and innovative forms of governance. On the other hand, others are restricted by traditions that narrow their beliefs and impose on their understanding of 'what we can and cannot do' (Ibid, p.9). Researchers may, therefore, examine how actors who have greater agency participate in the production of new traditions.[5]

1.2: Creating democratic governance: an analysis of co-production

Before I investigate co-production, I first acknowledge that there are a number of alternative processes through which citizens participate. In *section 1.1* I allude to passive forms of participation. These activities ask citizens to become consumers by providing feedback. Alongside the provision of feedback, citizens also engage in processes of choice and exit. These actions enable citizens to withdraw from their provider and engage with other service organisations. However, these actions are highly 'prohibitive' (Pestoff, 2009, p.201; Bevir, 2013). This means that outcomes are produced that do not reflect the conditions within which different segments of the population live. Rather, services are influenced by the few individuals who have the capacity to participate (Ibid). These are often individuals who have privileged access to information by means of their education or profession.

Another influential form of participation is the Ladder Model of Participation (LMP). Beginning in the 1960s, the LMP was designed to facilitate radical citizen control of services (Tritter and McCallum, 2006; Fung, 2006, pp.66-67). This is

[5] For example, I examine how the high operational status of actors with leading and specialist roles are empowered to engage in processes of learning and in the implementation of collective co-production. See *sections 4.2* and *4.4*.

because the model's founder, Sherry Arnstein (1969), was influenced by notions of positive liberty. To her the structural conditions of the 1960s meant that myriad minority groups were excluded from public decision-making. New models of administration were, therefore, needed that would enable people 'to be deliberately included in the future' (Arnstein, 1969, p.216).

The LMP presents a hierarchical and linear vision of how services facilitate empowered citizen participation. Ranging from the 'cosmetic and limited' participation of 'therapy' to the active involvement of 'citizen control', the LMP offers a means through which to augment our understanding of power within institutions (Osborne and Strokosch, 2013, p. 38). In this way the LMP presents citizen participation as achievable through zero-sum actions that diminish provider authority and provide people with power (Tritter and McCallum, 2006, p.158).

However, it is suggested that methods of participation have both theoretically and practically moved on since the 1960s (Bevir et al, 2019). Whilst the LMP provides an important means through which to envisage empowerment as a product of actual power, contemporary scholars now emphasise the value of collaboration (Voorberg, Bekkers and Tummers, 2014, p.9). One form of collaborative decision-making is co-production. Since the turn of the century co-production has become increasingly popular in the UK (Osborne, Radnor and Strokosch, 2016). This is reflected in increased usage within the NHS (Needham, 2008, p.222). For example, the 2002 Expert Patient Programme (EPP) promoted citizen collaboration with HCPs by encouraging patients to increase their understanding of illness and 'participate actively in their care by sharing knowledge of their condition' (Realpe and Wallace, 2010, p.13). Co-production is, therefore, viewed as a process through which to empower citizens, disrupt essentialist logics and reduce hierarchical relations (Verscheure, Vanleene, Steen and Brandsen, in Brandsen et al, 2018).

Defining co-production: from a simple idea to a meaningful process

Co-production was first conceptualised in the 1960s and fed in to a growing scholarly interest in public participation. At this time co-production was understood in simple terms. It involved the coming-together of 'consumers and regular producers' in an effort to produce or design a service (Ostrom, in McGinnis, 1999, pp.346-347; Percy, 1984, pp.431-440). In doing this actors combined their productive capacity and produced outcomes (Parks, Baker, Kiser, Oakerson, Ostrom, Ostrom, Percy, Vandivort, Whitaker and Wilson, 1981).

Beyond a basic allusion to provider and citizen coalescence, this definition provides little understanding of what co-production actually means. This has paradoxically meant that myriad forms of decision-making have been deemed to be co-production (Durose, Needham, Mangan and Rees, 2016). These range from transactive forms of participation to positive-sum interactions between citizens and providers (Osborne et al, 2016). This suggests that co-production is polysemic in nature (Dudau, Glennon and Verschuere, 2019, p.1578). The process means different things to specific people: some viewing it to be a source of empowerment (Needham, 2008 and 2009) and others a means through which to improve efficiency (Osborne et al, 2016).

Steen, Brandsen and Verschuere (in Brandsen et al, 2018, pp.290-291) suggest that sustained academic focus on any one of these particular interpretations does little to create a generalisable definition of co-production. Many of the studies from which these perspectives are based were founded on single case-study research (Nabatchi et al, 2017). Thus, the study of co-production has rarely been subject to comparative scrutiny (Brandsen and Honingh, 2016). This has led to a 'tremendous variety in how co-production is practiced and studied' (Nabatchi et al, 2017, p.767).

Yet, it is argued that the validity of the co-production literature is improved through an acceptance that the process is innately elastic (Ibid; Brandsen and Honingh, 2016). This is because the constitution of co-production is subject to the service environment in which it is taking place (Dadau et al, 2019). Co-production is, therefore, different within particular contexts (Bovaird, Flemig, Loeffler and

Osborne, 2019). As such, co-production is considered to be 'provocative', with particular conditions stimulating variety (Nabatchi et al, 2017, pp.768-769).

There have been a number of contemporary academic attempts to reflect the contextually dependent nature of co-production. These efforts have transpired through the generation of typologies. Brandsen and Honingh (2016) have produced a typology that defines co-production as 'core' or 'complementary' and comprising of design and delivery activities. In this typology they define core co-production as comprising of activities that are inherent to the service. Core activities consist of:

- Delivery interactions between citizens and providers that occur in GP surgeries or classrooms.
- Design interactions wherein citizens and providers define the objectives of a service (Ibid, pp.432-433).

On the other hand, Brandsen and Honingh (Ibid) define complementary activities as interactions that are supplementary to core activities. These interactions are not built-in to services and are voluntary. Complementary activities consist of:

- Complementary delivery wherein citizens and providers engage in activities that are important but do not contribute to core activities like teaching.
- Complementary design wherein citizens are involved in forms of service planning that do not contribute to the organisations core purpose (Ibid).

Beyond this typology, Bovaird and Loeffler (2013) have provided their own 'four co's' model of co-production that encompasses the entirety of the service cycle. In this typology focus is placed on how actors are included in different phases of co-production (Nabatchi et al, 2017; Jo and Nabatchi, 2016, p.1106). These include co-delivery, co-design, co-commissioning and co-assessment (Bovaird and Loeffler, 2013; Loeffler and Bovaird, 2019). Analyses of these phases offer a different way of conceptualising co-production. They engender an appreciation of co-production as not only encompassing notions of delivery and design but as constituting a wider vision of participation in the governance of services (Loeffler and Bovaird, 2019, pp.244-245).

This model contrasts with Brandsen and Honingh's (2016) framework. Brandsen and Honingh (Ibid) view co-delivery as a co-production process wherein citizens and providers engage in the implementation of aspects of a service. This transpires across different forms of collaboration with actors working together to make core or complementary changes. For example, students 'follow strictly defined lessons' or assist 'the university in organising welcome days' (Ibid, 2016, p.433).

By contrast, Bovaird and Loeffler (Ibid, p.242) assert that co-delivery transcends the dichotomy between core and complementary by emphasising that co-delivery is a 'must have' within services. To them co-delivery is core to services as the process produces externalities that benefit the public sector as a whole (Ibid). This means that co-delivery produces wider public sector value. This is seen in the following extract wherein Bovaird and Loeffler (in Loeffler, Power, Bovaird and Hine-Hughes, 2013) discuss potential externalities of the EPP:

> It is believed that people who are 'expert patients', giving advice to other patients, are less likely to relapse into the smoking or alcohol abuse behaviours which contributed to their own health problems.
>
> (Ibid, p.22)

Co-delivery should, thus, be understood to produce outcomes that not only benefit the co-producer or their social and familial circle (Bovaird and Loeffler, 2012, pp.1126-1127). Rather, co-producers indirectly participate in the production of public value. This is because participation in co-delivery often contributes to behavioural changes that enable actors to manage their conditions (Ibid).

However, these actions do not provide a means through which citizens and providers equally engage. This is because citizens are taking part in a collaborative activity the meaning of which has already been defined (Brandsen and Honingh, 2016, p.433). As such, the nature of the service that is being delivered is not changed through the involvement of the citizen. Thus, co-delivery is not a process through which citizens engage in governance. Rather it is a process that involves citizens in the reproduction of the intrinsic nature of the service (Nabatchi et al, 2017, p.772).

Conversely, co-design, co-commissioning and co-assessment are viewed to provide participants with opportunities to use their experience to influence the construction of services (Bovaird and Loeffler, 2013; Loeffler and Bovaird, 2019). Such a contrast introduces an important distinction within the definition of co-production. This is a distinction between activities that represent citizen actions and voice:

> These approaches to embedding co-production within the commissioning cycle can be divided into 'citizen voice' (in which citizens make substantive contributions to co-commissioning, co-design and co-assessment) and 'citizen action' (in which citizens make substantive contributions to co-delivery).
>
> (Loeffler and Bovaird, 2019, p.251)

Activities like co-design facilitate democratic governance. This is because co-design is a process wherein participants produce changes in the 'creation, planning or arrangements' of public services (Nabatchi et al, 2017, p.772; Bovaird and Loeffler, 2013). Examples of co-design are found when examining how citizens have participated in the design of institutional websites or parents have helped plan extracurricular activities (Bovaird and Loeffler, 2013; Brandsen and Honingh, 2016). These examples convey that co-commissioning activities enable actors to use their voices to influence the construction of services. Furthermore, the literature shows that co-design supports the implementation of co-delivery. For example, participative building projects enable housing tenants to engage in the design and construction of their homes (Ibid, p.433).

Co-commissioning is also a process wherein actors engage in construction. This activity refers to opportunities for providers and citizens to work together to define 'what needs to be delivered, to whom and to achieve what outcomes' (Bovaird and Loeffler, 2013, p.6). Examples of co-commissioning are found in forms of collaborative work that produce an understanding of where to focus mental health services, as well as in the inclusion of young people on the commissioning boards of young people's services (Loeffler and Bovaird, 2019; Bovaird and Loeffler, 2013). As such, co-commissioning involves citizens in producing understanding of what services are relevant to them, as well as how to organise and deliver these services.

In this way co-commissioning is also linked to co-design and co-delivery, as the identification of issues in the commissioning phase promotes collaborative forms of problem-solving (Loeffler and Bovaird, 2019).

Co-assessment is similarly understood to offer opportunities for construction. This is because co-assessment activities involve citizens in helping organisations to 'better understand how they feel about services' (Bovaird and Loeffler, 2013, p.11). In this way the understanding of citizens is amalgamated with empirical performance metrics and a holistic assessment of a service is produced (Ibid). Examples of co-assessment are found in the way that councils include citizens in the monitoring of budgets or police force recruits citizens to assess crime levels in a particular area (Lino, Busanelli de Aquino, Rocha de Azevedo and Brumatti, 2019; Bovaird and Loeffler, 2013). Like co-design and commissioning, co-assessment is linked to other co-production activities. This is because co-assessment often stimulates future co-design and commissioning (Loeffler and Bovaird, 2019).

Each of these voice orientated co-production processes coalesce with citizen actions. For instance, co-commissioning and co-design provoke delivery activities wherein citizens and providers collaborate in the implementation of outcomes. This occurs when co-design or co-commissioning lead to subsequent, or perhaps even immediate, co-delivery. Take the previous example of parents planning extracurricular activities. This co-design stage might be followed by a co-delivery phase wherein parents work with teachers in implementing the activity (Brandsen and Honingh, 2016, pp.432-433). This example speaks to a potential difficulty in categorising co-production as a set of singular activities (Loeffler and Bovaird, 2019, p.251). Rather, what is required is a contextual understanding of the locations in which processes are occurring and of the communities and individuals who are taking part (Ibid).[6]

Of course, democratic governance does not occur in a vacuum. Opportunities for construction require that processes of decision-making are equal (Bevir, 2016). This

[6] I.e. Loeffler and Bovaird (2019) suggest that researchers should consider how stakeholders who are embedded in different societal contexts are capable of, and desire, participation in different forms of activity.

means that co-design, co-commissioning and co-assessment should be founded on a commitment to those values of equality and empowerment discussed in my examination of democratic governance.[7] This supposition is supported by Loeffler and Bovaird (2019). Their analysis of co-commissioning provides a framework through which to build equality between citizens and providers. The authors argue that organisers of co-production need to 'open up a completely new dialogue with citizens and local communities about their strengths' as a precursor to inter-community interaction (Ibid, p.245). Through this organisers create an approach to co-production that does not bypass or disadvantage particular communities or individuals. In this way Loeffler and Bovaird (Ibid) are implicitly reflecting the normative character of democratic governance. They are highlighting the necessity to manifest forms of participation that transcend essentialist narratives related to identity. Such a proposition introduces a new element to analyses of co-production. This is co-production as a normative process.

Building a normative definition of co-production

Researchers often segment their analyses of co-production. Many focus on the process's procedural element (Barbera, Sicila and Steccolini, 2016). They examine co-production activities and explore how these processes produce different types of outcomes (Loeffler and Bovaird, 2013). Other academics focus on the process's normative element. They explore the 'how' of co-production by studying the way in which relations and interactions transpire. In doing this they contextualise collaborative decision-making: describing it as an emancipatory force that fights against the 'medicalisation of services' or as an empowering process that enlivens democracy (Bevir et al, 2019, p.197; Gale, Brown and Sidhu, 2019, pp.205-206).

In the UK these normative perspectives are viewed to have been influenced by the disabilities movement of the 1970s (Needham, 2011). The disabilities movement worked to alter how service users (SUs) with disabilities and other illnesses were perceived (Beresford, 2019). This was achieved through recognising and fighting against forms of oppression related to identity (Ibid, pp.8-9). Through this process

[7] I consider democratic governance in section *1.1* wherein I propose that it is founded on a commitment to the concept of positive liberty.

campaigners empowered SUs by increasing the personalisation of NHS services and improving forms of collaborative decision-making.

In the USA there was a similar normative basis for co-production (Cahn and Gray, in Pestoff et al, 2013). The civil rights movements of the 1960s and 70s and the federal government's 'war on poverty' emphasised the necessity for the 'maximum feasible participation' of citizens within society. Thus, public officials and community organisers sought to empower citizens so that they could deliberately engage in decision-making:

> Maximum feasible participation, therefore, was a call for citizen mobilization as much as it concerned citizen engagement. It grew out of a sense of outrage and injustice spurred by a different kind of war that had left the poor as civilian causalities of a campaign waged allegedly on their behalf and for their benefit.
>
> (Ibid, p.133)

This extract suggests that participation was built on a platform of 'mobilization'. Thus, like the disability movement in the UK, engagement was a function of actions through which people were supported to be included in decision-making. These were actions such as the creation of education programmes that enabled people to take advantage of opportunities for participation (Ibid).

This empowerment narrative has been applied and furthered by co-production advocates. For instance, the creators of time banking sought to manifest a process through which citizens could equally contribute to and benefit from participation. In doing this processes of time banking enabled citizens to share their skills, experiences, companionship and expertise with others (Needham and Carr, 2009). Contributors were then remunerated for their time through the provision of time dollars. Such a method of exchange meant that time banking eschewed notions of value that were founded on market pricing. Instead, time dollars were provided to all participants who spent one hour or more helping someone else (Cahn and Gray, in Pestoff et al, 2013, pp.134-138).

This analysis suggests that processes of time banking recognised that everyone has the capacity to contribute to decision-making (Ibid). This is because the process acknowledged and honoured work that exists outside of the conventional economy. In doing this every participant was understood to be an expert who was capable of engaging in the construction of their participation and in the production of outcomes (Ibid). As such, time banking provides an important normative basis from which one understands co-production and its relationship to democratic governance.

The normative approach to co-production displayed in time banking is not shared within much of the co-production literature. Cahn and Gray (in Pestoff et al, 2013, pp.136-137) suggest that many academics struggle to amalgamate the empirical with the normative. Thus, those who examine co-production activities are often left with few resources to explore the assumptions on which co-productive actions transpire. However, this does not mean that there are no references to normative co-production within academic texts. The definitions and typologies discussed in the previous sub-section provide implicit references to normative variables. For example, Loeffler and Bovaird's (2019) delineation of co-commissioning speaks to the necessity for citizen agency (Ibid, pp.245-247). In this sense the authors are conforming to the 'maximum possible participation' mantra of time banking. This is because they agree that people need to be empowered to share their lived and local experiences within activities like co-commissioning (Ibid).

Normative inclinations are also displayed in the later work of Ostrom (1996). In a revised definition of co-production, Ostrom (Ibid, p.1073) writes that 'co-production implies that citizens play an active role in producing public goods and services'. Joshi and Moore (2004, pp.39-40) similarly describe co-production as the 'provision of services through regular, long term relationships'. These definitions speak to a particular kind of relationship between co-producing partners. The terms 'active role' and 'long-term relationship' imply that citizens are important protagonists within co-production. This has led to the assertion that co-production should be understood as 'more than a method or tool of better decision-making, rather it reflects a political agenda to rebalance inequalities and promote democracy' (Bevir et al, 2019, p.197).

Not all academics have been implicit in their delineation of co-production as a normative process. Some have written detailed normative frameworks through which to manifest and evaluate co-production. In his work evaluating watershed partnerships in California and Washington State, Leach (2006) created an ideal normative framework of co-production that consisted of seven variables. These were inclusiveness, representativeness, impartiality, transparency, deliberativeness, lawfulness and empowerment. This assemblage of variables presents a vision of co-production as originating from a desire for equality between actors:

- Wherein organisers do not obstruct opportunities for participation.
- Communities participate irrespective of their identity.
- Mediators and facilitators are impartial.
- Information is provided equally and rules are understood.
- Participants are capable of considering and critiquing one another's perspectives.
- Existing laws are upheld.
- Participants influence and take part in the generation of outcomes (Ibid, pp.100-105).

In devising this framework, Leach (Ibid) emphasises how these variables relate to, and impinge on, the identities of those who participate in co-production. This is because these variables ideally remove barriers to participation that are based on the way that social norms interact with the identities of participants.

Barbera et al (2016) have produced a similar framework. In their study of participatory budgeting in Italy they explored how co-production is, and can be, successfully implemented (Ibid, p.1088). The authors found that successful implementation occurred when co-production was founded on a normative framework that they called the two R's (responsiveness and representation) and two I's (inclusiveness and interaction). The two R's speak to the importance of equal relations between citizens:

- Responsiveness works 'to avoid the prevalence of specific interests' that might be dominant within particular communities (Ibid p.1096).
- Representation enables citizens to 'define a set of rules, processes and criteria that ensure voice for different interests' (Ibid).

Similarly, the two I's highlight the importance of generating equal relationships between citizens and provider actors:

- Inclusiveness is a variable that ensures broader access to co-productive interactions (Ibid). The authors, thus, assert that organisers of co-production must view citizens as complex individuals with valid experiences.
- Interaction speaks to the socially constructed nature of decision-making. Thus, Barbera et al (2016) assert that the shape and method of co-production should be a product of interactions between co-producers (citizens and providers).

There are a number of similarities between the frameworks of Leach (2006) and Barbera et al (2016). Both emphasise inclusiveness by highlighting how inequalities should be limited and the experiences, skills and capacities of participants utilised. Furthermore, the variables of representation and interaction in Barbera et al (Ibid) and deliberativeness in Leach (2006) speak to the importance of providing participants with the capacity to engage in the construction of the process of co-production. Finally, both emphasise the significance of enabling participants to play an active role in outcome generation. This coalescence is viewed in the way that Barbera et al (2016) highlight responsiveness and Leach (2006) emphasises empowerment.

These frameworks portray co-production as a process that is founded on a particular notion of equality. Thus, co-production is conceived of as a process through which stakeholders are empowered to effect change and collaborate in the construction of outcomes. Co-production should, therefore, enable citizens and providers alike to alter and reform services irrespective of their identity or the voice related activity being used. In this way co-production is a route through which to achieve democratic governance.

1.3: Levels of co-production: from individual to collective

Co-production is not only understood through service activities, outcomes and normative assumptions. Nabatchi et al (2017) suggest that these features should be amalgamated with another typology: levels of co-production. This typology was first conceptualised by Brudney and England (1983) as a means of creating a co-production model that could be applied within the public sector. In doing this Brudney and England (Ibid) suggested that there were three levels of co-production: the individual, group and collective. These levels speak to the 'who' of co-production. They define the people who are involved in decision-making and describe the roles that they inhabit. In the following section I examine these levels and provide an analysis of how they are amalgamated with the 'four co's' of co-production (Bovaird and Loeffler, 2013). In doing this I adhere to Nabatchi et al's (2017) vision of a '3x4' co-production typology. This consolidation provides a means of discussing co-production in respect of who is participating in co-production, when it occurs and what it produces.

The individual, group and collective

Individual co-production often mirrors co-delivery (Brandsen and Honingh, 2016). It takes place as a result of interactions between individual citizens and providers in a GP's office or classroom. These exchanges conventionally occur at operational locations within services that citizens need (Brudney and England, 1983, p.63). This conveys that individual co-production is frequently involuntary and unavoidable (Osborne and Strokosch, 2013, p.38). As such, the individual type is often described as a 'captured' form of co-production (Brudney and England, 1983, p.63). This term refers to the fact that citizens have little choice but to engage in a relationship with a provider (Ibid). Of course, individual co-production is not always involuntary. As discussed in my analysis of co-delivery, co-production interactions are frequently complementary and separate to the core purpose of a service (Brandsen and Honingh, 2015).

Individual co-production should, thus, be viewed to reproduce paternal values that are associated with prescriptive service delivery (Osborne and Strokosch, 2013, p.38). This is because a patient who is engaging with a doctor is both taking part in

individualised co-production and participating in an orthodox form of operational provision (Brudney and England, 1983, p.63; Pestoff, 2014, p.386). Similarly, a parent engaging in complementary activities that support their child's learning is both participating in individual co-production and helping the service to perform its core function. This means that processes of individual co-production provide few opportunities for actors to use their voices to construct meaning and generate outcomes (Bevir, 2013, pp.174-176).

Group co-production commonly occurs when provider actors work with a group of citizens who share common characteristics to produce private benefit (Nabatchi et al, 2017). Within this dynamic citizens work alongside providers to simultaneously create and consume a service (Brudney and England, 1983, p.64). This cooperation occurs within small groups such as self-help groups. In these groups an environment is ideally fostered that promotes interactions between group members (Bovaird et al, 2015, p.6). This is because participants are often incentivised to become fully engaged in issues and themes (Olsen, 2009, p.53). In addition, the environment regularly provides participants with the chance to put forward their point of view and explain their experiences (Burkhalter, Gastil and Kershaw, 2002, p.406).

In the academic literature there are different perspectives regarding 'group co-production'. For Brudney and England (1983) and Needham (2008, pp.224-225) the fact that benefits are not enjoyed collectively means that this form cannot be defined as 'collective' (See *figure 1*). For them it is the end creation of a collective good that imbues a process with collective character (Ibid). This perspective suggests that group co-production occurs through processes of co-delivery, rather than co-design or co-commissioning. However, it is argued that the value of group co-production cannot simply be measured by direct gain. Collective action can be expanded to include those who benefit from the externalities of consumption (Bovaird and Loeffler, 2010, pp.233-234). This alludes to the idea that benefits are not just enjoyed by the co-producer. A variety of actors gain from group co-production (Ibid). This proposition links group co-production to Bovaird and Loeffler's (2013) vision of co-delivery as an essential part of a service.

Co-production type	*Interaction*	*Outcome*
Individual	Interaction between a single provider figure like a GP and a citizen.	Private outcomes enjoyed by participants.
Group	Group interaction between provider figures and citizens.	Private outcomes enjoyed by participants
Collective	Group interaction between provider figures and citizens (Brudney and England, 1983).	Collective outcomes enjoyed by wider society (Bovaird and Loeffler, 2010)

Figure 1: Co-production typology consisting of interaction and outcome types.

If there are competing perspectives regarding the status of group co-production, the same cannot be said for collective co-production. Like group co-production, collective co-production is a process in which a group of citizens and providers input time and energy to create outputs (Hudson, in Loeffler, Taylor-Gooby, Bovaird, Hine-Hughes and Wilkes, 2012, p.76). However, collective co-production is explicitly linked to collective outputs (see *figure 1*). Thus, actors engage in activities like co-design or co-commissioning to generate collective outcomes such as organisational reform or new ways of administering a facet of a service (Nabatchi et al, 2017; Needham, 2008, p.225). This means that participants use their voices to produce outcomes that 'may be enjoyed by the entire community' (Brudney and England, 1983, p.64).

As such, collective co-production seems to be the most convincing form of co-production in respect of democratic governance. Collective co-commissioning or co-design activities provide opportunities for actors to engage in the construction of services. This is because they involve a greater number of actors, each of whom has their own lived and local experiences. These actors use their voices as tools through which to influence decisions and manifest outcomes. This assertion is supported by Thomas (2013). In his exploration of SUs as 'citizens' he asserts that involvement in collective co-production enables citizens to 'contribute their ideas and share decision-making authority' (Ibid, p.787). Through this they influence 'the nature of public programmes' (Ibid). It, therefore, follows that the study of democratic governance requires an investigation of collective co-production.

Collective co-production: an opportunity for democratic governance?

As discussed, collective commissioning or design activities often provide citizens with opportunities to make decisions alongside provider actors (Ackerman, 2003, pp.450-451; Bovaird et al, 2015, p.5). This is demonstrated in the works of citizen school governors who work alongside providers and neighborhood watch organisations who meet with the police (Ibid). These actors use their experiences of being parents or living in their neighborhood to shape the future of their child's school or community. In this sense collective co-production is understood as a process through which provider expertise and lived and local experiences are amalgamated and turned in to an outcome.

This is evidenced in the work of Ostrom (1996). In her case study of collective co-production in Brazilian water and sanitation services, Ostrom examined how providers organised meetings that involved townspeople. In doing this she describes how organisers negotiated with citizens as a means of creating a collective forum. This is demonstrated in the proceeding quote:

> All of this effort to involve citizens is directed, however, toward facilitating their making real decisions in a process of negotiation among neighbors and with project personnel.
>
> (Ibid, p.1075)

This passage speaks to the implicit, or perhaps explicit, desire to provide participants with decision-making power. Regardless of the structural or institutional inequalities that occur as products of their identity, each participant was empowered to make decisions within meetings (Ibid, pp.1074-1075). This outcome suggests that collective co-production does not necessarily occur within a constricting prism of circumscribed roles and routines. Unlike individual and group co-production, collective co-production is not framed by an inherent inequality between the experience of the citizen and expertise of the provider. Rather, the citizen is elevated to the status of the provider as both become designers. In this way processes promote the kind of normative environment that is emphasised by Cahn and Gray (in Pestoff

et al, 2013) in the co-production literature and Bevir (2013) in the governance literature.

This equality is also found in Denters and Klok's (2010) exploration of the use of collective co-production in Roombeek, the Netherlands. In this study the authors examined how collective co-design activities were employed to regenerate a neighborhood that had been devastated by an explosion. The case study shows that the Dutch organisers of collective co-production were influenced by the 'maximum feasible participation' mantra of the US government in the 1970s. As such, they included participants from a wide range of communities such as those from the Turkish and Moroccan diasporas (Ibid, p.587). Furthermore, the authors argue that these communities were empowered to engage in collective decision-making through using salient discussion topics:

> The Roombeek example clearly suggests that such new forms of citizen governance may be successful only if they are used in the context of highly salient public issues…
>
> (Ibid, p.601)

Through orientating discussions around 'salient public issues' participants were motivated to affect the process. This effect occurred in respect of the process's rules and meaning. Furthermore, participants were able to influence outcomes via 'the right to vote on the acceptability of the draft plan' (Ibid, pp.589-590).

In the NHS, collective co-production might be used in similar ways. For instance, McMullin and Needham (in Brandsen et al, 2018, pp.152-153) suggest that collective co-commissioning enables citizens to participate in groups regarding the 'prioritisation of surgery'. Similarly, they propose that collective co-design promotes opportunities for citizens to become involved in the 'broader strategic decisions of the healthcare provider' (Ibid). An example of this comes from a case study by Jo and Nabatchi (in Brandsen et al, 2018). In this study the authors examine how citizens and providers in the USA have engaged in collective co-production as a means of 'improving diagnostic quality and reducing diagnostic error' (Ibid, pp.161-163).

Jo and Nabatchi (Ibid) assert that organisers achieved these outcomes by supporting participants to learn about the issue at hand. This enabled participants to engage in discussions about the topic and produce recommendations regarding institutional policy and the creation of a patient engagement tool kit aimed at encouraging future participation (Ibid). These outcomes show how collective co-production often promotes equal interaction and decision-making between communities. It enables actors to use their voices to influence meaning and create outcomes. Thus, like the Roombeek or Brazilian cases this study demonstrates the value of collective co-production in fostering democratic governance.

However, collective activities that enable participants to change services do not occur in a vacuum. In the Brazilian case Ostrom (1996, pp.1074-1076) demonstrated the value of actors who are sympathetic to collaborative decision-making and who come from within the service environment. Thus, she highlights the role of an engineer in understanding that services could be improved via the participation of citizens (Ibid). Furthermore, in the Roombeek case it is argued that the particularly acute nature of the issues around which collective co-production was used contributed to implementation (Denters and Klock, 2010). As such, the author's emphasise the importance of issue saliency in promoting active participation in collective co-production. These factors convey that the implementation of co-production, particularly those co-productive activities that are contingent on voice, is dependent on how organisers support stakeholders to participate.

1.4: Implementing collective co-production

As discussed, collective co-design, co-commissioning and co-assessment involve citizens and providers in processes wherein they construct meaning using their voices. In this way actors often influence the decision-making process and affect the creation of outcomes. However, these activities do not occur in a vacuum. Particular conditions need to exist from which collective co-production emerges. These conditions enable organisers to implement collective co-production processes that are founded on empowerment and participative equality (Leach, 2006; Barbera et al, 2016).

Processes of co-design, co-commissioning and co-assessment all, to one degree or another, provide communities with opportunities to influence the governance of services. However, this constructive capacity is often contingent on a number of conditional variables. In the DT literature it is suggested that actors within particular contexts find it difficult to conceive of democratic governance (Bevir and Rhodes, 2008). The normative constitution of this form of administration is often foreign to those who operate within services (Speed, in Bevir and Waring, 2018; Glynos and Howarth, 2008). Furthermore, the range of traditions that influence these actors may not encourage forms of reflection that lead to the formation of new modes of governance (Bevir, 2013). As such, actors may not be capable of using their situated agency to implement processes like collective co-production.

This supposition is supported within the co-production literature. Scholars have examined myriad variables that impede implementation. Thomas (2013, pp.792-793) argues that notions of cost, as well as fears of the limits of participatory democracy, inhibit the implementation of activities like co-commissioning and co-design. Similarly, Loeffler and Bovaird (2016) assert that co-production activities often conflict with hegemonic notions of value and objectivity. In stating this they suggest that variables like funding obstruct the implementation of co-production (Ibid, p.1015). This is because the provision of funding is often tied to the policy and organisational preferences of actors who favour innovations that address inefficiencies and increase effectiveness (Bovaird, 2007; Needham and Carr, 2009).

The necessity for objectivity is also linked to reduced opportunities for co-production. For example, Park (2020, p.13) writes that:

> Providers are subject to strong institutional pressure to behave as ‘experts’ and to subscribe to the scientific paradigm. In particular, emphases on effectiveness and safety may discourage providers from sharing decision-making power due to fear that the user may demand treatment via a practice with weak evidence.

By emphasising effectiveness and efficiency, providers are encouraged to eschew activities that do not empirically contribute to the production of economic value. This is evidenced by McQuarrie (2013). In his analysis of participatory technologies and urban transformation in America's Rust Belt he argues that the economic focus of community development in the USA has meant that the variable 'community well-being' is measured via 'real estate values' (Ibid, p.14). Accordingly, forms of participation aimed at improving communities from the bottom-up were avoided as they were seen to be 'standing In the way of community development' (Ibid, p.16).

The value attributed to professional expertise also diminishes opportunities for co-production in services. As discussed, providers often value the perceived expertise of the professional over forms of experiential understanding (Thomas, 2013). This preference for expertise often arises as a product of institutional pressure to value objectivity, and/or as a result of socialisation (Park, 2020, p.13). In the NHS the valorisation of professional expertise is viewed through an examination of HCPs. The literature shows that HCPs have conventionally had more power than citizens. Traditional models of healthcare have been based on the essentialist notion that patients are the recipients of care and HCPs hold 'the only valuable source of expertise' (McMullin and Needham, in Brandsen, Verschuere and Steen, 2018, p.156). This is because healthcare professionals have university degrees and have 'considerable knowledge of human anatomy and cure strategies' (Parrado, Van Ryzin, Bovaird and Loeffler, 2013, p.89). As such, HCPs have been found to be highly resistant to forms of co-production that go beyond individual co-delivery (Ibid, p.101).

However, the important role of HCPs within the NHS means that they are capable of supporting the implementation of co-production should they deem it to be valuable. In his study of cases of co-production Bovaird (2007) demonstrates the value of professional advocacy:

> What is needed is a new public service ethos or compact in which the central role of professionals is to support, encourage and coordinate the coproduction capabilities of service users and the communities in which they live.
>
> (Ibid, p.858)

These HCPs understand that citizens are 'experts on their own bodies, minds and family members' (Brandsen and Honingh, 2016, p.430). Furthermore, these HCPs should have 'collaborative skills' such as flexibility, empathy, good communication, the capacity to facilitate and mediate and an understanding of culture (O'leary, Choi and Gerard, 2012; Steen and Turnas, in Brandsen et al, 2018).

The above skill set may be more or less evident within particular parts of the NHS. For example, there are disparities between mental and physical healthcare services. In the former there is a history of compulsion when caring for SUs, as well as issues related to the entrenched stigmatisation of patients (Bee, Brooks, Fraser and Lovell, 2015). By contrast, physical health is characterised as an environment that is often less beset by problems related to control and stigmatisation (Ibid). Similarly, there are differences between departments that provide acute and long-term care. This is because the former department type tackles illnesses that are 'episodic and generally treatable' (Realpe and Wallace, 2010). Conversely, the latter is engaged in treating complaints that are ongoing and incurable (Ibid). These factors suggest that advocacy may be more likely in service environments wherein staff members learn to value and work alongside SUs.

It is, therefore, possible to suggest that HCPs from particular departments or those who engage in specific forms of practice are often more inclined to exhibit co-productive behaviours. HCPs who work with specific patients for long periods of time in an attempt to manage long-term or acute conditions like HIV or cancer may, therefore, be disposed to appreciate co-production. This is because individualised co-delivery is a 'key aspect of the management of these conditions, as medical staff offer diagnosis and support patients in self-care' (McMullin and Needham, in Brandsen et al, 2018, p.154). Similarly, HCPs who work alongside patients for

prolonged periods of time and make positive judgements on their capacity may be prepared to engage in shared decision-making (Bee et al, 2015).

The work of the organiser in implementing collective co-production

Implementation cannot only be understood through analyses of those who operate within institutions. The role of citizens must also be explored. This is because citizens are often ill-equipped for participation. As Pestoff (2012, p.25) writes, citizens are not equivalent to a 'jack in the box'. They are not always prepared for someone to turn the crank, thereby releasing their productive capacities. The self-governing model of democratic governance discussed by Bevir (2013) requires citizens to be capable of taking part. Similarly, the 'maximum feasible participation' maxim of co-production demands that citizens are fully engaged irrespective of the social and political context. These contingencies imply that the implementation of collective co-production should be complemented by preparatory processes that run parallel to the core activities of co-design and co-commissioning.

Thus, much like Brandsen and Honingh's (2016) example of the parent whose complementary actions support a services core activities, organisers may supplement their collaborative processes by offering encouragement to citizens:

> By engaging with those groups who are excluded, who lack the competence to participate, professional support can aid in strengthening the skills, knowledge and capacity needed to participate.
>
> (Verschuere, Vanleene, Steen and Brandsen, in Brandsen et al, 2018, p.246)

Supplementary preparatory processes occur in a number of ways and in relation to a myriad of contextually specific concerns. For example, it has been suggested that participation in service activities that require voice (co-design, commissioning and assessment) are frequently obstructed by participant's low self-efficacy (Loeffler and Bovaird, 2016).[8] By contrast, service activities that require action (co-delivery) may be less affected by this variable. This is because voice orientated activities often

[8] I define self-efficacy as 'the belief that (one) can make a difference with regard to a problem' (Jo and Nabatchi, in Brandsen et al, 2018, p.235)

require participants to take part in debates, thereby exposing them to scrutiny. Those who have experiences of the topics being covered may, therefore, shy away from participation because they feel incapable of engaging with others or of contributing to the production of outcomes (Ibid, p.251).

The organising actor may, therefore, address issues related to the low self-efficacy of participants by employing preparatory processes that provide information (Füller, Mühlbacher, Matzler and Jawecki, 2009). Cepiku and Giordano (2014, p.324) support this notion, writing that self-efficacy is increased through processes that reduce 'information asymmetries'. Similarly, Ostrom (1996) highlights the necessity for preparation in her case study of water and sanitation. Here participation was again supplemented by the provision of information to participants (Ostrom, 1996, 1074-1075).

Organisers of collective co-production also consider disparities related to social and economic conditions. For example, Michels (2011) suggests that myriad forms of participation such as referendums and participatory policymaking suffer from the tacit exclusion of groups that are societally underrepresented and disadvantaged. Agger and Larsen (2009) propose that this is often a product of what could they call 'structural exclusion' wherein those with fewer resources are less likely to participate in and influence decision-making.

To combat structural exclusion, Fledderus (in Bransden et al, 2018) suggests that organisers of co-production must consider the social identities of participants by exploring variables like class and education. Furthermore, he argues that organisers ought to reflect on how these facets of identity impinge on participant's motivation and self-efficacy (Ibid). To achieve this, Verschuere, Vanleene, Steen and Brandsen (in Brandsen et al, 2018) propose that organisers ought to directly recruit actors who are considered to be disadvantaged as a product of their socio-economic status.

This method of direct recruitment contrasts with methodologies like self-selection. This is a form of recruitment wherein participants choose to take part in decision-making (Fledderus, in Brandsen et al. 2018). Such a contrast feeds in to the idea that citizen involvement is not simply a product of participative freedom. Rather, it

occurs as a result of recruitment methodologies that entice individuals to participate (DeGraaf, Van Hulst and Michels, 2015). Organisers often achieve this by emphasising the empowering nature of co-production (Bovaird et al, 2019). In this way organisers eschew the recruitment of the 'usual suspects', or those actors who are able to regularly participate in decision-making (Vanleene and Verschuere, in Brandsen et al, 2018, p.204).

Of course, the recruitment of participants is not only achieved through direct invitations to take part. Rather, organisers of co-production must also tailor their recruitment to the type of co-production activity that is being employed (Loeffler and Bovaird, 2019). For instance, processes of co-commissioning that discuss macro-level issues such as national policy often necessitate the involvement of a range of actors from different societal groups. On the other hand, processes of co-design that discuss micro-level issues frequently require 'experts by experience' (Ibid, p.251). These are people who 'know and care' about a particular facet of a service and, subsequently, use their experiences to contribute to its reform (Ibid, p.247).

A final variable noticed within the literature is issue saliency. Pestoff (2012) proposes that citizens need to feel that they are contributing to an outcome or a set of outcomes that are important to them. Such a notion is exemplified in the work of Denters and Klock (2010). In their Roombeek case study they show how the saliency of the topics being discussed encourages citizens from a range of communities to participate. This suggests that processes of collective co-production should occur in reference to issues that are meaningful to participants. In the NHS this might mean that co-production is orientated around inherently social issues (Bovaird, 2007, p.857). These issues often relate to the purpose of the institution and the types of work in which it should engage.[9]

The literature shows that these factors all contribute to empowerment. However, it is asserted that there is an empirical issue of measuring these variables (Verschuere,

[9] See the example of the Caterham Barracks Community Trust discussed in Bovaird (2007, pp.852-853) for an example of how co-production can be employed to delineate the purpose, or in this case the repurposing, of an institution.

Vanleene, Steen and Brandsen, in Brandsen et al, 2018, pp.245-246). Self-efficacy, representation and salience are subjective concepts. Accordingly, they may be measured through analyses of the understanding of participants. Research must, therefore, engage in inductive methodologies that provide opportunities to measure understanding (Webler and Tuler, 2000). For example, one could examine empowerment by exploring how participant's feel after they have participated in collective co-production. As such, researchers should investigate whether participants perceive that they have had 'a real ability to actively participate' and manifest outcomes within a group (Verschuere, Vanleene, Steen and Brandsen, in Brandsen et al, 2018, pp.245-246).

Conclusion

My study of the literature shows that involvement in collective co-production provides communities with a voice. This is because involvement in collective co-production enables citizens to participate in activities like co-design or co-commissioning. Unlike individual and group co-production, collective co-production activities engage citizens and providers in collaborative decision-making. Its use within the NHS may, therefore, promote similar opportunities to those given to participants in Ostrom's (1996) case study of water sanitation or in Denters and Klok's (2010) research in to the rebuild Roombeek.

However, this democratic promise is contingent on the normative constitution of collective co-production. This supposition is highlighted in the works of scholars like Cahn and Grey (in Pestoff et al, 2013) and Leach (2006). These authors have explored co-production as an inherently normative process. Their works define co-production as a tool for empowerment that builds on the capacity of all peoples. In doing this they suggest that co-production should be founded on a normative framework consisting of variables like representation, accessibility and saliency. These variables enable each person to participate in the construction of their participation and in the creation of outcomes.

The literature also shows that the implementation of collective co-production is context dependent. Scholars like Loeffler and Bovaird (2016), Thomas (2013) and

Denters and Klock (2010) consider co-production to be the product of conditional variables. These are variables such as funding, notions of objectivity and the valorisation of expertise. Furthermore, it has been suggested that implementation is contingent on their existing service actors who act as advocates for co-production (Bovaird, 2007). These ideas mirror those of Bevir (2013). In his theory of the situated agent Bevir suggests that actors are often blocked from implementing new practices by hegemonic traditions. This perspective suggests that implementation requires the advocacy of actors who are able to escape from and eschew these traditions.

Of course, DT also teaches us that governance occurs differently in particular environments. My analysis of the literature shows that the NHS is an ever changing and deeply complex institution. Within its walls there are myriad departments, models of practice and power structures. Furthermore, the NHS is buffeted by exogenous variables related to government. These are Acts such as the 2012 Health and Social Care Act and the 1990 Community and Care Act (Speed, in Bevir and Waring, 2018; Ferlie et al, 1996, p.43). Moreover, the NHS is characterised by particular ethics such as collectivism and universalism (Delamothe, 2008). In this review I discuss how these factors influence collective co-production and suggest that they impinge on how actors implement and take part in collaborative activities.

My thesis builds on the works that have been examined in this review. In my framework of collective co-production and democratic governance I examine how traditions associated with the NHS influence implementation and participation. To achieve this I utilise a research design that is grounded within the interpretivist philosophy of DT and employ methodologies that explore the socially constructed nature of governance. These are methodologies like knowledge based practice and grounded theory. In doing this I use the perspectives of those who are intimately involved in participative practices to create a framework of collective co-production and democratic governance in the NHS in England.

Chapter 2: Methodology

Decentred theory suggests that governance results from the situated agency of individuals. These actors harness traditions as a means of addressing issues and solving dilemmas. This focus on the individual means that interpretivist researchers are required to examine the traditions that orient and influence actions. To do this I employ a research design that captures lived experiences. This consists of a co-production specific guide to inductive research called knowledge based practice and grounded theory. In amalgamating these methodologies I examine the testimony of actors and explore how traditions influence collective co-production and democratic governance.

Knowledge based practice provides a set of principles for inductive analysis. These relate to the collection and study of lived experiences. Knowledge based practice is, thus, an important means through which to channel the interpretivist orientation of decentred theory. In using it I appreciate the value of methodologies that capture the beliefs of actors. One of these methodologies is grounded theory. In employing grounded theory I examine the lived experiences of research participants and consider how the conditions in which they operate influence their actions. Through this I create a theory of collective co-production and democratic governance in the NHS.

This chapter begins with an exposition of the philosophical prism through which I undertook my research. In *section 2.1: The methodological foundations of decentred research,* I highlight how decentred theory demands that research be inductive. Thus, I present knowledge based practice as an appropriate form of methodological guide. Its promotion of inductive exploration means that investigations are shaped by the data, rather than deductive reasoning. After this I delineate how I generated a sample upon which I was to base my inductive research. In *2.2: Sampling and the exploratory questionnaire,* I explain how I employed a questionnaire to generate a cohort of participants who would take part in subsequent interviews.

In *2.3: Interviewing participants*, I describe the process of interviewing. I discuss how I planned my interviews and gained consent, as well as how I addressed potential ethical issues. Furthermore, I explain my use of telephone and face-to-face interview methods and illustrate my interview and transcribing processes. Finally, In *2.4: Grounded theory*, I describe how I employed techniques of theoretical sampling to orient the direction of my research. After this I discuss how I engaged in data analysis and coding as a means of generating a framework of collective co-production and democratic governance in the NHS.

2.1: The methodological foundations of decentred research

Decentred theories (DT) of governance require interpretivist researchers to explore subjectivity. This is because the study of governance equates to the study of complex and interrelated webs of meaning (Bevir, 2013). As such, research must examine the stories of those who play roles in the generation of governance (Bevir and Rhodes, in Finlayson, 2004). Thus, deliberation regarding appropriate methodology should occur under the banner of what Bevir calls 'meaning holism' (2013, pp.3-4). This term speaks to the desire to understand 'actions by attributing meanings and showing how these meanings fit in to larger patterns of belief and rationality' (Bevir, in Klosko, 2011, p.20). In this sense interpretivist researchers are invited to assume an epistemological approach that facilitates an appreciation of ontology. DT Scholars, therefore, extol the utility of ethnographic methodologies (Bevir and Rhodes, in Finlayson, 2004). This promotion of ethnography highlights the fact that DT does not provide a fixed route through which to understand social phenomena. Rather, it offers a means to explore the constructed nature of reality.

Decentred theorists must, therefore, choose methodologies that support attempts to explore the variables that construct meaning. Furthermore, decentred theorists should select methodologies that provide a means of examining how actors escape structures through reflexivity (McAnulla, 2006). These requirements shaped the construction of my research design. As such, I integrated a number of methodologies within my research. The first of these is a methodological guide called knowledge based practice (KBP). This guide places the study of belief, attitudes and experience at the forefront of research by emphasising the value of lived experience. Through

exploring KBP I also considered the integration of a further inductive methodology, grounded theory (GT). My use of this method supported attempts to examine the traditions that impact on actors who operate in and use the NHS in England.

Knowledge Based Practice

KBP conforms to the decentred notion that reality is constructed. In doing this KBP guides exploration by offering insight as to the means through which qualitative analyses should be actualised. This approach is important. Without this epistemological understanding the construction of governance may not be comprehended. Instead, researchers may only attain an appreciation of governance as separate to the social worlds in which organisations and institutions exist.[10] By contrast, KBP invites researchers to draw on the capacity of individuals to contribute to research (Glasby and Beresford, 2006, p.16; Durose et al, 2016, pp.11-16). KBP, therefore, enables researchers to produce analyses that are reflective of individuals' experiences and understanding. In doing this KBP promotes an understanding of governance as socially and institutionally situated.

However, KBP should not be viewed as a method. This is because it does not provide a set route for investigating phenomena. Rather, KBP is a collection of guiding principles that both challenges notions of an orthodox research design and emphasises the value of lived experience (Glasby and Beresford, 2006, pp.3-4 and p.16). As such, I employ KBP as a methodological bond that both builds on the philosophical implications of DT and sets the tone for my use of the interview method and GT in later sections of this chapter. This is because KBP emphasises the importance of understanding beliefs and provides a means of approaching investigation.

[10] See my examination of neo-liberal or networked governance theories in *section 1.1* for an example of this.

Principle 1: the best method

The first principle of KBP is, *the best method of investigating a topic is that which answers the question most effectively*. This notion is supported by a considerable number of social scientists, many of whom employ qualitative research methodologies within their work (Petticrew and Roberts, 2003, p.528; Concato, Shah, Horwitz, 2000, p.1890). Sackett and Wennberg (1997, p.1636), for example, contend that it is not methodological quality that should decide usage. Practice should be dependent on a method's utility in answering a specific question (Ibid). As such, research exploring subjective variables should employ methods that access 'the subjective, meaning, actions and contexts of those being researched' (Popay and Williams, 1998, p.35).

The interpretive orientation of my research necessitated the employment of a method that would capture understanding. This is because I aimed to examine forms of understanding that were proliferated through lived experiences and grounded by sets of distinctive, yet interrelated, societal and institutional traditions (Bevir and Rhodes, in Finlayson, 2004; Bevir, 2013). My employment of GT, therefore, acted as an important methodology through which to capture and interpret situated understanding (Charmaz in Denzin and Lincoln, 2013). As I show in the proceeding sections of this chapter, GT is often employed to inductively analyse understanding. Thus, GT enables researchers to explore how ontologies are shaped by, and shape, the world around us.

Principle 2: lived experience

The second KBP principle invites researchers to *employ methodologies that facilitate the provision of lived experience*. The sharing of lived experience is achieved by enabling participants to provide their own narrative (Glasby and Beresford, 2006). In doing this researchers access and assess discursive information related to rules and routines, actions, interaction routines, organisational constellations and the appreciation of past and current events (Bogner and Menz, in Bogner, Littig and Menz, 2009, p.52). Thus, I employed a methodology through which I could capture

discursive information.[11] This was the interview method (Charmaz, 2014). Through this I examined the dimensions of collective co-production by asking interviewees questions regarding their involvement in processes of collective co-production.

Of course, discursive information cannot tell us everything. DT suggests that lived experience cannot be understood without an examination of the way that 'traditions prompt people to adopt certain meanings and how dilemmas prompt them to modify them' (Bevir, 2013, p.50). This suggests that interpretivist researchers must capture and analyse the multiplicity of information types that constitute ontology and, subsequently, influence decision-making. Bevir and Rhodes (in Finlayson, 2004, p.133) suggest that this is achieved through the use of methodologies that offer 'thick descriptions of individual beliefs and preferences'. Through this researchers not only explore that which the subject discursively understands. Rather, one obtains information that is unknowable. That is, to use the vernacular of Giddens (1984), information that arises from the practical consciousness (Dowding, in Finlayson, 2004).[12]

Principle 3: proximity or distance?

Building on the idea that lived experience is important, is the notion that *proximity to the subject is imperative*. Proximity provides interpretivist researchers with a means through which to appreciate and analyse phenomena: proffering greater understanding of the multiplicity of traditions from which beliefs occur, as well as their impact on the wider environment. This is because research proximity often facilitates the transference of understanding (Glasby and Beresford, 2006, p.16). Through this researchers understand how traditions are 'viewed and experienced by service users and staff whose behaviour shapes and contributes to empirical outcomes' (Glasby, 2011, pp.92-93).

[11] This type of information relates to Giddens' (1979, p.5) notion of the discursive consciousness: a concept that speaks to the ability of participants to consciously describe phenomena (Giddens, 1984, p.49).

[12] The practical consciousness concerns implicit information about norms and processes "which actors draw upon in the constitution of social activity" (Giddens, 1979, p.5). Thus, the practical consciousness produces and reproduces appreciation of our temporal and spatial contexts (Giddens, 1984, pp.21-22).

The successful application of this principle is difficult. As Hay (in Finlayson, 2004, pp.145-146) notes in an analysis of DT, traditions and the routes through which they arise are not always knowable. Thus, interpretivist researchers must find methodological tools through which to interpret and understand the influence of unknowable traditions (Ibid). Bevir and Rhodes (2003) argue that this is achieved through the study of narrative. This is an interpretation of narrative analysis that emphasises the role of the researcher in acknowledging the contingency of traditions (Finlayson, in Finlayson, 2004). Through this researchers interpret narrative and understand how and why particular traditions occur within certain contexts. This is because researchers take on the perspectives of their subjects and in so doing comprehend how they are affected by situated traditions that occur within their social and institutional worlds (Glasby and Beresford, 2006).

Transitioning from KBP

The employment of these principles engenders an appreciation of how to undertake interpretivist exploration. In transcending notions of research hierarchy, emphasising lived experience and highlighting proximity, KBP offers clues as to the utility of approaches through which to explore the construction of phenomena. These clues emphasise that:

- The research subject possesses forms of understanding that are both knowable and unknowable.
- The researcher needs to take on the perspective of the subject and in so doing should examine the situated nature of knowledge.

In acknowledging the value of these clues I have applied a further approach within my research design, GT. This is a methodology that both enables researchers to examine lived experiences and encourages research intimacy through inductive analysis. The use of GT provides a means of creating frameworks through analyses of how people have experienced the social world around them (Charmaz, in Smith, Harre and Van Langenhove, 1996). Through this approach the beliefs and attitudes of research participants direct investigation (Charmaz, in Denzin and Lincoln, 2013, p.296)

GT encourages researchers to learn about and interpret the experiences of actors. In this way one understands how particular conditions influence the generation of processes like collective co-production (Ibid, pp.291-298). Of course, the study of collective co-production requires participants to have an understanding of the phenomenon that is under investigation. The application of GT would bear few fruit if participants had not taken part in or organised collaborative decision-making. In the following section I explain how I generated a sample of participants. These were people with lived experiences of collective co-production in the NHS in England.

2.2: Sampling and the exploratory questionnaire

As discussed, the study of experience and understanding demands that one maintains proximity to the setting and to those being examined (Glasby and Beresford, 2006). This proposition suggests that researchers ought to involve individuals who have experiences that are relevant to the aims of their study. Such a supposition is supported in the interpretivist literature. In this body of work the notion of 'doing inquiry from the inside' is advocated as a means of understanding the complexity of phenomena (Ospina, Esteve and Lee, 2018, pp.7-8).

To gain an inside perspective I generated a sample of participants who had experiences of collective co-production in the NHS in England. As such, I used the snowball sampling method to recruit potential participants. After this I employed an online and exploratory questionnaire to delineate whether respondents had the requisite experience to take part in interviews (See *figure 2*). In the following analysis I provide a description of the processes through which I engaged in sampling. In doing this I justify the spatial dimensions of my research, discuss the intricacies of examining a diffuse and potentially unknowable population and define how answers to my questionnaire were used to create a sample.

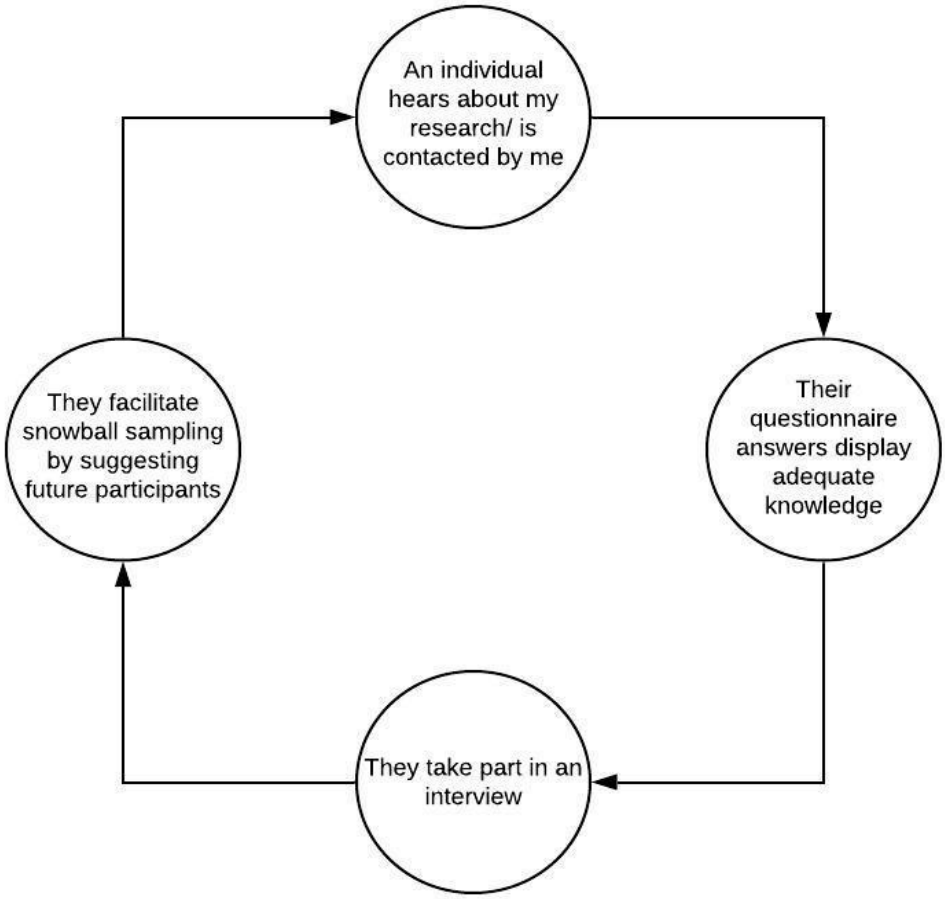

Figure 2: Illustrating how I used snowball sampling to create a sample of participants.

Why the NHS? A rationale for the focus of my research

The NHS is compatible with the study of collective co-production and democratic governance. This is because NHS services ideally operate as models of universal provision within which vast numbers of people from a range of communities are served. These are patients, carers and family members, as well as healthcare professionals and administrators, amongst other groups. As such, one could assert that there exists a procedural basis from which co-production emerges: offering prospective co-producers a guaranteed means of gaining experiences of the service (Szes´ciło, in Brandsen et al, 2018, p.140). Citizens are, therefore, significant within the immense ecosystem that is the NHS. They spend large amounts of time navigating through institutional locations and environments. Similarly, they often live with and appreciate the impact of illness on their lives, as well as on those of their friends and family members (McMullin and Needham, in Brandsen et al, 2018).

This means that they possess a ‘potentially important and valid way of understanding the world in its own right’ (Glasby, 2017, p.153).

The NHS is, therefore, an environment in which actors from different communities become experts. NHS services constantly offer their services. As such, regular users often gain an intimate understanding of the institution. Through this patients become ‘experts by experience’ (McMullin and Needham, in Brandsen et al, 2018). As demonstrated in my review, this expertise both conflicts with and complements the perspectives of healthcare professionals, administrators and policymakers (Glasby and Beresford, 2006). This is evidenced in bodies of literature such as mental health ‘survivor’ research. For instance, Sweeney (in Staddon, 2013) discusses the value of patient participation by emphasising how there exists an important role for ‘lived experience’ in influencing the administration and organisation of NHS services.

These factors are important for the study of co-production. As discussed, co-production is contingent on their existing particular knowledge bases from which different actors collaboratively make decisions. As such, the study of the NHS provides an important means of researching collective co-production. However this does not mean that I should nor can examine the entirety of the institution. The NHS is large and complex. Within its walls sit myriad departments, models of practice and power relations. This means that the provider and citizen cannot be understood as uniform actors. It, therefore, follows that a person’s proximity to NHS services does not equate to them having experienced collective co-production. In the following discussion I delineate how I overcame issues around sampling and gained a cohort of participants with experiences of collective co-production in the NHS.

Collective co-production experts: an unidentifiable community

Interpretivist researchers access and interpret phenomena by exploring the meanings that people share. In doing this researchers engage in the generation of theories that incorporate lived experience. It is, therefore, important that interpretivist researchers recruit individuals who have lived experiences of the phenomenon under investigation. In my research I define this as:

- Experience of collective co-production within the NHS in England.

Marshall (1996, p.523) asserts that conventional sampling techniques such as random or stratified sampling would not guarantee the existence of this variable within a sample of participants. As such, a sampling method was needed that would create a sample from a population of individuals whose suitability was already understood.

Ospina, Esteve and Lee (2018) assert that this is achieved through deliberately selecting participants. As such, I employed a purposive sampling approach that separated quantities of a population on the basis of an indicator or set of indicators (Snedecor, 1939, p.850). Through this I was able to gain access to information rich cases (Coyne, 1997, p.624). However, purposive sampling is difficult to realise in circumstances wherein the population under investigation is inherently nebulous. In my research I found that my desire to study actors with experience of collective co-production in the NHS provided a number of challenges:

- Unlike a distinct group such as General Practitioners (GPs), I could not find a resource that listed actors who have experiences of collective co-production. In the former case one might gain information from NHS trusts by asking them for a list of GPs in a local area. However, such a resource does not yet exist for co-producers.
- The academic literature has not yet provided an NHS specific elucidation of the types of locations in which collective co-production takes place. Furthermore, it has yet to offer a contextually specific description of the actors who are likely to take part.

- People who have experience of collective co-production in the NHS in England come from a range of different stakeholder communities. They may be healthcare professionals, patients, administrators, family members and carers amongst other communities.
- As an empirical area of research, the NHS is a difficult institution to examine. This is because it is large and disjointed, and power and autonomy are highly diffused (Greener and Powell, 2008, p.624). Thus, different types of actors may be involved in collective co-production across the myriad departments and practices that constitute the NHS.

As a result of these factors I engaged in initial conversations with actors who presented themselves as having experienced collective co-production. This occurred through the social media website Twitter wherein I found a small but vocal community of individuals who advocate for increased public participation in the NHS. I found this community by using my personal Twitter account to post requests asking for assistance in finding examples of collective co-production. An example of such a request is displayed below:

Figure 3: Showing how I first contacted people with experiences of collective co-production on the social media website Twitter.

Initial conversations: a first step

I engaged in 7 initial conversations with actors from healthcare professional (HCP), carer and service user (SU) communities. These conversations were informal and unrecorded. This means that their content has not been used within my analysis. However, this does not mean that they were not useful. These conversations were used as catalysts to improve my understanding of collective co-production in NHS services. Thus, they provided an appreciation of the types of communities who are involved in collective co-production, the NHS environments in which collective co-production is employed and the vernacular of those who work in and use the NHS.

However, my initial conversations did not simply increase my understanding. Perhaps more importantly, they demonstrated how little I knew about co-production and the NHS environments in which it occurred. The NHS was, thus, made to seem complex and disjointed, with a range of actors having the power to organise collective co-production. Furthermore, I learned that participation in collective co-production is not simply conferred to major stakeholders like SUs or HCPs. Rather, a variety of actors hold large and important or small and temporary roles in groups. These roles range from participants and facilitators to actors who secure the rooms in which groups are held. From this it became apparent that the generation of a sample required a formalised process of exploration that would enable me to access the experiences of a wide cross-section of actors. This occurred through the use of an online, self-administered and exploratory questionnaire.

The online questionnaire

My exploratory questionnaire acted as a tool through which to generate a sample of participants who I could interview. As such, I used the questionnaire to understand and assess the experiences and knowledge of individuals. This ambition conforms to notions regarding the purpose of exploratory research in the social science literature. This is because I was not aspiring to verify that which has already been theorised (Stebbins, 2001). Rather, the questionnaire supported the generation of an inductive understanding of collective co-production and the people and groups who are, or have been, involved in it.

To create and distribute my questionnaire I used the online survey company 'Survey Monkey'. This provider lets researchers generate surveys free of charge. This factor is important to researchers, particularly PhD candidates. This is because PhD candidates may not have the time or the funding to embark on extensive face-to-face surveying (Evans and Mathur, 2005, pp.198-199). The provision of a free tool through which I could create and quickly populate a survey, therefore, enabled me to distribute my questionnaire to a wide range of potential interviewees. This is because the website enabled me to share my questionnaire by providing potential respondents with a website address.

I also found the analytical capacity of Survey Monkey questionnaires to be helpful. The website provides analytical tools with which researchers examine individual results and compare them against those of other participants. This is because the website logs data provided by respondents and enables researchers to access information separately or as a whole. Moreover, it offers a number of options through which to create complex surveys. For example, the survey making tools on the website enable researchers to control the actions of respondents. This meant that I was able to design the questionnaire in a way that would prevent respondents from ignoring certain questions and skipping ahead (Bryman, 2016, pp.221-222).

Sampling and recruitment for the questionnaire

To recruit participants for the questionnaire I conformed to the snowball sampling method. This is an approach wherein researchers ask respondents to recommend future participants (Robson, 2002, pp.265-266). To engage in snowball sampling I first asked my initial contacts to complete the questionnaire. Those who completed the questionnaire and demonstrated that they had experienced collective co-production in the NHS where, subsequently, asked to participate in an interview. Upon finishing their interview participants were asked to recommend others who could participate in the questionnaire. I repeated this process until I reached the point of saturation.[13] This is an illustrative term used in the GT literature to describe the point at which researchers reflexively decide that they have collected enough data. I illustrate this sampling process in *Figure 4*:

[13] See *section 2.4* for a description of how I reached saturation point.

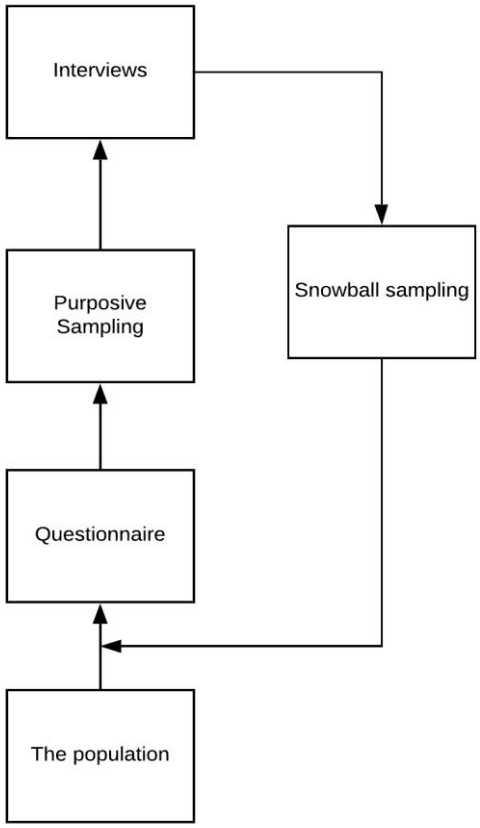

Figure 4: Illustrating how the snowball sampling method enabled me to maintain participation in my research.

My use of snowball sampling meant that I was able to maintain participation in the questionnaire stage of my research. Furthermore, it enabled me to focus my recruitment by delineating the types of individuals who I wanted to interview. This was based on topics and issues that arose during prior interviews. As such, my sampling methodology proffered a means through which to engage in a process called theoretical sampling. This is a sampling method promoted by advocates of GT that asks researchers work to the whims of the data by focusing their exploration around emerging concepts and processes.[14]

[14] I discuss GT in detail in *section 2.4* wherein I show how snowball sampling conforms to theoretical sampling. See *figure 7* for an illustration of this relationship.

Survey questions and interpretation

My exploratory questionnaire was employed as a tool through which to generate a sample of participants for the subsequent interview stage of my research. This sample consisted of people with lived experience of collective co-production in the NHS in England. As such, I needed to ask questions that would illuminate and clarify the experiences of respondents, thereby enabling me to assess whether they should be interviewed. This ambition meant that I needed to inquire as to the technical and processual facets of the group participation that they had experienced. As such, I asked questions regarding the organisation and constitution of the groups in which they had been involved (for a full list of questions see *Appendix 1*). Moreover, I believed it necessary to investigate potential participant's understanding of the normative facets of collective co-production. Thus, I questioned their understanding of how variables related to equality had been manifested within their group. These types of questions are demonstrated below:

Question 5: Who organised the group?
Prompt: Please explain whether the group was run by a charity or other third sector group, a public institution or privately.

Question 6: What were the aims of the group and who was involved?
Prompt: Please explain why the group met and list the different types of people who attended, i.e. people with diabetes, health care professionals, a peer mentor or a group facilitator.

Question 7: Did an open and equal discussion, which used the knowledge and expertise of group members, occur?
Prompt: Please try to describe this discussion by focusing on whether it was open to all and equal and how it harnessed lived expertise and knowledge.

Figure 5: A selection of questions used to examine the experiences of respondents.

In constructing these questions I attempted to reduce possible misinterpretation by ensuring that respondents appreciated my intentions. This is an important facet of the questionnaire method, as within every question there are often implicit and explicit suggestions and directives (Mishler, 1999, p.10). These directives move a participant away from intended meaning depending on their level of education, experience and

understanding, as well as the way that they interpret wording, structure and intent (Ibid). To combat misinterpretation I used standardised instructions and questions. This meant that wording and order were the same for all respondents (Selltiz, Wrightsman and Cook, 1976, p.236).

In addition to standardised questioning I also employed closed fixed alternative questions. These questions give respondents a limited choice of answers through the provision of stated alternatives (Robson, 2002, pp.274-275). The most obvious example of a fixed alternative question would be one that asks participants to respond by answering 'yes' or 'no'. However, fixed alternative questions include a variety of different answers depending on the kinds of information the researcher would like participants to share (Bailey, 2008, pp.118-119). I used fixed alternative questions three times in my questionnaire. This triad of fixed alternative questions forced respondents to make a choice. Therefore, it was also appropriate to provide a 'do not know' option in some questions (Ibid, pp.119-120). Such an option was used in the first fixed alternative question. This is because I felt that respondents may not have an opinion on or may not understand the question (please see *Appendix 1*).

Finally, I attempted to mitigate for misunderstanding by piloting the questionnaire. As such, I asked a number of academics who specialise in social science research and qualitative and quantitative methodologies to participate in a trial of my questionnaire. These were colleagues from the University of Coventry and Goldsmiths College. Upon their completion of the survey the academics suggested that I be less ambitious in my wording and construction. For example, they asserted that the use of simple words, as opposed to academic terminology, would engage respondents and promote understanding. Furthermore, they suggested that the questionnaire structure be simplified, thereby making it easier for respondents to navigate the survey.

Questionnaire results

At the end of my research 43 respondents had completed the questionnaire. These were individuals from a number of different backgrounds, including HCPs, SUs, administrators, academics and patient relatives. From this sample 38 individuals were invited to continue participating. These participants demonstrated their knowledge and experience of collective co-production by providing answers to questions 5 to 8 of the questionnaire. These questions inquired as to respondents' understanding of the groups in which they had participated. Thus, they questioned their understanding of group organisation, aims, participation and decision-making (see *Appendix 1*).

For example, question 5 asked respondents about their understanding of who implemented their group (see *figure 5*). Answers to this question would, thus, convey that respondents had knowledge of the processes around which collective co-production occurred. This meant that they might be capable of providing information as to the implementation of collaborative decision-making during an interview.

Similarly, question 6 asked respondents to state the aims of their groups and who participated (*see figure 5*). Answers to this question would demonstrate that respondents understood the technical and normative aspects of their group. For instance, an answer indicating that a wide range of participants had taken part in a group would suggest that the respondent was capable of discussing the value of representation and inclusivity during an interview. Some answers to question 6 are listed below:

Answer 1
“There was a mix of professionals and people with long term conditions with the aim of effecting policy.”

Answer 2
“Both people with long term conditions and professionals to discuss care.”

Answer 3
“All people with long term conditions and carers, alongside policy makers and health care professionals. The aim was to bring all these people together to understand experiences.”

Figure 6: A selection of answers to question 6 of my questionnaire.

These answers indicate that each respondent has experienced collective co-production and that they are capable of reflecting on the technical and normative aspects of their experiences. In ‘answer 1’ the respondent demonstrates that he/she was present within a group which involved different communities and aimed to influence policy. As such, the answer suggests that the respondent is able to discuss the value of engaging different communities in decision-making processes. In this sense I was able to assume that the respondent would be a valid interviewee.

This experience is similarly suggested in ‘answers 2’ and ‘3’. The second answer demonstrates that the respondent has experienced a groups wherein provider and user community members came together to produce an outcome. Likewise, the third answer shows that the respondent has experienced a group wherein a diverse selection of members interacted. These answers indicate that both respondents would be valid interviewees, as they are capable of discussing how different communities interact with one another and make decisions within collective co-production.

Of the 38 respondents who displayed experience of collective co-production, 26 agreed to take part in an interview. This disparity occurred for a number of reasons:

- Many participants simply could not engage in an interview the duration of which would be between 1 and 1.5 hours.

- Others had left their roles in the NHS and could not be contacted.
- Some SUs were unable to participate as a result of illness.

This discrepancy is methodologically immaterial. As discussed in *section 2.4*, case numbers are not important in GT research. Rather, what is important is the depth of understanding that is garnered from each case. Accordingly, 26 participants proved to be a sufficient number. Their testimony enabled me to reach a point of saturation wherein I could pragmatically and reflexively decide that I had collated enough information.

2.3: Interviewing participants

After participants had taken part in the exploratory questionnaire and demonstrated that they had experienced collective co-production in the NHS in England I asked them to participate in an interview. This is a methodological decision that is supported by the literature on DT. In this body of work, interviews are understood to be a form of ethnographic methodology. Thus, they are considered to provide opportunities to 'recover other people's stories' (Bevir and Rhodes, in Finlayson, 2004, pp.134-136). Through this researchers uncover narrative and engage in analyses of texts that are textured and nuanced (Ibid).

The use of the interview method also acts as a way of realising the principles of KBP. They offer a means of deliberately exhuming the lived experiences of situated agents (Dowding, in Finlayson, 2014). Furthermore, they enable researchers to reflect on and empathise with the perspectives of interviewees (Bevir and Rhodes, 2003). Thus, interviews provide a means of considering and interpreting situated knowledge. In the following section I describe my use of interviews. I discuss how they were planned and ethical issues addressed. After this, I consider my use of face to face and telephone interviews and reflect on the interview and transcribing process.

Planning and gaining consent

As mentioned interviewees were picked from those participants who were deemed to have experience of collective co-production. Their answers to the survey questions were, therefore, an important resource in generating my sample. However, this was not the only benefit of the exploratory questionnaire. This is because I used their answers to create a semi-structured interview guide for each interviewee (please see *Appendix 7* for an example of an interview plan from my interview with 'Linda'). In addition, I used my experiences of previous interviews with participants to further refine these guides: adding new areas of inquiry based on the testimony of others.[15]

My use of semi-structured interview guides did not diminish the capacity of interviewees to shape how interviews unfolded. As DT is the study of situated traditions, it is important that interpretivist researchers do not repress the emergence of information related to the lived experiences of participants (Bevir and Rhodes, in Finlayson, 2004). Thus, I used my interview guides to draft open-ended questions and stimulate narrative responses (Ortiz, in Stage and Manninge, 2003, p.41). To do this I used questionnaire answers to draft interview guides that asked open-ended questions such as 'how' participants had experienced collective co-production within particular services and 'why' they thought that certain outcomes had occurred (Ibid) (see *Appendix 7*). In doing this I hoped to provide sufficient scope for interviewees to reflect on their experiences.

Once an interview guide had been created, respondents were sent an Informed Consent Form (see *Appendix 4*). This consisted of two parts: an information sheet and a consent form. The former half of the document was used to explain the research, its aims, the participant's role and their rights. This was important. Due to the exploratory nature and ad-hoc sampling practice of the questionnaire phase participants had not yet been subjected to such information.

The second part of the form consisted of two distinct parts, each of which sought to test and prove consent. The first was a set of questions that acted as a means of

[15] This process of refinement conforms to my use of theoretical sampling. I discuss theoretical sampling and how it relates to grounded theory in *section 2.4.*

verifying whether the participant had understood the material contained in the information sheet. These were simple questions such as “do you know why I am asking you to take part in this study” and “will the research be paying you for taking part in this study” (see *Appendix 4*). The second part of the latter half of the informed consent form asked participants to confirm that they agreed to take part in the research. This was achieved through the provision of a signature.

Ethical issues

As discussed, informed consent is important in ensuring that participation in research is voluntary and in the best interests of the subjects being studied (Brinkmann and Kvale, 2018). Without the provision of informed consent there is a risk that participation is a product of deception or ignorance (Ibid). As such, I asked interviewees to provide their informed consent before participating in the interview phase of my research. Furthermore, I asked participants to provide their ‘reconsent’ before interviews, follow-up interviews and other recorded interactions (Ibid). This is where consent is tested during later phases of research. In doing this one orients the provision of consent around developments in research, thereby making participants aware of emerging areas of interest or changes in the research design.

The maintenance of privacy is another important ethical consideration. This is because social research often involves thick analyses of the lives and experiences of people. There is, thus, a risk that privacy could be breached through the publication of participants’ personal information or the emergence of ‘unanticipated revelations’ such as those that relate to criminal activity (Fisher and Anushko, in Alasuutari, Bickman and Brannen, 2008, p.100). To combat this, I engaged in the anonymisation of participants’ interview testimony. This occurred in a number of ways:

- Identifying participants with pseudonyms rather than using their real names. As such, I used names like ‘Paul’ and ‘Keira’ when analysing interviewee testimony (see *Appendices 5* and *6* for a complete list of interviewees and their pseudonyms)
- Removing identifiable information mentioned in interviews such as place names and family relationships (Saunders, Kitzinger and Kitzinger, 2015).

- Recognising that participants have a different understanding of what is identifiable information. As such, I asked them to think about their interview after it has taken place and highlight any information that they would want to be removed (Ibid).

Finally, the reduction of risk within qualitative research is important. This often occurs through reflexive contemplation regarding the potential consequences of participation (Brinkmann and Kvale, 2018). Thus, I examined how participation might put interviewees under undue stress. For example, the study of NHS experiences could act as a catalyst for reliving traumatic or distressing events. Accordingly, I told participants that they could stop their interview at any point and for any reason. Moreover, I examined the potential effect of my study on the communities from which participants derived (Ibid). Thus, I considered how my research might impact on communities, particularly those which are disadvantaged within society. To achieve this I spoke to a number of initial contacts about their experiences of participating in research. From this I explored how prior research has impacted on the lives of people with mental and physical health issues, as well as carers and professionals. In doing this I decided that it was unlikely that my work would negatively affect these communities.

(For more ethical information please consult my completed and accepted ethical approval form in *Appendix 2*, as well as my ethical self-assessment in *Appendix 3*.)

Telephone or face-to-face?

Upon demonstrating their experience and agreeing to take part in an interview, participants were given the option of participating in face-to-face or telephone interviews with the lead investigator, Thomas Kerridge. These two interviewing methods were chosen as a result of issues that relate to:

- The locations in which many participants live and work. These locations were often far away or difficult to access.
- The arduous and demanding nature of many participants' jobs. This factor reduced their capacity to engage in face-to-face interviews.

- The fact that a small number of participants had personal or familial commitments and, thus, could not take the time to physically attend an interview session.

The majority of interviews occurred over the phone. This outcome created a problem as much of the literature focuses on the face-to-face interview method (Novick, 2008, pp.391-398). This may be due to the enduring perception that telephone interviews are somewhat limited and insubstantial in comparison to the face-to-face alternative. For example, interviews by telephone are often viewed to be inappropriate for semi-structured and extensive interviews (Sturges and Hanrahan, 2004, p.108). This is because interviews by telephone inhibit the transmission of some social and physical clues (Opdenakker, 2006, p.5). Consequently, telephone interviews have been perceived to be useful only in short interviews (Novick, 2008, p.392).

However, this hierarchy of interview methods has been critiqued. In Novick's (2008, pp.393-394) far-reaching analysis of the literature, she criticises the claim that there is a difference between face-to-face and telephone interviewing and states that both methods provide access to rich and valid data. Furthermore, Sturges and Hanrahan (2004, p.108) assert that the suitability of an interview method should not be guided by an adherence to notions of a research hierarchy. Instead, they argue that adequacy is context dependent (Ibid). Moreover, certain sensitive topics are best discussed over the phone. This is because telephone conversations provide greater confidentiality (Schwarz, Strack, Hippler, Bishop, 1991, p.205). These factors conform to my experience. I found that many individuals were happier to talk over the phone as a product of their location, identity or the information that they were sharing.

The interview and transcribing process

After agreeing on a method it was important to settle upon a time, and if it was to occur in person a place, to conduct interviews. This occurred through email correspondence with participants. In doing this I attempted to conform to their respective schedules and preferences. This is important in interpretivist research as the comfort of the subject is thought to promote greater expression and enable participants to better describe their experiences (Scott, in Martin and Gynnild, 2011). In this sense choices relating to the interview method, time and location act as tools through which to manifest comfort and facilitate greater access to data (Bytheway, 2018).

Once the method, time and location had been decided I ensured that my recording equipment was capable of chronicling interviews of around an hour to an hour and a half. This is vital within methodologies like GT as every utterance is important in data collection and analysis (Ibid). I achieved this by using my Apple Mac laptop and a computer programme called Garageband. This is a digital audio programme that is often used to record and produce music. However, I used the programmes recording function and my laptops in-built microphone to record my interviews. In addition to this I employed a portable Dictaphone as a backup audio recording device that would be used in the event that my laptop and/or Garageband stopped working.

These devices were turned on at the start of each interview. This meant that they recorded all audio dialogue beginning from the provision of reconsent.[16] However, if the interviewee wanted to stop the recording then I would turn the recording programme and Dictaphone off. In face to face interviews the devices were placed out of sight and to the side of the interviewee. This was part of an attempt to make interviews as natural as possible: an ambition that I hoped would encourage interviewees to provide narrative answers (Charmaz, 2014, pp.70-73).

I also supported the creation of a natural and comfortable environment by conforming to the notion that the status of the interviewer is not higher than that of

[16] I define reconsent within my discussion of research ethics.

the interviewee (Ibid). Thus, I did not act in an authoritative fashion by demanding answers or leading the participant to discuss particular topics. Moreover, I considered how interviewees were feeling throughout interviews and attempted to mitigate for any potential distress by studying their tone of voice, body language and emotional responses (Ibid). If at any point the interviewee seemed upset or anxious then I would suggest that we stopped the interview.

During interviews participants were asked to describe their experiences of collective co-production in the NHS in England. For example, interviewees discussed their actions in implementing or participating in collective co-production. Furthermore, they explained how they understood the NHS and their roles within it, as well as how they considered these factors to have influenced implementation and/or participation. As such, my semi-structured interviews enabled participants to share their ideas, reflections and emotions through the provision of examples of their practice and the actions of others (Charmaz, 2006 and 2014). My process also enabled participants to direct the narrative of their interview. I achieved this by asking open-ended questions that provided opportunities for participants to delineate the orientation of our discussion. This approach enabled participants to tell stories, introduce new avenues of interest and reflect on events (Ibid).

After each interview I transcribed the dialogue on to a digital document using a computer programme called Microsoft Word. I did this by repeatedly listening to the recording and typing it on the document. This was a protracted and arduous task that required multiple replays of each interview. However, this provided me with an opportunity to learn more about interviewees. Whilst conducting each interview my focus was often centred on ensuring that I did not dominate and alter the narrative. Moreover, I found that the prospect of running out of time frequently loomed over each interview. These factors meant that I did not always fully engage with the content of each interview. Thus, the necessity to repeatedly listen to interviews during transcription meant that I could engage with the interviewee and their narrative.

The transcribing process can, thus, be viewed as the beginning of my analysis. The fact that I had to transcribe interviews meant that I had an opportunity to think about

the concepts that were appearing within interviewee testimony. As such, I gained an appreciation of how collective co-production was occurring in the NHS without having formally commenced analysis. Of course, this did not mean that I was ready to generate a framework of collective co-production and democratic governance. This task required the use of a methodology that offers thick descriptions of phenomena. Accordingly, I examined my interview transcripts through a methodology called grounded theory.

2.4: Grounded theory

Grounded theory (GT) is a methodology that enables researchers to produce frameworks from data. This outcome is achieved by collecting and comparing the properties of instances that occur in the real world (Charmaz, in Smith et al, 1995, p.28). From this researchers often identify important concepts and create frameworks that explain and describe phenomena. These frameworks are inherently interpretivist. This is because they result from the perspectives of individuals in combination with the interpretation of the researcher (Rennie, 2000, pp.483-484). Accordingly, the researcher must remain open to all aspects of a phenomenon and all perspectives that describe and explain its features (Goulding, 1998, pp.51-53). In this way GT conforms to the interpretivist epistemology of DT. It's focus on inductive analysis provides a platform from which to understand and assess the traditions that connect and conflict to form the beliefs of situated agents.

GT is also used to collect and analyse textual data. This is because GT supports the generation of understanding from multiple textual sources (Tweed and Charmaz, in Harper and Thompson, 2012). In this way GT conforms to, and complements, my decision to conduct interviews. The following analysis, therefore, describes how I used GT to analyse interview data. In this section I explore the concept of theoretical sampling, explain the process of data analysis and speak to the way in which I created meaning from interview data. Finally, I explore the notion of saturation point wherein I illustrate how grounded theorists know when to stop data collection.

Theoretical sampling and data collection

Like decentred approaches to governance, GT is designed to explore change. This is change that occurs across time and space and between perspectives (Glaser and Strauss, 1967, p.419). In exploring change, GT ideally captures the conditions that inform the creation, maintenance and evolution of phenomena. Additionally, it depicts how individuals act and interact within these conditionally fluid environments (Ibid). To do this GT encourages researchers to work to the whims of the data (Ibid p.47). This is achieved through 'theoretical sampling', a process where sampling, coding and analysis occur concurrently (Draucker et al, 2007, p.1138). Such concurrent collection and analysis provides an appreciation of where to turn next (Glaser and Strauss, 1967 p.47). This is because theoretical sampling enables researchers to become aware of unanswered questions.

To realise theoretical sampling I engaged in a number of approaches (see *figure 7*):

- Snowball sampling. As discussed in *section 2.2*, snowball sampling provided opportunities to ask interviewees whether they knew of anyone with whom I could next speak (see *figure 4*). Furthermore, I used prior interviews to alter my line of inquiry in respect of emerging topics and concepts.
- Follow up interviews. I asked some interviewees to participate in further interviews as a means of focussing on emerging topics that had been introduced within prior conversations (See *Appendix 5* for a full list of participants and how many times they were interviewed).
- Alternative 'slices' of data (Ibid, p.65). These were previous academic studies, legislation and publications from think tanks and charities that supplemented my understanding of emerging concepts.

In the following diagram (*figure 7*) I illustrate how I engaged in theoretical sampling. In doing this I build on the diagram in *figure 4* and show how I not only promoted participation in my questionnaire but also engaged in GT as a means of analysing interviews. Thus, *figure 7* displays that snowball sampling was used as a tool through which to increase the sample and a means of engaging in theoretical sampling alongside follow up interviews and alternative slices of data.

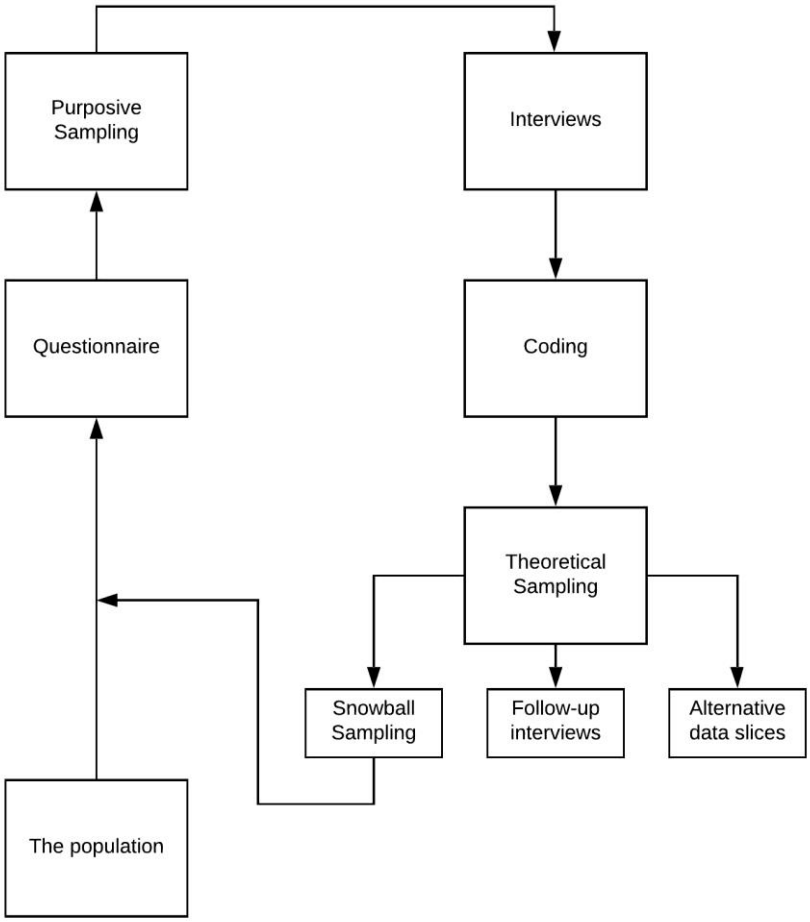

Figure 7: Illustrating how snowball sampling supported my use of theoretical sampling

The inductive focus of theoretical sampling contrasts with my stated use of purposive sampling.[17] This is because the latter method requires researchers to limit their sample by recruiting participants who have particular character traits. By contrast, Glasser and Strauss (Ibid, pp.50-51) assert that GT research should not construct barriers to data collection. This is because the objective of GT is not to validate theory. Instead, it is to inductively manufacture understanding from data (Ibid). Thus, a wide sample is needed to introduce concepts that have not yet been considered within research. The sole use of a particular population in my research, therefore, reduced the inclusivity of my data collection. As such, it is possible that my use of purposive sampling limited my inductive exploration.

[17] See my discussion of purposive sampling in *section 2.2*.

However, it is argued within some of the more recent GT literature that certain research boundaries are acceptable. For example, Corbin and Strauss (1990, p.419) state that investigators enter 'the field with some questions or areas for observation'. This conveys that the inductivity of GT is not absolute. Draucker et al (2007, p.1138) go further than this by asserting that selective sampling is admissible as a precursor to theoretical sampling. This means that a specific population can be delineated before inductive investigation commences (Ibid).[18] Such a proposition suggests that the purposive sampling stage of my research was merely a 'jumping off point' (Thompson, 1999). In selecting the population of people who were to take part in my research I was able to focus my exploration on how participants had experienced and understood collective co-production in the NHS in England.

The process of data analysis

GT is concerned with the inductive collation of data. Through this researchers generate categories that are based on concepts that have been noticed within data. These categories delineate the causes, consequences, dimensions, types and procedures of the phenomenon being researched (Glaser and Strauss, 1967, p.104). Accordingly, categories are the explanatory and descriptive building blocks of framework generation. This is because they give meaning to the instances that are observed or in my case relayed via interviews (Ibid, p.51).

Instances are the stories that people tell in interviews. As discussed in my examination of KBP in *section 2.1*, instances can be explicit or implicit. It is, therefore, the researcher's role to capture instances and assess how they relate to categories (Charmaz, in Smith et al, 1996, pp.36-37). I achieved this by asking participants to provide narrative answers within interviews. In doing this I examined the conditions in which interviewees operated and interpreted how particular traditions had influenced their actions.

In examining and capturing instances researchers build an understanding of properties. These are the variables that are found in participant's stories which explain and describe categories. Properties are then compared with one another and

[18] For an example see Draucker et al (2007, pp.1140-1145)

those deemed to be conceptually similar are stored within a category. Through this process categories are given meaning (Corbin and Strauss, 1990, p.420). This means that categories are reflective of the participants who are involved in the study. Thus, a category is not only a delineation of the process but a treatise on the conditions and characteristics that inform its creation.

Categories are also compared with one another. In doing this one understands the potential for cumulative or transactional relationships between different categories (Ibid, p.106). For example, my literature review provided a basis to hypothesise that there is a link between the concept of 'accessibility' and that of 'active engagement within groups'.[19] This could be abstracted to categories of 'preparation' and 'interaction'.[20] From this, one might explore how preparation, and the properties that it subsumes, affects and is affected by properties related to the category of interaction.

This comparative analysis of the data increases the relevance of concepts and the properties that reside within them. In this way re-occurring information begins to define categories. However, these categories are not all weighted equally. Depending on their contextual relevance, categories are either 'core' or 'normal' (Glaser and Strauss, 1967, p.70). A core category is one that has sizeable explanatory power (Ibid). This means that the category, and the properties that it subsumes, plays an important role in forming the conceptual framework. As such, core categories should contain as many different properties as possible (Ibid). To illustrate how I separated categories in my research I include the following table:

[19] See my analysis of variables like self-efficacy in *section 1.4.*
[20] See my discussion of the implementation of co-production in *section 1.4*.

Core Categories	Normal Categories
Meaning creation	Power relationships
Normative understanding	Follow through
Participant identity	Support in implementation
Organiser identity	Transferring knowledge
External environment	Generating participation
Institutional environment	Dimensions of group
Facilitation	Advocacy
Preparation	Co-production as inherited concept
Outcomes	Explicit understanding of co-production
Reproduction	Process type
Third Sector	Resistance
	Location

Figure 8: Listing core and normal categories found within my data analysis.

Figure 8 shows how categories like the 'creation of meaning' and 'normative understanding' were powerful explanatory and procedural factors in my framework. This means that these categories play an important role in interviewees' experiences of collective co-production and democratic governance in the NHS in England. Their prevalence within testimony, thus, conveys that interviewees consider these categories to be significant in supporting collective co-production.

To understand how I segmented concepts in to core and normal categories, it is important that I provide relative frequencies for the concepts mentioned in *figure 8*. Through this I demonstrate how particular concepts had substantial explanatory powers within my research. I obtained relative frequency by multiplying the number of properties related to a particular concept (n) by 100, for simplicity of reporting, and then dividing that figure by the total number of properties (N). In my analysis the total number of properties amounted to 2115. This calculation provides a percentage figure of relative frequency and is viewed as ((n x 100)/N).

Of the 2115 individual properties found in interviews, properties related to 'meaning creation' occurred 119 times. This provided a relative frequency of the category of 5.6%. Properties of 'normative understanding' were mentioned 238 times by

interviewees. Thus, the relative frequency of normative understanding was 11.2%. Similarly, properties related to ‘participant identity’ were mentioned 196 times. This meant that the category had a relative frequency of 9.2%. See the below table for a full delineation of the relative frequencies of my core categories:

Category	Frequency	Relative Frequency
Meaning creation	119	5.6
Normative understanding	238	11.2
Participant identity	196	9.2
Organiser identity	213	10
Institutional environment	275	13
Facilitation	133	6.3
Preparation	129	6.1
Outcomes	110	5.2
Reproduction	115	5.4
Third sector	112	5.3
TOTAL	1640	77

Figure 9: Listing the relative frequencies of core categories found in my analysis.

By contrast, properties relating to ‘power relations’ occurred in my analysis 41 times. As such, the category has a relative frequency of 1.9%. Properties of the category entitled ‘co-production as inherited concept’ occurred 15 times. This means that the concept had a relative frequency of 0.7%. Similarly, properties of ‘resistance’ transpired 32 times. The concept, therefore, had a relative frequency of 1.5%. See the below table for a full illustration of the relative frequencies of my normal categories:

Category	Frequency	Relative Frequency
Power relations	41	1.9
Follow through	63	3
Support	45	2.1
Dimensions	28	1.3
Advocacy	50	2.3
Inherited concept	15	0.7
Explicit understanding	37	1.7
Process type	41	1.9
Resistance	32	1.5
Location	14	0.7
Mediation	21	1.0
External environment	88	4.1
TOTAL	475	23

Figure 10: Listing the relative frequencies of normal categories found in my analysis.

The distribution of properties displayed in *figures 9* and *10* conveys how particular concepts were understood to be core and normal. The fact that so many participants talked in-depth about concepts like the creation of meaning, identity or preparation enabled me to understand that these categories would be useful when creating my framework. Thus, my framework is orientated around these categories, their related concepts and the properties that occur within them. This is not to say that normal categories are not also important. Concepts like follow through, external environment and advocacy all play a part in my framework. However, these concepts have less explanatory potential in comparison to core categories.

Coding

As discussed, theoretical sampling requires that research engages in the concurrent collection and analysis of data. This means that researchers both participate in the assemblage of information via forms of qualitative methodology and engage in processes that facilitate understanding. In GT this latter requirement is satisfied through coding. This is an arduous task. Researchers who undertake GT must embark on a multi-stage coding process that enables them to identify, conceptualise and compare information. In doing this one appreciates emerging categories and their properties and formulates analyses that support the construction of a framework.

To begin my analysis, I engaged in 'line by line coding'. This is a form of analysis that is discussed by proponents of GT like Kathy Charmaz (in Smith et al, 1996). Line by line coding provides a means of understanding emerging themes, potential gaps in research and the direction of future interviews (Tweed and Charmaz, in Harper and Thompson, 2012, p.136). Furthermore, line by line coding enables researchers to sift through and manifest meaning from large quantities of data such as semi-structured interviews (Charmaz, 2012, p.5).

Line by line coding occurs in each line or sentence of an interview (Tweed and Charmaz, in Harper and Thompson, 2012, pp.136-137). These lines and sentences are annotated and given labels that describe their properties. From this one considers the emergence of concepts: reflecting on the importance of particular properties in giving them meaning. This occurs by considering how properties explain or describe a concept. For example, my line by line analysis of a number of interviews provided information as to the importance of 'accessibility' as a concept. This is exemplified in the following quote taken from my interview with 'Paul':

> I can't tell you how many times people from our organisation in collaborating with and trying to work with other non-user led organisations have fundamental difficulties in trying to work with them, to institute real co-production. They are without recognising it, they are so inaccessible.
>
> ('Paul' interview, p.2)

To use line by line coding I first segmented the sentence in to its component parts by identifying instances. These are the myriad stories that are embedded within the narratives of interviewees. After this I examined individual segments for properties. This is demonstrated in *figure 11*:

Segmented text from 'Paul' Interview	Line by line coding
1-I can't tell you how many times people from our organisation,	1-Frustration with organisations that are not acting in a way that he thinks is acceptable.
2-in collaborating with, and trying to work with other non-user led orgs,	2-Different organisations work together to implement collective co-production.
3-have fundamental difficulties in trying to work with them, to Institute real co-production.	3-Difficulty in entering in to foreign organisational environments wherein collective co-production is occurring.
4-because they are without recognising it, they are so inaccessible	4-Accessibility as a product of recognising potential inequalities between members.

Figure 11: Illustrating how I employed line by line coding in my analysis of interviews.

The preceding quote provides explanatory and descriptive properties that give meaning to the concept of accessibility. These properties are found in the second column of *figure 11*. For example, the interviewee's suggestion that actors find it difficult to enter in to foreign environments conveys that co-production requires the purposeful mitigation of inequalities. Through the mitigation of inequalities actors participate in what the respondent calls "real co-production" (Ibid). Thus, properties related to inter-organisational or inter-sectoral co-operation, entering in to foreign

environments and the importance of recognising identity feed in to a growing appreciation of the conceptual category of accessibility.

Figure 12 proffers a more detailed description of how I realised line by line coding. It shows how I considered a slice of my interview with Karlee, a researcher who has worked extensively in NHS participation projects**.** In this figure I demonstrate how I segmented sentences in to their component parts and examined them for meaning. Furthermore, it shows how line by line coding supports understanding of emerging concepts. This occurs through considering how accessibility is related to other concepts:

> He went and got one of the patients from his home in his wheelchair, you know, so we collect people, rather than saying to them "come and get here". We will pick them up and make it as easy as possible for them to get there.
>
> ('Karlee' Interview, p.6)

To analyse this extract I first segmented the text. This again transpired by looking for different instances:

1-He went and got one of the patients from his home
2-in his wheelchair, you know,
3-so we collect people, rather than saying to them "come and get here". We will pick them up and make it as easy as possible for them to get there.

From this segregation a number of initial properties were identified:

1-Hierarchy within environment
2-Understanding the identity of the other
3-Physical actions to support participation

After this I considered how these properties might fit in to categories:

1-Power
2-Understanding of identity
3-Methodological flexibility

Figure 12: Illustrating how I used line by line coding.

As *figure 12* demonstrates I used the text from my interview with Karlee to generate initial properties that would describe and explain accessibility. These properties were then used to understand how a number of concepts related to accessibility. This is because the text shows that, in particular circumstances, accessibility is linked to categories like power, understanding of the other and methodological flexibility.

Of course, the generation of this type of limited understanding does not lead to the creation of a framework. Rather, what is needed is a comparative understanding of the categories and properties that exist within the entirety of the data. Thus, Charmaz (2014, p.138) suggests that researchers engage in a second coding stage called ‘axial coding’. This is a process that introduces an analytical form of exploration within the analysis of data (Charmaz, in Smith et al, 1996). It, therefore, requires that information be studied conceptually and in respect of previous and future analysis. Through this analysis one builds larger and more conceptually important categories

than those that were noticed during line by line coding. Moreover, one starts to consider and compare properties of these larger categories, thereby generating an understanding of their conditionality within particular contexts (Ibid, p.42).

I actualised axial coding by moving my annotated line by line codes in to a single document that contained data sets from each of my interviews. This transition helped me to group codes together via the formation of categories. Through this process I explored the codes at a higher level, as the conditional and consequential relationships between different categories became easier to understand (Glaser and Strauss, 1967, pp.108-109). As such, I was able to form narratives regarding my emerging categories. These narratives furthered my appreciation of the underlying variations identified during the previous stage of my analysis.[21]

Through this amalgamation of data sets I was able to test the value of categories. For example, I produced a greater understanding of what accessibility meant relative to the experiences being analysed. I found that accessibility was not only related to concepts of power, understanding of identity and methodological flexibility. Rather, it was itself a sub-category of a larger core category. This was the normative understanding of the organiser of co-production: a category that also enveloped concepts like representation and solidarity. In *figure 13* I provide a code tree that illustrates these relationships by delineating the connections between categories that have been subsumed by the core category of normative understanding:

[21] These are variations such as those discussed in *figure 12*. In this figure I show how my use of line by line coding enabled me to consider how accessibility was linked to concepts such as power.

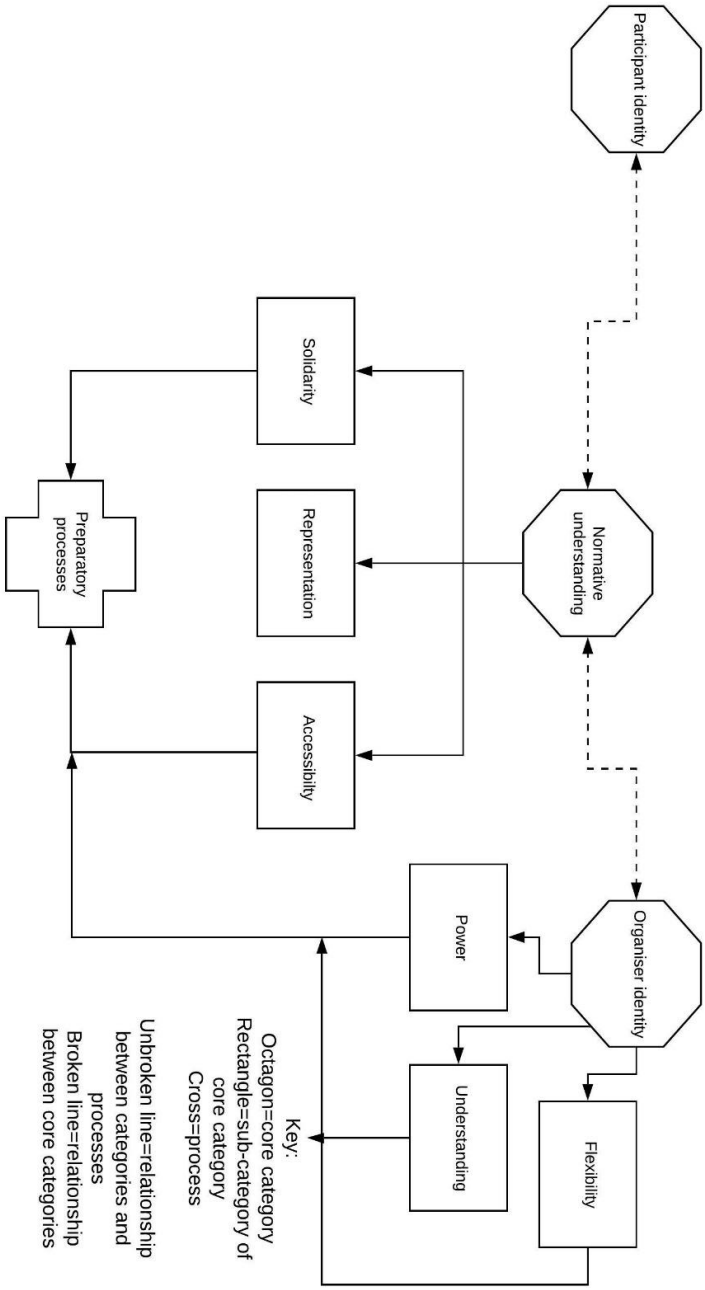

Figure 13: Displaying how I used axial coding to explore the concept of normative understanding.

This diagram is not an exhaustive illustration of the myriad relations found in my research. However, it demonstrates that my axial analysis facilitated an understanding of a number of core categories that play an explanatory role in my research. For instance, the diagram shows how participants discussed the important role of organiser identity in creating accessible processes of collective co-production. Moreover, it shows how notions of the self and the other are important variables in unlocking the potential for equal interactions between communities. Thus, my use of

axial coding proffered a means of understanding concepts as both individual categories, and as interrelated factors in the organisation of collective co-production and democratic governance.

The axial coding stage, thus, represented the point at which I began to fit together the multitude of information gained through my line by line analysis. From this I began to formulate a framework of collective co-production and democratic governance. This framework was further refined through my use of theoretical sampling and during the writing of my thesis. Furthermore, it was supported by my use of memo writing. This is a form of reflexive analysis wherein researchers consider their impressions of each emerging category and explore the tacit and explicit properties that gave meaning to concepts (Charmaz, 2014).

Saturation point

GT requires researchers to maintain the collection and analysis of data until the point where nothing new is obtained by studying a phenomenon. This is the point of theoretical saturation. Such a rationale asks researchers to move away from an understanding of sample size as the ultimate factor in appreciating the validity of research. Instead, what matters is that researchers obtain thick descriptions of a phenomenon. Through gaining thick descriptions researchers ideally collate an ocean of properties that give meaning to categories. Thus, Bowen (2008) asserts that a researcher who has conducted interviews with 10 respondents may obtain more opportunities for analysis than studies with a greater number of participants.

Of course, the notion that there exists a point of saturation is critiqued. From constructivist and interpretivist perspectives it is argued that saturation point cannot ever truly be achieved. This is because data can be interpreted in different ways by different people (Furniss, Blandford and Curzon, 2011). Moreover, it is suggested that theoretical saturation if often imprecise. Claims that one has reached saturation are often subject to pressures that impose on the methodological sanctity of research. For example, a researcher may end their study as a result of an impending deadline (Ibid; Charmaz, 2011). In this sense Glasser and Strauss (1998) propose that saturation should be understood by degree. This means that categories are never entirely and objectively saturated. Rather, saturation is understood to occur at the

point where it becomes theoretically costly to add new properties in to an analysis (Ibid).

It is, therefore, important that researchers engage in a critique of their data by considering how they could expand on their framework (Glaser and Strauss, 1967, p.61). This critique is easily accomplished. Grounded theorists are often highly sensitive to the concepts occurring within their data. As a product of the fact that they have spent hours, if not days, examining particular concepts and how they relate to other categories researchers should understand whether there is a need to continue data collection (Lawrence and Tar, 2013). Through this one may discover the point at which it becomes costly to introduce new areas of interest.

In my research I considered saturation by evaluating the utility of adding extra cases (Ibid; Mason, 2010, p.1). This was achieved by detecting repetition of properties within categories. This detection was made easier as a product of my use of theoretical sampling. My concurrent data collection and analysis meant that I appreciated whether properties were being repeated. Through this I began to improve my understanding of concepts and increase saturation. This is not to say that my analysis is objectively saturated. As discussed, saturation should be understood by degree. Thus, I gradually stopped my use of theoretical sampling as it became clear that the emergence of new avenues through which to explore concepts would detract from and harm my previous analysis.

At the end of my analysis I concluded that 26 interviews, as well as a number of follow up interviews and email correspondence, were sufficient to reach the point of saturation (see *Appendix 6*). This sample size has precedence within the GT literature. Whilst most of the literature agrees that sample size is nominally immaterial, some suggest that saturation is more likely to be achieved through a sample of 12 or more participants (Guest, Bunce and Johnson, 2006). Others argue that 20 is a more appropriate number: citing that this sample size enables researchers to properly examine and evaluate phenomena within ‘relatively homogenous’ groups (Griffin and Hauser, 1993, p.32).

Conclusion

In this chapter I illustrate how an idea regarding the best methodological philosophy to capture the experiences of individuals developed into a functioning method of investigation. This was reduced from an abstract desire to implement an interpretive epistemological exploration of understanding to the notion that there exists a methodological guide that orients co-production research. KBP, thus, provided an understanding of how to institute a successful investigation in to this area of interest. This is an understanding that highlights the value of lived experience and emphasises the importance of researcher proximity to the subject.

I then added to my research design by introducing GT. This addition offered an inductive means to analyse information and create a framework. In GT understanding is generated through comparative analyses of properties and concepts. Through this researchers create conceptual categories that illustrate the conditional and procedural dimensions of phenomena. I used GT to analyse information produced through interviews with 26 participants. In doing this I created a framework that is representative of people's lived and local experiences. This shows how collective co-production is, and has been, employed as a process through which to realise democratic governance in the NHS.

Theoretical framework of democratic governance in the NHS in England

In the following chapters a number of concepts form the pillars upon which my framework is based. These are core concepts like ‘normative understanding’, ‘institutional conditions’, ‘identity’ and ‘preparation’. My presentation of these concepts has been informed by my use of axial coding (see my analysis of core categories and coding in *section 2.4*). In employing this mechanism I have found that a number of core and normal categories are related to one another. Thus, their place within my framework is defined by the conceptual interrelationships noticed during my research.

I begin my framework by exploring the conceptual constitution of collective co-production. In doing this I outline the importance of normative interpretations of participation. Furthermore, I discuss how a particular conceptualisation of equality manifests an understanding of collective co-production as a function of democratic governance. This is a conceptualisation of equality that is composed of variables such as representation, accessibility, solidarity and openness.

I then study the realisation of this conceptualisation of equality. I do this by investigating how macro-exogenous, meso-institutional and micro-departmental traditions influence implementation. Moreover, I explore how organisers of collective co-production engage in supplementary processes that mitigate for and address inequalities that impinge on representation, accessibility and solidarity. This occurs through an examination of recruitment, co-design and preparatory processes such as trigger films.

After this discussion I examine interactions within collective co-production. I do this by considering how co-producers feel within deliberative forums. I suggest that prior phases of co-design and preparation enable actors to engage with individuals from other stakeholder communities. Finally, I study the outcomes of collective co-production. I consider the realisation of outcomes in the NHS and reflect on the different types of products that have been noticed within my analysis. In doing this I argue that co-design outcomes should be amalgamated with the realities of the

environments in which they are being applied. Furthermore, I propose that private outcomes such as alterations in self-understanding contribute to incremental systemic change within the NHS.

Chapter 3: The normative definition of collective co-production

Much of the established literature presents collective co-production as a process that should be founded on and produce empowered participation (see *section 1.2*). In the following chapter I build on this empowering characterisation by using interview testimony to present a normative definition of collective co-production. This definition acts as a prism through which the rest of my framework is presented. As such, I employ the following definition when considering how collective co-production is implemented and experienced in the subsequent chapters of my thesis.

My definition is comprised of four normative variables: representation, accessibility, solidarity and openness. These are similar variables to those discussed in my literature review wherein I examine the works of Cahn and Gray (in Pestoff et al, 2013) and Leach (2006), amongst others. These scholars provide explicit normative co-production frameworks against which practical involvement processes have been measured. I have, therefore, based the structure of my definition on these works. However, the normative constitution of my definition is founded on my examination of interview testimony. Each variable was discussed at-length by interviewees. Thus, in examining their testimony within my axial coding phase I saw how these variables individually and cumulatively promoted an ideal vision of equal and empowering collective co-production.

I begin this chapter with a broad examination of co-production as a normative process. In *section 3.1* I consider how co-production and democratic governance require the active participation of citizens. As such, I argue that participation is contingent on a form of equality that enables communities to participate in the construction of meaning and outcomes. In *3.2* I describe how collective co-production should be founded on a number of variables. The first is representation. This variable is realised by appreciating the complexity of stakeholder identities. The second is accessibility. This is a variable that mitigates for physical and structural inequalities. Finally, I consider the importance of solidarity and suggest that it manifests collective purpose.

3.1: The Normative origins of co-production

In my literature review I discuss normative models of co-production by Cahn and Gray (in Pestoff et al, 2013), Leach (2006) and Barbera et al (2016). I show how they each describe co-production as a process that is founded on a particular notion of equality. This is a notion that alludes to the concept of positive liberty (see *section 1.1*). They implicitly conform to its philosophy by discussing means through which to reduce inequalities that preclude or disadvantage individuals within participative forums. Such a notion is also mentioned by Crocker (1980). In his thesis examining the relationship between positive liberty and equality Crocker (Ibid, p.121) provides an understanding of society as preferencing those who 'naturally swim with the stream'. This claim suggests that systems advantage certain groups within society.

These references to the concept of positive liberty provide an understanding of the basis on which democratic governance is built. They infer that co-production is contingent on the existence of a space in which actors are free, irrespective of their identity (Cole, 2019). This freedom empowers individuals from diverse communities: enabling them to make decisions and effect change. Such a notion is viewed in Cahn and Gray's (in Pestoff et al, 2013) study of time banking wherein the authors refer to the value of acknowledging and including all forms of expertise within decision-making. Equally, it is found in the work of Leach (2006). His democratic framework for collaborative decision-making emphasises the importance of reducing inequalities that occur as products of the environment.[22]

This type of analysis is also found in studies that focus on the products of co-production and the types of activities in which it is used. Loeffler and Bovaird (2019) and Nabatchi et al (2017) both, to one degree or another, discuss the mitigation of inequalities. In doing this the authors emphasise the necessity to include and empower individuals before participation occurs. Furthermore, they speak to the importance of reducing differentials in power between co-producing actors.

[22] This hypothesis is similar to that proffered by Bevir (2013) in his decentered thesis. I examine this in *section 1.1*.

In my research I found that the literature's affinity towards notions of positive liberty was shared by interviewees. Many had experienced the consequences of being isolated within decision-making and understood that service improvements could be generated through their participation. Motivation for co-production was often a product of this desire to see themselves, and members of their communities, play a role in decision-making. In this way one may link their understanding of co-production to a desire for equality. Some interviewees were able to formulate a discursive narrative related to this desire. 'Paul', an academic who sits on the board of a third sector organisation, noted that his understanding of co-production was founded on a notion of equality wherein all constituents could participate in NHS governance:

> There have been those who have been arguing for public involvement to be for those whom services are intended. That is to say the end users as patients in the NHS, those who work in them, their families and those people in the local area who pay for them. That the service should work to their benefit. That is the model of involvement that is the democratic ideal.
>
> ('Paul.1' Interview, p.4)

This perspective suggests that citizenship should act as the foundation for democratic governance. The role of the NHS, as an outward facing institution that both takes in and is funded by constituents, means that democratic opportunities are a right of citizenship. In this sense one could view democratic governance to be a product of the universalism and collectivism embedded within a number of historically contingent conceptions of the NHS.[23] These values promote an understanding of the institution as operating on behalf of the population and its myriad constituencies. Furthermore, they portray the NHS as a public good within which all peoples can, or perhaps should, contribute (Milewa, 2004, p.241).

[23] I discuss these values in *section 1.1* wherein I consider the traditions that influence the situated agency of actors within the NHS.

Of course, this does not tell us how patients, NHS workers, family members and constituents become free within decision-making.[24] In my review I discuss how citizens have participated in a number of NHS forums. I suggest that opportunities for participation do not necessarily enable participants to actively engage in governance (Alderwick, Dunn, Mckenna, Walsh and Ham, 2016). Milewa (2004) supports this assertion. In his examination of NHS participation under the New Labour government he argues that participation was often orientated around involvement in public bodies. These bodies had authority to monitor and make recommendations to NHS trusts (Ibid, pp.244-245). Involvement in these bodies, therefore, enabled citizens to make decisions that could influence the policy-direction of the institution. However, these decisions were often made within parameters set by government authorities (Bevir, 2009; Davies, 2009). In this sense patients, NHS workers, family members and constituents were not free to shape the meaning of their participation nor manifest outcomes that reflected their lived and local experiences.

The provision of opportunities to participate are not, therefore, equivalent to the attainment of powers to actively engage in decision-making. Thus, notions that citizenship is the foundation for democratic governance need to be developed through the addition of variables related to empowerment. This proposition is supported in a later part of my interview with 'Paul' wherein he discusses the work of an academic from the University of Birmingham called Sarah Carr. He presents Carr as a theorist who views co-production to be a product of, and for, empowerment ('Paul' Interview, p.1). Co-production, therefore, requires that participation is supplemented by processes that enable actors to transcend hegemonic ideas and norms and realise their interests (Carr, 2007, pp.269-272).

By including Sarah Carr 'Paul' has amalgamated the notion of participation as a right based on citizenship with an understanding that this alone is insufficient for democratic governance. Carr argues that the provision of rights without complimentary powers legitimises the work of the hegemonic group (Ibid).

[24] As explained in *section 1.1*, this notion of freedom is important when considering democratic governance.

Accordingly, empowerment is viewed as the "essential element" ('Paul.1', Interview, pp.5-6). It is, thus, important that organisers of co-production are committed to a vision of equality which acknowledges that actors are situated against different social and biological backdrops (Bevir, 2013). In acknowledging this and mitigating for perceived inequalities individuals can be empowered to participate in the production of change. This proposition is seen in the following extract taken from my interview with 'Karlee':

> And yeah, everyone was given a voice and in the meetings where I was at. Everyone was heard and if a patient hadn't said something for a while a staff member would say "would you like to say something".
>
> ('Karlee' Interview, p.6)

3.2: Democratic variables: understanding the normative constitution of participation

Interviewees understand collective co-production to be a process that requires more than the freedom to participate. They suggest that it necessitates the mitigation of inequalities that limit participation. In this sense I propose that our understanding of collective co-production should encompass variables that promote participative equality. In exploring interview testimony I have arrived at the following list of variables. These are representation, accessibility, solidarity and openness.

Interviewees consider this collection of variables to support the realisation of collective co-production (see *figure 14*). They propose that representation facilitates decision-making that is influenced by stakeholders; accessibility promotes equality within decision-making; solidarity fosters notions of collective purpose; and notions of openness produce an interaction environment wherein all feel free to participate. I, therefore, propose that the proceeding sections of my thesis be examined against this backdrop. In doing this one may consider how stakeholders are empowered to engage in the governance of NHS services.

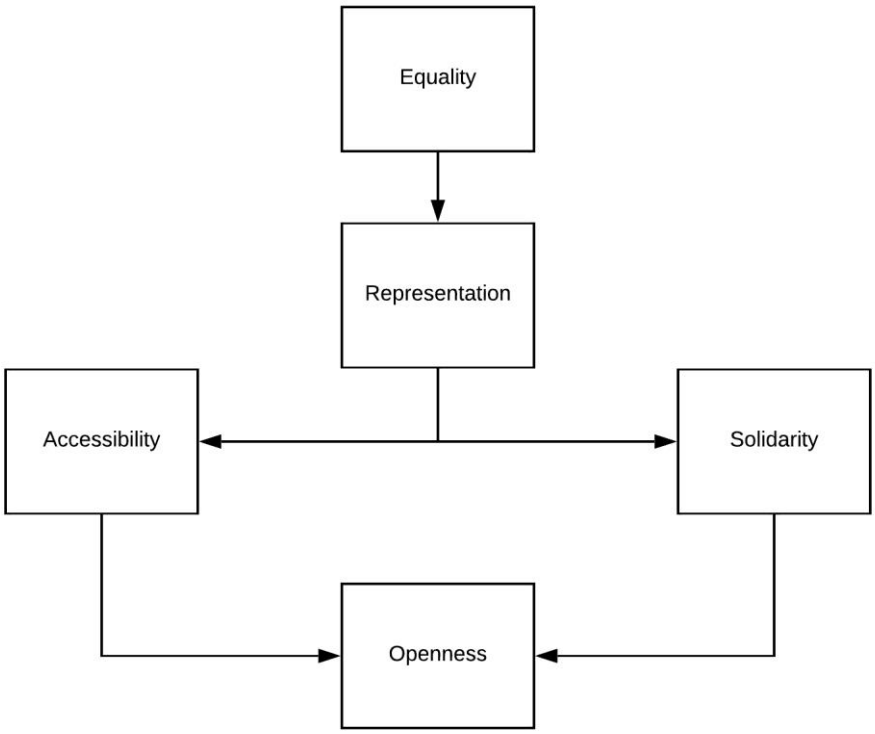

Figure 14: Mapping the normative variables that define interviewees' understanding of collective co-production.

Representation

In the co-production literature 'representation' is often understood through an appreciation of the stakeholder population. Thus, one might consider the inclusion of participants from a contextual perspective. For example, Leach (2006, pp.101-102) emphasises how decision-making regarding natural resources in the USA necessitated the involvement of actors across regional, generational, class and economic divides. In the NHS a similar focus on stakeholders means that representation would subsume 'more than just service users' (Dudau et al, 2019, p.1583). This is because the beneficiaries of services are not just users themselves but the multitude of actors who directly and indirectly benefit from provision (Ibid, pp.1586-1588). As such, citizens, associations and interest groups are considered to be stakeholders (Barbera et al, 2016, p.1089).

This supposition is supported by interviewees. 'Holly', a charity worker who supports participation in healthcare decision-making, argues that the NHS stakeholder population consists of actors who are both 'affected by' and 'affect'

services. These actors contribute to collective co-production because they have experience of the way that NHS services have affected them and vice versa:

> We called people to an evening meeting. People who had used our services, people who had been involved as volunteers and staff and partners from the council and a few local organisations.
>
> ('Holly' Interview, p.4)

This vision of representation is supplemented through an analysis of the testimony of 'Michela', an NHS patient who also cares for a family member. In our interview she discusses how carers are an important community within the NHS stakeholder population. This is because carers are recipients of service provision. They benefit from the provision of NHS services because it supports their attempts to care for friends and family members:

> For many years, my total and full time job was as a carer for him. To keep him alive. So that has dominated every day of my life and I…. I've had a lot of experience of negotiating health services and dealing with health professionals and trying to negotiate what is best.
>
> ('Michela' Interview, p.1)

These extracts suggest that stakeholders are actors who have experiences of NHS services. These are actors who contribute to provision, partner with a service and directly or indirectly benefit from the delivery of services. The experiences of these differing actors are, thus, akin to a ticket. They enable stakeholders from a number of communities to participate in groups and engage in discussions regarding "what that had been like" and "why that had or hadn't been helpful" ('Holly' Interview, p.4).

This understanding of representation is important. The relationship between affect and the stakeholder population suggests that notions of representation are influenced by the issue at hand. The more common the issue and the greater the range of people affected, the larger the possible stakeholder population. Thus, 'Holly's' experience of representation as consisting of service users (SUs), volunteers, partners from the council and local organisations may be a function of the group's aims. These aims

centred on the creation of an understanding regarding the future of a particular service. The group, therefore, asked questions like "what we need to focus on?" (Ibid, p.3). In this sense I suggest that the group was orientated around macro-level planning and should be understood to have engaged in co-commissioning. As such, the selection of participants required more than the sole inclusion of SUs and carers who were experts by experience (Loeffler and Bovaird, 2019). Rather, the service needed to 'collaborate creatively with a more diverse group of people' (Ibid, p.247).

By contrast, 'Michela's' experience shows that groups aimed at improving a particular aspect of a service are contingent on the selection of actors with lived experience. For example, 'Michela' participated in a group that sought to reform a particular aspect of her local cystic fibrosis service:

> She ran workshops with us, which was a form of co-production, where she genuinely wanted our opinion about what we felt was beneficial about having home IV's, also what was beneficial about having IV's in hospital because some do want that and what is not beneficial about being in hospital. That kind of thing.
>
> ('Michela' Interview, p.2)

In this example the stakeholder population was understood to consist of actors who were directly and indirectly affected by the provision of the service ('Michela' Interview, pp.1-2). Carers and family members were, therefore, important actors in this group because they had lived experiences of caring for their dependents and negotiating with local services. These participants, subsequently, used their experiences of "having home IV's" and "having IV's in hospital" to engage in the co-design of the service (Ibid).

However, understanding of who is affected by a particular issue is not the only prism through which to achieve the representation of a stakeholder population. 'Beth', a third-sector organiser of user involvement, suggests that identity is also an important consideration. In the following quote 'Beth' argues that representation within the co-design of disabled peoples' services is achieved through the involvement of stakeholders with different identities:

> It is no good just saying that we are going to get a group of disabled people together and then we are sorted. These may not be disabled people who are going to use that service. It may be 16-18 year olds or it may be pregnant women, but if it is 16-18 year olds or pregnant women have you got a homeless 16-18 year old, have you got people from a range of different ethnic minorities, have you got a 16-18 year old with learning difficulties, have you got disabled 16-18 year olds.
>
> (Ibid, p.5)

This extract suggests that representation occurs through an understanding of the complexity of the stakeholder population. It, thus, conveys that broad notions of who is affected by a particular service are inadequate. This is because such a selection criterion implicitly or explicitly excludes actors from within communities.

Such a complex understanding of representation is often missing within participatory processes. Academics like Agger and Larsen (2009) speak to the prevalence of structural exclusion: a term used to describe how particular groups of people are often implicitly disenfranchised as a product of their identity. Accordingly, actors who are both affected by service provision and can afford to spend time participating are more likely to take part. In my research I found that interviewees had experienced exclusion based on social and economic factors. For instance, 'Paul' (interview, p.3) discusses how groups have often ignored notions of identity that go beyond an understanding of citizens as SUs. This has meant that representation is limited to those who desire participation and have the time to engage:

> People are different in terms of…. some have got speech impairments, some have limited education background and some can't read and write fully. Those are major issues as if you want to avoid being an elitist arrangement and a clique you can't just have everybody from middle class comfort doing everything in the conventional way.
>
> (Ibid)

This extract suggests that participation is often oriented around the inclusion of particular actors. 'Paul's' use of terms like "elitist", "conventional" and "middle class comfort" suggests that participation regularly favours actors who have higher education and class backgrounds. Such a proposition is supported by 'Nigel', a healthcare professional (HCP) who helps citizens to engage in the lay organisation of co-production. In his interview 'Nigel' (Ibid, p.3) suggests that citizens who understand themselves to be "credible" as a product of their professional backgrounds take advantage of participation opportunities. This relationship is also evidenced in the testimony of 'Karen' (Interview, p.2), a SU who has participated in collective co-production. In our interview 'Karen' asserts that her educational and professional background has provided her with the confidence to engage in participation processes that involved staff and lay people.

Such examples demonstrate that there are a number of variables that impinge on representation. These variables limit the inclusion of people who do not have an educational or professional background which enables them to feel capable of participating. Thus, there may exist a divide in respect of those who are capable of organically and immediately participating in collective co-production and those for whom the very idea of participation is foreign. This latter group may not only decline participation because they do not have the confidence. Rather, their position and place within society may mean that they often never hear about participative opportunities ('Karen' Interview, p.6).

This assertion is supported within the literature. Much has been written about the potential for participation to be skewed towards 'professionalised citizens' (Park, 2020, p.4). These are actors who have the capacity and desire to engage in processes of involvement. This focus has led to concerns related to the value of recruitment methodologies like self-selection (Mosley and Grogan, 2013).[25] This form of recruitment is considered to be a major route through which participatory processes are manifested (Fung, 2003). However, critics suggest that people who come from privileged backgrounds are more likely to choose to participate. These people are often highly motivated to engage in activities and are knowledgeable about the

[25] I introduce self-selection as a recruitment strategy in *section 1.4*.

topics at hand (Ibid, p.342). By contrast, those who are not motivated to attend, are less knowledgeable about issues or believe that they hold different views and experiences may not choose to participate (Fledderus, in Brandsen et al, 2018, p.267).

'Nina', a third sector worker who regularly supports public participation in NHS services, responds to this possibility by suggesting that organising bodies need to proactively engage in activities that promote greater representation. These are actions wherein organisers directly invite particular stakeholders to participate ('Nina' Interview, p.7). This proposition conforms to the work of Denters and Klok (2010) and Verschuere, Vanleene, Steen and Brandsen (In Brandsen et al, 2018).[26] These authors have explored the value of direct recruitment as a means of overcoming issues related to representation and self-selection. As such, they suggest that organisers select participants who are thought to be disadvantaged as a result of their identity (Ibid, p.245).

I expand on this proposition in a later section of this thesis. In *section 5.1* I contend that the extent to which organisers of co-production are capable of engaging in selective processes of recruitment is contingent on their exposure to particular stakeholder communities. Thus, I propose that the recruitment of a complex cohort of participants may require organisers to engage in processes of reflection in which they consider the identities of stakeholders. Additionally, I suggest that organisers may be required to employ specialist actors who have experiences of certain stakeholder groups. This provides organisers with a means of delegating their recruitment to actors who understand the complexities embedded within the NHS stakeholder population.

[26] I examine their perspective on recruitment methodologies in *section 1.4*.

Accessibility

Alongside representation, a multitude of interviewees emphasise the importance of variable that they call accessibility. This is a variable that speaks to the way that participants engage in and take advantage of co-production. Interviewees suggest that different actors experience accessibility differently. Those with learning disabilities or low self-efficacy may feel that a group is less accessible. Conversely actors who do not have physical or mental health difficulties and have high self-efficacy may find participation to be more accessible. Collective co-production groups are, therefore, sites wherein a number of inequalities are evident:

> Because they (groups) are, without recognizing it, so inaccessible. You know, in relation to all sorts of things. When we talk about inaccessibility we talk about physical and environmental, communication accessibility and cultural accessibility.
>
> ('Paul' Interview, p.2)

In this extract 'Paul' provides a typology of inequalities that occur within, and diminish opportunities for, co-production. These are physical, environmental, communication and cultural inequalities, amongst others. In providing this typology 'Paul' indicates that people experience participation differently depending on who they are and the social and economic traditions that influence their actions.

This perspective is supported by Bevir (2013). In his study of decentred theory he (Ibid, pp.183-184) argues that opportunities for participation are often insubstantial. Participating actors are not autonomous. Rather, their actions are limited by sets of institutionally and societally situated traditions that orient their beliefs and influence their actions.[27] Thus, participatory equality requires that actors are freed from traditions that limit their, and other peoples', participatory capacity.[28] In doing this people ideally interact with one another and engage in the governance of services.

[27] For an examination of the effect of traditions on situated agency see *section 1.1*.
[28] This is a proposition that corresponds to notions of positive liberty. I briefly touch on this concept in *section 1.1*.

However, the involvement of diverse actors introduces different amalgamations of inequalities within collective co-production. Macro co-commissioning groups that are orientated around issues that affect a variety of sectoral and civil actors may present issues in respect of cultural and environmental accessibility. For example, the inclusion of HCPs, administrators or council workers, alongside patients and volunteers may create inequalities in respect of knowledge and understanding (Loeffler and Bovaird, 2019). This proposition is represented in the following quote wherein 'Holly' (Interview, p.9), a third sector worker who helps to organise co-production in the NHS, discusses the risk that professionalised participants will talk in 'jargon' and alienate other group members:

> So, you explain in plain English and you ask people their opinions individually and very carefully handle if someone doesn't understand something. So they don't feel stupid for not understanding.
>
> (Ibid)

Equally, it is suggested that the representative inclusion of 'experts by experience' within co-production activities like co-design promotes inequalities (Loeffler and Bovaird, 2019, p.251). This is because stakeholders who are in receipt of services often have complex social identities. For example, they may come from a disadvantaged background and, consequently, find it challenging to communicate:

> I think issues of class and education are very important here as people have special or limited education or have learning difficulties that makes it difficult to work and to take things for granted.
>
> ('Paul' Interview, p.3)

In the co-production literature the question of how to promote greater accessibility has, in some cases, been framed around the variable of responsiveness. This is a variable that speaks to how groups are designed (Barbera et al, 2016). Thus, accessibility may improve when a group is designed in a way that reflects participants and is concerned with issues that are meaningful to members. Such a variable is, thus, linked to the notion of salience discussed in my review. Scholars like Denters and Klock (2010) suggest that issue saliency promotes greater

engagement in collective co-production.[29] In their Roombeek case study, for example, they show that high issue saliency acted as a catalyst for the active participation of citizens from different ethnic, race and class backgrounds (Ibid).

These perspectives are reflected in the testimony of interviewees. 'Roxy', a co-production advocate who works in the third sector, discusses how collective co-production often works better when groups address concerns and create outcomes that mean something to participants. This democratisation of meaning promotes an environment wherein actors from diverse backgrounds feel valued ('Roxy' Interview, p.8). Furthermore, it produces a greater sense that each participant is involved in creating, and has ownership over, the outcomes that are produced:[30]

> But there also needs to be some meaningful local stuff that happens as well that people can meaningfully work together on and be involved in.
>
> ('Roxy' Interview, p.7)

Beyond responsiveness, Leach (2006), and Barbera et al (2016) highlight the necessity for organisers of co-production to introduce preparatory processes that support citizen participation. In doing this they examine how preparatory processes reduce existing power imbalances between actors from within the same and different communities. Such a proposition is also reflected in the wider public participation literature. For instance, academics like Fung (2003) examine the value of training citizens before they engage with one another.[31] Thus, high accessibility often occurs as a product of specific training processes such as those that address information asymmetries (Loeffler and Bovaird, 2019; Cepiku and Giordano, 2014).

This proposition is supported by 'Christie', a third-sector worker and SU. In her narrative she juxtaposes consultation and collective co-production. She suggests that the former requires civil rights, yet does not guarantee active involvement. By

[29] I explore the concept of issue saliency in *section 1.4*.
[30] For a detailed study of how organisers of co-production promote issue saliency see my study of co-design in *section 5.2*.
[31] Fung (2003) suggests that these processes improve the civic skills of citizens. I briefly touch on this supposition in *section 5.3*.

contrast, the implementation of the latter is contingent on attempts to reduce inequalities that occur between participants:

> You need to plan it. It doesn't happen by accident. How are you going to support people? You need to think about that. There will also be points where you will go out to full engagement that is a one off where you invite 50-100 people to a meeting. That is pure engagement where you talk to people and hear their feedback. But co-production is different. It's about power sharing, sharing information.
>
> ('Christie' Interview, p.2)

Interactions within collective co-production should, therefore, be supplemented by processes that empower participants.[32] In the above extract it is suggested that empowerment occurs through mechanisms that promote understanding and the sharing of information. This proposition is supported by 'Sonia' (Interview, pp.2-3) and 'Karlee' (Interview, p.12). In their respective interviews both assert that the provision of information throughout the life cycle of a collective co-production process enables participants to learn about one another, the NHS and the co-production process, amongst other topics.

In addition to responsiveness and the provision of information, my analysis shows that accessibility is improved through mechanisms that address societal and cultural inequalities. In the following extract 'Paul' suggests that inequalities frequently arise because participants feel insecure in collective co-production groups. He indicates that social and economic traditions restrict the agency of actors by defining the spaces in which they feel comfortable:

[32] I discuss how organisers practically empower stakeholders in *sections 5.2* and *5.3*.

> If you are a service user it is quite possible that your life has been and is difficult and that there are large areas outside of your comfort zone. You might have quite a limited comfort zone so when you make a leap and become involved, which might be very difficult, you might want that to be as pleasant a leap as possible.
>
> ('Paul' Interview, p.3)

This extract speaks to the potential influence of societal traditions on self-efficacy. Participants who come from backgrounds wherein they have had fewer opportunities to engage in groups, speak in public or discuss their perspectives may, thus, feel less capable of operating within collective co-production. As such, accessibility is increased through processes that mitigate for differences in the lives of participants. In the participation literature processes that enable citizens to practice and engage in participation are considered to be important in producing this outcome (de Graaf, van Hulst and Michels, 2014). These processes empower citizens by improving their civic skills. These are skills such as the capacity to communicate, think critically, negotiate and compromise (Fung, 2003).[33]

In sum, I suggest that a number variables related to accessibility affect how stakeholders participate in collective co-production within NHS services. Thus, in *section 5.2* and *5.3* I provide frameworks through which to understand how organisers of collective co-production increase the accessibility of their involvement processes. In *section 5.2* I examine how processes of co-design, or procedures in which stakeholders shape the meaning and methodology of collective co-production, promote active participation. Furthermore, in *section 5.3* I explore how preparatory processes such as reflective practice act as routes through which participants improve their self-efficacy and attain civic skills.

[33] See my exploration of these processes in *section 5.3*.

Solidarity

Beyond representation and accessibility, my analysis suggests that solidarity is a powerful normative variable that also gives meaning to collective co-production. In the literature solidarity is believed to create collective notions of work and ambition, as well as outcomes like trust between and within stakeholder communities (Loeffler and Bovaird, 2016). Scholars like Ostrom (1996, p.1082), thus, define solidarity as a 'clear commitment to one another'. In doing this Ostrom (Ibid) states that solidarity promotes an environment wherein actors see others, both within and outside of their communities, as allies in improving services.

This perspective is similar to that provided by Fung (2003). In his analysis of the role of associations in strengthening democracy Fung (Ibid, pp.519-520) alludes to the importance of civic virtues such as 'attention to the public good, habits of cooperation, toleration' and 'respect for others'. In doing this he suggests that civic virtues promote co-operation between different cohorts of participating actors. This perspective is supported by De Graaf et al (2014, p.48) who suggest that the attainment of civic virtues supports "feelings of being public citizens and part of (a) community". In this way the authors propose that civic virtues promote inter-community commitment and responsibility (Ibid).

This emphasis on the value of solidarity is evident in interviewee testimony. In the following excerpt 'Liv', a HCP within an NHS trust, suggests that participants from different communities need to be aware of their common ambitions:

> I think they were aware that they had been asked to try to improve the service. What we tried to do throughout the process is to make it clear how valued their contributions were. I think that probably helped.
>
> ('Liv' Interview, p.9)

In this extract 'Liv' indicates that participants understanding of their common aims and desires contributes to their active engagement. She shows that solidarity is a function of participants' awareness regarding their collective commitment to improving a service. Thus, she advances the notion that solidarity is related to

processes through which participants learn about, and subsequently commit to, one another.

This perspective is supported by 'Nigel'. In his interview he suggests that preparatory processes enable actors to learn about and value the lived experiences of fellow citizens.[34] He proposes that this learning is often formalised around regular interactions wherein actors from different communities listen to each other:[35]

> We make sure everyone is alright but keep talking about the realities in front of us. Say "yes that's sensible" and they see me get it as well, you know, and they see really good managers coming along and we encourage people to be honest about the elephant in the room. That really helps. It really helps.
>
> ('Nigel' Interview, p.2)

In this extract 'Nigel' proposes that processes in which citizens are able to talk about their lived experiences support solidarity generation. This is because these types of processes promote an understanding that each participant is, or has been, subject to difficult circumstances in respect of their relationships with the service. Thus, in having opportunities to talk about the "realities in front of us" participants begin to understand that they each share common problems, as well as a mutual ambition to improve the service (Ibid).

This perspective regarding the importance of learning is supported in the literature. Ostrom (1996, p.1082) suggests that 'opportunities for officials to get to know citizens and vice versa' act as incentives through which the influence of inter-community hierarchies and structures are reduced. For example, learning processes may reduce the value that HCPs, and other communities, attach to professional expertise (Vanleene, Verschuere and Voets, 2016). Through this actors realise that members of other communities hold significant and valid forms of understanding. In

[34] I discuss preparatory processes in *section 5.3*.
[35] I examine processes like trigger films in which stakeholders learn about one another in *section 5.3*.

this way stakeholders are encouraged to work together to attain outcomes that they collectively desire (Vanleene and Verschuere, in Brandsen et al, 2018).

Of course, the manufacturing of solidarity may be difficult within NHS services. This is because the reification of professional expertise is deeply and historically embedded within the institution (McMullin and Needham, in Brandsen et al, 2018).[36] Thus, HCPs are frequently considered to resist initiatives that call for the proliferation of non-clinical and subjective understanding. For example, processes of co-design aimed at improving the environment of a ward have been resisted by professionals who do not understand the value of, and cannot empathise with, the lived experiences of lay actors ('Renata' Interview, p.7).[37]

Thus, I propose that attempts to manufacture solidarity between, and perhaps within, communities requires an understanding of the traditions that impose on conceptions of expertise. In *section 5.3* I consider how professional resistance to collective co-production is reduced through opportunities to learn about and understand the value of lived experiences. In doing this I suggest that coaching processes act as routes through which professionals act in solidarity with SUs. Furthermore, I argue that solidarity is manufactured through processes that interviewees call trigger films. These are films that depict the shared experiences and ambitions of actors who come from different stakeholder communities.

Openness: allowing for interaction between communities

Openness is a variable that speaks to the way in which stakeholders are free to engage with one another within collective co-production. My analysis suggests that this variable is related to the conception of equality discussed in the previous section of this chapter. In this discussion I propose that equality should not be considered to be a natural function of citizenship. This is because citizenship is not necessarily a prerequisite for equal participation. Rather, equality transpires as a result of the realisation that identities are unequal as a product of the social, institutional and medical contexts against which stakeholders exist.

[36] I consider how the literature discusses the valorization of clinical expertise in *sections 1.1* and *1.4*.
[37] In my analysis I use the term "ward" to denote a geographical entity that is both a part of a department, yet often has its own unique relations.

Processes that empower stakeholders may, therefore, promote openness within collective co-production (see *figure 15*). This supposition suggests that openness is both a function of complimentary processes that promote accessibility and solidarity and a means through which to characterise the ideal environment for inter-community interaction:

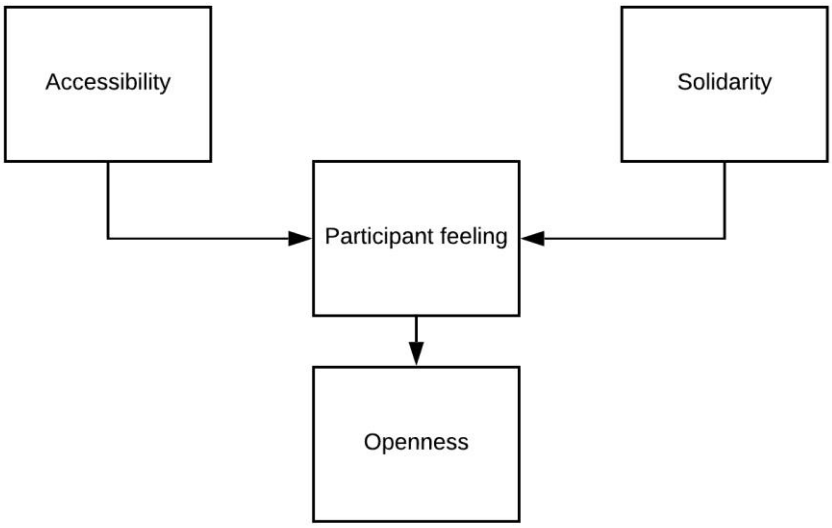

Figure 15: Portraying how participant understanding of openness is linked to variables of accessibility and solidarity.

Of course, openness is not directly and explicitly linked to the realisation of accessibility and solidarity. Rather, it is a product of the way that participants reflexively understand that they have been empowered (see *figure 15*). Such a notion is supported in the literature. Verschuere, Vanleene and Steen (In Brandsen et al, 2018) assert that the openness of a participatory forum is measured by participant's reflexive understanding of their capacity to take part. Thus, they propose that complementary activities which improve accessibility and increase solidarity enable stakeholders to feel capable of participating (Ibid).

This assertion is reinforced by Van Eijk and Steen (2015) who suggest that notions of self-efficacy and external-efficacy (the belief that others will include and accept your inputs) influence how participants interact within groups. These variables are inherently subjective. They pertain to the way that participants understand that they are capable of participating and how they consider that others will acknowledge and

respect their attempts to participate (Ibid). As such, complimentary processes through which stakeholders gain skills and learn about others are important in promoting understanding of capacity and manufacturing trust between and within communities (Ibid, pp.40-42).

This perspective is evidenced in the following excerpt taken from my interview with 'Karen'. In this passage the interviewee highlights how the openness of participative forums are linked to participants' feelings of comfort and security:

> Every meeting I have been too has been completely open like that so that people can voice an opinion or make a statement in an environment where I have felt safe and comfortable.
>
> ('Karen' Interview, p.5)

In this extract 'Karen' indicates that her feelings of safety and comfort acted as a catalyst for her active engagement in a co-production process. This is because she reflexively comprehended that the group had been designed in a way that reflected her understanding of these variables. Such reflexive understanding arrived as a product of the fact that 'Karen' had "a say regarding how the meeting will take place" ('Karen' Interview, pp.5-7). Through this involvement the location and size of the group was altered to reflect her identity and experience.[38] Thus, her conception regarding the apparent openness of the process can be understood to be a facet of her subjective understanding of the way in which the process was designed.

This association is also observed in my interview with 'Nigel', a healthcare professional who has created a formal space for co-production within his NHS trust. In our interview 'Nigel' suggests that participants' understanding of the groups in which they are taking part influences how they engage:

[38] For an examination of this effect see my discussion of co-design in *section 5.2*.

> Once you have got both sides openly talking about their experience then you're really co-producing. Sometimes people's past experience is about having those kind of mental health problems and that can really, really help if someone is feeling strong enough to talk about that because it gets rid of them and us and we realise that we are all just people with different experiences. Not different people or different species you know.
>
> (Nigel Interview, p.6)

This extract shows that the creation of an environment wherein stakeholders are "openly talking" is contingent on their empowerment. 'Nigel' suggests that the production of greater efficacy has enabled actors from different stakeholder communities to engage in reciprocal interactions. In doing this he highlights the variable of strength and proposes that "feeling strong" empowers actors to participate in decision-making (Ibid).

Accordingly, I contend that the openness of collective co-production is a function of the subjective understanding of participants. In *section 6.1* I expand on this proposition and assert that the quality of interactions within collective co-production are inextricably linked to participant feelings. In doing this I suggest that feelings of security and strength act as variables in enabling participants to actively engage in decision-making. This is because these variables empower participants to interact with others and produce outcomes. However, I also submit that feelings of strength and security do not wholly contribute to the production of active engagement. Rather, organisers of collective co-production must also enact protocols through which to maintain equality and reproduce empowerment.

Conclusion

Interviewees present a vision of collective co-production as expressed through a set of interlinked and interdependent variables. This vision is founded on the notion that services exist as sites for democratic involvement. This is because they are, in-part, owned by citizens. However, participative rights bestowed on to citizens are not sufficient for co-production. Rather, co-production is contingent on citizens becoming powerful actors within decision-making. In this sense co-production is orientated around activities, norms and assumptions that increase equality between different actors. This is why I suggest that variables of representation, accessibility, and solidarity improve the participative capacity of participants.

I propose that the amalgamation of these variables supports the institution of an open interaction environment. As such, I present my subsequent analysis through this normative prism. In doing this I promote an understanding of how my definition of collective co-production is implemented and contributes to democratic governance. However, this analysis would not be complete without an exploration of the NHS environments within which collective co-production processes are implemented. In the following chapter I study the macro, meso and micro conditions that impact on implementation. Within this investigation I show how contextual factors like legislation, provider hierarchies and notions of SU capability affect implementation. Furthermore, I examine the identity of organisers and explore how professionals and SUs implement collective co-production within NHS services.

Chapter 4: The conditions for collective co-production

The normative vision presented in *sections 3.1* and *3.2* is important when conceptualising democratic governance. In these sections I assert that representation, accessibility, solidarity and openness provide participants with a means to engage in decision-making. These variables work together to embed equality and facilitate participation in the production of outcomes. However, democratic governance does not occur in a vacuum. The implementation of collaborative decision-making is affected by a multitude of traditions that exist within and are external to the NHS.

In this chapter I examine how conditions affect the implementation of processes of democratic governance. As such, I draw on the work of Bevir (2013) in considering how social and institutional traditions impact on the actions of situated agents. My analysis of interviewee testimony shows that NHS stakeholders are often subject to traditions associated with paternalism and the market. Likewise, my analysis demonstrates that agency is limited by traditions that occur within departments. In the following investigation I explore how these different traditions affect stakeholders and influence implementation.

In this chapter I segregate my examination of conditions by level of aggregation. This segregation is reflective of interviewee experiences with many suggesting that macro, meso and micro conditions impose on the implementation of collective co-production. In *section 4.1* I examine macro conditions. I study the effect of contemporary political economy on participation and explore how market ethics have influenced ontologies within the NHS. After this I study the effect of legislation and investigate how acts of government promote participation.

In *section 4.2* I discuss how institutional values and norms influence organisation. I examine the potential for change within the NHS and the apparent separation between strategic and operational actors. In discussing this I delineate how this separation provides high-status professionals with greater agency, thereby empowering them to shape their operational environment. Finally, I explore the relationship between operational actors and service users and outline how institutionalised notions of user capability block lay participation in co-production.

In *section 4.3* I explore how localised variables that are embedded within the department impinge on the generation of collective co-production. I argue that long-term and 'slow' relationships between staff and users are associated with greater patient participation. Moreover, I contend that established departmental involvement processes and co-productive norms promote professional/user partnership. Lastly, I explore the potential for collective co-production to occur across different departments.

Finally, in *section 4.4* I describe the different types of organising actors found in my analysis. The first is the 'entrepreneur'. This is an operational NHS actor who is capable of spending time learning about and implementing collective co-production. The second is the 'standing group'. This is a lay collective that engages in research and uses the experiences of its members to support the implementation of collective co-production.

4.1: External conditions and the NHS

External conditions influence services and the way that we use them. They are the prism through which services are deductively reformed and reconstructed (Bevir, 2013). As such, they are important traditions within the inner negotiations of NHS actors. This supposition is supported by my analysis of interview testimony. Interviewees have discussed the impact of political economy on healthcare. They have asserted that this variable has influenced understanding of the NHS. Moreover, they have argued that it has altered the role of the professional: adapting concerns and responsibilities to conform to the ethics of the market.

Of course, external conditions are not wholly defined by market ethics. Interviewees have suggested that externally located variables also support participation. Acts of Government such as the 2012 Health and Social Care Act are considered to support the implementation of involvement processes. However, Interviewees also suggest that the potency of legislation in affecting the implementation of collective co-production is contingent on their existing appreciative institutional actors. These are

situated agents who harness legislation and implement collaborative decision-making within the NHS.

Political economy and the NHS

Proponents of decentred theory (DT) tell us that institutions are complex. As such, governance cannot only be appreciated through an exclusive examination of exogenous factors. Rather, governance must be understood as the product of any number of traditions that influence the negotiations of situated agents (Ibid). In arguing this point decentred theorists do not assert that the study of exogenous variables are not important. In declaring that exogenous variables do not explicitly structure governance, decentred theorists do not suggest that they play no role at all. This is because exogenous variables inform the rules and norms that orient our understanding of the world around us (Bevir, 2006).

Political economy may, therefore, influence the ethics and practices of actors who operate in institutions. This proposition is supported within Davies' (2008) description of the dilemmas facing council workers in Dundee and Hull. These actors were influenced by factors relating to new public management (NPM) such as a lack of time and the monitoring of work. This, subsequently, caused them to adapt their behaviour in a way that meant that they ignored competing institutional demands to increase social inclusion. Such a notion is also supported by interviewees. They speak to the effect of market ethics in changing the service and the way in which healthcare professionals (HCPs) understand their roles.

Interviewees reference the extent to which contemporary political economy impacts on healthcare. In particular interviewees talk of the effect of the inclusion of market ethics within the NHS. For example, they assert that NHS services are now dominated by the "ethics, thinking and the structures and business and management models of the private sector" ('Paul.1' interview, p.3). Such a declaration is reminiscent of the neo-liberal philosophy described in my literature review. In *section 1.1* I explain how thinkers like Majone (2001) considered the centralised and bureaucratic public sector to be ineffective and lacking in legitimacy. Thus, Majone (Ibid) recommended that institutions transcend the limiting confines of the state and embrace an understanding of services that emphasises outcomes.

Interviewees often referenced notions of efficiency when discussing the contemporary state of the NHS. They propose that the narrative of 'financial pressure' has permeated the myriad rungs of NHS authority: implementing alterations within the understanding of strategic and operational actors alike. One HCP interviewee talked about how "we have less and have to do more with it" ('Keira' Interview, p.5*)*. This supposition speaks to the effect of market ethics within the NHS. It shows that professionals often conceive of themselves as actors for whom conventional clinical responsibilities are framed by demands for efficiency.

Strategic actors like chief executives have also been affected by these demands. 'Martin' (Interview, p.3), a service user (SU) who supports research within the NHS, asserts that this is observed in the behaviour of clinical commissioning groups (CCGs). CCGs are bodies that commission NHS services within particular constituencies. When commissioning services, CCGs are required to involve SUs (Health and Social Care Act, 2012, Section 26). As such, CCGs are potential sites for co-commissioning (Loeffler and Bovaird, 2019). However, the following extract indicates that opportunities for co-commissioning have been diminished:

> So the outcome was that, of course, CCGs don't talk about this stuff. All that they are interested in is bed occupancy and what the financial aspects are. But when they were set up it was very much that they should reflect the needs and hopes of their local communities. None of that was reflected in the business of CCGs in their board meetings.
>
> ('Martin' interview, p.3)

In this extract the interviewee proposes that CCG boards are replacing demands related to the NHS as a collective and public good with matters related to finance. As such, the Interviewee suggests that the necessity to do more with less has diminished opportunities for the co-production of commissioning. This outcome has resulted in the valorisation of variables related to bed occupancy and spending.

'Martin's' (Ibid) experience of being marginalized within CCG meetings contrasts to legislation embedded within the 2012 Health and Social Care Act. In this Act CCGs

are mandated to make arrangements to 'secure that individuals to whom the services are being or may be provided are involved' in 'the planning of the commissioning arrangements of the group', amongst other activities (Health and Social Care Act, 2012, Section 26). The apparent marginalisation of constituent voices within CCG commissioning meetings, therefore, suggests that economic variables have superseded the normative desire and legislative mandate to involve constituents in co-commissioning. This analysis conforms to my previous examination of NPM. In my review I consider how the association of accountability with outcomes and increases in managerialism have contributed to an environment wherein providers feel less inclined to engage in participatory activities (Speed, in Bevir and Waring, 2018; Dent and Barry, in Chandler, 2017).

This is not to say that the NHS does not provide opportunities for involvement. Independent living is a principle employed within NHS services. It is a concept that was originally conceived to be "about people having the right to live independently and having the support to do that" ('Beth' interview, p.4). Independent living should, therefore, challenge the idea of the passive patient by empowering citizens to 'live on as equal terms as possible' to those who are not in receipt of healthcare services (Beresford, 2019, p.6). However, interviewees assert that this principle has been appropriated by the ethics of the market:

> Over years government has turned independent living, which is a concept about people having the right to live independently and having the support to do that, in to 'you need to get on with it on your own without any finance or welfare state behind you because you want to be independent'.
>
> ('Beth' interview, p.4)

This extract suggests that the necessity for greater economic effectiveness moves the locus of care in to the community. In this way contemporary political economy may not completely diminish opportunities for participation. Yet, the constrained nature of independent living means that it cannot be considered to empower citizens. This is because it does not provide mechanisms through which citizens are supported to participate in the provision and management of their own care.

These examples demonstrate that citizens are often removed from decision-making fora. They show that whilst there may exist legislative mandates or philosophical precedent for participation, the voices of citizens are frequently disregarded. In this way the citizen can be understood to be unequal within conditions wherein strategic and operational provider actors are influenced by the necessity to do more with less ('Keira' Interview). This dynamic is illustrated in my interview with 'Paul':

> The position of the consumer is almost invariably much weaker than the position of the shareholder.
>
> ('Paul' Interview, p.4)

This passage indicates that market ethics promote an understanding of citizens as consumers. These are actors who contribute to the attainment of improved outcomes through their often passive adherence to the economic desires of providers (Beresford, 2019, p.5). Consumers are, therefore, alienated from opportunities for empowerment. They are removed from decisions regarding the 'content or features' of services and, instead, provided with the means to choose, comment and complain (Pestoff, in Brandsen et al, 2018, pp.31-32; Beresford, 2019).

In introducing this dichotomy between consumers and shareholders, 'Paul' presents an ideal vision of the co-producing citizen. He suggests that citizens should be understood as 'shareholders' who are provided with the same rights, access and power as provider figures. This proposition is supported by 'Nigel':

> I think that is a key point of co-production or co-design is that you want everyone to step away from their role as patient or staff and just say "you know what for today we are all just designers" and that really, really helps. That shifting of identity.
>
> ('Nigel' Interview, p.10)

This statement suggests that the ideal relationship between provider and citizen contrasts to the type of dynamic discussed previously. Rather than conceive of users as actors who contribute to improved effectiveness and efficiency, citizens need to be understood as equal to providers. The notion of the 'designer' as a person who

comes from any background and inhabits any identity is, therefore, useful in characterising the ideal co-production participant. This is a stakeholder who is empowered to make decisions and produce change.[39] It is, thus, important that I now consider routes through which to realise this ideal. In the following analysis I consider how legislation designed to instigate citizen participation affects collective co-production and democratic governance.

Legislation: imposing participation

The NHS in England has undergone a number of systemic changes since its inception. These transitions occurred, in part, as products of external factors such as legislation. For example, the 1990 Community and Care Act imposed changes to the institution by defining the macro environment within which HCPs, administrators, patients and carers operated (Ferlie et al, 1996, p.43). It is, therefore, important that I study the role of legislation in establishing the conditions for democratic governance. This investigative route may seem counter-intuitive when conforming to DT. After all, theorists like Bevir and Rhodes (2007) speak to the inadequacy of attempts to centralise administration via mechanisms like legislation. Yet, Bevir (2013) also suggests that legislation is a pillar on which participation is, and has been, cultivated.

Whilst it is argued that many contemporary legislative initiatives are reflective of ideals related to NPM (Boudioni, McLaren and Lister, 2017), Milewa, Dowswell and Harrison (2002, p.806) suggest that acts of government ensure that 'partnership structures are a given'. For example, the 2012 Health and Social Care Act (section 75) promoted an understanding of involvement by emphasising the value of patient choice. In doing this the British Government 'Put NHS services out to competitive tender' by enabling citizens to choose from a variety of service options (Hudson, 2015, p.5). Hudson (Ibid, pp.6-7) suggests that this focus on competition has acted as a catalyst for an appreciation of citizens as consumers who provide feedback on the quality of services.[40]

[39] See my normative framework for co-production in *section 3.2* for a discussion of how such equality is produced.
[40] See *section 1.2* for an elucidation of passive forms of participation such as the provision of feedback.

However, the actions of patients and professionals alike were not circumscribed by the 2012 Act. It is suggested that the rationale for increases in consumer choice did not take in to account the notion that citizens do not always have access to perfect, or even imperfect, information (Ibid, pp.5-6). In spite of the publication of a Government White Paper (Department of Health, 2010) discussing the necessity to improve access to information, the behaviour of many citizens did not change (Hudson, 2015). This negative correlation between legislation and governance suggests that legislation alone does not implement participative opportunities within institutions.

Such a hypothesis conforms to my earlier examination of the effect of the 2012 Act (section 26) on public involvement in CCG commissioning activities. In this discussion I consider the experiences of 'Martin' and examine how traditions related to the market have diminished opportunities for co-commissioning. Thus, I suggest that the legislative mandate for co-commissioning has been diminished by CCGs:

> That for a member of the public to walk in and attend the CCG meeting to be told that you can't ask questions and do this or that. For someone that would be really distressing and off-putting whereas they might really have a valid point. But of course, the CCGs are…what is the phrase that someone used? They are meetings open to the public but they are not public meetings.
>
> ('Martin' interview, p.3)

In this extract 'Martin' indicates that legislation is a weak variable in implementing co-production. The notion that citizens are "told" that they cannot "ask questions" demonstrates that CCG board members have tempered government mandates to democratise commissioning activities (Ibid). This suggests that board members are less influenced by the necessity to provide empowered participation than to meet pressing demands related to metrics like bed occupancy.

Of course, DT tells us that no one variable is responsible for the production of change. Thus, legislation should be explored alongside alternative traditions. In this vain I return to Milewa et al's (2002, p.806) supposition that Acts of government lay

the groundwork for citizen participation. This perspective suggests that legislation supports the valorisation of complementary traditions that encourage the implementation of involvement processes. Such a notion is shared by interviewees. 'Nina' extols the importance of the legislative environment in helping to create an agenda for co-production. In doing this she states that legislation puts "co-production on the table… as an area of priority focus for public organisations" ('Nina.2' Email Correspondence).

Likewise, 'Roxy' (Interview, P.3) asserts that legislation increases awareness of co-production. In our interview she explores the impact of legislation regarding participation in Welsh mental health services. This legislation was designed to ensure that all mental health SUs were "involved in the development of their care and treatment plan" (Ibid). However, 'Roxy' questions the extent to which patients and HCPs actively work together to achieve these goals:

> Sometimes it is difficult for orgs to stay on top of the quality of what they do. I think there has been more emphasis on the numbers who have a care and treatment plans rather than the quality.
>
> (Ibid)

This extract demonstrates that legislation has a relatively weak influence on the behaviour of actors in institutions. The notion that treatment plans vary in quality across Welsh mental health services indicates that the vitality of legislation as a variable in generating participation is impeded by alternative factors. 'Roxy' (Ibid) suggests that these variables relate to the working cultures and practices that exist within mental health services in Wales.

My analysis, therefore, presents legislation as a variable that is affected by traditions that exist within institutions. This notion is advanced in my interview with 'Keira' (Interview, p.3) wherein she asserts that legislation alone does not manifest democratic governance. This is because legislation is one of many variables that imposes on the ontologies of NHS operatives. As such, 'Keira' indicates that legislative demands related to involvement need to be supported by operatives who

have an existing appreciation for participation. Without such internal advocacy legislative mandates may be co-opted by alternative factors:

> It has to be done at pace but my challenge would be that if you want to work alongside to co-deliver and design services then you cannot do it at pace. One of the fundamental things we do know is that it takes a lot longer. There are a lot of challenges around some of the rhetoric and the policy direction in regard to it. I think NHS England has to take more responsibility for all the demand that they put down while saying that you have to work with service users and families. The two don't work together.
>
> (Ibid)

This passage shows that legislation does not generate the explicit ability to produce democratic governance. Regardless of "policy direction", legislative proposals are often superseded or enveloped by alternative concerns. For example, understanding of involvement may be shaped by pressures to work within timeframes and maintain normal clinical operations (Ibid).

Such a hypothesis suggests that those who work to implement processes of involvement face an ontological dilemma. This is a conflict between their desire for involvement and the demand to maintain notions of efficiency and productivity. As such, I contend that the generation of democratic governance requires a different form of internal calculation. This is a calculation that eschews norms related to the market and welcomes traditions associated with the empowering 'maximum feasible participation' maxim of the disabilities movement ('Paul' Interview; 'Paul'.1 Interview).[41]

However, as I have indicated this type of understanding is not promoted from above. It is not a product of the transactional relationships promoted by contemporary political economy. This variable has encouraged NHS workers and administrators to understand the service and their role within it through the prism of values such as

[41] See my discussion of this movement in *section 1.2*.

efficiency. In this way participation processes often revolve around opportunities for citizens to act as consumers and contribute to the attainment of improved outcomes:

> The model of involvement that Mrs. Thatcher understood, and that is the dominant one since, has been a consumerist model of involvement where the assumption is that the public sec will meet our needs as consumers.
>
> (Ibid, p.4)

Nor is empowered participation a product of legislation. As discussed, legislation is a variable that intersects with traditions that occur within institutional environments. As such, national policies are frequently interpreted by providers through the prism of priorities and norms that occur within services.

Accordingly, I propose that the value and impact of legislation in promoting empowered participation is institutionally situated. The successful institution of participation legislation is, thus, contingent on the existence of appreciative actors who operate within services. In this way I propose that centralised and deductive methods through which to understand opportunities for democratic governance hold less analytical value in comparison to factors that arise from within the NHS itself. Such a supposition leads me to consider the value of exploring traditions are inherent to the NHS.

Conclusion: political economy and legislation

In this section I suggest that political economy alters notions of participation. It diminishes the value of citizen voices and reduces stakeholder involvement in decision-making. Moreover, I propose that involvement legislation does not directly empower stakeholders to participate. This is because the application of legislation within services is often diminished by institutional traditions. As such, I assert that the study of democratic governance requires an investigation of variables that occur within NHS services.

It is, therefore, important that I now consider the role of institutional actors in implementing collective co-production. In the following analysis I explore traditions

that enable actors to implement collective co-production. I examine the effect of institutional traditions such as strategic and operational division. Furthermore, I build on my examination of external conditions by considering how market ethics influence the agency of operational actors within NHS services. Finally, I investigate how notions of service user (SU) capability impinge on the formation of partnerships between stakeholders.

4.2: Institutional conditions within the NHS

Having discussed how interviewees understand collective co-production and explored how this is influenced by political economy and legislation, I now turn to an investigation of institutional conditions. These are conditions that dominate the operations and design of the NHS. They are also conditions that are manifested within and as a result of the institution. To examine these conditions I explore traditions related to strategic and operational divisions of labour, priorities and notions of capability. In doing this I acknowledge that governance regimes like NPM have an enduring influence on the institution and recognise that paternal traditions continue to shape the ontologies of NHS operatives.

The relationship between change and the NHS

Decentred theories of governance stress that institutional cultures are not static. Rather, they are constructed and reconstructed by actors who operate within institutions (Bevir, 2013). These actors understand culture differently. They use their situated agency to interpret traditions that are shared within their environments. As such, traditions are understood to be contingent (Ibid, pp.3-6). However, this does not mean that shared traditions do not permeate the ontologies of different, yet comparable, actors within institutions. My analysis shows that operational actors like doctors and nurses often share a common understanding of the NHS. Moreover, it suggests that these forms of understanding influence possibilities for democratic governance.

In the following quote ‘Samira’, a third sector worker who supports people with disabilities, presents the notion that shared operational traditions shape conditions for collective co-production:

> I think that, particularly in the NHS, it is a mind-blowingly big deal to imagine this really happening. I mean I want to believe it will happen and I have to.
>
> ('Samira' Interview, p.4)

This passage suggests that operational actors often hold strong beliefs about the NHS and their roles within it. Furthermore, it conveys that the preponderance of these beliefs hamper prospects for change ('Samira' Interview, p.2). For example, the notion that HCPs should have power is presented as a tradition that blocks co-productive interaction. This belief supports the manifestation of an environment wherein professionals refuse to "let go" of their authority (Ibid). Such a notion is fairly consistent across interviews with 'Sonia', a researcher in healthcare participation, stating that HCPs are often "resistant to any change and would rather things were happening as usual" ('Sonia' Interview, p.7).

Veronesi and Keasey (2011, p.875) believe that this operational ontology is grounded within paternal notions of patient need.[42] Thus, operational actors are concerned with issues that do not inherently lend themselves to active participation. Instead, they remain tied to traditions such as those that delineate and reproduce regard for their professional expertise. This suggestion is evidenced in the narrative of 'Holly'. In her interview 'Holly' states that democratic governance is blocked by the desire of operational actors to maintain control:

> People are still very set in a consultation mind-set where it is about asking people what they want and then deciding whether you can deliver or not. I think that is where most services are at the moment.
>
> ('Holly' Interview, p.2)

[42] I consider how the literature discusses governance and paternalism in *section 1.1* wherein I examine a form of administration called old public management (OPM).

Strategic and operational relations

This operational ontology is not dominant within the NHS. Rather, different sets of traditions characterise the institutions operational and strategic locations. This separation has led to the notion that there exists a 'great divide' between strategic and operational actors (Veronesi and Keasey, 2011, p.864). Both are viewed to have a respective world view with the understanding of the professional and administrator segregated (Diefenbach, 2009, p.903). This segregation may be a natural consequence of the fact that each actor has a different history (Bevir, 2013). The professional is often trained in and has experience of aspects of provision that are alien to administrators. Conversely, strategic actors commonly promote the financial health and physical reproduction of trusts and hospitals (Veronesi and Keasey, 2011, pp.881-882).

Strategic actors may, therefore, find it difficult to be explicitly appreciative of operationally located activities. This supposition is supported in the narrative of 'Renata' (Interview, p.2), a healthcare professional who has participated in and helped organise collective co-production. In her interview 'Renata' talks of her experiences organising processes of co-production that were not strategically supported. In doing this she makes it clear that strategic actors are often concerned with variables that relate to and interlink with external conditions such as those associated with budgets:[43]

> Interviewer: Do you think that your organisation is prepared to engage in this new, or perhaps not new but different, way of running a service?
>
> 'Renata': I think they weren't against it. To be honest they probably don't really care as long as it doesn't cost them money and take away from our time a lot. They didn't really care. It wasn't a lot of responsibility from their side either. That was the impression I kind of got.
>
> ('Renata' interview, p.3)

[43] See my discussion of external conditions in *section 4.1* wherein I consider how market ethics and legislation impact on the institution.

Accordingly, I suggest that conventional social relations between strategic and operational actors conform to a division of labour wherein strategic actors are disconnected from the works of operational actors. This great divide means that there may be few opportunities for operational organisers to engage in the production of change on a scale wider than that which they can themselves implement.

Of course, this does not mean that all operational actors have the capacity to act in this way. Whilst there may exist a division between operational and strategic actors, it is apparent that many professionals remain incapable of organising collective co-production. This is because strategic actors regularly influence behaviour through implicit and explicit mechanisms of control. Thus, organisational capacity is determined by the extent to which professionals transcend these mechanisms.

The power of priorities

In alluding to the existence of a strategic and operational division I have suggested that operational actors attain partial agency. HCPs commonly have freedom within their operational environments because chief executives and administrators are not concerned with the minutia of their everyday working life. However, I assert that their agency is often constrained through the introduction of devices like targets, performance reviews and inspections. In some cases these factors coalesce and reduce professional engagement in non-clinical activities.[44]

In the literature NPM is considered to have augmented understanding of the role and place of the professional within the NHS (Hogget, in Hill, 2013, pp.419-421). Academics suggest that the introduction of internal NHS competition has promoted greater managerialism in services (Dent and Barry, in Chandler, 2017). Furthermore, they argue that internal competition has resulted in the introduction of compliance mechanisms such as audits that have been designed to improve the effectiveness of services and HCPs (Ibid; Harrison, 1999; Dent and Barry, in Chandler, 2017). This has led Speed (in Bevir and Waring, 2018, p.193) to state that a ‘rule of competition’ has come to ‘replace a rule of cooperation’ within the NHS.

[44] These are cases in which professionals do not have sufficient status to overcome or ignore mechanisms like targets. I discuss this proposition in the following sub-section.

My analysis supports this proposition. It shows that traditions of productivity and efficiency inform understanding of the purpose and place of healthcare professionals within NHS services. These traditions are reproduced through explicit mechanisms that measure performance such as targets:

> On a stroke ward every month you need to see a certain amount of patients at certain times of day.
>
> ('Renata' Interview, p.9)

In this extract 'Renata' suggests that professionals are required to see a "certain amount of patients" at particular "times of day" (Ibid). This suggests that targets are often employed as a means of controlling the actions of HCPs: delineating the extent to which they are free to engage in, or even consider possibilities for, non-clinical activities such as learning.

This form of control is made more potent as a result of the way that targets are measured. 'Renata' (Ibid) illustrates that her activities are measured by stating that "we get like points on that and that is published nationwide". This appraisal serves the valorisation of notions of productivity through generating competition between staff members. Hogget and Hill (2013, p.420) propose that competition based on performance may result in reduced solidarity between colleagues and increased job insecurity. Thus, staff may be reluctant to take on non-clinical activities or responsibilities for fear of falling behind their peers.

Deadlines also dissuade professionals from engaging in non-clinical work. This is because deadlines promote an understanding of the professional as operating within a temporally scarce environment. Professionals with looming deadlines, therefore, conceive of themselves as time-poor actors who lack the flexibility to engage in extracurricular activities. This conception is exemplified in the narrative of 'Holly' (interview, p.2) who states that implicit norms make professionals "feel a lot of time pressure, getting things done by a certain deadline". As such, the interviewee asserts that many HCPs view participation processes as "an extra burden on top of (their) heavy workloads" (Ibid).

This growing understanding of the HCP as a time-poor actor is supported within the testimony of 'Liv'. In her interview 'Liv' suggests that traditions of productivity and efficiency have been internalised to such an extent that staff often eschew reflection:

> …because lots of them commented on the fact that when the patients are having treatment there are lots of things for them to be doing while the patient is in hospital. So they don't often have the time to step back and reflect and think about what it might be like going home and how we can prepare the patients for that.
>
> ('Liv' Interview, p.5)

This extract conveys that HCPs are often subject to a number of responsibilities and roles. They are consistently busy actors who feel that they are required to continue engaging in clinical activities as a means of meeting institutionally located notions of efficiency and productivity (Ibid). This rigidity may, therefore, frustrate opportunities for many staff members to engage in activities that support inter-community relationships and collaboration. As such, I argue that actors who aim to implement collective co-production need to operate within conditions that are not informed by mechanisms that reproduce notions of temporal scarcity.

Organisation at the operational level

I have shown that traditions related to market ethics impinge on opportunities for democratic governance. The institution of control mechanisms like deadlines and targets affect HCPs by altering their understanding of time and reducing their capacity to engage in non-clinical activities. However, I suggest that certain actors are able to operate outside of this dynamic and intermittently abstain from concerns related to efficiency and productivity. As such, I arrive at a vision of the ideal organiser. This is an actor who has status within their operational environment and is, thus, capable of reflecting on and changing their service.

Interviewees have indicated that status is distributed unevenly amongst professionals in NHS services. For example, 'Mary', a consultant in intensive care who has

organised processes of collective co-production, refers to an instance wherein a nurse had to gain permission to engage in non-clinical work:

> I have been in practice particularly with nurses having to ask permission to do things and I think maybe there is an element of your characteristic blue tick role.
>
> ('Mary' Interview, p.2)

In this excerpt 'Mary' asserts that professionals like nurses have to gain an explicit stamp of approval from higher-status operational actors before they are able to engage in non-clinical activities. She indicates that this is because nurses are, as a product of the responsibilities attached to their role, unable to spend time considering or making improvements to their operational environments (Ibid). They cannot, therefore, spend time learning about how to reform the services that they provide nor are they able to unilaterally alter the way in which decisions regarding provision or design are made. Rather, they must continue to deliver services within environments that are both explicitly and implicitly constrained by mechanisms of control such as targets.

However, 'Mary' (Ibid) suggests that nurses are able to "earn their colours". They are, thus, provided with opportunities to increase their status by proving that they are capable of handling their clinical work-loads and taking on a greater range of responsibilities (Ibid). In doing this nurses have in some cases gained permission from leading operational practitioners to transcend concerns related to the efficient delivery of services.[45] These nurses have, subsequently, been trusted to engage in a range of non-clinical activities like research and training ('Liv' Interview).

These examples suggest that the status of a person within a service influences their capacity to engage in developmental activities and change their environment. Nurses and other similar actors are, thus, immediately segregated from opportunities to shape their environment because they are not conventionally responsible for, or

[45] My analysis suggests that these are cases in which operational superiors have supported their attempts to engage in a greater range of responsibilities.

regularly provided with opportunities to, develop and improve their practice. This means that they are frequently incapable of overcoming mechanisms of control and engaging in organisation. On the other hand, interviewees have advised that actors like consultants, lead clinicians and specialists have an immediate capacity to directly engage in the production of operational change. These actors do not need to "earn their colours" because they are often already professionally responsible for improving their respective practices ('Mary' Interview, p.2). They are, thus, able to spend time pursuing 'other activities in education, research and management without any ambiguity about clinical responsibilities' (Frost and Wise, 2018, p.150).

In 'Mary's' (Interview, p.2) experience this ability to engage in research and learning has enabled her to implement processes of collective co-production. She states that her consultant role empowered her to eschew clinical responsibilities and unilaterally investigate the viability of collaborative decision-making within an intensive care department, as well as a number of other operational environments:

> I think that I have not had to legitimize what I am doing. I was never micro-managed. I was at liberty to go wherever the research took us. I didn't have to ask permission for anything. I think that was really key as that did two things: one it allowed me to follow the way things were going and also they trusted me and that trust in me was really important.
>
> (Ibid)

This extract indicates that traditions related to the distribution of status within operational environments are important in defining who is able to implement co-production.[46] Consultants like 'Mary' are, thus, able to spend time inquiring about, examining and changing aspects of their service environment. They are not "micro-managed" nor do they have to "ask for permission" (Ibid). Instead, their role means that they are "at liberty" to explore their working culture and change how actors operate and make decisions (Ibid).

[46] In my analysis I use the term "department" to mean singular, geographical units that exist within the NHS such as emergency departments, cardiology and pediatrics. These units provide different types of services.

This hypothesis is supported by other interviewees. For example, 'Amelia' (Interview, p.7) proposes that high ranking clinical actors like "lead anaesthetists" are explicitly provided with opportunities to spend a "certain percentage of time" participating in non-clinical learning activities. This is because lead clinicians are often tasked with engaging in forms of learning that help them to improve the quality of their working environment (Kendall and Kendall, in James, Worrall and Kendall, 2005). These actors do not, therefore, only act as clinicians. Rather, like consultants their role provides them with opportunities to investigate, examine and change their service by participating in the development of their practice and department.

Similarly, 'Liv' (Interview) argues that specialists are often provided with opportunities to participate in processes of learning that are external to their role. She states that high ranking professionals like clinical nurse specialists have received opportunities to learn about organising processes of collective co-production through their involvement in activities such as The Vanguard Programme (Ibid, p.1). This is a programme that contributes to the development of new models of care. Clinical nurse specialists and other similar actors were chosen to participate in this programme because they had a number of higher level qualifications relating to their practice (McCorkell, Brown, Michaelides and Coates, 2013).[47] This again demonstrates the role of status in apportioning opportunities to engage in learning and change services.

These examples indicate that high-status operational actors receive opportunities to implement processes of democratic governance. Their specialist, lead or consultant roles enable them to spend time examining services, engaging in learning and implementing changes to operational environments. This capacity to reflect and learn is important. As discussed in *section 1.1*, Bevir (2013, p.32) argues that 'opportunities to reimagine democracy' are precursors to the implementation of radical and participative forms of governance. This is because new models of governance are contingent on the institution of novel traditions which, subsequently, manifest dilemmas within the minds of situated agents (Ibid). Thus, processes

[47] These were actors like lead clinicians and matrons who have significant operational authority within environments like departments and wards ('Liv' Interview).

through which actors learn about new traditions, or critically examine those that have previously defined administration, may be viewed to facilitate the growth of innovative forms of governance. Accordingly, procedures like the vanguard programme and opportunities for learning that are built in to the professional roles of lead clinicians and consultants act as routes through which new traditions may be founded.

Service user challenges

Just as lower ranking professionals are regularly prohibited from organising processes of participation, SUs are frequently blocked from taking part in collaborative decision-making. The literature suggests that this obstruction often results from the notion that the design and delivery of services should be founded on technical and scientific expertise (Callaghan and Wistow, 2006). My analysis conforms to this assertion. As discussed, the desire for operational control augments and influences the understanding of many HCPs.[48] Thus, interviewees like 'Samira' (Interview, p.4) and 'Holly' (Interview, p.2) assert that SU involvement is regularly disrupted by staff members who are resistant to the prospect of losing their operational authority.

However, my analysis indicates that this relationship is often tempered by variations in professional exposure to SUs. 'Imogen' (Interview, p.2) suggests that exposure has an impact on how professionals perceive SUs. For example, short and superficial exposure to patients often produces conceptions of them as problems to be managed ('Nigel', Interview, p.5). This relationship is demonstrated in the following extract:

> Especially in intensive care unit the average maximum stay is 3 days and the patients are in a coma almost with organ support. So it is very difficult for them to see them as a whole person because they never get to see them fully clothed or talking.
>
> ('Sonia' Interview, p.10)

[48] I present this assertion at the beginning of this section wherein I consider opportunities for change in the NHS.

This excerpt shows that shorter periods of interaction between HCPs and SUs breed conditions for superficial and paternal relationships. For instance, 'Sonia' suggests that HCPs who see SUs in brief bursts and over shorter periods of time find it difficult to consider their patients as "whole" people (Ibid). These HCPs are, therefore, understood to be less likely to work with SUs because they do not interact with or learn from patients within their regular operations.

However, this excerpt also indicates that the impact of exposure is influenced by the variable of clinical identity. In suggesting that patients who are not "fully clothed" or "talking" are less likely to be understood as "whole", 'Sonia' (Ibid) demonstrates that there are differences in how exposure affects HCPs. Thus, patients who are incapacitated and unable to represent themselves may be more likely to be deemed to lack capacity, irrespective of the time that HCPs spend with them. By contrast, SUs who are able to exhibit aspects of their personality through their clothing or in the way that they communicate may be more likely to be considered as potential collaborators in decision-making (Ibid).

These propositions are supported by 'Imogen'. In the following extracts 'Imogen', a user of mental health services and NHS volunteer, explores how mental health SUs are treated. In discussing this topic she elucidates how professional exposure to mental health SUs impacts on their desire to work with patients:

> We know as a group it is not a personal thing. It is just certain services you would be surprised that there is more stigma in the NHS mental health system. Certainly around particular diagnoses…. It is just one of those things.
>
> ('Imogen' Interview, p.3)

> Staff are aware of some of us but don't forget that staff tend to see you at your worst. They very rarely see you at your good points. So, it is that fear of only knowing someone at their worst and wondering what I guess will come to the door.
>
> (Ibid)

These extracts suggest that the clinical identity of SUs impacts on the understanding of staff members. 'Imogen' shows that SUs with mental health conditions that are understood to be debilitating are less likely to be seen as capable partners. Furthermore, she asserts that staff are frequently scarred by their experiences of treating patients who have complex conditions. Thus, HCPs may develop a "fear" of collaborating and partnering with mental health SUs (Ibid).

This hypothesis is reinforced by 'Nigel'. In his interview he discusses the results of a study in to mental health stigma within the NHS ('Nigel' Interview, p.6). This study was published in the British Journal of Psychiatry and used by a UK charity called Time to Change to improve attitudes towards mental health SUs. The results of the study show that a large proportion of mental health SUs have experienced discrimination.[49]

By referring to this study 'Nigel' is highlighting that mental health stigma is 'extremely common' in NHS mental health services (Corker, Hamilton, Henderson, Weeks, Pinfold, Rose, Williams, Flach, Gill, Lewis-Holmes, Thornicroft, 2013, p.61). For example, the authors assert that there was no significant reduction in stigma between 2008 and 2011. They purport that this may be due to:

> Professional contact selects for people with the most severe course and outcome (the 'physician's bias'); contact occurs in the context of an unequal power relationship; and prejudice against the client group is one aspect of burnout, which is not uncommon among mental health professionals. The implications of this finding may bear upon 'diagnostic overshadowing', namely the provision of worse physical healthcare for people with mental disorders…
>
> (Ibid)

These points support the idea that discrimination occurs as a product of exposure to patients with particular clinical identities. The report shows that HCPs who have

[49] For more information see: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/experiences-of-discrimination-among-people-using-mental-health-services-in-england-20082011/589CC410075F7940A2D6DF287DFDB15A

regular interactions with patients in which there are 'unequal power relationship(s)' are more likely to develop stigmatised conceptions of SUs (Ibid). This is because these relationships are often characterised by an inherent inequality in respect of the extent to which SUs are capable of pushing their perspectives in comparison to HCPs. Thus, interactions between these actors are dominated by provider figures.

'Nigel' (Interview, p.6) suggests that this inequality reproduces an understanding of the value of clinical knowledge. In frequently interacting with SUs who find it difficult to express themselves or promote their perspectives, HCPs are reminded that they hold an effective and conducive form of expertise. As such, 'Nigel' suggests that learnt understanding regarding the value of clinical expertise acts as a barrier to co-production:

> The reason is that they think that they have expert knowledge. That is our biggest enemy in co-production in mental health, is people who have very fixed views about their patients. Maybe they have had bad experiences, but they aren't open to reconsidering it, they think they know.
>
> (Ibid)

Thus, I do not suggest that co-production is necessarily and directly resisted as a product of the value attached to professional expertise. Rather, my analysis shows that variables related to professional exposure and clinical identity influence how HCPs understand and value knowledge. Collective co-production is, thus, a function of the traditions that impose on the ontologies of staff members within the multitude of operational environments in the NHS. Staff who work in arenas in which they are regularly exposed to SUs who are capable of representing themselves are, therefore, more likely to envisage possibilities for partnership. By contrast, HCPs who work in departments wherein they are exposed to patients who cannot, as a product of their conditions, speak or engage in self-care are likely to view partnership as undesirable. In this way patients who have complex clinical identities may be prohibited from shaping the services that they use.

Conclusion: relations, priorities and service user capability

In this section I explore the NHS as an institution in which there are a number of traditions that influence the implementation of collective co-production. I suggest that traditions define strategic and operational roles within NHS services. These traditions orient understanding of purpose and provide HCPs with limited operational agency. Furthermore, I discuss how traditions associated with political economy reduce the capacity of operational actors to engage in and implement innovations. These traditions are reproduced through mechanisms like targets and deadlines and impose on operational notions of time. Finally, I consider how notions of patient capacity impinge on partnerships between HCPs and SUs and propose that variables of exposure and clinical identities influence notions of SU capability.

In studying these traditions I suggest that certain HCPs are able to engage in organisation. These are actors whose status enables them to overcome the influence of compliance mechanisms and participate in processes of learning. Furthermore, these are actors who are able to shape their operational environment and persuade colleagues to accept and participate in collaborative processes. In considering these factors I now turn to the study of the department as a location within the NHS. In *section 4.3* I explore how interviewees understand departments and consider how departmental traditions affect the implementation of collective co-production.

4.3: Departmental culture within the NHS

I have shown that the implementation of collective co-production is often influenced by traditions that shape understanding of stakeholders and impinge on conceptions of work. These traditions structure relationships between communities by defining notions of status and capability and delineating who can engage in learning. However, these are not the only traditions that influence the implementation of decision-making processes. Traditions are also created through relationships and interactions that occur within departments. In the following analysis I consider how interviewees describe departments. As such, I examine how departmental traditions impinge on the implementation of collective co-production. These are traditions related to proximity, time, pre-existing involvement opportunities and intra and inter-departmental interactions.

Proximity to the institution

Departments are not all alike ('Keira' Interview, p.5). Many operate differently, valorise distinctive norms and work with different types of SUs (Ibid). As such, it is vital that I do not take for granted the nature of departments by viewing them as homogenous and determined by the institution. Rather, it is important that I recognise that departments are both related to and separate from the institution.

A number of interviewees suggest that the relationship between the institution and department can be explored through an analysis of how departmental proximity to the institution affects implementation. It is suggested that certain departments benefit from distance as, like the operational actor to the strategic actor, they enjoy greater agency. Thus, appreciation of factors related to co-production may increase the further a department is from the 'big system' ('Holly' Interview, p.3). This proposition is demonstrated in the following extract:

> Interviewer: when you meet individuals that really, for want of a better word, 'get it'. In your impression of these people what makes them different to those who are more reticent?
>
> 'Holly': that's an interesting question. Some of the people who have been most pro are the people who have been working as GPs and actually GPs are, although they work within the NHS, not a part of that big system. They are independent and own, or part own, the practice that they work for and they kind of work for themselves. They have a lot of freedom I think.
>
> (Ibid)

The freedom of the department may, therefore, be a variable in enabling operational appreciation of processes such as co-production. This is because institutional isolation separates a location from those "systems that stop everybody" from thinking and acting differently ('Roxy' Interview, p.4). Normative appreciation of values like equality may have not yet been corroded by the caustic nature of "regulations", "paperwork and process and administrative problems" (Ibid). These

aspects of work "grind people down and everybody is dealing with that" (Ibid). This correlation conveys that traditions related to the institution play an important role in shaping how individuals who operate within departments conceive of their work and consider opportunities for collaboration.

Departmental culture and time

This is not to say that institutional conditions impose on proximate departments to the extent that they risk homogeneity. My analysis shows that there are myriad departmental traditions that influence the ontology of actors. One of these traditions is understanding of time. The way in which certain departments are associated with particular notions of time impacts on the normative appreciation of actors within institutions. This is represented by 'Mary':

> One of the big things I recognised was that within urgent care you have to be quick in decision making, quite pacey, work at a fast pace and prioritise. But when you work within network care the culture was sort of 'manana'.
>
> ('Mary.1' Interview, pp.2-3)

Different departments, thus, have dissimilar conceptions of time. As a result of the urgent nature of their treatment, intensive care departments prioritise speed. By contrast, other departments valorise careful consideration (Ibid). As such, collective co-production within the former environment may be more difficult than in the latter.

'Mary's' testimony, therefore, suggests that the treatment pathway of an illness acts as a prism through which notions of time are structured. For instance, urgent care departments are fast-paced medical environments. In these environments "quick decision-making" and working "at a fast pace" are norms. By contrast, other departments work at a slower pace. For example, 'Mary' (Ibid) asserts that long term illnesses like lung cancer promote a gentler working tempo. In these departments professionals and SUs are able to regularly interact and form longstanding relationships.

This evidence conveys that a defining variable of departments is the way that they are associated with time. Those conditions deemed by professionals as short-term and pressing block collective co-production. Their critical nature reduces opportunities for regular communication between SUs and HCPs. Thus, high-status actors in emergency and urgent treatment departments are often less inclined to engage in processes of learning that are orientated around increased communication and the use of collaborative decision-making (Ibid).

The presence of existing involvement opportunities

Another departmental tradition found in my analysis is the presence of existing involvement opportunities. Departments that provide established methods of personalised care are often open to collective co-production. For example, NHS maternity services provide SUs with personalised care plans ('Amelia' Interview, p.4). In doing this patients are permitted to choose the provider of their services and make decisions about the support that they receive (NHS England National Maternity Review, 2016, pp.101-102). 'Amelia' asserts that expecting mothers experience this involvement throughout the period in which they are in receipt of services ('Amelia' Interview, p.4). This means that HCPs in maternity wards often appreciate, and learn to be a part of, involvement processes.

'Amelia' (Ibid) suggests that the slow process of working with SUs across the pregnancy cycle provides an appreciation of the benefits of interaction. This has meant that those working in maternity departments are frequently open to the prospect of participating in involvement processes that enable SUs to be actively engaged in decision-making:

> …in some senses it feels like an almost natural extension of already having, and already developing, a much more interactive role as you go through personalised care. Lots of the agendas within better births are around women being much more involved and it feels like this is just a natural extension of that.
>
> (Ibid)

Of course, existing involvement opportunities are not always as explicit as personalised care in maternity departments. In many cases individual co-delivery activities embed an understanding of, and an appreciation for, collective co-production. For example, dieticians implicitly manifest individualised forms of co-production (‘Renata’ Interview, p.1). This is because they often combine their clinical knowledge with contextual information relating to their patients:

> Yes definitely. You need to engage with the patient one by one and with the families when they go home as well. You are used to engaging with the whole family. Yes, so possibly that did help me.
>
> (Ibid, p.4)

This extract implies that dieticians are ideal candidates in respect of organising, or taking part in, collective co-production (‘Liv’ Interview, p.6). This is because they already appreciate the benefits of including lived experiences in decision-making. Thus, their involvement in co-delivery may contribute to their wider involvement in activities that require citizen voices such as co-commissioning or co-design.

However, this hypothesis is tempered by the notion that organising actors need to have status within their respective environments. As discussed in *section 4.2*, traditions related to status enable actors to overcome compliance mechanisms and engage in processes of learning. These activities, consequently, empower high-status actors like lead clinicians and specialists to alter their operational environment and implement innovative processes like collective co-production. By contrast, lower-status actors find it difficult to implement collective co-production. In our interview ‘Renata’ demonstrated that her low-status role hampered her attempts to implement collective co-production:

> I think maybe if we had someone in the org. Like if we had the consultant he could have talked to the powers that be to organise that. But we didn’t have that person.
>
> (‘Renata’ Interview, p.9)

This passage speaks to the value of high-status professional roles. Had 'Renata' been an operational leader who was responsible for improving her practice then, perhaps, she would have been capable of implementing processes of collective co-production.[50] This supposition is supported by her assertion that "consultants" often have sufficient status to implement changes in operational environments (Ibid). As proposed in *section 4.2*, these types of actors are regularly empowered to alter the operational environments in which they work. This is because they are commonly responsible for maintaining and increasing the quality of care that transpires in their departments. As such, I propose that the valorisation of lived experience, exemplified in the testimony of 'Renata', is insufficient in respect of implementing collective co-production in NHS services. Rather, normative understanding needs to be complemented by traditions that provide status, thereby enabling actors to alter their environment.

The presence of co-productive norms within a department

My analysis has also shown that departmental norms are important in defining how professionals react to and engage in collaborative processes. Some departments operate under the influence of normative frameworks that are conducive to the values of co-production. This does not mean that these departments manifest collective co-production. Departments that operate in this way would not necessarily provide SUs, carers and other stakeholders with opportunities to equally interact with professionals. Rather, they are defined by egalitarian relationships between professionals:

> What came out of the staff interviews was how little hierarchy they feel that there is. So the anaesthetists, midwives and obstetricians work pretty effectively and we have worked quite a lot to remove hierarchy in terms of being able to ask questions and create a safety culture…
>
> ('Amelia' Interview, p.5)

[50] See my exploration of the testimonies of 'Mary', 'Liv' and 'Amelia' in the *section 4.2* for an example of how high-status supports organisation.

This extract displays how departments often operate co-operatively. In these departments structures related to identity are reduced. Furthermore, the liberty of provider figures is increased, thereby enabling professionals to interact with one another on equal terms (Ibid). By contrast, the presence of an established order often produces co-productively antithetical outcomes. This is because departmental hierarchies are linked to an inability to consider the value of partnering with actors like dieticians and nurses who are, in many cases, of lower-status:

> …but there are references to the fact that the nurses who come from almost a completely different planet in terms of hierarchical structure and rules and checklists to the midwifery and the obstetrics' side. So that is going to be the biggest challenge I think is letting… You don't concede your own professional standards by embracing a different attitude or set of behaviours towards women. That doesn't have to impact it. It just layers on top of your high professional standards…
>
> (Ibid)

Consequently, departmentally ingrained equality influences appreciation of co-production. This correlation is supported by 'Gareth' (Interview, p.4) who asserts that staff who do not feel confident enough to question decisions within their own departments may not desire engagement in collective co-production. This is because staff often need to feel as if they operate within an environment that encourages reflection and open engagement (Ibid). Through this environment staff members appreciate the benefits of collaborative decision-making as they themselves have been included in the production of change within their own operational ecosystems.

The impact of departmental barriers on collective co-production

My preceding analysis has focused on collective co-production in singular departments. However, this demarcated vision is not inevitable. As such, there is a necessity to consider the possibility for processes of collective co-production that encompass different departments. Processes that deal with cancer are examples of this. This is because cancer is "a pathway through the trust" and often involves "a lot of different departments" ('Mary' Interview, p.11). Accordingly, opportunities to

learn about departmental cultures are important in the manifestation of cancer related collective co-production. This may occur naturally as some departments encourage "co-location" wherein individuals from different departments regularly "talk and have good relationships" ('Roxy' Interview, p.4).

However, interviewee testimony shows that co-location is rare within NHS services. Even in respect of illnesses that require pathways through the trust there seem to be relatively few formal opportunities for professionals from different locations to interact:

> A lot of different departments are involved along the way and this project enabled us all to get in to the same room at the same time and talk about the whole process from the patient's perspective. That has never happened before. You think why not? Why has this never happened before? It hasn't happened. I guess in intensive care it is a geographical unit, as are the other departments I have researched. But cancer crosses the whole hospital.
>
> (Ibid, p.11)

This passage conveys that departmental segmentation is often accepted within NHS services. It portrays that departments are considered in reference to their geography. This means that departments are defined by the spaces in which their HCPs regularly operate.

'Amelia' advances on this hypothesis. She suggests that professionals frequently eschew opportunities for co-location in departments such as maternity. Surgeons are, thus, viewed to encroach on maternity staff within situations in which expecting mothers require caesarean sections ('Amelia' Interview, p.8). In these circumstances the surgery and maternity staff have to work together "in theatre" (Ibid). However, no regular attempt has been made to establish notions that they are a collective. Consequently, staff have suggested that surgeons "come from a different planet" (Ibid). This is because staff "learn differently", "don't do any training together" and "There is no common forum." (Ibid). Thus, the absence of co-location is viewed to impinge on the possibility for collaborative activities within the NHS.

Processes of collective co-production may, therefore, experience difficulties when they require the transcendence of departmental barriers. This complication has been overcome through processes of negotiation. 'Amelia' asserts that she was able to implicitly transmit an understanding of the importance of creating a collective whilst 'selling' her process to potential participants. Thus, she was able to manifest value in the idea that her process would bring "everyone together to be patient centred and understand each other much better" (Ibid, p.9). This example demonstrates the importance of organiser status. Furthermore, it shows that 'Amelia's' understanding of the mores of the department, as well as her apparent expertise in connecting with different departmental cultures, meant that she could understand and negotiate with diverse operational actors. In this way status, and the ability to spend time understanding culture, are important factors in the implementation of co-production.

Conclusion: time, existing involvement, hierarchies and departmental culture

In this section I examine how departmental culture impacts on implementation. In doing this I suggest that many of the norms and values that promote or block democratic governance arise as a result of the peculiarities of departments. For example, proximity, understanding of time, established forms of involvement and departmental hierarchies all affect implementation. Taken together these factors promote an understanding of how departmental environments act as catalysts for implementation.

In my analysis the majority of these factors were found within singular departments. However, many issues cut across departments. The treatment of a multitude of conditions require pathways through trusts and demand the expertise of a number of different actors. In this sense it is important to consider the ability of organisers to bring together diverse actors from within the NHS. In considering the multifaceted nature of collective co-production I show that traditions related to status are important. Moreover, I suggest that a desire to learn about departmental cultures is valuable.

4.4: Types of organisers: implementing collective co-production Within the NHS

In the preceding sections of this chapter I examine how traditions associated with macro, meso and micro levels of NHS services influence the implementation of collective co-production. I show that traditions related to market ethics, strategic distance, paternal norms, learning and development, proximity, notions of time, pre-existing participation and departmental culture impinge on implementation. These traditions influence the capacity of individuals to change their environment. They restrict actors with low-status by reducing their ability or desire to implement collaborative processes. This means that nurses, dieticians and a host of other actors often find it difficult to engage in implementation.

Other actors are less bound by these traditions. I propose that those with high-status are often capable of transcending concerns related to efficiency and productivity. These actors harness the division between strategic and operational levels of the NHS and spend time reflecting on the value of collaboration. I expand on this hypothesis in the following section. In doing this I examine how two actors, entrepreneurs and standing groups, engage in organisation. Entrepreneurs are internal actors who participate in developmental and innovation activities alongside their conventional clinical duties. By contrast, standing groups are lay collectives who operate in NHS services and engage in regular learning and research activities.

Entrepreneurs: powerful professionals

Entrepreneurs are characterised by a willingness to act on issues that they deem to be important. These actors reflect on the inadequacies of their working conditions and engage in activities that address perceived issues (‘Liv’ Interview, p.1). For example, the entrepreneur might notice that a particular group of patients has fewer opportunities to participate in collaborative decision-making in comparison to other SUs:

> The words (co-production) get bandied around and I find that really challenging because for the group of people that I work with. Their words are so important. If someone says they are going to be working alongside us they don't question that, unlike me. I think that what people say and do is different and that makes things very difficult for people with a learning impairment.
>
> ('Keira' Interview, p.2)

This extract shows that 'Keira' had the capacity to both recognise and mitigate for a perceived issue. She saw that a certain group of people were often marginalised within NHS services. Moreover, she did not passively assent to this marginalisation: perceiving it to be a natural facet of the healthcare system. Rather, she worked proactively to support the community to engage in co-production:

> I think we are very good at saying the right thing but not doing the right thing. I repeatedly say that back to the board, "Your behaviour doesn't reflect what your values are"
>
> (Ibid)

This passage suggests that 'Keira' challenged senior administrative actors to overcome what she viewed to be a democratic deficit within the care of the learning impaired. In this sense I contend that 'Keira' had a pre-existing understanding of the value of co-production. The fact that she addressed the issue by turning towards a position that advocated for empowered participation indicates that she had already reflected on the value of lived experience and collaboration. Empowered participation was, therefore, a powerful belief within 'Keira's' working life. This belief encouraged her to innovate and generate democratic processes within her department.

Not all actors are capable of obtaining this kind of understanding. 'Keira' (Interview, p.6) argues that "key individuals" in NHS departments are more likely to be appreciative of co-production. These people have the operational authority to spend time reflecting on the need for greater participation and the status to then "champion

the value of user experience" (Ibid).[51] This proposition suggests that people who are capable of making changes to their environment are important players in the implementation of collective co-production. They need to own their practice. In this way they have opportunities to "think differently" and "get around barriers" (Ibid).

This supposition is supported by 'Amelia'. In her interview she describes her journey towards entrepreneurship. In doing this she asserts that she was free to consider and reflect on aspects of the care that she was providing prior to the implementation of collective co-production. These reflective activities enabled her to learn about the value of patient participation in the design of services:

> I used to follow women up after labour or after coming to theatre to have a baby and sit and chat to them. They would often have a lot to say about what had happened to them. But that wasn't represented in any kind of checklist that we would ask them to fill in to give some kind of numerical rating of their experience. The qualitative stuff wasn't represented in any way.
>
> ('Amelia' Interview, p.1)

The above extract shows that 'Amelia' spent time talking to patients about their experiences in the NHS. It conveys that she did this because she wanted to reflect on the adequacy of her care. This illustration suggests that 'Amelia' had power within her environment. Her role as a lead clinician may have, therefore, provided her with a means to build on and harness beliefs related to the greater inclusion of patients. This is because lead clinicians often have powers to engage in forms of development:[52]

> I am an anaesthetist and within that job as the lead I started to attend forums that involved users.
>
> ('Amelia' Interview, p.1)

[51] I consider how operational status often enables actors to have the capacity to reflect in *section 4.2*.
[52] See my discussion of the lead clinician role in *section 4.2*.

This passage suggests that high-status actors take advantage of learning opportunities. In 'Amelia's' experience she had the freedom to harness regular learning opportunities that were afforded to her as a function of her status. Through these opportunities she spent time attending patient forums and talking to patients. In this way 'Amelia' considered the inadequacy of regular participative processes, as well as the value of empowering patients to share their voices:

> I figured there was something in that. In terms of using women's experiences to shape… not as an afterthought but to actually feed very much in to our behaviours and attitudes and the way we frame making women welcome in theatre.
>
> ('Amelia' Interview, p.2)

Accordingly, I suggest that 'Amelia' used her situated agency to consider new ways of working.[53] The above extract shows that her reflective and developmental experiences augmented her understanding of ways in which to provide and improve care: acting as routes through which new traditions emerged. These traditions may have, subsequently, conflicted with more established norms such as those that had previously defined her understanding of care. 'Amelia' indicates that these norms advanced the value of clinical expertise and promoted an understanding of lived experience as an ancillary form of information (Ibid).[54] However, it is clear that her emerging understanding of participation enabled her to overcome the influence of these norms and implement an empowering participative process that examined female experiences of maternity wards.

Of course, there is a difference between learning about participation and implementing collective co-production. Entrepreneurs need to have status within their working environment to practically implement co-production activities. This is because high operational status enables entrepreneurs to negotiate with alternative sources of operational authority:

[53] See my discussion regarding Bevir's (2013) hypothesis of the value of reflective practice as a route through which to conceive of new forms of governance in *section 1.1*.
[54] I examine how the literature considers that traditions affect understanding of care in *sections 1.1* and *1.4*.

> I put together a project proposal plan and estimated how much time it would take me. I then went back to our lead clinician and had a chat with her and said this is how much time I think it will take me over the next 6 months, do you think this is something that we should prioritize at the moment? I think that was helpful in actually doing the project because we ran pretty much to time.
>
> ('Liv' Interview, p.2)

This passage shows that entrepreneurs negotiate with other actors when implementing processes of collective co-production. Furthermore, it demonstrates that negotiations are supplemented through an understanding of the traditions that influence the negotiating partner. In the case of 'Liv' these were traditions relating to time. The lead clinician with whom she had been negotiating felt that colleagues may not have the time to participate in processes of collective co-production. Thus, 'Liv' needed to demonstrate that she would address this issue within her "project proposal plan" (Ibid).

The success of negotiations are often contingent on the entrepreneur understanding the conditions in which the negotiating partner operates. In discussing how she negotiated with an authority figure 'Amelia' (Interview, p.8) suggests that she had to investigate departmental culture. In doing this she understood the value of variables related to quality:

> I think I had to use the word quality a lot. The emphasis also within the project, as well as on women and co-production, was about staff development process that would be a result of it.
>
> (Ibid)

This extract suggests that entrepreneurs need to be capable of exploring the traditions that define particular NHS environments. Furthermore, it conveys that these traditions should be acknowledged and included in the methodology and aims of the participative process. As such, I hypothesise that entrepreneurs need to have the capacity to spend time learning about the working cultures of departments and

the actors who operate within them. This again demonstrates the importance of status in providing opportunities for operational actors to orient their working life around learning.

Standing groups: service user collectives

Entrepreneurs regularly benefit from traditions that orient power within the NHS. Their specialist and leading professional roles often provide them with status through which they are afforded opportunities to reflect on the inadequacies of their working culture and implement new decision-making processes. By contrast, standing groups do not directly rely on status to implement reform. This is because they are formal spaces within the NHS wherein SUs engage in research activities:

> The standing group are a group of volunteers that meets weekly and their role and remit is to undertake any aspect of mental health research they are interested in.
>
> ('Teresa' Interview, p.6)

To achieve this standing groups emphasise that their ambitions are not limited to influencing service design. Rather, they show that they also want to improve the efficacy of participating SUs ('Imogen' Interview, p.7). This ambition is commonly realised through regular meetings wherein SUs interact, build solidarity and generate understanding of themselves and others:

> We do a lot of preparation to get the individual ready to just, you know, get beyond their own story, start listening to other patient's stories that might be different from theirs and also start listening to staff stories.
>
> ('Nigel' Interview, p.2)

This passage suggests that standing group members are not immediately ready to engage in the implementation of research activities. Rather, they have to be taught to understand their own story and empathise with those of a variety of stakeholders. 'Nigel' supports this notion. In his interview he asserts that standing group members are taught to reflect on their lived experiences and trained to gain "mastery" over

their story (‘Nigel’ Interview, p.1). This preparatory training enables standing groups to work in trusts: manifesting participative research projects that involve patients and HCPs (‘Imogen’ Interview, p.3).

This necessity to learn was also noticed in my analysis of entrepreneurs. Like standing group members, entrepreneurs often spend time reflecting on the value of citizen voices. This reflective practice was demonstrated in ‘Amelia’s’ (Interview, pp.1-2) narrative wherein she discusses how conversations with patients acted as a catalyst in developing her understanding of participation. Thus, I again hypothesise that traditions which encourage learning and development are important variables in supporting implementation. These traditions promote an understanding of participation and enable organisers to critically examine NHS services.

Of course, curiosity and a desire to learn count for nothing if standing groups cannot implement processes of collective co-production. As discussed in *section 4.2*, operational actors often have significant levels of agency and possess stigmatised impressions of SUs. This means that HCPs frequently resist the work of standing groups. For example, ‘Imogen’ (Interview, p.3) asserts that HCPs have resisted her attempts to increase collaboration because of her identity as a user of mental health services.

Accordingly, standing groups have to prove their efficacy within NHS environments. This necessity contrasts to the experiences of entrepreneur interviewees none of whom suggested that their capacity to implement participatory innovations had been actively resisted. Rather, the leading and specialist status of the entrepreneur often provides this actor with the freedom to engage in the implementation of collective co-production.[55] As such, interviewees suggest that standing group members regularly participate in preparatory activities that enable them to form relationships with staff members:

[55] This is a freedom that is often born from the status of the entrepreneur whose leading role enables him/her to change their working environment and persuade colleagues and peers to accept or engage in processes of collective co-production. See *sections 4.2* and *4.4*.

> We do spend a lot of time trying to break down those barriers and do a lot of other work really, purely staff-focused work, just to get a relationship with these people. So that when we get asked to do larger projects or research based projects we are not seeing so much fear.
>
> (Ibid)

Standing groups ask their members to explore NHS environments and build affiliations with staff. As such, members often shadow HCPs, learn about operational traditions and manufacture inter-community relationships. These activities enable standing group members to build trusting relations with HCPs:

> You can't battle it otherwise you just get in to a battle. I'm not being funny but you want to battle it. With all your heart you want to battle it. So the standing group has to be the grown up and has to build trust. I would say that where that trust doesn't work the project doesn't work and you have to abandon it.
>
> ('Nigel' Interview, p.6)

This extract shows that trust is as an important variable in supporting the work of standing groups. As such, preparatory forms of learning in which members examine and empathise with the operations of staff are vital. These processes promote an understanding of HCPs as actors who are limited by a range of traditions that diminish their capacity to engage in or support collective co-production. Thus, learning processes enable members to augment their ambitions around the operational realities of staff members. This often acts as a catalyst for their participation. For example, 'Imogen' (.1 Interview, p.3) indicates that an understanding of the conditions in which HCPs operate, as well as an appreciation of the regular changes that occur in respect of the priorities of departments, has promoted a vision of her standing group as trustworthy. This means that 'Imogen' has been able to increase HCP participation in her participative research activities:

> Obviously depending if there are any particular incidents, rather than attending things where people are stressed or whatever has happened that day or that week, we will say 'look we know you have things going on. Give us another day and we will come back.' That is something they really appreciate as well. So they are quite happy with the flexibility on that side of it.
>
> (Ibid, p.5)

The necessity to learn is supported by the fact that standing groups are often in existence for long periods of time. In many cases groups do not have a high-turnover of members. My analysis shows that members are frequently resident within standing groups for a number of years ('Nigel' Interview, p.3). This means that there is a possibility that standing groups "outlast many of the problems that are thrown our way" (Imogen.1, p.9). They will not be harmed by a sudden and institutional turn towards prudence. Nor will their objectives be damaged by an unexpected medical crisis. Instead, standing groups are capable of biding their time and waiting for the right moment to begin, or recommence, working ('Nigel' Interview, p.2).

As such, I suggest that standing groups value learning and development. Whilst entrepreneurs balance their reflective activities alongside clinical duties, standing groups only exist to implement forms of research. This means that they have an incentive to wait for, or indeed create, conditions that support their investigative ambitions. Accordingly, standing group members engage in learning activities throughout the life cycle of their group. This enables them to reflect on operational conditions, change their work and engage in the implementation of processes like collective co-production.

Conclusion: status, learning and the organiser

In the preceding analysis I explore the identities of the entrepreneur and standing group. In doing this I suggest that entrepreneur and standing group implementation is contingent on variables related to status. Entrepreneurs regularly engage in implementation due to their position as high-status professionals. They are actors like lead clinicians whose roles enable them to learn about and manifest processes wherein citizens express their voices. By contrast, standing groups are less immediately able to engage in organisation. This is because they are comprised of members from patient communities and are, therefore, subject to traditions that promote notions of patient capability. However, this does not mean that standing groups are not valid organising actors. Their long-term nature enables them to explore the NHS and form relationships with professionals. In this way they appreciate the inherent volatility of the service and understand how to account for the demands placed on operational actors.

Overview of Chapter 4

In this chapter I explore how traditions influence the implementation of collective co-production in NHS services in England. I argue that external traditions such as contemporary political economy and legislation impose on our understanding of the NHS. However, I suggest that these traditions play a limited role in promoting collective co-production. This is because implementation is often contingent on the work of actors who operate within services. These are actors like entrepreneurs or bodies such as standing groups who are able to spend time learning about and organising collective co-production. Ideally, these collective co-production processes would conform to the normative framework provided in *section 3.2*. Organisers should, therefore, initiate supplementary procedures that promote representation, accessibility and solidarity and produce open interactions between stakeholders.

Chapter 5: Preparing for collective co-production

In the literature scholars consider a number of processes through which to support the implementation of co-production (see *section 1.4*). They propose processes that generate representative samples within decision-making (Loeffler and Bovaird, 2019); improve the efficacy of participants (Bovaird and Loeffler, 2016; Ostrom, 1996); and enable citizens to contribute to an outcome or a set of outcomes that are important to them (Pestoff, 2012). This chapter builds on these propositions. I consider interviewee experiences of supplementary processes through which collective co-production activities are often implemented. These are processes of recruitment, co-design and preparation.

My analysis of interviews shows that these supplementary processes enable organisers to increase representation, generate accessibility and manufacture solidarity. This is because they promote understanding of stakeholders, enable co-producers to reflect on their lived experiences and, subsequently, empower participants to produce service improvements. As such, I propose that this chapter be read in conjunction with my analysis of collective co-production embedded within *Chapter 3* (see *figure 16*). In this chapter I discuss how my analysis of interviewee testimony has enabled me to produce a normative definition of collective co-production. Thus, the following analysis should be considered to conform to, and supplement, this normative definition: portraying how the values of representation, accessibility and solidarity are realised.

In *section 5.1* I study how organisers of collective co-production achieve representative samples of stakeholders. In doing this I consider the importance of exposure as a variable in delineating how organisers achieve representation. This is because exposure enables organisers of collective co-production to appreciate communities as comprising of a multitude of people with complex identities. Furthermore, in *section 5.2* I examine how co-design provides citizens with opportunities to influence the methodology and ambition of collective co-production. In doing this I argue that processes of co-design enable organisers to address inequalities and, consequently, empower participants to shape the meaning of interactions and engage in the construction of governance.

Finally, in s*ection 5.3* I explore how explicit preparatory processes promote equal and empowered interactions. I begin by examining how preparation increases the accessibility of collective co-production. This occurs through processes that improve conceptions of the self and that reduce information asymmetries between participants. I then examine how preparation promotes notions of collective purpose. This outcome transpires through processes that encourage solidarity and that reduce professional resistance.

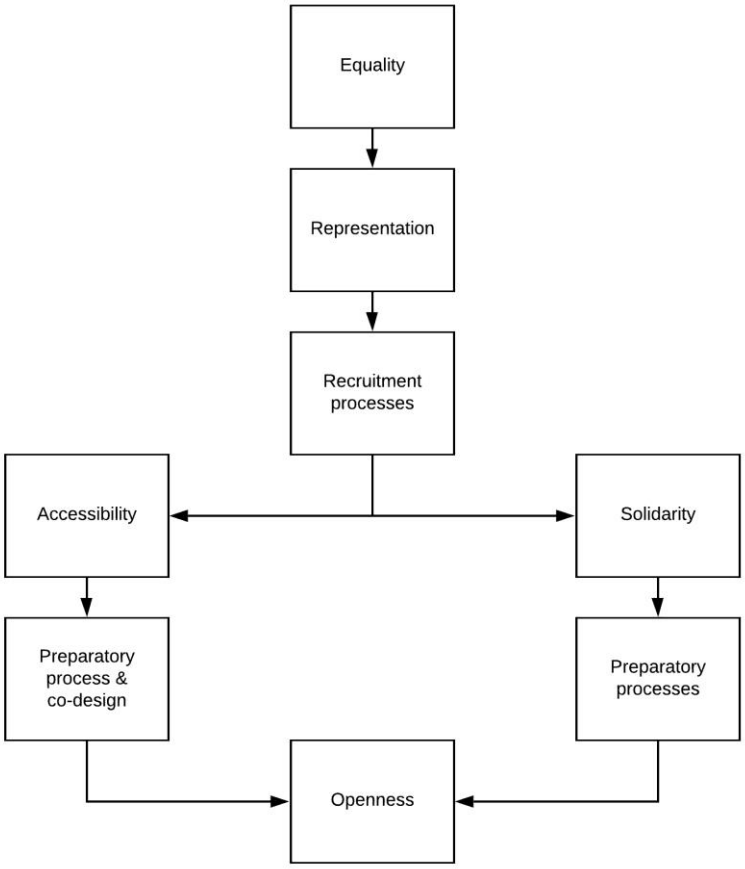

Figure 16: Showing how collective co-production occurs through processes that improve representation, accessibility and solidarity.

5.1: Representation and Recruitment

In *section 3.2* I examine the necessity for the participation of a greater range of actors within collective co-production. In doing this I touch on the work of Leach (2006) who proposed that the inclusion of an array of stakeholders is an important facet of decision-making. These are people who are affected by decisions made within participative forums. Thus, Leach (Ibid, pp.101-102) spoke to the value of contextual knowledge in supporting the participation of people from different generations, class backgrounds, regions and economic divides. In the NHS these community variations are different. This is because service users (SUs), healthcare professionals (HCPS), carers, volunteers, local authority workers and members of other communities are all affected by the provision of services.

However, organisers also need to appreciate that notions of representation often go beyond the participation of stakeholder communities. As I discuss in *section 3.2*, organisers should understand that communities contain many complex forms of identity. In the following analysis I examine how interviewees suggest that organisers achieve complex representation. To do this I explore how entrepreneurs and standing groups understand stakeholder populations and highlight the importance of exposure to stakeholders in manifesting representative recruitment.

Implementing a representative process

Organisers need to appreciate their stakeholder population. This appreciation often occurs through an understanding of stakeholders as the people to whom particular services and decisions are relevant. Such a notion is supported by Verschuere, Vanleene, Steen and Brandsen (in Brandsen et al, 2018, p.244) who assert that:

> It is, after all, important, and a matter of legitimacy, that those who are affected by co-produced services or by participatory decision-making are also included in the process, and have an actual influence on the outcome.

In this extract the authors suggest that representation is a function of our understanding of who is ‘affected’ by a service. Thus, Verschuere, Vanleene, Steen and Brandsen (Ibid) declare that the ‘affected’ should be empowered to participate in

and ‘have an actual influence on’ decisions made regarding the services that affect them.

This perspective promotes an understanding of stakeholder populations as consisting of broad communities of actors. The ‘affected’ are citizens, workers, interest groups, associations and local partners (Barbera et al, 2016, p.1089). However, critics suggest that this understanding of representation may lead to ‘the exclusion of particular groups’ (Michels, 2011, pp.285-286). In the literature exclusion is often considered to be a product of structural factors (Agger and Larsen, 2009). These are inequalities of resources, skills and networks, amongst other variables. This notion is evidenced in Lombard’s (2013) case study of neighbourhood participation and urban governance in Mexico. She shows that inequalities of class and income impact on citizen participation by reducing the likelihood that lower socio-economic actors engage in democratic processes.

Thus, notions of representation as consisting of the ‘affected’ are regularly supplemented by processes through which to recognise and capture the complexities that are embedded within communities (Barbera et al, 2016, p.1096). Denters and Klok (2010, p.588), for example, discuss the value of ‘mobilisation campaigns’ wherein organisers of participatory processes directly invite a range of stakeholders to participate. They suggest that this process enables organisers to mitigate for issues related to the self-selection of participants: an approach that is often considered to result in the participation of ‘the usual suspects’ (Ibid; Vanleene and Verschuere, in Brandsen et al, 2018, p. 200). These are people who, as a product of their educational and professional identities, regularly participate in civic and community activities (Goodlad, Burton and Croft, 2005).

However, Interviewees suggest that targeted recruitment can be difficult to achieve. In the following extract ‘Nina’ asserts that a participation event that she helped to organise did not achieve a representative sample of stakeholders. This is because ‘Nina’ and her fellow organisers held the event in the “early afternoon” and did not engage people from ethnic minority backgrounds:

> …we only got 30 people and there were groups that weren't represented at all. We didn't have any gypsy travellers. We didn't even have any ethnic minorities at all. Everyone was white in the room. We didn't have any children or young people partly because we had to turn around the event quickly and we just ran it at early afternoons in a community centre so everyone was at school.
>
> ('Nina' Interview, p.7)

Whilst this may not have been an explicit choice, the preceding passage indicates that the decision of the organisers to hold their event at a particular time promoted the participation of SUs who could attend in the "early afternoon" (Ibid). Thus, people who were at work, attending school or had other responsibilities were excluded from taking part. Moreover, their failure to enable the inclusion of ethnic minority actors further narrowed the range of participants. This resulted in a limited cohort of older and "white" individuals (Ibid).

The above extract, thus, speaks to the inadequacy of 'Nina's' approach to recruitment. Her assertion that she "had to turn around the event quickly" suggests that she and her fellow organisers were unable to consider the value of, or engage in processes through which to facilitate, wider representation. Accordingly, 'Nina' underscores the virtue of knowledge in promoting the participation of groups such as "gypsy travellers" and "young people" (Ibid).

In the following extract 'Nina' advances on this proposition. In doing this she suggests that processes through which organisers learn about stakeholder identities improve their capacity to facilitate wider representation:

> If you really want to engage citizens we need to find them where they are. We still are, by default, self-selecting because people feel comfortable enough to come to this kind of environment.
>
> ('Nina' Interview, p.7)

The supposition that one needs "to find them where they are" supports the emerging hypothesis that knowledge imposes on the realisation of representation. In doing this,

however, the interviewee implicitly criticises the reified forms of knowledge that are often valued within NHS services. She indicates that the classification of stakeholders as patients, carers and professionals provides few means to understand how identities are situated within society. They do not tell us about stakeholders as people. In this way they do not provide clues as to their social identities, experiences or ontologies. As such, 'Nina' (Ibid) proposes that organisers consider stakeholders on their terms and engage with notions of identity that are separate to the empirical classifications conventionally used within NHS services. These are historically and societally situated notions of identity that are meaningful to stakeholders.

Thus, I advise that organisers' understanding of the backdrops against which identities are formed may determine the representativeness of collective co-production processes. This hypothesis is advanced by de Graaf et al (2014) who suggest that organisers with high levels of stakeholder exposure often achieve the participation of diverse arrays of participants. These organisers spend time interacting with and acquiring knowledge of stakeholders. As such, they may consider stakeholders to be more than just patients, carers, clinicians and family members who are affected by services. Rather, they may envision representation to be a function of their understanding of how actors who are affected by situated traditions interact with services. In this way representation becomes a facet of their capacity to learn about and appreciate identity, rather than a concept through which to involve an array of reductively classified characters.

Interviewees suggest that entrepreneurs benefit from regular interactions with different stakeholder communities. Their enduring work caring for SUs exposes them to the experiences of a variety of stakeholders.[56] This is because the departments in which entrepreneurs work are sites within which a multitude of stakeholders regularly assemble. Patients, carers and family members are seen in consulting rooms, wards, corridors and a number of similar institutional locations. Therefore, entrepreneurs do not "need to find them (stakeholders) where they are" ('Nina' Interview, p.7). Rather, stakeholders are shown to find, and often actively

[56] Not only do they regularly interact with patients, but interviewees assert that entrepreneurs have frequent contact with carers and family members, as well as actors like administrators.

pursue interactions with, entrepreneurs. This enables entrepreneurs like ‘Amelia’ to interact with and learn from stakeholders:

> I used to follow women up after labour or after coming to theatre to have a baby, and sit and chat to them, and they would often have a lot to say about what had happened to them
>
> (‘Amelia’ Interview, p.1)

Thus, ‘Amelia’ and other entrepreneur interviewees claim that their professional exposure to particular groups of SUs has enabled them to go beyond simply understanding stakeholders as patients, family members or carers. Instead, they illustrate that their exposure to these stakeholders in departments and on wards has enabled them to consider people as coming from different class and gender backgrounds (‘Amelia’ Interview, p.1; ‘Sonia’ Interview, p.2).

Of course, the type of relational contact shown in the above extract is not typical of all HCP and SU interactions. As discussed in *section 4.2*, interactions between these communities are often affected by factors relating to the clinical identity of SUs. Thus, the extent to which HCPs are regularly exposed to patients with complex and debilitating conditions may impose on their desire to learn about SU identities. In this way the variable of clinical identity may be understood to produce variations in how HCP exposure affects notions of representation.

Furthermore, traditions related to the operational status of HCPs may affect whether they are capable of spending time interacting with and learning from SUs. In *section 4.2* I suggest that the variable of HCP status interacts with and affects the vitality of institutionally located traditions such as the valorisation of efficiency and productivity. This is because high-status professionals are often free to engage in processes of learning and development. In this way they are empowered to eschew priorities and spend time talking to and learning from stakeholders (Ibid). On the other hand, lower status actors are often constrained by the impact of priorities that define notions of work and their understanding of time. As such, I propose that

lower-status professionals are less likely to engage in relational interactions with and learn from SUs.

By contrast, interviewees suggest that standing-groups are more likely to have an immediate and complex understanding of representation. This is because standing groups often consist of a wide variety of individuals from within the citizen population. Standing group members, therefore, have an understanding of SUs because they are themselves SUs. This understanding is maintained by the internal work of standing groups members who regularly spend time reflecting on one another's experiences ('Nigel' Interview, pp.3-4).

Standing group members are, thus, frequently exposed to experiential divergences. These are divergences that occur between those who have different illnesses. Furthermore, they are differences that arise as a product of social traditions related to characteristics like gender, sex and ethnicity. Equally, their time spent investigating and learning about life working in hospitals and NHS trusts enables members to understand differences embedded within the HCP community. This learning increases their understanding of the necessity for representation to extend beyond the reified categories of staff and patients because it exposes them to narratives regarding the lived and local experiences of stakeholders:

> So, we do a lot of preparation to get the individual ready to just, you know, get beyond their own story, start listening to other patient's stories that might be different from theirs and also start listening to staff stories.
>
> (Ibid, p.2)

This extract again demonstrates the importance of exposure. However unlike entrepreneurs, standing group exposure is often formalised through explicit and regular learning processes. In this sense consistent opportunities to acquire knowledge about the experiences of actors from within and outside of their own community act as important variables in achieving the complex representation of stakeholders. For example, processes wherein standing group members have shadowed HCPs have enabled them to learn about the stresses that define the operational lives of professionals:

> We do spend a lot of time trying to break down those barriers and do a lot of other work really, purely staff-focused work, just to get a relationship with these people so that when we get asked to do larger projects or research based projects we are not seeing so much fear when we try to approach these different areas I guess.
>
> ('Imogen' Interview, p.3)

Conclusion: organising representative recruitment

In this section I contend that the attainment of representative recruitment is often contingent on organisers appreciating the complexity of identities embedded within the stakeholder population. As such, I propose that exposure to communities is an important variable in building representation. However, organising actors experience exposure differently. Entrepreneurs are exposed relative to the conditions within which they operate. Thus, they often find it difficult to consider representation as a result of traditions that define their role and understanding of SUs. By contrast, standing groups often achieve a complex appreciation of representation. The lay identity of members promotes exposure to a diverse array of SU identities. Furthermore, standing groups frequently engage in formal development activities. These activities enable members to learn about other SUs and the conditions within which HCPs operate.

5.2: Design

The following exploration of design should be considered through the prism of my normative definition of collective co-production in *section 3.2*. In this section I explore accessibility as a variable that delineates the extent to which participants engage in collective co-production. I examine how different forms of inequality produce and reproduce inaccessibility: suggesting that social and health identities regularly manifest less than ideal co-production environments. Thus, I speak to the importance of variables like issue saliency in supporting the participation of actors who come from disadvantaged backgrounds.

In the following analysis I examine how organisers reduce inequalities by incorporating the experiences and understanding of participants within the design of collective co-production. In doing this I explore a process called co-design. This is a notionally different process to that discussed by Bovaird and Loeffler (2013) and Brandsen and Honingh (2016). In these works the author's define co-design as the collaborative design of a service or a part of a service. However, in my analysis I define co-design as the collaborative design of a collective co-production process. Involvement in co-design, thus, enables actors to influence the meaning and methodology of collective co-production.

Co-designing collective co-production

Processes that involve initial phases of co-design provide a forum through which actors direct the meaning and methodology of collective co-production activities ('Keira' Interview, p.4). To achieve this outcome co-design processes include individuals from different communities. Furthermore, co-design occurs before the collective co-production process ('Michela' Interview, p.7). [57] Through co-design participants examine issues that matter to them and consider how they can be supported to actively engage in collective co-production interactions. These actions suggest that co-design is employed to improve accessibility. This is because co-design processes ideally increase issue saliency and facilitate reductions in inequalities between members of the same and different communities.

This vision of co-design inhabits a similar processual space to those co-design processes discussed by Bovaird and Loeffler (2013) and Brandsen and Honingh (2016). These conceptualisations consider co-design to be a potential precursor to later action. Thus, they conceive of the process as a route through which the voices of stakeholders attain prominence and metamorphize into subsequent actions. In Bovaird and Loeffler's (2013) and Brandsen and Honingh's (2016) typologies action is constituted by the process of co-delivery. However, in my analysis action occurs through the realisation of a collective co-production process, the strategy and plan of which have been influenced by participants within co-design.

[57] See *figure 18* for an illustration of how co-design occurs before collective co-production.

The spirit, if not the letter, of this processual journey is noticed within the participation literature. As discussed in *sections 1.4* and *3.2*, issue salience is thought to improve the effectiveness of participation. Denters and Klok's (2010) case study examining the rebuild of Roombeek shows that those who are considered to be marginalised can be highly motivated to participate when the issues being discussed are meaningful to them. Thus, scholars suggest that high salience improves the quality of interactions: enabling active involvement from actors who are often alienated from decision-making as a result of their identity (De Graaf et al, 2014).

Barbera et al (2016) conceptualise the variable of saliency through their notion of 'responsiveness'. In defining this term they assert that it is important for organisers to respond to the needs and desires of participating stakeholders (Ibid, p.1095). Such a notion, therefore, presupposes a more active role for stakeholders within the design of co-production. For example, Barbera et al (Ibid, p.1096) suggest that responsiveness is achieved when participants work to 'define a set of rules, criteria and processes that ensure voice for different interests, views and power positions'. This proposition indicates that notions of responsiveness impose on the accessibility of participation. As such, it conveys that opportunities to define rules and processes act as routes through which to generate equal and empowered engagement.

My analysis of interview testimony shows that the variable of responsiveness is often realised through processes of co-design. This is because phases of co-design empower stakeholders to alter their participation processes, thereby enabling them to actively participate ('Michela' Interview, p.2). Co-design occurs in a number of ways. Interviewees suggest that co-design is manifested through preliminary workshops. In these workshops actors from stakeholder communities come together to consider themes and discuss issues that diminish their participation ('Holly' Interview, p.8). Likewise, co-design regularly transpires as a training process wherein actors from stakeholder communities consider how collective co-production processes can reflect their needs. This procedure is shown in the following extract taken from my interview with 'Linda', a HCP who operates in the NHS:

> Certainly the training I attended, part of that was representation from the patient participation group because they wanted to have a say as to how (later groups) were designed to ensure that their needs were met and to ensure things like, you know, safety. So we would be happy to talk about this and to ensure that what we discussed stays in the room. Certainly from the perspective of my locality, I can't speak to what has gone before, but the practices that will be undertaken in (later groups) the patients are at the heart of it. They are not periphery to that.
>
> ('Linda' Interview, pp.2-3)

In this extract 'Linda' demonstrates that responsiveness is achieved by providing participants with opportunities to alter their participation. This is because she and her fellow organisers used a co-design process to understand how participants valued principles such as safety. Through this they changed their later collective co-production process to reflect this perspective: guaranteeing the anonymity of participants. This example suggests that co-design is an important precursor to co-production. In providing opportunities for stakeholders "to have a say" regarding how co-production groups are designed, one enables them to orient their participation around values and processes that are meaningful to them, as well as variables that facilitate their active engagement (Ibid).

This proposition is supported when examining how interviewees discuss the effect of variables like location on the participation of stakeholders. Location is shown to impose on the participative capacity of communities differently. For SUs, location often affects their ability and desire to participate. This is because they may feel divorced from and intimidated by the institutional locations in which co-production processes regularly occur. These are locations such as "public sector offices" or "formal committee settings" ('Roxy' Interview, p.6). 'Gareth' (Interview, p.3) suggests that SUs frequently associate these locations with staff members. As such, these locations promote and reproduce traditions related to the paternal authority of provider figures (Ibid). This has meant that SUs have felt inferior to providers within institutionally located collective co-production processes.

‘Mary’ (Interview, p.7) advances on this proposition. In her interview she argues that particular types of institutional settings are often more unrepresentative of SU experiences. She asserts that SUs feel safer within institutional locations that have been constructed for the purpose of facilitating active discussions. These are arenas such as “seminar rooms” that have been designed to promote small group interactions (Ibid). ‘Liv’ (Interview, p.6) supports this notion. She contends that SUs regularly conceive of institutional locations that are “used for educational things rather than for a clinic” as informal and comfortable. Thus, she suggests that participants feel safer within rooms that have been designed for learning as opposed to formal spaces such as board rooms and offices (Ibid).

Of course, location is not the only variable that imposes on participation. ‘Mary’s’ testimony also indicates that a number of additional factors affect how stakeholders participate:

> We tended to use the same seminar rooms so people would know where to come to. We would always have tea and cake. That became a bit of a standing thing but actually it was really important as it was a social aspect and created a safe social space for them to be able to say and do what they obviously wanted to do.
>
> (‘Mary’ Interview, p.7)

In this extract ‘Mary’ illustrates that the use of a consistent location, the provision of refreshments and opportunities to socialise enabled her to build a participatory process in which participants felt able to “say and do what they obviously wanted to” (Ibid). This is evidenced in the way that the group is portrayed to have become an extension of the social lives of participants. For example, ‘Mary’ indicates that the group became a “social space” in which participants could meet, talk over a cup of coffee and build friendships. In this way the forum was transformed from a simple seminar room in to a space in which people felt able to share their experiences.

Beyond these variables, interviewees suggest that factors such as the provision of pens and paper, the use of whiteboards, the employment of the computer programme PowerPoint and the number of facilitators have all been raised as issues that impact

on participation ('Nina' interview; 'Mary' Interview). This indicates that the effectiveness and vigour of participation can be, and regularly is, affected by a variety of variables. In this way processes through which organisers learn about and shape participatory processes around these and similar variables can be understood to act as bulwarks against ineffective and disempowered participation. Accordingly, organisers should employ phases of co-design as forums through which to comprehend how participation can be supported. Preliminary workshops or training processes that empower participants to consider their participation are, thus, important routes through which to achieve this goal. In doing this organisers may promote the equal and empowered participation of stakeholders.

Implementing co-design

Of course, the normative argument for co-design as a tool through which to improve accessibility may not be enough to ensure that it is actualised as a precursor to collective co-production. This is because the identity of the organising actor is an important factor in delineating whether co-design phases transpire. Standing groups often generate co-design due to their ability to spend long periods of time implementing their projects. This durability endows them with the capacity to overcome institutional conditions that might otherwise restrict their ability to create processes of collective co-production that include phases of co-design:[58]

> Sometimes we have hit brick walls and like I say we have had to pause a project more than stop it I guess. Even if it is a year down the line we have revisited in some form. You know, someone shuts a door we find a window to go through. That sort of thing. Services change so often as well that normally the people who might be putting a stopper to things, they move on.
>
> ('Imogen' Interview, p.3)

This extract illustrates that standing groups are capable of waiting for the right conditions before engaging in the implementation of processes such as co-design. In doing this they may "pause a project" as a means of avoiding institutional and

[58] For a description of the durability of standing groups please see *section 4.3*.

departmental conditions that would otherwise damage their research. One of these conditions relates to the effect of powerful operational actors within NHS services.[59] 'Imogen' (Ibid) suggests that lead clinicians and specialists regularly use their departmental authority to reduce the organisational capacity of her standing group. She indicates that this resistance has occurred because these actors do not see value in collective co-production processes.[60] The following extract demonstrates how powerful operational actors often view the work of standing groups to lack value:

> Someone else just didn't deem it important enough for what the service needed at the time and thought we were taking up too much time.
>
> (Ibid, p.4)

It is, therefore, important that standing groups are able to pause their processes and wait for the right conditions to emerge. This durability enables members to spend time building relationships with other operational actors who may act as future advocates for their work. These actors may, subsequently, promote opportunities for co-design by providing standing groups with time and space to enact workshops and training processes within operational environments. This is why interviewees have suggested that standing groups "outlast many of the problems that are thrown (their) way" ('Nigel' Interview, p.9).

Entrepreneurs are also capable of implementing co-design as a precursor to collective co-production. Whilst they may not enjoy the luxury of pausing their projects, entrepreneurs often harness their operational status to create processes of co-design. For example, 'Liv' (Interview, pp.2-3) asserts that her status as a lead clinician enabled her to manifest a co-design workshop. This is because she could negotiate with authoritative colleagues such as clinical nurse specialists from other departments:

[59] As proposed in *section 4.4*, powerful operational actors are capable of resisting the work of standing groups.
[60] I examine the literature on reasons for resistance in *section*s *1.1* and *1.4* wherein I explore the valorization of clinical expertise, amongst other variables.

> Interviewer: You mentioned that you had to go to quite a few different teams. How easy was it to communicate with them, to get them on board and to ask them for access to people?
>
> 'Liv': Again, I think that wasn't too much of a challenge. I think that is because I work in a hospital and they know me
>
> (Ibid)

Through this process of negotiating 'Liv' gained the space and time to create co-design workshops wherein staff and patients were able to discuss their experiences. This example suggests that entrepreneurs may be characterised by an ad hoc and individually orientated capacity to implement co-design. Furthermore, it displays that entrepreneurs are often required to validate the norms and procedures embedded within the process of collective co-production. They do not, therefore, have to prove their worth as organising actors. Rather, they have to demonstrate that the process itself is worth engaging in.

Conclusion: the value of co-design

In this section I propose that co-design processes embed an understanding of stakeholders within collective co-production. This is because co-design centres processes of collective co-production on the understanding of stakeholders. As such, I assert that the use of co-design within collective co-production empowers stakeholders to contribute to the construction of their participation. However, co-design alone does not enable stakeholders to actively engage in governance. The generation of an environment wherein stakeholders engage in governance is frequently contingent on the establishment of more invasive processes that manifest inter and intra-community equality. These are processes of preparation that mitigate for inequalities related to skills and the provision of information. Furthermore, they are processes that manufacture solidarity between and within communities of stakeholders.

5.3: Preparatory phases

As in the previous sections of this chapter, the following analysis should be examined in reference to the normative definition of collective co-production presented in *section 3.2*. In this section I highlight the value of variables of accessibility and solidarity. I suggest that accessibility is often realised through the mitigation of inequalities that diminish participation. Furthermore, I propose that solidarity is regularly attained through manufacturing collective purpose between and within communities of stakeholders. In the following section I build on these analytical threads. I explore how processes of preparation promote accessibility and solidarity. In doing this I examine preparatory processes such as trigger films and reflective practice.

This section begins with an examination of how preparatory processes increase the accessibility of collective co-production. Thus, my analysis complements the work of Leach (2006) and Barbera et al (2016), both of whom emphasise the importance of inclusivity as a variable in generating collective co-production. Furthermore, this analysis complements my prior examination of co-design. This is because phases of co-design ideally reduce inequalities between stakeholders by empowering them to shape their participation. After this I consider how preparation processes are employed to manufacture solidarity. In doing this I build on the work of academics like Ostrom (1996) who suggest that the production of inter-community commitment improves interactions within co-production. As such, I consider how organisers embed notions of collective purpose between and within stakeholder communities through procedures wherein stakeholders learn from one another.

Increasing accessibility

As discussed in my review, stakeholders are not immediately capable of engaging in co-production. They are not akin to a jack in the box: waiting patiently to be invited to share their perspectives and make-decisions (Pestoff, 2012). Rather, stakeholders need to be prepared to engage with one another. In the literature scholars suggest that preparation is realised through processes of 'education and discovery' (Leach, 2006, p.103). Furthermore, they propose that it is achieved through processes wherein individuals consider the reasons for their low self-efficacy (Strecher, McEvoy, Becker and Rosenstock, 1986). Similarly, academics assert that preparation is actualised through processes of training that reduce asymmetries of expertise by providing individuals with information (Van Eijk and Gasco, in Brandsen et al, 2018).

In the governance literature the necessity to train actors for involvement is discussed in reference to notions of citizenship. This is not the citizenship discussed in *section 3.1*. It is not, therefore, a form of citizenship that is constituted by an individual's capacity to enter in to a participative forum. Rather, it is a citizenship that frees citizens from those traditions that inhibit their participation. These are social traditions such as those that are related to class, ethnicity and gender (Bevir and Richards, 2009). These traditions orient a person's situated agency by influencing their beliefs and informing their actions. Thus, people with certain types of identities often find that active engagement is difficult. This is referenced within the co-production literature wherein identity characteristics such as age and class are considered to influence participation (Bovaird et al, 2015; Steen, Brandsen and Verschuere, in Brandsen et al, 2018).

My analysis supports this proposition. In the following extract I show how 'Liv' considers age to be a variable that impinges on participation. This is because she suggests that younger people are less likely to have been exposed to past events wherein they have shared their experiences:

> You might have someone who is a lot younger, who may have just started at school or university and isn't used to talking in front of group necessarily. You know it can vary highly from person to person.
>
> ('Liv' Interview, p.5)

In this excerpt 'Liv' indicates that generational inequalities influence accessibility by disempowering those who have not experienced participation and do not have confidence in their participative capacity. Such a hypothesis is supported by 'Nina'. In her interview 'Nina' (Interview, p.4) provides evidence that older stakeholders are often "engaged citizens". These are people who have had a greater number of opportunities to engage in participative forums:

> There was an over 50's forum who I tend to describe as engaged citizens: people who tend to be representatives, speak up at events and talk at conferences.
>
> (Ibid)

The preceding extracts demonstrate that attempts to improve accessibility are often contingent on the type of stakeholders involved within a group. As such, the manifestation of an environment wherein all actors are capable of engaging equally is, in part, dependent on the preparation of individuals who are inhibited by traditions that are associated with their identity.

This is why the "over 50's" in 'Nina's' experience required fewer preparatory procedures in comparison to the younger people in 'Liv's' group. 'Nina's' testimony shows that the older group "were confident" and immediately felt comfortable within her collective co-production process (Ibid). Conversely, 'Liv' believes that the latter group's participation was contingent on their involvement in preparatory processes wherein they reflected on and formulated an understanding of their priorities:

> I think it is actually taking them through a process where they reflect on their own experience, hear others experience and gather some info and put their experience in to… because some of them I don't know if they had reflected on that experience by reflecting on it, putting it in to context and prioritizing what would be the things they would change.
>
> ('Liv' Interview, p.5)

This assertion conforms to the literature on participation. It suggests that traditions associated with a person's age influence the extent to which they have civic skills (Bovaird et al, 2015).[61] Younger people may, therefore, have fewer experiences of engaging in civic activities like speaking in public (Fung, 2003). Furthermore, it indicates that age influences the subjective civic skills of participants. Thus, younger participants may not view themselves as capable of actively engaging within collective co-production because they have not participated previously (Denters and Klok, 2010). Preparatory processes should, therefore, be employed to nurture civic skills and increase the subjective civic skills of those who have fewer participatory experiences (de Graaf et al, 2014).

In my analysis I found that civic and subjective civic skills had been cultivated through the provision of opportunities for participants to consider their lived experiences and arrive at an understanding of priorities. These opportunities enabled participants to engage in forms of participation wherein they could meet and discuss their experiences with peers. In this sense preparatory processes are akin to 'schools of democracy' (Fung, 2003). They are arenas in which actors learn participatory skills such as reflection, listening to others and the arrangement of priorities:

> Then the first event in the cycle is an event for members of staff to discuss their priorities. Then there is an event for patients to discuss their priorities. That we thought was quite important, that they both have their own space to discuss what their priorities are and come up with their own priorities.
>
> ('Karlee' Interview, p.4)

[61] I provide a definition of civic skills in *section 3.2* wherein I suggest that they are skills such as the ability to think critically. These skills are, thus, considered to enable actors to engage in decision-making.

This excerpt suggests that preparation is successful because it enables actors to "discuss their priorities" within a homogenous cohort (Ibid). 'Karlee' states that the provision of such a space provides participants with opportunities to learn about and discuss their experiences with actors from within the same community.

'Karlee's' testimony, thus, indicates that the necessity to foster civic and subjective civic skills occurs alongside a requirement to mitigate for the impact of political culture. This term pertains to the traditions that limit the situated agency of actors within inter-community interactions (Denters and Klok, 2010). Bevir and Rhodes (2008) suggest that power arises as a product of traditions that occur within an environment.[62] Thus, HCPs often have power within inter-community relations in NHS services because their identities are associated with traditions like paternalism and the valorisation of clinical expertise (Steen and Turnas, in Brandsen, Steen and Verschuere, 2018). Accordingly, homogenous preparatory processes may be important in building the civic and subjective civic skills of actors who are conventionally diminished by these traditions. This is because homogenous spaces enable participants to express themselves without fearing that they may be looked down upon by actors who they deem to be figures of clinical authority ('Karlee' Interview, p.4).

However, the limiting and constraining impact of power is not only noticed within inter-community relations. Older people (such as the over 50s) have been found to have power within SU relations because their identities are associated with traditions that have enabled them to attain civic and subjective civic skills ('Nina' Interview, p.4). These may be traditions such as valuing, and regularly participating in, community events and activities (Bovaird, van Ryzin, Loeffler and Parrado, 2015). This proposition suggests that the segregation of preparatory processes by stakeholder communities may not be enough to promote reflection and build civic and subjective civic skills. Rather, it shows that organisers of collective co-production must also consider how intra-community relations, and the traditions that

[62] Power is, therefore, a function of tradition. Power occurs through variables such as status and subsequently imposes on others, thereby limiting their situated agency (Bevir and Rhodes, 2008, pp.8-10).

impose on particular sub-sections of communities, limit participation and diminish opportunities for preparation.

Not every form of preparation focuses on reflective practice. Another form of preparation noticed within my analysis was that which reduces the impact of 'information asymmetries'. In the literature this inequality is often discussed in reference to asymmetries of understanding between stakeholder communities. For example Palumbo (2016, p.79) asserts that information asymmetries between HCPs and patients reduces mutual understanding and discourages engagement. This is supported by Pestoff (2014) who asserts that asymmetric information damages productive communication between stakeholders and often results in their frustration.

In my analysis I found evidence for the notion that information asymmetries lead to increased frustrations. In her interview 'Michela' talks about how her lay identity did not prepare her to interact with individuals from the professional community. In elucidating this 'Michela' refers to an experience of participation wherein she felt exasperated and unfulfilled:

> …I felt that the other people were at a greater advantage because of their knowledge of the NHS, their training as well. Myself and my colleague on the NHS England board did get quite frustrated at times. We were told off for getting angry about something. I mean, admittedly we might have dealt with stuff better but we hadn't had the training that the others had to try and deal with that kind of thing.
>
> ('Michela' Interview, p.6)

This extract demonstrates how interactions are damaged by asymmetries of information. It shows that the unequal distribution of information between communities produces resentment. This is because disparities in information stifle communication between stakeholders and reduce the likelihood that the lived experiences of SUs and other similar actors will be used to produce outcomes (Ibid). Accordingly, I propose that preparation should be used to manifest a greater balance of understanding between communities. This has occurred through opportunities for

"training" that promote understanding of the task at hand and the topics being broached (Ibid).

Creating solidarity

Another form of preparation noticed within my analysis is that which manufactures solidarity. This is important within inter-community decision-making. Solidarity, or the collective desire to make the service work for the common good, enables participants to engage together. This statement is considered in a number of academic texts. As discussed in my review, scholars like Ostrom (1996, p.1082) have examined the importance of communities having 'a credible commitment to one another'. In doing this Ostrom (Ibid) suggests that inter-community solidarity promotes reciprocal interactions between stakeholders. This notion is supported within Benjamin and Brudney's (In Brandsen et al, 2018, pp.53-54) exploration of co-production in the third sector. In this case study the authors assert that the manufacture of inter-community commitment encourages SUs and providers to work together. They propose that this can be achieved through learning processes that help stakeholder communities to understand one another (Ibid).

This emphasis on inter-community learning was noticed in my analysis. In the following extract 'Nigel' discusses the effect of preparatory processes such as trigger films on inter-community relations. These films offer a means through which stakeholders learn about and empathise with the experiences of actors from other communities. Within these films excerpts from individual interviews that relate to similar themes are edited together. This process ensures that films have coherent narratives that delineate similar experiences from a number of community perspectives:

> You have a really big moment when you bring two diverse populations together: the staff and patients. What you have done is enormous amounts of preparatory work before that happens. If the preparatory work is there then it is wonderful to see both sides really discovering a lot.
>
> ('Nigel' Interview, p.8)

The language used in this quote provides a clue as to the changes that occur through exposure to processes such as trigger films. The categorisation of different communities as "sides", as well as the way that the interviewee asserts that preparation enables participants to "discover a lot" about one another, suggests that preparation changes the relational dynamic between communities. As such, I propose that preparatory processes that increase solidarity contribute to the attainment of civic virtues such as co-operation, tolerance and respect (Fung, 2003). These virtues are considered to promote reciprocity between communities and, thus, encourage active and co-operative engagement in decision-making (de Graaf et al, 2014).

This proposition is supported by 'Karlee'. In her Interview she suggests that trigger films have enabled participants to empathise with and learn from the actors being interviewed:

> …this is to really show to staff what the patients think and to create a sense that their voices are heard and probably also trigger some emotions in healthcare professionals to make it very apparent to them that these are things that people want changed.
>
> ('Karlee' Interview, p.4)

In this extract 'Karlee' asserts that trigger films are employed to alter pre-existing conceptions of stakeholders. Trigger films are, thus, used as tools through which to show that stakeholders are people with complex needs and important perspectives. In this way stakeholders are portrayed as actors who have legitimate forms of understanding and experience. This suggests that trigger films promote a vision of stakeholders as potential members of a wider community of competent and credible actors who are capable of co-operating in the production of change (de Graaf et al, 2014).

This correlation between the employment of trigger films and co-operation is evidenced in the testimony of 'Mary'. In a follow up interview she discusses how a trigger film was used in a co-production process that aimed to improve an emergency department. The film supported solidarity generation by facilitating

learning regarding the difficulties that professionals had experienced when working in this location. This film enabled SUs to consider and, subsequently, value the perspectives of HCPs:

> When the staff spoke about their experience, and they were so honest and that goes back to that culture thing, they were so honest with the patients and relatives and they then said right 'we need to do something for the staff'.
>
> ('Mary.1' Interview, p.4)

However, solidarity is not only achieved through trigger films. Procedures that reduce professional resistance are also important. In the co-production literature professional resistance is viewed to be a significant barrier to collaborative decision-making. Bovaird (2007) discusses how staff members are frequently unwilling to participate in and support co-production practices. This is because staff often consider co-production to be a threat to their expertise and status. Similarly, Vennik, van de Bovenkamp, Putters and Grit (2015) argue that HCPs are resistant to participation because they do not want to be exposed to criticism from citizens. As such, processes that diminish resistance are important in manifesting an environment in which stakeholders reciprocally engage with one another.

My analysis shows that professional resistance has been reduced through processes that lessen the value attached to the paternal vision of the medical professional. These processes address the prevalence of conceptions of HCPs as paternal leaders who must maintain emotional distance to SUs:

> When I did a lung cancer one there was one particular consultant who wanted to see the trigger film, bearing in mind these were online trigger films so not of our own patients, but he wanted to see the films because he didn't want to let himself down by getting emotional in front of patients and relatives. We had to really coach him and say that was kind of the whole point "you can't prepare for this or you will start putting your defences up and that is not what we want."
>
> ('Mary' Interview, p.10)

This extract suggests that preparation can transform the understanding of those who are instinctively resistant to collective co-production. In this way preparation plays an important role in the reproduction of democratic traditions within NHS services. This is because preparatory processes that coach staff members often reduce ingrained "cynicism and negativity" towards processes like co-production ('Gareth' Interview, p.5).[63] This correlation is reflected in the following extract taken from my interview with 'Gareth'. In this quote he suggests that preparatory processes wherein staff are coached to engage with and accept the normative and procedural tenets of co-production act as forms of "entrapment" (Ibid). Staff members are, thus, taught to value the lived experiences of patients as a means of promoting later collaboration:

> My former colleague who has retired now he would talk about it as a bit of a Trojan horse and a form of entrapment as we do all this work early on in the process and it almost entraps the staff because they can't disconnect from it.
>
> (Ibid)

Embedding preparation processes within the NHS

The preceding examples of preparation show that context is important. The identity of participants and the traditions that impose on and influence their actions are contingent on a number of factors. These are related to the social backdrops against which they exist. Thus, the engagement of citizen stakeholders may be improved through the use of preparatory processes that mitigate for professional, class, generational or educational inequalities. Equally, the participation of HCPs may be enhanced through the employment of preparatory processes that diminish resistance and cynicism.

Traditions are also important in influencing how organisers implement preparatory activities. Entrepreneurs may be likely to create processes that improve accessibility. Their status within operational service environments enables them to spend time learning about methods through which accessibility is increased. For example,

[63] I discuss this type change in *section 6.3*.

entrepreneurs may attend training courses wherein they learn about innovative preparatory methodologies:

> So it was with the lead clinician and the matron. We had been together to this point of care foundation workshop and we all came away from that thinking that it was a really good methodology and something we could use within the dept.
>
> ('Liv' Interview, p.1)

> I have done the qualitative interview training and I know it is very achievable with technology nowadays…
>
> ('Mary.1' Interview, pp.3-4)

The preceding extracts display that entrepreneurs engage in explicit processes that develop their understanding of methodology.[64] This is because entrepreneurs like 'Mary' (Interview, p.2) and 'Liv' (Interview, p.1) have access to training opportunities that are either built in to their role or are a function of their leading and qualified positions. Through these processes these entrepreneurs have learnt to employ innovative practices such as trigger films. These are practices that require actors to appreciate qualitative methodologies that are founded on forms of thematic analysis. Thus, they can be understood as important methods through which to elicit understanding of the self and manufacture empathy for other stakeholder communities.

In spite of this capacity to learn about methodology, entrepreneurs have found it difficult to engage in processes that successfully build solidarity. Entrepreneur interviewees have suggested that their operational status has meant that lower-ranking staff members like nurses have found it difficult to be open with them when creating trigger films ('Amelia' Interview). This is because these actors have been afraid to share negative experiences with individuals who are viewed to be figures of operational authority. As such, entrepreneurs have often used their operational status

[64] I examine the relationship between high operational status and engagement in learning processes in *section 4.2*.

to recruit actors who support the manufacture of solidarity.[65] These are actors like therapists who have experience of engaging in activities that build trust ('Teresa' Interview). These actors, thus, engage in the implementation of preparatory processes on the entrepreneurs behalf.

Conversely, standing groups have found it easier to manifest solidarity. This is because they regularly engage in activities that promote reflective practices and build bonds with stakeholder communities:

> We do quite a lot of work actually, a couple of years ago for a few months every week doing reflection sessions with particular health care professionals on all the acute wards around engaging with families and carers in conversation. Just general conversation.
>
> ('Imogen' Interview, p.6)

This extract suggests that standing group members engage in regular developmental and learning activities alongside individuals from stakeholder communities. Unlike entrepreneurs, standing group members are continually involved in processes that improve their understanding of the environments in which they work. This is because they are able to work in the long-term. In this way standing group members are able to build and maintain trusting relationships with operational staff members, as well as continue to develop their understanding of and camaraderie with members of the patient community. This type of long-term work has, thus, enabled a number of standing groups to develop enduring affiliations with a multitude of stakeholders who have actively participated in their research.

[65] This is a similar proposition to that which I present in *section 5.1* wherein I propose that entrepreneurs improve representation through recruiting colleagues.

Conclusion: increasing accessibility and manufacturing solidarity

In this section I assert that preparation processes increase the quality of interactions within collective co-production. I propose that the creation of collective identity and reductions in professional resistance increase solidarity. This outcome is achieved through training processes and the use of trigger films. Equally, I suggest that processes that increase self-efficacy and promote understanding improve accessibility. This outcome is attained through procedures that enable co-producers to reflect on their lives and learn about the experiences of others.

I suggest that these forms of preparation produce open interactions. As discussed in *sections 1.4* and *3.2*, openness is a function of the feelings of participants. Thus, actors who engage in preparatory processes often feel that the space in which they are interacting is open. These participants may, subsequently, feel capable of participating in collective co-production. In this sense it is now important that I turn to the interaction process itself. In *section 6.1* I examine interviewees' perspectives of interactions within collective co-production. In doing this I consider the character of co-production interactions and explore the value of facilitation.

Overview of Chapter 5

In this chapter I examine a number of supplementary procedures that inform interactions within collective co-production. I suggest that the attainment of representative recruitment is often contingent on organisers appreciating the complexity of identities embedded within the stakeholder population. Furthermore, I argue that co-design focuses collective co-production processes on local conditions by orienting meaning and methodology around the lived experiences of stakeholders. In this way processes of co-design are shaped around values and variables that support the participation of stakeholders. Finally, I propose that processes of preparation increase the quality of interactions within collective co-production. Thus, trigger films and reflective practices often improve participant efficacy and promote solidarity. Taken together these supplementary procedures promote open inter-community interactions. They encourage participants to work together, support one another and produce outcomes that reflect their lived experiences.

Chapter 6: Interaction and outcomes

Preparation and co-design support co-productive interactions between communities. The promotion of increased capability, collective understanding and reduced resistance promotes and maintains the democratic normative framework defined in *Chapter 3*. For instance, preparatory procedures like trigger films enable participants to interact together within environments defined by an implicit, or perhaps explicit, commitment to solidarity. Such an assertion is supported by interviewees:

> Then the event where we bring the staff and patients together for the first time is always really, really interesting. I mean I am trying to think of one that hasn't gone well and I can't think of one. If you have done the initial work well in the initial stages of the process, by the time you bring the staff and patients together at the co-design events you are fairly confident and secure that it is going to go well.
>
> ('Gareth' Interview, p.3)

In this extract 'Gareth' asserts that the success of collective co-production is contingent on the initial stages of the process. Such a notion implies that initial stages enable actors from diverse communities to work in partnership and produce outcomes. As such, I propose that democratic governance is a product of processes through which stakeholders are empowered to actively and collectively participate.

In this chapter I use my analysis of interviews to build on this proposition. In *section 6.1* I show how the employment of initial phases of co-design and preparation are linked to open collective co-production. In doing this I propose that initial phases enable participants to feel free within groups. After this I examine the value of facilitation. I contend that facilitation is valuable in maintaining the procedural legitimacy of co-production interactions. For example, facilitation promotes an environment wherein participants are able to overcome grievances and health inequalities.

In *section 6.2* I explore how outcomes are realised within real world environments. I show how organisers promote contestation beyond that which occurs within collective co-production interactions by moving outcomes in to practical environments like departments. I also discuss the value of operational advocacy in enabling co-producers to practically manifest outcomes within these real-world arenas. Finally, I illustrate how these processes enable outcomes to both correspond to the ideals of those participating in decision-making and the ontologies of non-participating stakeholders.

In *section 6.3* I examine the products of collective co-production. I show how a number of outcomes found within my analysis were associated with co-design activities. This is because they were the products of stakeholder voices. Furthermore, I suggest that these outcomes conformed to the realities of non-participating stakeholders. In this way I propose that co-design outcomes are often operationally sustainable. Lastly, I consider private outcomes like alterations in understanding of the self and the NHS. In doing this I argue that private outcomes often contribute to the generation of systemic change by enabling stakeholders to engage in future processes of democratic governance.

6.1: Interaction

In my literature review I suggest that the democratic quality of collective co-production processes is understood through an exploration of participants' feelings (Verschuere, Vanleene, Steen and Brandsen, in Brandsen et al, 2018, pp.245-246). This is because 'co-producers perceive a real ability to actively participate' (Ibid). They understand whether they have been provided with opportunities to 'make meaningful contributions and maintain substantive control' of collective co-production (Jo and Nabatchi, in Brandsen et al, 2018, pp.232-233). Research that seeks to examine interactions within collective co-production may, therefore, inquire as to participants' reflexive understanding of participation processes.

This assertion is supported in my analysis. Interviewees often refer to co-productive interactions by expressing their ephemeral qualities. Notions of "energy" are cited in respect of creating interactions that are accessible and characterised by solidarity

('Gareth' Interview, p.3; 'Keira' Interaction, p.4). These variables are not easily measured. Understanding of whether processes are accessible and characterised by solidarity hinges on the esoteric appreciation of those who have experienced the event. Thus, an appreciation of the process is engendered through an exploration of participants' feelings. In the following analysis I examine how stakeholders have felt when co-producing. As such, I consider how initial processes of preparation, as well as forms of facilitation, empower participants to feel capable of actively engaging in collective co-production.

The character of interaction

As discussed in *section 3.2*, notions of 'openness' are important in promoting an environment wherein individuals interact equally. In this section I suggest that openness is a product of freedom. Groups are open because each person feels that they are free within the decision-making forum. This freedom enables participants to transcend essentialist logics. No longer are stakeholders and their relations defined in ideal terms. Rather, they are understood as and understand themselves to be co-producers who support one another, work together and collectively produce outcomes.

In this sense participative freedom is produced through participants' reflexive understanding that they are equal partners in decision-making. This is why previous phases of co-design and preparation are important. As discussed in *sections 5.2* and *5.3*, co-design and preparatory processes ideally enable actors to learn about one another, address inequalities and manufacture collective purpose. Through this participants no longer consider that they belong to separate communities within which there exist particular identities and relations. Rather, they learn that they are all, within the confines of the participative forum, a part of a wider cohort of people each of whom is interested in, and working towards, the same goal.

This proposition is supported in the co-production literature. Cahn and Gray (in Pestoff et al, 2013) promote a vision of co-production that accepts and includes human capability as a central tenet.[66] As such, they assert that participation in

[66] I examine the work of Cahn and Gray in *section 1.2*.

processes like time banking should be predicated on the notion that all perspectives, skills and experiences are valid (Ibid). To achieve this participants learn to regard one another 'as possessing assets' that can be used to advance their collective ambitions (Glynos and Speed, 2012, pp.413-414). Carr (2007, pp.273-274) similarly discusses the importance of processes through which people are supported to collaborate.[67] She states that training processes are often used to create a 'safe environment in which both staff and service users can express themselves honestly' (Ibid). This understanding of the importance of training in building notions of openness and freedom is also provided by interviewees:

> …actually it doesn't feel like that because people are on a more equal footing. That allows for a nice platform then for people to talk openly and staff to talk openly about some of the difficulties that they may experience, and the facilitators to you know… for people to bounce off each other I guess.
>
> ('Roxy' Interview, p.6)

This extract suggests that open interactions are a product of procedures through which stakeholders engage "on a more equal footing" (Ibid). As such, processes that promote alterations in stakeholder understanding are important.[68] These processes diminish essentialist notions of service user (SU), healthcare professional (HCP) and other stakeholder identities and empower actors to "talk openly" and "bounce off each other" (see *figure 17*). This supposition is further evidenced in the following extract wherein the interviewee discusses the risk of not mitigating for inequalities associated with identity:

[67] I briefly discuss the work of Carr in *section 3.1*.
[68] As discussed in *sections 5.2* and *5.3*, this is understanding of the self and other communities.

> I don't think sometimes that people feel free to talk in the way they do when it is just me or the other… the deputy ward manager that comes with me. I don't think… if the ward manager was there I don't know if they would say some of the things that they say because they are conscious that she has a different perspective than we do.
>
> ('Teresa' Interview, p.9)

In this quote 'Teresa', a therapist who works in the NHS, shows that participants' understanding of the space in which they are participating contributes to behavioural change (Ibid, p.10). This notion is akin to decentred theory (DT). In this approach actors use their situated agency to negotiate between traditions which guide their behaviour (Bevir, 2013). Thus, stakeholder participation may be diminished within spaces wherein democratically antithetical traditions are evident. In these spaces participants understand that they are unequal. They grasp that their perspectives may not be respected by actors who have not participated in supplementary and preparatory processes and whose agency is, therefore, situated against a backdrop of paternal and/or market traditions.[69] As such, participants may respond to this environment by choosing to engage in behaviours that typify and reflect these traditions.[70] In this way actors may return to notions of themselves as patients or carers, rather than empowered citizens who are capable of actively participating. This is evidenced in the preceding quote wherein SU participants decided not to speak because of the attendance of a provider figure who was understood to have a "different perspective" (Ibid).

[69] In *sections 4.1* and *4.2* I contend that these types of traditions impose on the ontologies of many actors who operate in the NHS.

[70] Democratically antithetical traditions impose on the situated agency of SU stakeholders and discourage them from actively engaging within the group. The notion that traditions impose on the situated agency of others is discussed by Bevir and Rhodes (2008, pp.8-9).

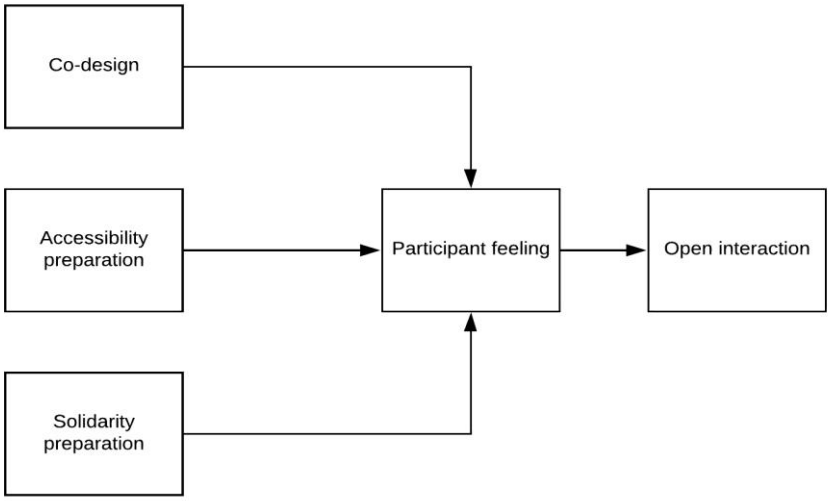

Figure 17: Process through which co-design and preparation impact on the openness of collective co-production.

Organisers must, therefore, cultivate traditions that promote equality (see *figure 17*). In my analysis I found that this necessity often acted as a catalyst for phases of co-design that altered interaction forums to reflect participant experiences. Moreover, this requirement frequently encouraged organisers to employ phases of preparation that empowered participants by increasing accessibility and solidarity. These processes regularly changed participant understanding by encouraging stakeholders to feel capable of participating as a collective of co-producers:

> Sometimes people's past experience is about having those kinds of mental health problems and that can really help if someone is feeling strong enough to talk about that because it gets rid of them and us and we realise that we are all just people with different experiences, not different people or different species you know.
>
> (Nigel Interview, p.6)

This quote suggests that co-productive feeling is a product of strength. If a person feels "strong enough" they can choose to transcend notions of paternalism that often pervade relations between HCPs and SUs and, thus, interact with stakeholders from other communities. Strength may, therefore, be a way of conceptualising how participants choose to actively engage in collective co-production. The reflexive choice to engage with and alongside actors from other communities requires

strength. This is, perhaps, a strength of feeling regarding the value of one's "past experiences", as well as an understanding that other actors will accept and engage with one's perspective (Ibid). Thus, subjective notions of strength may be considered to promote empowerment and enable participants to participate as equals within collective co-production:

> You see a lot more relational dynamics. Often you will see the patients comforting the staff about what it is like to work in the service.
>
> ('Gareth' Interview, p.3)

Accordingly, idealised collective co-production processes result from participants' understanding of their capacity and place within decision-making. Thus, organisers need to supplement collective co-production with initial processes that empower participants, thereby enabling them to overcome traditions that reproduce disparities and differences between stakeholder communities.

Facilitation

Of course, this idealised interaction environment is not always possible. Indeed, it may be entirely fanciful to suggest that organisers are capable of entirely mitigating for the effect of externally and institutionally located traditions. Such a notion is discussed by Habermas (1994, pp.3-6). He asserts that the potential differences between the communities which constitute the polis may render attempts to manifest equal interaction ineffective. Thus, Habermas (Ibid, p.4) critiques the notion that one can simply produce stakeholder equality through processes in which actors learn to be self-efficacious and virtuous.

This supposition indicates that co-design and preparation alone do not redress the impact of deep and historical cleavages between communities. Such a perspective is supported within the governance literature. Bevir (2006, p.16) asserts that whilst democratic governance is founded on a commitment to positive liberty, it is also preserved by 'rights and liberties'. Open participation is, therefore, a product of processes though which stakeholders are empowered to actively and equally make-decisions and a result of regulatory practices that support and facilitate their

contributions. For example, forms of macro-participation are ordinarily informed by regulations that provide minimum levels of education and welfare. Equally, forms of micro-participation are often supported by protocols that define how interactions transpire (Ibid, pp.16-19).

It is, thus, important to consider the protocols that guide and supplement collective co-production interactions. In doing this I am drawn to an examination of the facilitator. My analysis shows that facilitators are often important actors in enabling stakeholders to overcome their differences. This is because facilitators are understood to be arbiters of what is fair ('Imogen' Interview, p.7). They are deemed to be bridging actors who transcend notions of community and bring "both sides together" (Ibid). In this way they are considered to bring "balance" to collective co-production groups: promoting a vision of interaction wherein every participant is able to put forward their views and express themselves ('Liv' Interview, p.7).

This conceptualisation of the facilitator is similar to that provided by Leach (2006). In his normative study of co-production he argues that the processual work of facilitators, in structuring collectives around opportunities for equal participation, should be founded on a commitment to impartiality. For example, Leach (Ibid, p.101) contends that facilitators should "treat all participants equally by giving each an equal right to speak, vote or veto". In this way the facilitator is presented as an actor who implements invasive procedures, such as selecting participants to talk, as a means of reproducing notions of equality.

Facilitation, grievance and communicative inequalities

Interview testimony shows that facilitators uphold notions of fairness because they are tasked with ordering interactions. They often delineate how topics are to be discussed within groups and promote under-represented perspectives ('Karen' Interview, p.2; 'Beth' Interview, pp.6-7). Furthermore, facilitators frequently promote open and respectful discourse through the employment of phrases like "there are no stupid ideas" and "everyone's view is valid" ('Holly' Interview, pp.5-6).

In addition, facilitators regularly support co-producers in managing grievances. This perspective is exemplified in the following passage:

> People say "use your communication skills" but no one tells you what that is. I think what it is probably like being a UN peace negotiator. That is the closest description I have found for it. It is very under-described in the literature.
>
> ('Nigel' Interview, p.6)

In referencing the United Nations peace negotiator 'Nigel' is inferring that facilitators ideally manifest inter-community interactions that are not diminished by conflict. Facilitators are, thus, characterised as actors who manifest and maintain peace between disparate and potentially belligerent communities. This characterisation of the facilitator implies that grievance is a variable that threatens collective co-production. It suggests that negative experiences moderate and temper the collaborative tendencies of co-producers. This proposition is supported by Fledderus (in Brandsen et al 2018) who asserts that negative experiences of services impact on levels of trust between stakeholder communities within decision-making processes.

This claim is also supported by interviewees. 'Sonia' (Interview, p.2) proposes that negative experiences of NHS services lessen opportunities for constructive interactions within collective co-production. For example, SU experiences of professionals making bad decisions have clouded inter-community interactions and resulted in SU participants challenging HCPs ('Samira' Interview, p.2). Similarly, 'Nigel' (Interview, p.1) asserts that SU experiences of feeling invalidated by HCPs have damaged group interactions. For instance, feelings of invalidation have resulted in an unwillingness to take on professional perspectives (Ibid).

Interviewees suggest that facilitators mitigate for adversarial interactions between communities. This alleviation occurs through the provision of opportunities for participants to vocalise their resentment and mistrust ('Renata' Interview, p.7). Such a hypothesis is supported in the testimony of 'Imogen':

> So, basically it is about helping them to acknowledge their personal experience, but also bringing them back in to the room in terms of we can't necessarily do anything about that individual experience but what we can do for the greater service.
>
> ('Imogen' Interview, p.9)

This quote demonstrates the value of acknowledging grievance.[71] It suggests that even if negative experiences are not relevant to groups, their airing offers catharsis. Facilitators should, therefore, encourage participants to express themselves by asking them to talk about their experiences (Ibid). In doing this they ideally help participants to move beyond their negative experiences and engage constructively with one another.

Facilitators also improve the fairness of collective co-production by addressing communicative inequalities. In the literature co-production is regularly characterised as a dialogic process in which participants deliberate and manifest outcomes (Lember, in Brandsen et al, 2018). However, it is apparent that dialogical engagement is often inaccessible to stakeholders who are disadvantaged because of their social and/or health backgrounds (Beresford, 2019). As such, interviewees emphasise the value of facilitators in increasing the accessibility of interactions. For example, 'Holly' (Interview, p.9) discussed how facilitators often require participants to use "plain English" language when interacting with one another. In doing this facilitators ask participants to moderate their language and reduce their use of jargon and technical wording:

> So, you explain in plain English and you ask people their opinions individually. You very carefully handle it if someone doesn't understand something so they don't feel stupid for not understanding.
>
> (Ibid)

[71] This value is also noticed in my analysis of preparation processes in *section 5.3*.

Equally, facilitators mitigate for inequalities when dealing with participants who are unable to communicate as a result of illness. For instance, 'Karen' suggests that facilitators engage participants in alternative and non-dialogical forms of interaction:

> When we have worked in small groups there has always been a card on each place. So if you feel like you have something to say but don't know how to get heard you just hold the card up.
>
> ('Karen.1' Interview, p.4)

This quote speaks to the difficulty in manifesting collective co-production within a healthcare context.[72] The participation of actors who have health conditions that reduce their communicative capacities means that facilitators need to implement mechanisms through which participants are able to share their experiences. Thus, facilitators often limit conversations and promote alternative forms of communication within groups. These activities empower those who are less able to communicate within groups by providing distinct and explicit opportunities through which they are able to share their perspectives.

Facilitation and organiser type

The conditions that impact on the institution of representative recruitment, co-design and preparation also regularly affect the use of facilitation. This is because facilitator identities often conform to those of organisers.[73] As such, I suggest that opportunities for facilitation can be explored through an examination of organiser identities. The way that organisers are exposed to stakeholder communities, therefore, provides a means of understanding how they engage in facilitation.

Facilitators from standing groups enjoy regular exposure to stakeholder communities. Their desire to engage in learning, as well as their long-term and future-orientated perspectives, means that they regularly participate in processes of relationship-building with staff members. These activities have been characterised as

[72] I consider how the accessibility of collective co-production is contingent on the health of participants in *section 3.2*.
[73] This coalescence is noticed within the majority of transcripts wherein the interviewee discusses facilitation.

processes of "networking" by interviewees ('Imogen' Interview, p.8). Furthermore, the lay identities of standing group members, coupled with their engagement in learning about the lived experiences of their peers, means that they are exposed to the complexities embedded within the SU community. In this way I propose that standing group members understand how to facilitate groups that involve different stakeholder communities. This assertion is supported by 'Imogen', a standing group member who has facilitated a number of meetings:

> So, I think the more info you have about a service and about those accessing the service the smoother it will go. You can anticipate a few things maybe…. or at least be prepared for what may come up or have a little bit more understanding of what might come up.
>
> (Ibid, p.10)

This extract suggests that prior exposure to communities enables facilitators to predict issues that are related to stakeholder communities. For example, standing group facilitators may appreciate the risks associated with asking patients to relive trauma ('Mary' Interview, p.8).

This link between community exposure and facilitation is also applicable to entrepreneurs. 'Amelia' (Interview, p.2) infers that her clinical role has provided her with an understanding of SU trauma. Through this understanding she has been able to direct interactions between stakeholder communities in ways that do not harm SU participants. This claim is evidenced in the following extract wherein 'Amelia' discusses how regular interactions with patients have enabled her to understand how giving birth has affected SUs:

> So in that sense, what we are referring to is the psychological take home from the experience which does last for a long time because when you talk to women. (They say that) "We all remember our own births even if you weren't traumatized by them and you often remember the people who looked after you."
>
> (Ibid, p.5)

This excerpt conveys that entrepreneurs understand the needs of communities. However, the notion that understanding is contingent on opportunities to "talk" indicates that status is an important factor in enabling entrepreneurs to appreciate the experiences of SUs (Ibid). Entrepreneurial appreciation of trauma may, thus, be subject to the entrepreneur having the authority to engage in regular and relational communications with stakeholders within their clinical duties. As such, I propose that HCPs who are constrained by traditions related to efficiency and paternalism, described in *section 4.2,* are less likely to be exposed to the complexities of service users and other stakeholders. On the other hand, those who enjoy significant operational freedom are likely to have opportunities to consider identity when preforming the role of the facilitator.[74]

Conclusion: participant feeling, facilitation and interaction

In this section I suggest that interactions within collective co-production are contingent on the feelings of those who are participating. Processes of preparation and co-design are, therefore, significant stages in manifesting understanding that one is capable of participating in decision-making alongside individuals from other stakeholder communities. These processes empower participants by emphasising strength and promoting the value of lived experience. However, initial processes alone are often insufficient when implementing collective co-production. Thus, facilitation is a vital supplement to co-design and preparation. This is because facilitators play an important role in reducing grievances and communicative inequalities.

However, interactions are not where the collective co-production story ends. Simply because interactions between stakeholders have occurred does not mean that outcomes have been produced. The majority of outcomes found in my analysis required formal application within NHS services. These are outcomes that physically alter the practices of those who operate in departments and wards. In *section 6.2* I examine the apparent necessity to validate the outcomes of collective co-production. In doing this I consider a process that I call 'follow through'.

[74] This is a freedom to engage in activities on their terms and construct their operational environment. I consider this in *sections 4.2* and *4.4*.

6.2: Follow Through

'Follow through' is an illustrative term. It describes the necessity to actualise outcomes of collective co-production within practical environments. These are outcomes that are produced through activities like co-design.[75] This is because co-design enables co-producers to use their voices to produce changes to services (Loeffler and Bovaird, 2019, pp.244-245). However, the implementation of these changes is contingent on their occurring processes of follow through wherein groups consider the actualisation of outcomes. In doing this groups search for a settlement between initial outcomes produced through inter-community interactions and the traditions that influence actors in the real-world. This settlement enables non-participating stakeholders to alter and consent to changes (see *figure 18*).[76] In the following section I examine follow through and consider how it enables co-producers and non-participating stakeholders to influence outcomes. Furthermore, I show how the realisation of outcomes in NHS services is often contingent on the support of high-ranking operational actors.

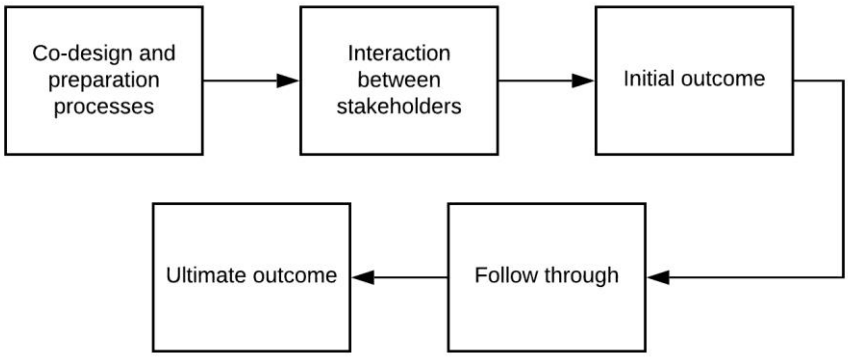

Figure 18: Illustrating the place of follow through in collective co-production.

[75] In referring to co-design I am not speaking about the initial process through which stakeholders shape the meaning and methodology of collective co-production. Rather, I am commenting on the co-production activity discussed in *section 1.2*.
[76] Non-participating stakeholders are actors who have not taken part in collective co-production, yet operate in or use the service environment.

Maintaining democratic engagement through follow through

The majority of outcomes that were found in my analysis were associated with co-design activities. These are activities in which citizens use their voices to improve public services (Loeffler and Bovaird, 2019; Bovaird and Loeffler, 2013). I found that collective co-production processes had provided numerous opportunities for stakeholders to share their perspectives and contribute to the production of initial outcomes.[77] These opportunities occurred through preliminary processes (co-design and preparation) and collective co-production interactions between communities (see *figure 18*). Some initial outcomes are listed below:

- Increasing patient satisfaction ('Karlee' Interview).
- Improving services environments ('Renata' Interview).
- Helping staff members who work in emergency departments ('Mary' Interview).

However, I also discovered that initial outcomes needed to be implemented within services. This meant that co-producers were often required to go beyond simply using their voices within collective co-production activities and preliminary events like co-design. In doing this co-producers engaged in actions that enabled initial outcomes to be accepted and utilised within NHS services. This transition between the provision of stakeholder voice and action is noticed by Loeffler and Bovaird (2019):

> Attempts to segment co-production activity into neat, non-interacting categories is almost certainly doomed, as many citizens who are keen to use their voice in the decision-making process are often also prepared to undertake at least some actions which help to implement the decisions concerned.
>
> (Ibid, p.252)

This statement indicates that collective co-production should not be viewed as solely consisting of activities such as co-design and co-commissioning. Rather, it suggests

[77] I use the term 'initial outcomes' because they are the first products to be produced through collective co-production activities like co-design. These outcomes are then changed through follow through and ultimate outcomes are created.

that there is required an appreciation of collective co-production that encompasses the production and implementation of outcomes. This suggestion is evidenced in Brandsen and Honingh's (2015, p.433) example of participative building.[78] In this illustration the authors demonstrate that stakeholders are capable of contributing throughout the co-production cycle. Thus, Brandsen and Honingh (2015, p.433) show that participants both engaged in co-designing the building and in implementing the outcome through participating in its construction.

This confluence of production and implementation is also discussed by Bevir (2013). He states that stakeholders should be included in the production of change. As such, stakeholders should engage in phases of dialogue wherein they manifest compromises and participate in the implementation of outcomes. Bevir (Ibid, pp.182-185) suggests that implementation occurs through a number of different activities. These include 'publicity' wherein authorities ask citizens to comment on proposed policies. Furthermore, they include 'decision' activities in which citizens join authority figures in negotiations that define how a policy is implemented. The following extract describes how citizens participate in 'decision' activities:

> They could create committees as sites for face-to-face negotiations between agency representatives and various citizens, and they could provide citizens with places on the drafting committees that define their operating rules and procedures.
>
> (Ibid, p.183)

This latter activity type resembles that way in which interviewees consider the ideal implementation of outcomes. The relational nature of 'negotiations' and 'committees' reflects interviewee understanding regarding the role of stakeholders in practically applying initial outcomes of collective co-production within NHS services. This likeness is evidenced in the following extract wherein 'Mary' describes how she regularly includes co-producers in the actualisation of outcomes:

[78] I discuss the example of participative building in *section 1.2*.

> I suppose it is like being a good leader, you follow through. When you say you are going to do something you do it and I included them in absolutely everything.
>
> ('Mary' Interview, p.8)

My analysis of interviews has, therefore, enabled me to consider the value of co-produced outcome implementation. As such, I suggest that the employment of phases of follow through provides co-producers and non-participating stakeholders with opportunities to actualise initial outcomes within NHS services. This is because follow through enables co-producers and non-participating stakeholders to engage in the production of change.

New arenas of contestation

My analysis shows that the co-production of implementation often occurs through explicit phases of follow through. In these phases the collective of individuals who participated in prior interactions take part in a process that offers them formal powers to actualise outcomes. As discussed, these were often co-design outcomes that altered the constitution of service environments. To achieve this actualisation collective co-production groups were typically segmented in to sub-groups (see *figure 19*). Participants in sub-groups then considered how initial outcomes, produced through interactions in the wider collective group, could be actualised within services. This deliberative activity moves participants in to a new arena of contestation wherein they test outcomes relative to the realities of the practical world. This transition is shown in *figure 19* and in the following extract:

> …staff and patients volunteer in to the specific co-design working groups that are formed around the specific priorities that they have decided together to improve.
>
> ('Gareth' Interview, p.3)

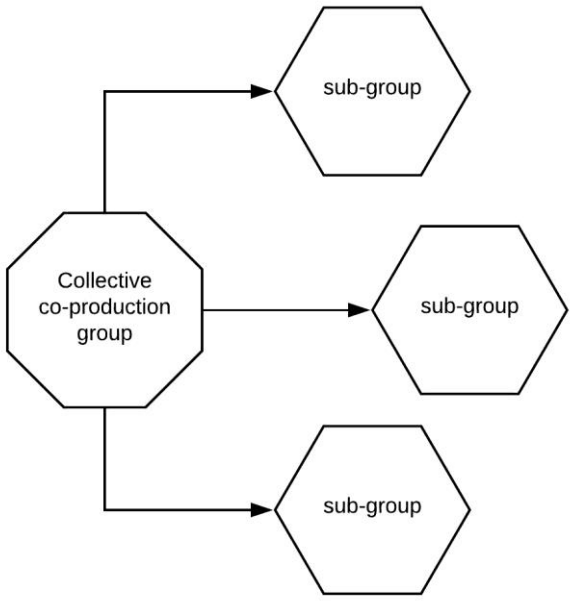

Figure 19: Showing how follow through results from the movement of co-producers to sub-groups.

The transition from collective co-production interactions to "specific co-design working groups" demonstrates that participants take on the responsibility for producing change. This is a change that is formed around decisions made within the prior interaction phase ('Mary' Interview, p.4; 'Sonia' Interview, p.2). For example, initial outcomes that relate to improving a departments environment have been formalised within a specific follow through sub-group:

> So, we were in what we called the Environment Group. So we were there to see ways we could change the hospital ward environment and make it more homely, more warm and comforting for the patients.
>
> ('Renata' Interview, p.5)

Accordingly, follow through maintains stakeholder participation in the production of change. This is because initial outcomes and participants transition between interaction and follow through phases. This transition is important. Pettit (2012, pp.261-262) suggests that the ability to move between phases of contestation enables co-producers to make their case in new contexts. Thus, co-producers seek to consider and, subsequently, legitimise their outcomes in respect of the wider service environment. This is not always an active process. Non-participating stakeholders may simply be persuaded by the value of an outcome. As such, they implicitly or

explicitly validate outcomes by incorporating them within their daily routines (Ibid). This complex web of contestation is displayed in *figure 20* wherein I show how sub-groups both work in respect of initial outcomes and in terms of the traditions that orient the operational lives of non-participating stakeholders.

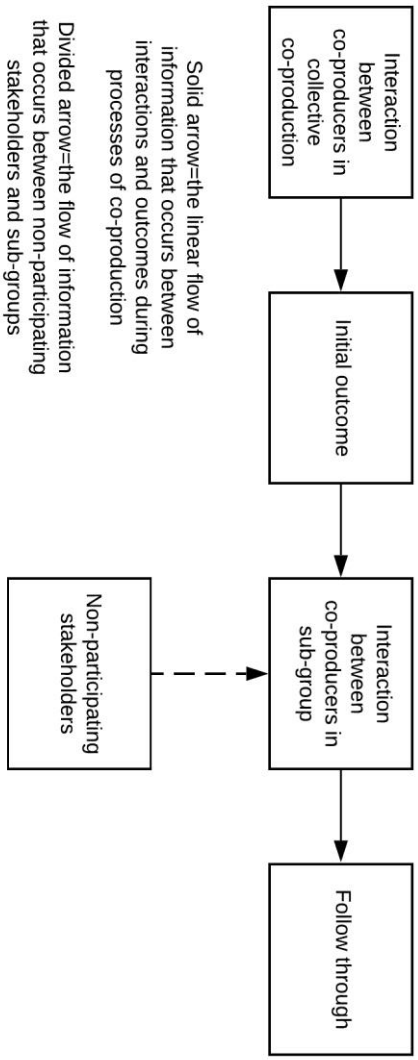

Figure 20: Showing how follow through was found to transpire through the amalgamation of initial outcomes with external traditions.

Interaction and Follow Through

Follow through sub-groups are responsive to the conditions of the environments that they are attempting to change. This is because they are tasked with applying an initial co-design outcome within a real-world setting (see *figure 20*). Accordingly, sub-groups regularly include participants who have lived experiences of the environment ('Nigel' Interview, p.5). These participants validate the practicality of proposed improvements by answering questions like "can we do this?, Can we do that?" ('Teresa' Interview, p.8).

Ideally, this contestation would be achieved co-productively. If priorities are institutionally or departmentally problematic then sub-groups should revisit their initial outcomes and find new compromises that acknowledge the realities of the operational setting. Interviewees contend that this process should be guided by the same ethics that define co-production activities like co-design. For example, 'Gareth' assert that follow through sub-group meetings transpire within locations wherein participants feel secure:

> We try to do it off site whenever we can, so an outside environment. People aren't identified as staff and patients. You know, all those usual things you do to try and bring the group together.
>
> ('Gareth' Interview, pp.3-4)

This extract suggests that sub-groups, like previous collective co-production groups, acknowledge the complexity of participants. They do not, therefore, essentialise and rationalise notions of identity. Rather, they attempt to ensure that everyone is equal within the group by removing barriers to participation. This ambition is also noticed in the way that interviewees suggest that follow through sub-groups are characterised by solidarity:

> …those smaller groups were, as we already had travelled a path together and they already had those relationships and they were really committed to the project and to each other and there was something about the patients and relatives turning up for the staff and often it would be the service users standing up for the staff and getting them a cup of tea and a biscuit.
>
> ('Mary' Interview, p.6)

In this extract 'Mary' asserts that democratic ethics are magnified within follow through. The time spent considering one another's experiences and discussing ways to improve services prepare co-producers for participation in sub-groups. This preparation reduces hierarchies and paternal traditions within sub-groups, thereby empowering participants to speak openly ('Renata' Interview, p.5; 'Karlee' Interview, p.9).

This open environment may also mean that participants apply and harness aspects of their identity within implementation. Accordingly, follow through sub-groups benefit from the skills, interests and experiences of participants. This notion is presented within the testimony of 'Renata'. In her interview she discusses how she achieved follow through of an initial outcome by asking HCP participants to use their administrative skills ('Renata' Interview, p.6). As such, HCP participants took part in "organising the painters and choosing which wall needed to be painted" ('Renata' Interview, p.2). This assertion suggests that follow through can be active, rather than solely dialogical. Thus, like time banking follow through often enables people to contribute value in any way that they can.[79]

However, this active vision of follow through may be contingent on the constraining impact of traditions associated with the identities of co-producers. For instance, professionals are often unable to engage in time-consuming processes like organising painters. Furthermore, SUs may be physically incapable of engaging in the practical work of implementing an outcome. This inability to participate does not necessarily diminish the democratic nature of follow through. An inability to physically engage in the realisation of an improvement does not speak to a lack of

[79] See my discussion of time banking in *section 1.2*.

shared ownership of the ultimate outcome. Instead, what matters is that communities have the opportunity to determine what needs to be improved. As such, the following scenario does not reduce the democratic strength of follow through:

> …everybody tried to work together and I think what was difficult was that there were a lot of things that were the more practical stuff like for example setting up an Ikea table and a lot of times people were too busy to help with that, and I couldn't ask the patients or the family members because they were quite elderly or not able. So it came down me and the maintenance to do that.
>
> ('Renata' Interview, p.8)

In this sense I propose that there may exist a clear distinction within follow through. This is between the moment wherein co-producers equally decide on an improvement within a sub-group and the point at which the improvement actually occurs. I suggest that in ideal circumstances both of these aspects would be co-productive, with co-producers engaging together to manifest an outcome that they both own. This dual approach enables stakeholders to contribute value irrespective of their identity.

The importance of advocacy

Follow through does not occur in a vacuum. Like other phases of collective co-production, follow through requires a sympathetic environment. This environment provides the "momentum" to maintain democratic participation in the generation of change ('Amelia' Interview, p.12). However, follow through is difficult to achieve. It is a display of tremendous loyalty for an organisation or department to provide sub-groups with the power to manifest change. Thus, to permit groups to do "whatever they want" requires the devolution of power to these groups or to operational actors who subsequently legitimise outcomes ('Karlee' Interview, p.4). As such, organisers often require support from within NHS services. In my analysis of interviews I found that support often arrived as a product of relationships that exist within departments.

In *section 4.3* I discuss how the department is a site that informs operational behaviour. In doing this I suggest that the generation of co-production is more likely within departments wherein there exist fluid and porous hierarchies. However, this does not mean that departmental hierarchies are necessarily damaging. This is because authoritative individuals like departmental managers often act as allies in unilaterally promoting the conditions for follow through:

> So I, an organiser, went to the high-ranking individual and said "I would like to feel that I have your support for whatever comes out of this when women start to talk about it and that I have your support to be able to have decisions be made in terms of influencing change."
>
> ('Amelia' Interview, p.11)

In this extract 'Amelia' illustrates the importance of advocacy in supporting outcome implementation. She shows how the support of high-ranking colleagues is valuable when attempting to alter operational conditions within the NHS. This is supported by 'Imogen' who asserts that high-ranking advocates promote conditions wherein follow through "just gets done" ('Imogen.1' Interview, p.5). Likewise, 'Renata' (Interview, pp.8-9) describes how her processes of follow through have been diminished as a result of a lack of advocacy from operational colleagues.

Organisers enjoy varied access to advocates. Standing groups members spend time reflecting on the nature of NHS services. Members have, thus, learnt that NHS services are prone to flux and that staff members lead busy and temperamental lives. This understanding has, subsequently, been applied within the work of standing groups, thereby promoting an idea of members as helpful and supportive:

> Because we see people moving around the org, I'm sure it's the same in any NHS structure in wards or services, it is really handy that when you go on to work somewhere else chances are that you will have a relationship with one or two people. It is more of that getting a presence out there and getting everyone ready to work together without any fear.
>
> ('Imogen' Interview, p.11)

I propose that the efficacy of standing groups in actualising and implementing change may be contingent on their understanding that the NHS is a difficult place in which to work. Standing group members may, therefore, need to prove that their works do not impinge on the capacity of operational actors before they gain the support of advocates and manifest changes to departments:

> It is about getting your foot in the door to allow them to give you the time to have that conversation. Most of the time people can be swayed but it takes time. It takes weeks sometimes.
>
> (Ibid, p.3)

By contrast, interviewees have suggested that the status of entrepreneurs within NHS services promotes advocacy. This correlation is evidenced in the following extract wherein 'Mary' indicates that her clinical status enabled her to gain the advocacy of a key actor:[80]

> I mean, when I first went to speak to the matron and I said can we do this in your department and I explained the process and it went over her head and she said "how long will it take?"
> And I said "I don't know."
> Then she said "how many people will it involve?"
> "I don't know."
> "What will the outcomes be?"
> "I don't know."
> And she still said yes.
>
> ('Mary' Interview, p.10)

This extract illustrates how high-status provides entrepreneurs with access to advocacy. It shows that 'Mary' was capable of attaining the support of key departmental figures, irrespective of whether she was able to provide information

[80] I examine 'Mary's' status in *section 4.2* wherein I consider how her clinical role has enabled her to alter the behavior of colleagues and engage in forms of learning and development.

about her collective co-production process. In achieving this 'Mary' subsequently manifested outcomes that were understood to be legitimate within the department:

> So I think that kind of legitimizes it for everyone. I think influential senior people saying yes to it in the department was key.
>
> (Ibid)

As such, I suggest that entrepreneurs are often capable of immediately accessing advocates. Their operational status means that they do not have to engage in long-term processes of learning and relationship formation. Rather, they are capable of garnering, or indeed demanding, the support of colleagues. However, this is not to say that standing groups are less likely to engage in the follow through of outcomes. My analysis shows that standing group members learn to become functioning and supportive parts of service environments. In this way I propose that the capacity of standing groups to enact change may be contingent on their displaying that they are credible partners who are able to incorporate the experiences of HCPs within their work.

Conclusion: follow through and advocacy

In this section I theorise that a lack of follow through prohibits processes of collective co-production from being characterised as democratic. This is because follow through involves participants in the manifestation of outcomes. Thus, participants who have engaged in follow through enjoy ownership over the decision-making process and its outcomes. Similarly, I explore how follow through promotes engagement from non-participating stakeholders. I assert that follow through processes require co-producers to amalgamate their initial outcomes with the realities of operational actors. This process enables non-participating stakeholders to validate co-produced outcomes. In *section 6.3* I build on this analysis. I discuss how traditions of objectivity and expertise make phases of follow through necessary. In doing this I provide examples of co-design outcomes that have been generated through follow through.

6.3: Outcomes of Collective Co-production in the NHS

Having examined the influence of conditions on the constitution of collective co-production, the way processes are implemented and the means through which interaction and follow through are generated it is now appropriate to turn to the final aspect of collective co-production: outcomes. In this section I examine outcomes in two distinct yet interrelated ways. The first is through an exploration of how outcomes are changed to conform to the beliefs that influence and orient actors who operate in NHS services. In this way I build on my prior investigation of follow through by considering how it is used to meet demands related to effectiveness and efficiency.

The second route through which I explore outcomes is by investigating the production of private value. In doing this I consider how collective co-production affects understanding of the self, other communities and the NHS. These are changes that have occurred through participation in supplementary processes (co-design and preparation) and interactions between stakeholder communities. In examining these private outcomes I propose that collective co-production also produces value that extends beyond co-design and changes in understanding. Rather, collective co-production produces what Bovaird and Loeffler (2012) call political value. This means that processes create outcomes that contribute to and reproduce democracy within the NHS.

Operational resistance to collective co-production outcomes

My analysis of interviews shows that collective co-production outcomes are often resisted by operational actors. This is because operational actors are affected by a range of traditions that frequently conflict with the ontological orientation of democratically produced service improvements. As discussed in *sections 4.1*, *4.2* and *4.3*, operational actors often operate against backdrops that preference particular forms of understanding. For example, many HCPs are affected by traditions related to efficiency and productivity and that delineate understanding of SU capability. As such, HCPs are often limited by considerations regarding the realisation of their clinical duties within temporally scarce conditions.

These traditions inform the beliefs and actions of operational actors. They affect HCPs by orientating their understanding of what is important and valuable. This is why Bevir (2013) proposes that agency is situated. He suggests that agency is a product of the way that actors negotiate between and respond to social and institutional conditions. Thus, the perceived necessity for HCPs to productively and efficiently engage in clinical work is a consequence of their harnessing traditions learnt through education, training and on the ward. However, the imposition of collective co-production outcomes within wards and departments introduces dilemmas within the minds of operational actors. HCPs, therefore, respond to these dilemmas by challenging previously held beliefs or eschewing the interloping traditions (Ibid).

My research demonstrates that HCPs often deem collective co-production outcomes to be a waste of time.[81] This is because the majority of outcomes found within my analysis did not explicitly contribute to the capacity of HCPs to treat patients. Rather, they were frequently centred on normative improvements:[82] changing ward environments, altering how clothing was stored and providing SUs with access to activities:

> We compiled activity boxes and the nurses just had to give them out if somebody wanted something to do a puzzle, a game or read a book, but it is really difficult to get them to do that. I think if they just understood that if they do that the patients will be busy, happier and they will have more time to do more work.
>
> ('Renata' Interview, p.9)

This extract shows that staff members understood the activity box to be a diversion. In this sense the introduction of the box did not act as a catalyst for HCPs to revise their understanding of their work. Rather, HCPs responded to the introduction of the box by continuing to engage in their clinical duties. This effect was noticed

[81] In *Chapter 4* I show how time is an important variable in delineating what is possible for operational actors. As such, normative outcomes that impinge on time are often rejected or ignored.
[82] I use the term "normative improvement" to denote how the outcome of collective co-production did not contribute to any form of objective value. Rather, the outcome was deemed to be a good in and of itself.

elsewhere in my analysis. Outcomes that implicitly went against the ontologies of staff members by conflicting with or distracting from their desire to engage in clinical work were often considered to be frivolous and non-essential ('Renata' Interview, p.7). Consequently, a number of organisers struggled to implement and sustain co-design outcomes within NHS services.

As such, I propose that the acceptance and sustainability of co-design outcomes is contingent on their occurring a change in the way that they are understood. In my analysis of interviews this change transpired through processes in which the ambitions of co-producers were merged with the traditions that inform stakeholders. In this way I contend that phases of follow through are important in amalgamating these often competing positions. This is because follow through sub-groups enable co-producers to consider how traditions influence the understanding of non-participating stakeholders.

Improving the sustainability of outcomes

In *section 6.2* I propose that follow through enables co-producers and non-participating stakeholders to influence the production of ultimate outcomes (see *figure 21*). This is because processes of follow through ask co-producers to consider how their initial outcomes will be utilised within the real-world. As such, I assert that ultimate outcomes are reflections of different ontological positions. They both incorporate the desires of co-producers and the traditions that impose on situated agents within departments.

This supposition is evidenced in the testimony of 'Mary'. In her interview 'Mary' (Interview, pp.9-11) describes how a collective co-design process resulted in an ultimate outcome wherein a group of volunteers was employed to ease the workload of HCPs in an emergency department. This outcome occurred as a product of a follow through process that enabled participants to personally experience the practical environment about which they had been deliberating. In doing this members of the group witnessed the reality of life in the department and, consequently, arrived at an accommodating decision as to the best way to generate improvements. This process is illustrated in the following figure:

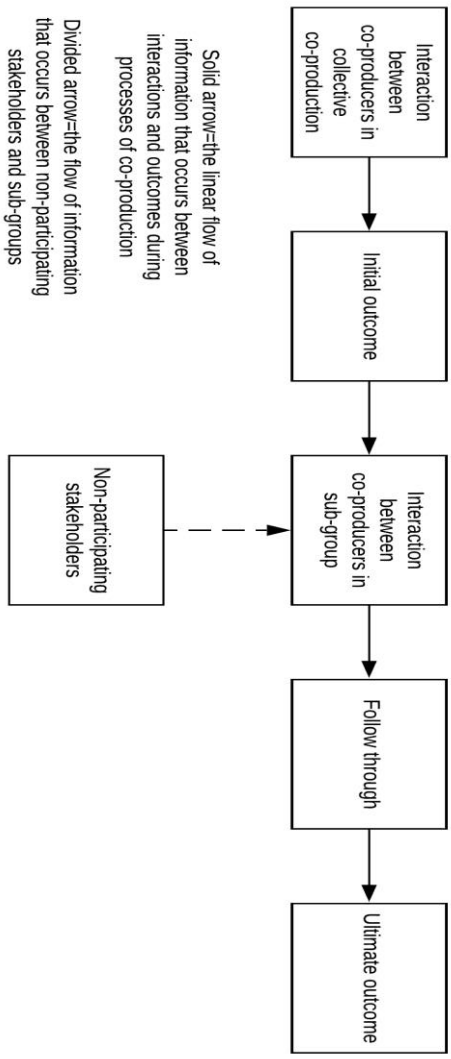

Figure 21: Delineating how follow through produces ultimate outcomes that conform to the ontologies of co-producers and non-participating stakeholders.

In *figure 21* I show that ultimate outcomes are produced through amalgamating initial outcomes with the realities of the environments that are being changed. This occurs during processes of follow through wherein sub-groups consider the realisation of initial outcomes within operational environments that contain non-participating stakeholders. In this sense ultimate outcomes result from negotiations between dissimilar epistemological positions. Ultimate outcomes are not simply reflections of a singular understanding of what change is and should be. Rather, ultimate outcomes represent an acceptance that changes are understood differently. As such, ultimate outcomes incorporate the ontological pluralities that exist within collective co-production groups and in institutional and departmental environments.

Accordingly, processes of collective co-production that include phases of follow through endeavour to mitigate for the situated nature of change. In acknowledging that their attempts to alter services occur against a complex backdrop of social and institutional traditions, organisers lessen the risk that outcomes will be rejected. This is exemplified in 'Mary's' testimony. She shows that the creation of a volunteer workforce did not distract HCPs from fulfilling their clinical or administerial responsibilities. Rather, she suggests that co-producers recognised that HCPs work in environments wherein they have to be productive and sought to support them in meeting these priorities.

The notion that changes are environmentally situated is also acknowledged in the literature. Joshi, Koulolias, Garcia Moran and Loeffler (in Brandsen et al, 2018) discuss how a wide range of stakeholders were involved in the design of Mobilearn, an online platform that helps migrants receive public services in Sweden. The authors suggest that the design of Mobilearn occurred across multiple stages such as initial workshops, multi-stakeholder consultations, prototyping, piloting and validation. Participation in these processes enabled migrants and public officials to influence the design of the platform.

Joshi et al (in Brandsen et al, 2018) assert that participation occurred differently in each stage of the Mobilearn design process. Those who engaged in initial workshops and consultations were more involved in shaping the outcome in comparison to those who participated in later stages. Nevertheless, actors who participated in stages of piloting and validation were influential. This is because they verified the utility of the Mobilearn platform by testing its efficacy 'with the migrant community and public officials' (Ibid). These latter processes were, thus, akin to follow through. They enabled organisers to amalgamate their initial outcome, what they call a prototype, with the traditions that influence those actors who would likely use the platform.

However, I suggest that there are degrees to which this integration can occur. This is because integration often diminishes the democratic orientation of collective co-production. For example, conventional measures of and targets for patient satisfaction have been used to validate co-design outcomes. As suggested in *section*

4.2, targets are pervasive in the NHS. Therefore, professionals frequently seek new ways of meeting targets. As such, organisers have presented collective co-production as an innovative route through which to meet targets. For example, 'Karlee' asserts that she has recorded and measured the effect of collective co-production using methodologies like Participant Reported Outcome Measures (PROMS) and Participant Reported Experience Measures (PREMS):

> We sent out questionnaires, participant reported outcome measures and participant reported experience measures. We did this before the intervention and after.
>
> ('Karlee' Interview, p.4).

PROMS and PREMS are widely used measures of quality in the NHS. They are used in different services to explore and analyse the experiences of patients (de Silva, 2013). Thus, the use of these measures in assessing the value of collective co-production presents the process as a mechanism through which to achieve targets related to quality.

Nevertheless, I propose that the employment of positivist evaluation mechanisms when assessing the outcomes of co-production is antithetical to democratic governance. The objective focus of PROMS and PREMS diminishes the extent to which co-producing actors engage in the construction of change (see *figure 22*). This is because PROMS and PREMS are not informed by the ontologies of actors who have participated in collective co-production. Rather, they result from an externally located and internally reproduced desire to produce empirical knowledge. Thus, the framing of ultimate outcomes through these measures essentialises the products of collective co-production: delineating their validity by showing how they affect patient satisfaction and experience.

I propose that this process alienates co-producers from their products. Co-producers are no-longer in control of the way that ultimate outcomes are applied and understood. Instead, ultimate outcomes are employed as tools through which traditions relating to quality are reproduced. This hypothesis is illustrated in the

following figure wherein I show how initial outcomes have been altered to reflect traditions that exist within the institution:

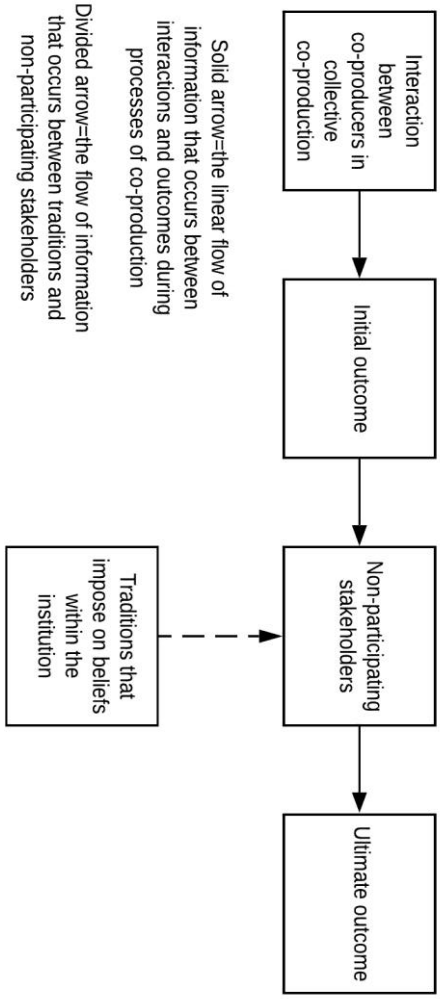

Figure 22: Showing how initial outcomes are often changed to conform to traditions that exist within the institution.

Of course, the potential alienation of the co-producer does not mean that the melding of outcomes with external traditions is inherently destructive. As suggested follow through increases the likelihood that outcomes will be accepted within operational environments. This is because outcomes are taken in to a new realm of contestation wherein co-producers change their initial products to reflect operational conditions. Therefore, co-producers maintain control of the production process by acknowledging the situated nature of change and, subsequently, incorporating environmental considerations within their decision-making.

Private outcomes

Not all outcomes discovered in my analysis are explicitly associated with co-design. Many outcomes were more personal: pertaining to the way that participation produces private value. In my review I touch on the notion that the co-delivery of services generates more than that which is directly produced (Bovaird and Loeffler, 2012). For example, processes of co-delivery like the expert patient programme (EPP) often produce externalities that benefit the wider public. This is because involvement in the EPP reduces the likelihood that people require future support from clinical services (Ibid). My analysis shows that interviewees have experienced similar externalities of production. However, these externalities frequently extended from the public to the private.

This proposition indicates that the outcome value chain of co-design is more complex than first depicted in this thesis. Rather than resembling that which I show in *figures 18, 20, 21* and *22*, the outcome value chain should be understood to be multi-faceted. This means that a linear vision of the value chain that runs from collective co-production interactions to initial outcomes, follow through and finally ultimate outcomes is insubstantial. Instead, the value chain should encompass and delineate the ways in which collective co-production processes produce private value.

Throughout this thesis I assert that involvement in phases of co-design, preparation and inter-community interaction promote changes in the understanding of co-producers. For example, co-design and reflection activities build accessibility by improving self-efficacy and civic skills.[83] Equally, preparatory processes like filmed interviews improve inter and intra-community solidarity.[84] Interviewees view these empowerment products as outcomes in and of themselves. As such, I propose that they be included within our understanding of collective co-production outcomes. This is shown in *figure 23* wherein I demonstrate how collective co-production is not likely to be restricted to voice related outcomes that alter services. Rather, it is probable that private value is also created:

[83] See *section 5.2* for examples of this outcome.
[84] See *section 5.3* for examples of this outcome.

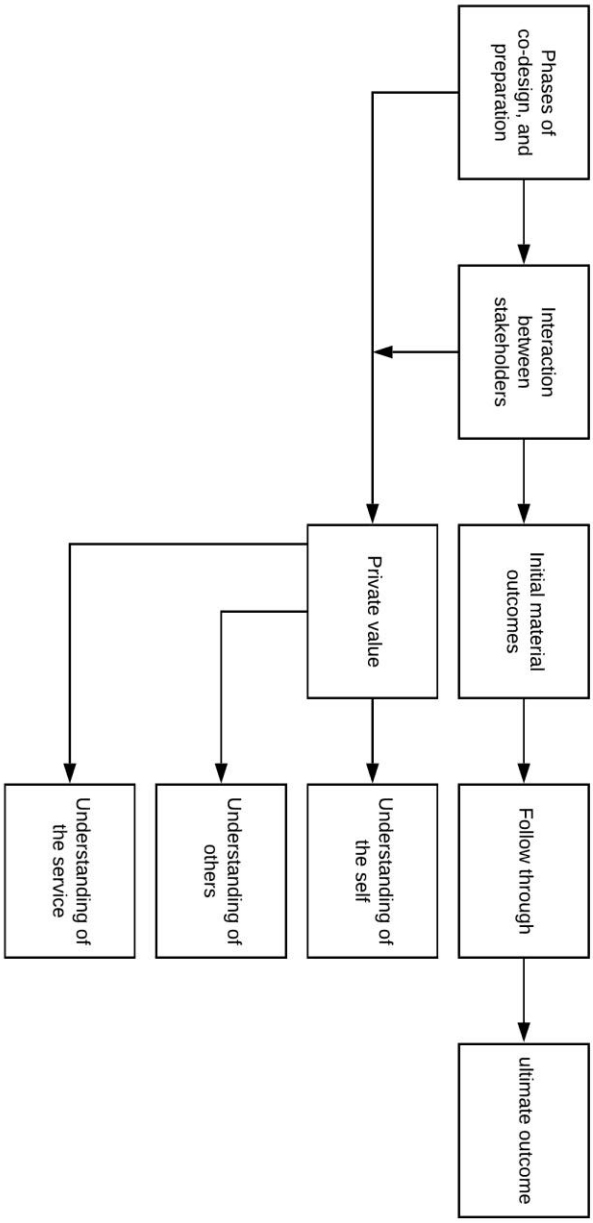

Figure 23: Expanded outcome value chain demonstrating how participation in collective co-production was found to produce private value.

Private outcomes can be viewed in the way that participation influences stakeholder understanding of identity and capacity. For example, processes that enable participants to engage in phases of preparation such as trigger films have facilitated increases in participant understanding of lived experience:

> Some of our service users said when they were doing it "I knew I felt something about that aspect of my experience but I had never actually named it. I never actually found a word for it before and doing this has helped me find the words for my experience." And once they found the words for it, not only could they articulate it, but they could ascribe meaning to it and look at the shared experience.
>
> ('Teresa' Interview, p.1)

The above extract shows that reflective processes promote alterations in appreciation of identity. This is because participation in creating and analysing trigger films has enabled participants to reflect on their experiences (Ibid). Involvement in this process has, therefore, exposed participants to the experiences and understanding of their peers. This process, consequently, enabled participants to change, and perhaps improve on, how they considered and talked about their lives and identities.

This finding is mirrored in the testimony of 'Imogen'. In her interview she states that the communal nature of collective co-production has increased her self-efficacy. Her involvement in collective co-production meant that she was exposed to the testimony of her peers. This enabled her to return to a perception of her identity that had long-since been diminished by her experiences of living with a long-term illness:

> It makes me feel like my old career in a way, as well as meeting other people and hearing other people's stories.
>
> (Ibid, p.8)

Private outcomes are also found in the way that participation affects how HCPs understand their identity and role. This is because involvement in collective co-production processes that include preparatory phases in which staff listen to and learn from the testimony of SUs has promoted alterations in how HCPs appreciate their professional positions. This suggestion is evidenced in the following quote wherein 'Mary' talks about the effect of participation on staff members:

> There was something about having the patients besides them that reenergized them and reconnected them to why they became healthcare professionals in the first place. It has an amazing effect.
>
> ('Mary' Interview, p.10)

This extract suggests that supplementary processes such as trigger films enable staff to return to notions of identity that have been diminished. This is a similar transformative effect to that noticed in the testimony of 'Imogen'. As such, I propose that collective co-production processes that expose participants to stories of peers and other stakeholders provide opportunities for co-producers to remake their identities.

Private outcomes are also noticed in the way that participation in collective co-production alters understanding of other communities. My analysis shows that these changes were often a product of involvement in preparatory processes that aimed to build inter-community solidarity. These were processes like trigger films wherein staff learnt about the value of lived experience and patients discovered that HCPs work in difficult operational environments. Through exposure to these processes co-producers learnt to consider stakeholders from other communities as potential partners. This supposition is supported in the testimony of 'Gareth' (Interview, p.9) who suggests that exposure to trigger films promotes the growth of "new relationships" between communities.

Furthermore, my research suggests that participation often produces alterations in understanding of the NHS. For example, processes that employ phases of reflective preparation expose participants to emotive stories that delineate patient and staff experiences. 'Karlee' asserts that this preparatory activity promotes alterations in understanding of the service. No longer is it viewed as a haven of paternal norms. Rather, preparatory processes promote an understanding of how co-production can be applied within the future operations of staff and patients alike. For example, the stories told within trigger films are often reflective of the dangers of not listening to and working with SUs:

> In their meeting staff were crying. So their meetings were really emotional as they had someone saying in the videos that they weren't allowed to be with their husband at meal times and she really wanted to help him and I guess some staff were quite shocked by what they were hearing…
>
> ('Karlee' Interview p.5)

This extract demonstrates how preparatory processes enable HCPs to appreciate the value of lived experiences. It shows that involvement has enabled HCPs to see that they could have applied experiential information within their previous work and, consequently, improved their service. This has prompted a number of HCP interviewees to assert that they now see lived experience as a vital component of service design:

> The whole process I found it amazing and the group and the information that we gathered from all the different levels of people, that kind of inspired me and opened up a whole new world of possibilities for me.
>
> ('Renata' Interview, p.4)

Systemic outcomes: embedding co-production within the NHS

My analysis shows that private outcomes contribute to learning. These outcomes frequently alter how actors understand themselves, other communities and the systems in which they operate. As such, they often change the traditions that orient their situated agency. No longer do stakeholders consider paternal norms to be natural. Nor do they conceive of expertise as a panacea. Rather, participation in processes of collective co-production promotes an understanding of the shared capacity of stakeholders to contribute to governance. Accordingly, I suggest that private outcomes are catalysts for further democratic participation (see *figure 24*).

This cumulative effect has been discussed by Bovaird and Loeffler (2012). In their categorisation of values produced by co-production they suggest that participation contributes to the democratic efficacy of services. They call this 'political value' (Ibid, pp.1126-1127). This term means that participation in decision-making

processes, and presumably in supplementary procedures, adds value to collective co-production by generating externalities that strengthen democracy within services.

Thus, processes of collective co-production that occur over stages often act as catalysts for political value. This is because co-design, preparation and interaction regularly embed co-productive norms in the system and the stakeholder population. This is portrayed as working in a similar way to Keynes's multiplier effect: with the empowerment of participants in prior collective co-production resulting in the manifestation of future collaboration ('Amelia' Interview, p.12).

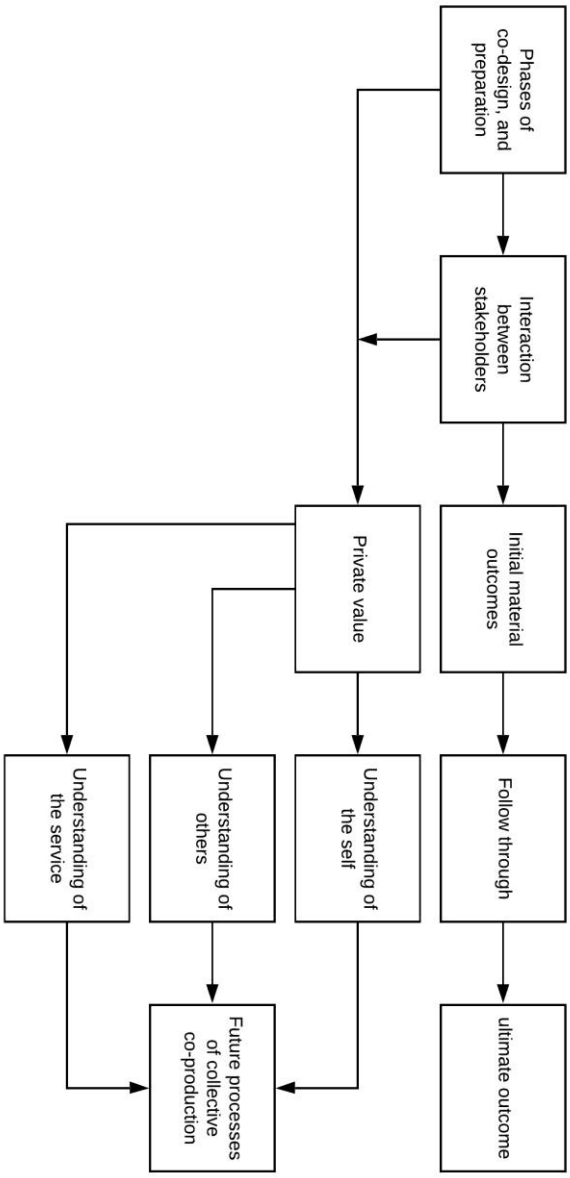

Figure 24: Process through which the production of private values were found to enable democratic governance to become 'business as usual'.

In *Figure 24* I show the potential cumulative effect of participation on the production of democracy within NHS services. I portray how the private outcomes discussed in the prior sub-section ideally contribute to the growth of an environment wherein stakeholders conceive of their, and other communities, capacity to engage in decision-making. Furthermore, I illustrate that private outcomes manifest an environment in which stakeholders understand that the system in which they operate is an arena for co-production. In this way I suggest that participation promotes an environment wherein "speaking with patients" becomes "business as usual" ('Christie' Interview, p.2).

Interviewees have, therefore, suggested that outcomes related to cultural change should be used to measure the quality of processes of collective co-production. 'Amelia' provides an example of this:

> How I measure it will be a very interesting aspect of it, which is why I have to keep a log on everything that has happened. I have to look at it with an education hat on in terms of seeing behavioural change or conversations that are happening outside between different staff groups or different forums where women have much more prominence.
>
> ('Amelia' Interview, p.12)

This extract indicates that measures of collective co-production should contrast to those objective metrics discussed earlier. Notions of success should be associated with processes that promote "behavioural change" and conversations between different communities, rather than notions of effectiveness, efficiency and productivity (Ibid). Accordingly, I propose that future collective co-production research consider the extent to which organisers acknowledge and reinforce the multifaceted value chain displayed in *figure 24*.

Conclusion: outcomes and the NHS in England

In this section I contend that outcomes occur in a number of ways. Co-design outcomes are formalised around physical changes within an environment. These outcomes can be more or less democratic. The extent to which they are changed to conform to dominant institutional ontologies influences their democratic quality. Those that are informed by objective notions like effectiveness are examples of outcomes with diminished democratic quality. However, processes that employ phases of follow through to transparently combine initial outcomes with the experiences of those who operate in the wider organisation maintain democratic legitimacy. This is because these processes provide opportunities to produce outcomes that conform to the understanding of participants and the concerns of those who operate in NHS services.

Collective co-production processes also produce private outcomes. These are products that change how participants view themselves, others and the service. As such, I assert that processes of collective co-production should be studied in reference to how they produce alterations in ontology, in addition to how they physically change services. In studying the production of private value researchers may also explore opportunities for systemic change. This is because changes in understanding are linked to future participation processes. Thus, I suggest that the production of private value is a catalyst for further democratic opportunities within the NHS.

Overview of Chapter 6

In this chapter I consider how stakeholders interact with one another and produce outcomes. I examine the value of participant feeling in generating open interactions. In doing this I highlight the importance of processes of preparation and co-design and affirm the value of facilitation in reducing grievances and inequalities. Furthermore, I explore how processes of follow through promote engagement from non-participating stakeholders. I assert that follow through processes ask co-producers to amalgamate their initial outcomes with the realities of operational actors. This process enables non-participating stakeholders to validate co-produced outcomes and supports co-producers in maintaining democratic control of the

production process. Lastly, I contend that collective co-production processes produce private value. These are changes in the way that participants understand themselves, other communities and the institution.

Discussion: conclusions for the organisation of democratic governance

In my thesis I create a framework for collective co-production as a form of democratic governance. This is a framework that acts as a composite vision of the normative variables described in *Chapter 3*. Thus, I propose that collective co-production leads to democratic governance when it is founded on a vision of empowerment and equality. To realise this vision organisers often engage in processes of representative recruitment, co-design and preparation. These processes empower stakeholders within collective-production interactions. They enable stakeholders to harness their lived experiences, interact with others, develop their understanding and contribute to the production of service improvements.

These notions are not entirely novel. A large segment of the literature has long emphasised the value of studying variables related to representation, inclusivity, solidarity and empowerment (Leach, 2006; Barbera et al, 2016).[85] In doing this scholars have proposed that the capacity of stakeholders to participate is related to a number of variables such as efficacy and age (Bovaird et al, 2015). Thus, the literature often suggests that stakeholders are not akin to a 'jack in the box' (Pestoff, 2012). They are not organically capable of participating in governance. Rather, academics emphasise the importance of supplementary processes that enable stakeholders to participate (Cepiku and Giordano, 2014).

However, I contend that the literature often eschews the exploration of implementation. Whilst many academics acknowledge the value of contextual understanding, few have committed to examining implementation within particular institutional precincts. Many offer contextual analyses of co-production activities (e.g. Loeffler and Bovaird, 2019) or examine how stakeholders participate in different services (e.g. Park, 2020), yet few investigate routes through which co-production processes transpire. Thus, my inductive exploration of participation in the NHS in England acts as a potential catalyst for further discussions regarding implementation. Future researchers may, therefore, examine how individuals or

[85] This is a section of the literature that is focused on the normative aspects of co-production. I examine this body of literature in *section 1.2*.

groups implement collective co-production in different institutions. Equally, further research may consider the effect of social and institutional traditions on opportunities for organisation within public service contexts.

The following discussion chapter represents an attempt to guide future research. To achieve this I separate my discussion in to three threads. In the first thread I consider the role of the entrepreneur in implementing collective co-production. As such, I examine the importance of status in enabling entrepreneurs to make changes to operational environments. In doing this I propose that status is a pillar on which grows the capacity to learn about and reflect on the value of collective co-production. However, I acknowledge that status may be of less importance within service environments wherein there already exists an appreciation for inter-community collaboration and partnership. These are services in which professionals regularly interact with service users.

In the second thread I explore the standing group. I investigate how the relative agency of standing group members influences their understanding of time and enables them to work flexibly and in the long-term. Furthermore, I discuss the role of standing group members in reproducing collaboration within services and suggest that their lay identity is a catalyst for the introduction of new traditions within operational environments. Finally, I explore how standing groups are tied to many of the same traditions that impose on entrepreneurs. In examining this I propose that researchers consider how notions of service user capability impact on standing group members.

In the final thread I move away from discussing implementation and reconnect with a topic that is often considered in the co-production literature: outcomes (e.g. Dadau, Glennan and Verschuere, 2019; Loeffler and Bovaird, 2019). I consider whether co-production activities like co-commissioning can be employed as a process through which to democratise public services. Furthermore, I examine how democratisation has been produced through decisions made by strategic actors. In doing this I introduce examples of systemic changes that have been strategically implemented by American healthcare providers like Kaiser Permanente. Finally, I explore

opportunities for incremental change and return to the notion that the production of private value is a catalyst for future collaboration.

Professional organisers: manifesting entrepreneurship

Entrepreneurs often implement collective co-production in NHS services. Their role as gatekeepers of operational design enables them to introduce innovations within arenas wherein they are powerful. In this sense it is important that the study of entrepreneurship is grounded by an understanding of the relations that occur within operational environments. This understanding is gained through the application of decentred theory (DT). By focusing on the traditions that influence the beliefs of individuals DT subsumes notions of power, hegemony, and structure (Bevir and Rhodes, 2008). This capacity enables decentred researchers to examine the relations that limit the situated agency of actors who operate in institutions.

In the NHS notions of power are associated with status. The attainment of advanced qualifications, as well as specialist and lead professional roles, enables entrepreneurs to alter their environment and change the behaviour of colleagues.[86] Thus, power is both a product of the status of the entrepreneur within their institutional, or indeed operational, setting and reproduces notions regarding who can and cannot engage in transformative and innovative governance (Ibid, p.9). Therefore, I propose that power, manifested through contingent status, affords entrepreneurs opportunities to change NHS services (see *figure 25*).

This proposition means that entrepreneurs have greater agency in comparison to their peers. In *figure 25* I show how the operational status of the entrepreneur enables them to spend time developing their understanding. This understanding is attained through learning processes in which they are exposed to traditions that relate to and are associated with democratic governance. Furthermore, I show how these learning processes empower entrepreneurs to respond to issues that occur within their environment. In my analysis these issues related to the necessity to increase the quality of care, involve disadvantaged users and advance their practice:[87]

[86] See my examination of these facets of status in *sections 4.2* and *4.4*.
[87] I examine how these types of issues act as catalysts for entrepreneurialism in *section 4.4*.

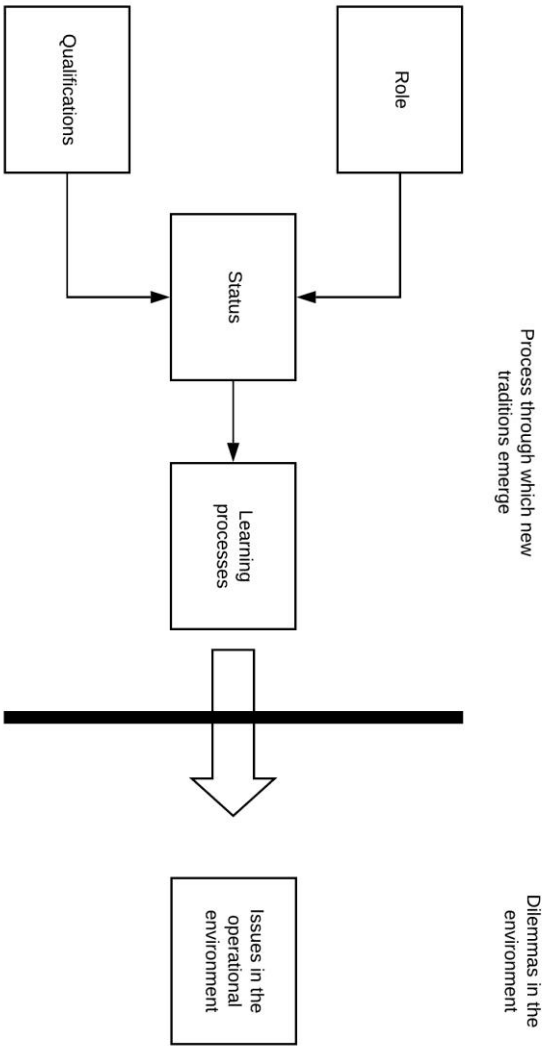

Figure 25: Delineating the process through which entrepreneurs were found to address dilemmas that occur within NHS services

In conceptualising the relationship between development and situated agency I address a major criticism of DT. Academics like Glynos and Howarth (2008), and Speed (in Bevir and Waring, 2018) suggest that DT does not account for the generation of new traditions (Bevir and Rhodes, 2008). Rather, they present DT as an approach that enables researchers to consider interactions between existing traditions. However, in finding that high-status actors are capable of engaging in learning activities I consider one route through which new traditions are manifested. This discovery conforms to Bevir's (2013) hypothesis regarding the value of opportunities 'to reimagine democracy'. In this thesis Bevir (Ibid, p.32) asserts that

reflective processes empower situated agents to envisage and enact creative responses 'to relevant issues'.

Of course, this dynamic may be different in alternative service environments. I suggest that services that have dominant traditions related to values like accessibility and solidarity may promote greater understanding of democratic governance. Future research may, therefore, consider how professionals within public sector institutions have been trained to value post-foundational ideals regarding the social contingency of freedom. Likewise, research may examine how these ideals have resulted in the manifestation of decision-making processes through which service users (SUs) are supported to make their own freedom (Ibid, pp.174-176).

The study of alternative service environments may, therefore, provide a means of discovering how institutional traditions related to equality and participative freedom promote entrepreneurship and democratic governance. For example, Vanleene and Verschuere (in Brandsen et al, 2018, p.199) view community development services as 'inherently co-productive and co-creative'. In these services their exist shared traditions that emphasise the value of lived experience and citizen empowerment (Ibid; de Graaf et al, 2014). These ideals foster notions regarding the value of partnership and collaboration between and within stakeholder communities (Vanleene and Verschuere, in Brandsen et al, 2018). Research may, consequently, consider how these traditions encourage entrepreneurship by enabling professionals to 'identify, encourage and promote local initiatives' related to stakeholder participation (de Graaf et al, 2014, p.57).

In my analysis I found that a number of operational actors valued similar traditions to those valorised in community development services. These were actors like dieticians who regularly work alongside service users.[88] However, these actors held less power within the institution and in their departments. As such, they were often incapable of altering the physical constitution of their working environment and engaging in entrepreneurship. This offers a vision of NHS entrepreneurship wherein

[88] See *sections 4.3* and *4.4* for my examination of the capacity of dieticians to become entrepreneurs within the NHS.

a multitude of actors are discouraged from engaging in implementation. Accordingly, future research may consider the extent to which an appreciation for the normative ideals that constitute co-production and democratic governance enables entrepreneurship within service environments.[89] In doing this researchers should examine interactions between normative understanding and status: considering how these variables interrelate and enable actors to implement new and innovative practices.

Lay organisation: increasing opportunities for standing groups

Standing groups are lay-led. As such, their collective perspectives are often informed by SU experiences. Furthermore, they acknowledge and integrate meso and micro service conditions within their work. This is because they operate within and have an understanding of services. Moreover, the place of standing groups within NHS services means that they are not limited by requirements to participate in effective service delivery. Accordingly, they are not influenced by traditions related to service provision nor by norms associated with market ethics. Rather, they are free to learn about the NHS, its stakeholders and research methodologies.

This latter trait promotes a vision of the standing group as a relatively autonomous being. The standing group is internal to the NHS, yet it does not directly contribute to, nor is it explicitly influenced by, clinical outcomes.[90] In this sense I suggest that standing groups have a different understanding of time in comparison to entrepreneurs. As I show in *figure 26*, entrepreneurs are engaged in more tasks and influenced by a greater range of traditions relative to standing groups. This means that entrepreneurs spend less time engaging in learning and the implementation of innovations:

[89] I consider these normative ideals in *sections 3.1* and *3.2*.
[90] See my study of the standing group in *section 4.4*.

Organising actor	Tasks found in my research	Traditions found in my research	Notions of time
Entrepreneur	• Clinical work • Administrative work • Learning • Implementation	• Paternalism • Priorities related to effectiveness • Service user capability • Development	• Scarcity • Immediacy
Standing group	• Research • Implementation	• Development	• Flexibility • Future-orientated

Figure 26: Table outlining how the tasks and traditions associated with organising actors were found to affect notions of time.

As discussed in the communications and organisational psychology literature, notions of time emerge from the reflexive understanding of actors who operate in organisations (Ballard and Seibold, 2006; Starkey, in Blyton, Hassard, Hill and Starkey, 2017). These actors perceive that they have more or less time because they are embedded within different, yet associated, worlds (Ibid). In these worlds actors are involved in different tasks and influenced by distinctive traditions. These tasks and traditions, subsequently, affect how actors experience time (Klitzman, 2007). As such, I suggest that future research explore the relationship between identity and time and how this dynamic imposes on the implementation of innovative practices.[91]

In studying this relationship researchers may find that those who are time-poor are less likely to implement collective co-production. These may be professionals who are bound to traditions that orient their understanding of role and place within particular institutional contexts. I suggest that this hypothesis is not contingent on departmental traditions. Irrespective of whether a professional operates within a department wherein a slower understanding of time is valued, he or she remains linked to and grounded by tasks and traditions that increase notions of temporal scarcity (Ballard and Seibold, 2006). This is because professionals who regularly

[91] I believe that this would be as valuable an area of research when studying the entrepreneur as in explorations regarding the organisational capacity of the standing group.

work alongside patients are also tied to traditions that emphasise the value of paternalism and productivity. These traditions often orient the understanding of professionals and act as a foundation upon which other traditions, such as those related to learning and development, are interpreted (Starkey, in Blyton, Hassard, Hill and Starkey, 2017).

By contrast, standing groups often have a subjective understanding of temporality that emphasises flexibility and future orientation. Their research focus and capacity to wait for the right conditions to undertake implementation means that they are not influenced by notions of temporal scarcity. They are not, therefore, constrained by consistently inflexible processes and traditions such as those that influence the understanding of entrepreneurs.[92] This extends from the fact that standing group members choose when to work to the notion that standing groups are in charge of the types of work in which they engage. Through this agency standing group members often spend time learning about one another, developing understanding of the institution and building relationships with stakeholders (see *figure 27*). As such, I propose that further research explore how this temporal understanding empowers standing groups and other lay collectives to implement innovations within public services.

[92] These processes and traditions are inflexible because they define what it is to be a HCP. For example, they constrain the HCP by demanding that they value and engage in clinical work.

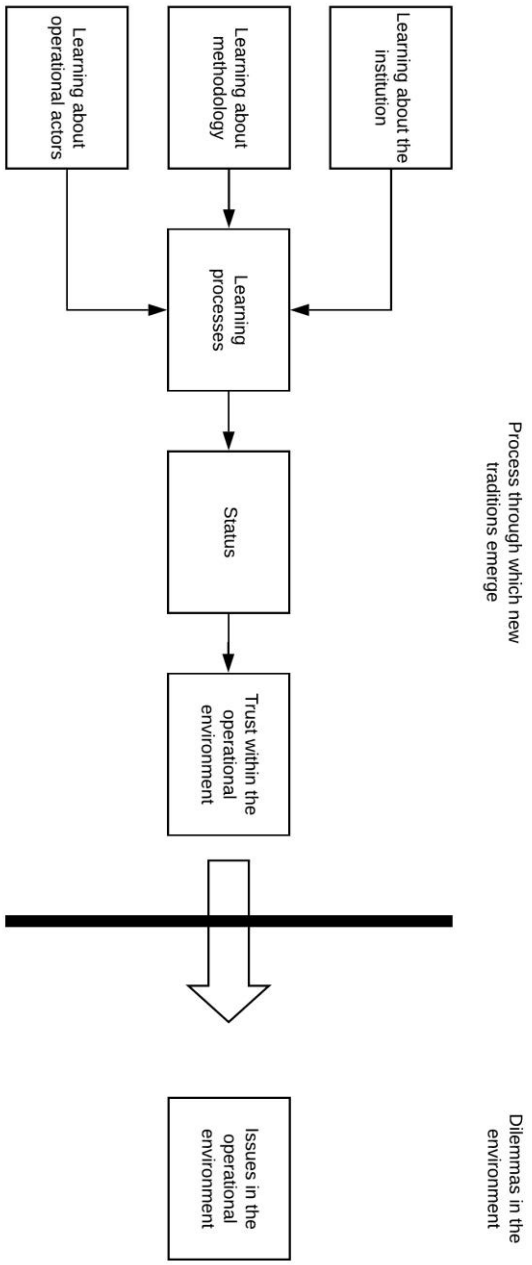

Figure 27: Delineating the process through which standing groups were found to address dilemmas that occur within NHS services.

Another important feature of standing groups is their lay membership. In my research I found that the identity and work of standing group members provides provider figures with a physical reminder of the value of non-clinical expertise. Thus, their relationship-building work and capacity to gain advocacy promote tacit changes in the way that patients are perceived.[93] This aspect of the standing group has led 'Gareth' to assert that:

[93] I consider these aspects of standing groups in *section 4.4*.

> Certainly, the standing group is a really interesting relatively radical model for introducing this type of thinking in to healthcare organisational contexts.
>
> ('Gareth' Interview, p.7)

Thus, I propose that future researchers examine the extent to which the works of standing groups contribute to the implicit reproduction of democratic governance in services. This investigation could be conceptualised through the decentred notion of dilemmas (Bevir and Rhodes, 2008). In my research I found that standing groups were a means through which new traditions had developed. Their work building relationships and generating advocacy facilitated a greater understanding of the value of lived experience in addressing problems.[94] In this way I suggest that the existence of standing groups challenges many of the traditions upon which provider ontologies are often based.[95]

Of course, future researchers may find that opportunities to study lay collectives are rare. As discussed in *section 4.2*, SU clinical identities influence the extent to which lay stakeholders engage in governance. Thus, HCPs are often reluctant to partner or collaborate with SUs who are deemed to have complex clinical identities. For example, I found that mental health SUs, individuals with learning impairments and citizens with disabilities had all been discouraged from participating in collective co-production.

I suggest that this finding might be applied within future standing group analysis. Standing groups are comprised of SUs. This means that the identities of standing group members are similar to those of the SUs with whom professionals regularly interact. As such, standing groups may be subject to the same, or similar, traditions that promote the stigmatisation of SUs. This is why I have previously indicated that the locus of validation is placed on standing group members.[96] Accordingly,

[94] See my analysis of how standing groups learn to work alongside HCPs in *sections 4.4*, *5.2*, and *5.3*.
[95] I discuss these traditions in *section 4.2*.
[96] See my analysis of the standing group in *section 4.4*.

members have to prove that they are operationally worthy and valid partners by demonstrating that:

- They understand the conditions in which professionals operate. Thus, standing groups regularly engage in forms of learning that enable them to understand HCPs.
- Their work does not impose on or alter the operations of professionals. Thus, standing groups often have to change their work to reflect the understanding of operational actors.

In this way standing groups have to incorporate the understanding and complement the expertise of professional actors. They must, therefore, integrate their ontologies with the traditions that impose on and influence the situated agency of professionals within services. These are traditions that define the operational environments in which professionals work. Thus, I propose that standing groups do not simply act as catalysts for greater appreciation of lived experience. Rather, they are also influenced by conditional factors. This is demonstrated in *figure 28*:

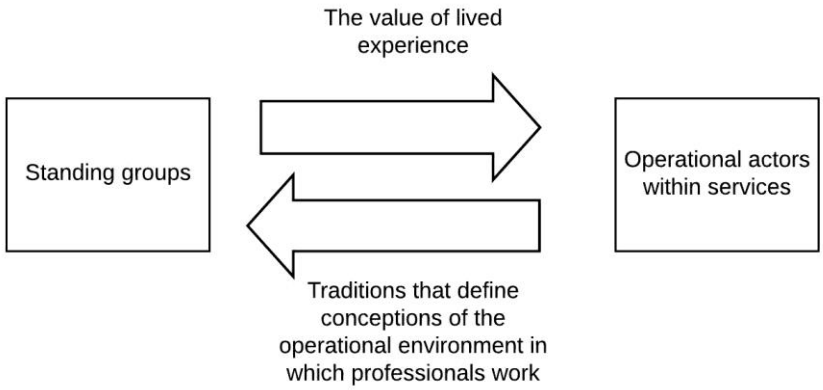

Figure 28: Showing how standing groups and operational actors are influenced by traditions that are associated with the other actor.

Consequently, further researchers may explore how interactions between different sets of traditions affect standing groups. In doing this researchers may investigate how the emergence of new traditions act as catalysts for dilemmas within the minds of standing group members and operational actors respectively. Additionally, researchers may study how both actors draw upon established traditions as a means of interpreting, understanding and responding to emerging dilemmas.

Collective co-production outcomes: generating systemic changes within services

In my research I found a number of examples of outcomes that were produced through processes of collective co-production. These were:

- The introduction of activity boxes or the installation of coat hooks in wards.
- Support for communities who operate in or have regular experiences of operational services through the creation of volunteer teams.
- Changes in how communities are perceived.
- Changes in the way that participants perceive themselves.

These outcomes affect the design of operational services and influence individual co-producers. This means that they have not affected services in their entirety. Rather, they have produced public and/or private value. A large proportion of the co-production literature has considered these value types (Dadau, Glennan and Verschuere, 2019; Loeffler and Bovaird, 2019). In doing this authors suggest that the production of public value provides a means through which to meet the collective needs of a stakeholder population. Furthermore, they propose that the creation of private value advantages individual co-producers (Ibid).

I propose that my findings are a reflection of the types of co-production activities that were examined in my research. The majority of participants had experienced co-design. Thus, participants shared stories of how they had used their voices to produce public outcomes such as improvements to services (Ibid). Furthermore, I established that participation in co-design often generated additional private value through altering understanding of the self, other communities and the institution. These outcomes regularly occurred through participation in processes wherein co-producers engaged in activities that increased accessibility and solidarity.

However, the study of a greater range of voice-related activities may have provided a means through which to examine opportunities for changes that extend beyond service improvements and alterations in understanding. For instance, Loeffler and Bovaird (2019, p.245) suggest that co-commissioning activities produce ‘a new

vision for a service'. This outcome occurs through interactions between communities that produce alterations to the priorities of services (Bovaird and Loeffler, in Edelenbos and van Meerkerk, 2016). Future research may, therefore, examine how co-commissioning activities enable stakeholders to change the priorities and influence the vision of NHS services.

One way to undertake this analysis would be to employ DT. In doing this researchers would examine the traditions that influence the beliefs of elected politicians, strategic decision-makers from within institutions, HCPs and SUs (Loeffler and Bovaird, 2019). This approach would require researchers to reflect on the myriad narratives that permeate the environments in which these actors operate. Through this analysis researchers would explore how co-commissioning is influenced by priorities and norms that are embedded within these environments. For example, Loeffler and Bovaird (Ibid, p.247) suggest that local and national political traditions impose on how politicians operate within and implement co-commissioning processes:

> Local politicians will be under pressure to involve as many people as possible in such prioritization decisions, regardless of whether these groups know or care about the issue concerned.

In this extract it is suggested that notions of democracy, particularly values attached to representative democracy, influence political actors. These ideals change processes of co-commissioning by demanding that they accommodate ideal notions of representativeness (Bovaird and Loeffler, in Edelenbos and van Meerkerk, 2016). Furthermore, Bovaird and Loeffler (Ibid) propose that political actors are influenced by traditions that affect their understanding of fiscal policy. For example, It has been asserted that politicians often resist demands to spend large amounts of money or ask citizens to contribute more in taxes (Ibid). These traditions may, consequently, alter co-commissioning by limiting the range of possible outcomes.

Moreover, decentred co-commissioning research must consider how traditions associated with political actors interact with those that are related to other stakeholders. These are traditions that delineate the power of politicians relative to

other stakeholder communities: enabling them to take charge of co-commissioning groups and advance their perspectives. Additionally, these are traditions that impose on alternative stakeholders. For instance, they may influence understanding of political actors by promoting suspicion of or subservience to their beliefs. Through examining these interactions researchers produce an understanding of how systemic changes might be created through co-commissioning. In doing this one discovers that reforms are not simply products of political will. Rather, they are consequences of the situated agency of actors who respond to dilemmas through harnessing beliefs that have arisen as products of their social and institutional backgrounds.

One of the few instances of systemic change mentioned by interviewees transpired within an American healthcare provider, the Mayo Clinic in Minnesota. This change, however, was not a product of co-commissioning. In fact, it was not the result of any co-production or participative process. Rather, it was a consequence of a strategic decision to develop a systemic commitment to co-production within the organisation:

> There are some interesting examples. So, if you look at some of the big healthcare systems In the USA for example. So if you look at the Mayo Clinic they have made a strategic decision that they will invest significantly in capability and capacity development and around co-design and co-production. So they have trained huge numbers of their staff around co-production/co-design thinking processes and methods.
>
> ('Gareth' interview, p.11)

In this extract 'Gareth' asserts that the Mayo clinic made a strategic decision to prioritise co-production and co-design (Ibid). This conception is supported in the literature. For example, Haskell and Lord (in Sanchez, Barach, Johnson and Jacobs, 2017) argue that leading decision-makers within the Mayo clinic sought to reinvent the organisations clinical practice through schemes like Minimally Disruptive Medicine. This is an approach to service delivery that asks HCPs to 'tailor treatment regimens to the realities of the daily lives of patients' (May, Montori and Mair, 2009).

The strategic nature of this change is mirrored in the work of an alternative US healthcare provider, Kaiser Permanente. Like the preceding illustration of the Mayo Clinic, Kaiser Permanente is a healthcare organisation that has developed a system-wide approach to collaboration. Alongside a number of innovative peers, it has engaged in the implementation of an approach called Human Centred Design (HCD). This is a concept that positions the service in respect of 'the needs and contexts of end users of a product or service' (Bazzano, Martin, Hicks, Faughnan and Murphy, 2016, p.2). Accordingly, HCD mirrors many of the normative and procedural tenets of co-production. This is because HCD incorporates the perspectives of stakeholders within processes that change the nature of the organisation (Carlgren, 2016).

These examples speak to the potential for systemic changes within healthcare services. They show that the implementation of system-wide participative processes have occurred through strategic decision-making. Future researchers may, therefore, use these cases to examine opportunities for change within NHS services. In doing this researchers may question whether NHS services are capable of making strategic decisions aimed at imposing greater collaboration. American healthcare providers differ from public services in the UK. In the USA providers are not connected to a wider national system. Rather, they are local and/or regional and are separated by non-profit, private, and government ownership.

By contrast, NHS organisations are nodes within a wider network of actors. As such, strategic decisions are often influenced by bodies like NHS England, the Care Quality Commission and The Department for Health, as well as by actors who operate in and use NHS services (Hudson, 2018). In addition, strategic decisions are affected by the commitment of actors to situated ethics that define their understanding of the NHS (Bevir, 2013). This confluence of actors and ethics suggests that systemic changes are likely to be produced through activities that enable different stakeholders to collaborate in and contribute to the production of change.

Such a hypothesis is evidenced in O'Rourke's (2013) study of co-commissioning in the London borough of Lambeth. In this case study the author describes how the

local authority and the NHS implemented processes of co-commissioning as a means of changing constituency mental health services. To achieve this these actors created the Lambeth Living Well Collaborative: a commissioning body comprising of NHS commissioners, actors from the local authority, carers and SUs. This diverse array of actors, subsequently, collaborated to generate system-wide changes to the way that Lambeth's mental health services were organised and delivered.

Of course, DT tells us that strategic edicts and co-commissioning alone do not constitute governance. Rather, governance is formed through the actions of situated agents who operate in and use services (Bevir, 2013). This means that the work of strategic actors and co-commissioning groups in respectively increasing inter-community collaboration should be complemented by attempts to alter the beliefs of the stakeholder population. After all, these are the people who need to incorporate prospective changes within their operational routines.[97]

In the Kaiser Permanente case, systemic changes regarding the implementation of HCD were contingent on the production of operational advocacy. As such, Kaiser Permanente promoted HCD to their HCPs:

> They soon discovered a need to adapt the methods and language to a prevailing number-driven culture, as the solutions of their innovation efforts ultimately had to appeal to health care professionals accustomed to evidence-based facts.
>
> (Carlgren, 2016, p.10)

Likewise, the Mayo clinic "trained huge numbers of their staff around co-production/co-design thinking, processes, and methods" ('Gareth' Interview, p.11). These examples suggest that processes which enable stakeholders to learn about and engage with the features of a proposed change act as routes through which to introduce and sustain innovative practices.

[97] I expand on this supposition by discussing the situated nature of change in *section 6.3*.

This supposition is supported in my findings. In *sections 6.2* and *6.3* I show how the organisers of co-design examined in my thesis often recognised the need to embed outcomes within services. This is because outcomes regularly conflicted with established traditions. Thus, organisers introduced processes of follow through wherein they sought to facilitate support for co-produced outcomes. This was achieved through engaging non-participating stakeholders in processes of contestation. In these processes co-producers altered their initial outcomes to reflect the realities of operational environments.

However, it is possible to suggest that processes of follow through would struggle to sustain systemic changes. As suggested in the Mayo clinic case, changes to the priorities of a service require a greater array of advocates than those noticed in my research. Rather, than only changing the minds of a small number of HCPs in a ward or department, these changes demand a far larger number of committed stakeholders. Thus, I propose that the sustainability of systemic changes is affected by the extent to which organisers or systems are capable of generating large-scale commitment. This hypothesis is supported in the testimony of 'Gareth':

> We are a long way from seeing that in any NHS trust. It is just that the slack and the resources aren't there. A lot of the stuff that goes on in these us healthcare systems is, I suspect, quite strong identity management but they are undoubtedly at least committed to training huge numbers of their staff in this way of thinking.
>
> ('Gareth' Interview, p.11)

In this extract 'Gareth' proposes that the implementation of systemic change is contingent on a services "slack" and "resources". Thus, 'Gareth' is implying that the relative autonomy and financial muscle of many American healthcare providers enables them to commit to "training huge numbers of their staff in this way of thinking" (Ibid).

By contrast, the NHS and its component trusts continue to suffer from what has been described as a 'funding shortfall' (Dolton, 2017). This is considered to be a product of the rising demand for healthcare services in the UK and falling government

funding relative to inflation (Ibid). Future research may, therefore, consider how these factors influence the capacity of NHS organisations to commit to processes of "training" ('Gareth' Interview, p.11). In doing this researchers could ask questions such as:

- In an environment wherein demand for services is growing, can NHS organisations ask staff to spend time training and developing their understanding of and appreciation for collaboration?
- In an environment wherein funding for the NHS is decelerating relative to inflation, do NHS organisations have the financial capacity to create and undertake training programmes that require staff to re-train and/or learn about the value of lived experience and collaboration?

Alternatively, systemic change in the NHS may be a facet of smaller and gradual alterations to the contexts in which stakeholders operate. In *section 6.3* I propose that participation in collective co-production activities promotes alterations in the understanding of co-producers. 'Gareth' asserts that these alterations in understanding enable co-producers to engage in and organise future collaborative processes:

> I think it is also in viewing the staff and patients who have gone on to other roles as active champions in formal roles within orgs that didn't exist before these processes is very important as well.
>
> (Ibid, p.10)

This extract suggests that change occurs through private outcomes that reproduce traditions associated with co-production. These private outcomes ideally lead to a growing mass of empowered SUs and activated HCPs who, subsequently, participate in or organise future collaborative processes. In this way I highlight 'Gareth's' (Interview, p.5) proposition that participation in co-production is tantamount to the eponymous 'trojan horse'.[98] This is because he suggests that co-production processes draw stakeholders in, enable them to reflect on their service and, consequently,

[98] I provide this quote in *section 5.3* wherein I discuss how preparatory processes such as trigger films alter understanding of the self and other communities.

facilitate the reimagining of the NHS. In this way democratisation is presented as a product of incremental socialisation, rather than something that is imposed on a service by a commissioning group or strategic actor. This supposition is illustrated in *figure 29* wherein I show the potential relationship between participation, the production of private value and the generation of further engagement:

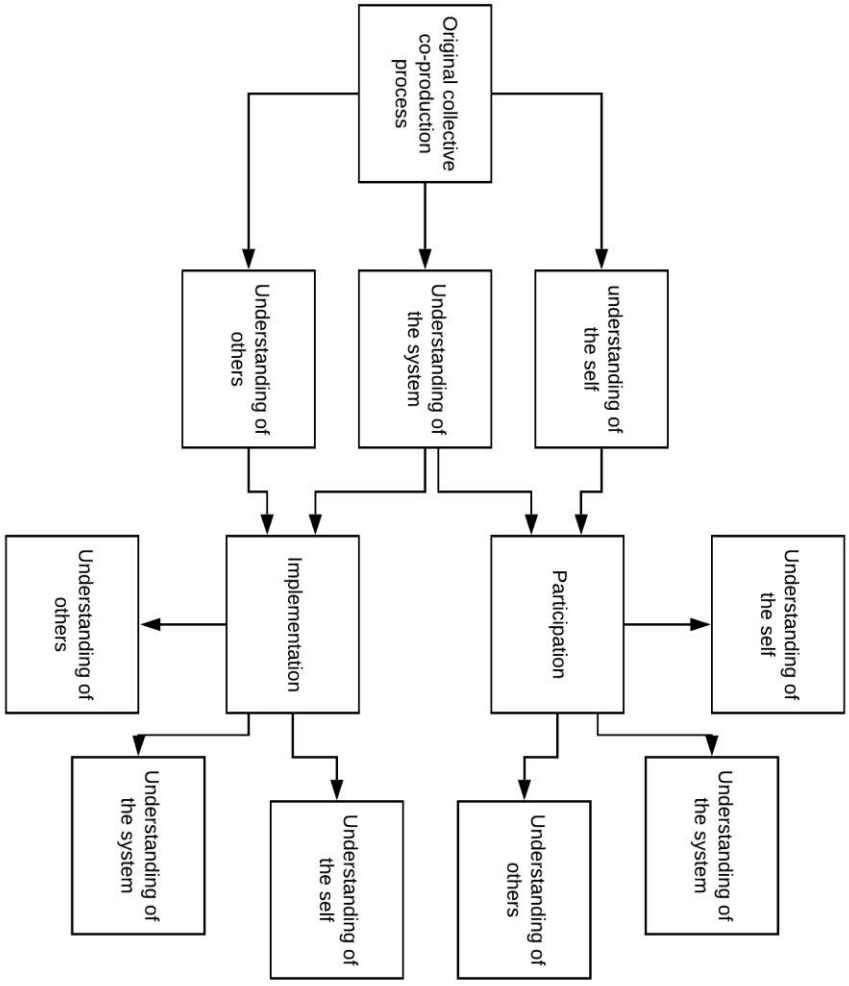

Figure 29: Demonstrating how the production of private value promotes participation in and the organisation of future participation processes.

As such, I recommend that future researchers examine how the externalities of co-production promote future participative opportunities. Researchers could achieve this by committing to longitudinal and qualitative examinations of the ontologies and actions of stakeholders who have participated in processes of co-production. Through this researchers ideally explore how private outcomes of co-production are sustained and, subsequently, transformed in to future collaborative processes.

Conclusion

My thesis is a framework for the creation of democratic governance within the NHS in England. This framework is founded on a normative approach to collective co-production that encompasses variables of representation, accessibility and solidarity. As such, I argue that the realization of collective co-production is contingent on the employment of processes of representative recruitment. In my analysis these processes often ensured that samples of participants were illustrative of the stakeholder population. These populations included actors affected by the issues being addressed within co-production groups, as well as people who had complex clinical and social identities.

Furthermore, I propose that Individuals need to have power within collective co-production. In my analysis empowered participation frequently occurred through the application of processes that increased the accessibility of groups. Processes of co-design were, thus, important methods through which to empower stakeholders. These processes enabled participants to shape the methodology and objectives of collective co-production. In doing this stakeholders were often provided with the means to construct their involvement.

Accessibility is also increased through preparatory processes. Opportunities for reflection and procedures that reduced information asymmetries were important in empowering actors. These procedures enabled participants to take control of their lived experiences, learn from one another and build their knowledge of the issues at hand. Moreover, preparatory processes were regularly employed to build solidarity. I found that filmed interviews were used as mechanisms through which to manufacture empathy between and within communities. These devices often enabled stakeholders to work together and produce collective outcomes.

In my framework I show how these initial processes contribute to the fulfillment of values of representation, accessibility and solidarity. The realization of these values empowered stakeholders and promoted collaborative interactions. As such, I suggest

that they are vital forerunners in the production of open co-productive space. This is a term that I use to characterise interactions wherein stakeholders understand themselves to be free within processes of participation. However, open co-productive space is not only produced through co-design and preparation. I assert that open interactions are also promoted through facilitators who address entrenched grievances and health inequalities.

In a number of cases I found that collective co-production interactions were followed by stages of follow through. These stages enabled co-producers and non-participating stakeholders to influence the manifestation of outcomes within operational environments. Thus, follow through was employed as a mechanism through which outcomes were altered to reflect the desires of co-producers and the realities of non-participants. In doing this organisers of co-production sought to promote the value, and increase the sustainability, of co-produced outcomes.

Not all outcomes require phases of follow through. Collective co-production processes often produce private outcomes. These are outcomes that impact on the understanding of participants by affecting their appreciation of the system, other communities and themselves. In my analysis I suggest that these outcomes are likely to produce wider empowerment and, thus, contribute to incremental systemic change. As such, I assert that private outcomes are important routes through which to facilitate future democratic governance.

The employment of collective co-production is contingent on the relationship between the organiser and the conditions in which they operate. Entrepreneurs are powerful front line professionals who have significant authority within operational locations like departments. This means that they are often able to overcome the limiting constraints of traditions related to notions of effectiveness and paternalism and engage in processes of learning. Furthermore, it means that they are capable of making changes to their environment and the behaviour of their colleagues. These factors coalesce and empower entrepreneurs to implement radical forms of decision-making within their practices.

Standing-groups are similarly capable of implementing collaborative decision-making. The lay identity of members means that they have an innate appreciation of the importance of lived experience. Furthermore, standing group members gain status within operational service environments through engaging in constant processes of learning. In doing this members appreciate the conditions in which professionals operate. This understanding enables them to attain the trust of stakeholders and implement processes of collective co-production within services.

My analysis leads me to consider the value of status as a variable in enabling implementation. Status occurs differently for both organising actors. For entrepreneurs it is a product of their role and rank within operational environments. Through this entrepreneurs are provided with opportunities to engage in learning. By contrast, standing groups achieve status through their formal engagement in regular processes of learning. Such a focus on development empowers standing groups to learn about the NHS and, subsequently, alter their work to reflect its propensity for flux.

Organisers who harness status are, therefore, able to implement collective co-production and generate democratic governance. This is a hypothesis that is not evident within the existing literature. For the most part, research in this area has examined collective co-production theoretically. Many offer typologies of collective co-production activities. In this way they present it as a procedural tool. Some texts offer limited practical examples of collective co-production. These, however, are based on case study analyses of co-production activities. Thus, they eschew practical analysis of implementation: choosing instead to explore the dynamics of inter-community interactions.

Furthermore, the literature has often ignored the potential for collective co-production to manifest democratic governance. In exploring co-production as a process in and of itself much of the academic literature has not yet proffered an appreciation of the wider implications of collaborative decision-making. Accordingly, I assert that there is a dearth of practical research that examines collective co-production as a democratising force. My framework fills this void. This

is because I present collective co-production as a process through which to produce democratic governance.

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Appendices

Appendix 1: Exploratory questionnaire

This questionnaire, including the introductory letter, was sent to all individuals who expressed an interest in taking part in my research via the Survey Monkey website.

Hello and welcome.

Below you will find information explaining the purpose of this survey and giving you instructions. Please take the time to read this.

What is this questionnaire about?

This questionnaire will be used to learn about experiences of collective co-production. To achieve this the questionnaire will ask you questions about any potential exposure to collective co-production within health-care orientated groups such as support, peer mentor, wellbeing and expert-patient groups. To answer these questions you are asked to reflect on your involvement in groups where collective co-production may have occurred. In doing this the research hopes to gain an understanding of how collective co-production can transpire.

Who is this questionnaire for?

This questionnaire is for individuals who have practical experience in the fields of healthcare co-production, patient self-management, patient involvement or any number of similar topics and concepts related to giving patients a greater say in the way illness is managed. This could mean that you are a researcher, healthcare professional, patient expert, peer mentor, wellbeing coach, group leader/facilitator, or a person that speaks at group meetings.

How does this questionnaire relate to wider research objectives?

This survey represents the introductory part of a greater research project looking at how collective co-production is actualised and understood. The results of this survey will provide the research with a background understanding of the ways that collective co-production can occur. These results may be used to aid the creation of interview questions.

What will you be asked to do?

In this survey you will be asked to answer questions that can either be answered with a simple sentence or as a tick box, where you select the field that is relevant to you. Please take note of any instructions. These are italicised and they will guide you through the survey. Once you have finished the questionnaire please skip to the end and press the 'done' button.

Policies on privacy:

Any answers that you provide will be completely private and at no point will you be asked to provide any identifying information other than an email address. This is so that we may contact you in the future to discuss our results and findings. However, this is completely voluntary and you do not have to provide this information.

Thank you.

Survey Begins

Question 1: What is your profession?

Question 2: How does your job relate to increasing patient involvement in healthcare?

If you can please answer this in relation to the concept of co-production.

Question 3: Below you will see a definition of collective co-production, do you agree with this? Please indicate the extent to which you agree with this definition by selecting the statement that you most agree with**.**

"Collective co-production is a process that brings together communities of interest, individuals who share common traits, problems or goals, within a group setting. In this setting, individual service users (group members) and service providers (professionals and other trained forms of authority) deliberate together on the best ways to tackle problems and achieve goals etc. This deliberation relies on the assembled service users and providers feeling comfortable enough to share their individual experiences and knowledge to the group and confident and trusting enough to use and harness the experiences of others as means of learning. From this an output can be created that may improve the service at the operational or strategic levels. Collective co-production is, therefore, a process that brings members of a community of interest together in inputting experiences and knowledge as a means of creating a hopefully beneficial output."

Option 1: I completely agree with the definition of co-production
Option 2: I somewhat agree with the definition of co-production
Option 3: I do not know
Option 4: I do not think that the definition wholly captures co-production
Option 5: I completely disagree with the definition of co-production

Question 4: In your experience of attending, leading, facilitating, speaking at or researching group sessions related to healthcare do you remember an occasion when collective co-production, as defined above**,** has occurred?

If you are finding this difficult please simply try to think about whether groups, in your experience, have provided open and equal spaces where service providers and users could share experiences, deliberate and learn together.

Option 1: Yes

Option 2: No

If you have been able to recall an occasion when collective co-production has occurred can you provide a brief description of it by responding to the next three questions?

In doing this it is important that you think about the way that collective co-production occurred in your own experience.

Question 5: Who organised the group?

Please explain whether the group was run by a charity or other third sector group, by a public institution or privately.

Question 6: What were the aims of the group and who was involved?

Please explain why the group met and list the different types of people that attended, i.e. people with diabetes or another illness, health care professionals, a peer mentor or a group facilitator.

Question 7: Did an open and equal discussion, which used the knowledge and expertise of group members, occur?

Please try to describe this discussion, focusing on whether it was open to all and equal, and how it harnessed lived expertise and knowledge.

Question 8: Do you feel that group members were able to learn from listening to the expertise of other members?

Was the diverse array of experiences within the group listened to and taken on board by the rest of the participating individual service users and providers?

Question 9**:** Below you will read three statements that describe how collective co-production can occur. Please answer yes in the field that most matches your experience. Please only choose one answer.

Statement 1: It was the active and intentional policy of the group leaders (this could be you) to use collective co-production. As such, collective co-production was explicitly used in the design of the group.

Statement 2: It was not explicitly planned for in the design of the group. However, it did occur due to the group leader/facilitator/speaker and group members engaging in open, equal and reciprocal deliberation regarding ways to manage illness. As this was happening, the group leaders began to understand that the group was organically collectively co-producing the service and accepted it as means of decision-making.

Statement 3: It was not explicitly planned for in the design of the group. However, it did occur due to the group leader/facilitator/speaker and group members engaging in

open, equal and reciprocal deliberation regarding ways to manage illness. The group leaders did not recognise that collective co-production was organically happening.

Survey Ends

Thank you for taking part in this questionnaire. Could you now share your contact email address in the box below? This is so that we can keep you informed about future results and findings.

You do not have to share your email address with us. If you do not wish to do this then please follow the instructions below.

After you have answered this question, please exit the questionnaire by skipping to the end and pressing the 'Done' button. Thank you for your time.

Appendix 2: Ethical approval Form

This document was sent to the Goldsmiths ethics committee in March of 2017, wherein it was judged to meet ethical standards. As such, I was allowed to continue with my research. A number of facets of the research have changed since the date of submission. For example, I altered my research to focus on democratic governance, rather than chronic illness. However I believe that this does not prejudice the ethics of my research, as I did not alter my methodological ambitions. For instance, I remained committed to capturing experience via qualitative methods such as interviews.

Ethical Approval Form (EAF1)

CONFIDENTIAL

GOLDSMITHS COLLEGE University of London

Research Ethics Committee

NAME OF APPLICANT ....Thomas Kerridge.....

DEPARTMENT
…Politics…….

This form should be completed in typescript and returned to the Secretary of the Research Ethics Committee, for any research project, teaching procedure or routine investigation involving human participants or animals to be undertaken in the College or by or upon Goldsmiths College staff outside the College.

Title of proposed project:

Collective Co-Production In the NHS: a case study analysis of collective co-production and its impact on quality of life for people with long-term illnesses

2. **Brief outline of the project, including its purpose:**

My research explores how collective co-production is manifested within the case study setting. My research will, thus, analyse the existence or inexistence of egalitarian decision-making between providers and service users. The research will then seek to explore how co-production affects quality of life for participants in groups. These aims necessitate the gathering of evidence in a way that eschews formal evaluation. To fully comprehend how co-production works and how it affects lives requires an understanding of subjective experiences, knowledge and actions. To achieve this I wish to undertake different methodologies:

Interviews that will be guided by Knowledge Based Practice: a set of methodological principles that encourages researcher proximity to participants. This allows for the

transference of lived experiences regarding decision-making within collective co-production settings through narrative expression.

After this, I will use my appreciation of collective co-production to understand the way that participation in collaborative decision-making affects quality of life. This will be achieved through Interviews that should provide a narrative regarding the extent to which involvement impacts on variables related to quality of life.

3. **Proposed starting date:**

June 2017

4. **If external grant funding is being secured, does the research need ethical approval prior to the initiation of that funding?**

N/A

5. **Has the project been approved by an Ethics Committee external to the College? If so please specify.**

(NB for projects so approved, applicants may if they wish submit a copy of that application, but should sign the back of the form and return it as specified above)

N/A

6. **Please provide an ethical self-evaluation of the proposed research. Reference should be made to the ESRC Research Ethics Framework , to professional guidelines (such as provided by the BPS, the BSA or the SRA) or to guidelines by government (e.g. GSR) on ethical practice and research. You may wish to provide your response on a separate sheet.**

This has been provided on a separate sheet[99].

7. **State the variables to be studied, topics to be investigated, procedures to be used and/or the measurements to be made. (Please attach a separate sheet if necessary)**

Topic 1: Collective co-production
Variables involved: Structure of co-production group, within group trust and rapport
These variables were created from: Understanding gained from previous literature. However, not all the variables that the research intends to use are deductively realised. It is my intention to add to these through gaining an inductive

[99] See *Appendix 3*

understanding of collective co-production in practice and, subsequently, appreciating a greater number of relevant variables.
Procedures used to explore topic 1: Interviews informed by the principles of Knowledge-Based Practice.

Topic 2: Quality of Life
Variables involved: Participant self-conception pre illness onset, participant quality of life expectation and participant subjective understanding of how decisions made through collective co-production have affected them
Procedures used to explore topic 2: Interviews informed by the principles of Knowledge-Based Practice (see above for a description of this method).

8. **Specify the number of and type of participant(s) likely to be involved.**

I believe that it is difficult to know the quantity of participants who are likely to be involved. This is because I plan to use snowball sampling as a tool to increase the inductivity of my research. However, I suggest that the participants are likely to be adults. Furthermore, they will have experience of group involvement in the NHS from either the service user or provider side.

9. **State the likely duration of the project and where it will be undertaken.**

3-4 months of practical research

10. **State the potential adverse consequences to the participant(s), or particular groups of people, if any, and what precautions are to be taken.**

This has been described in my ethical self-evaluation

11. **State any procedures which may cause discomfort, distress or harm to the participant(s), or particular groups of people, and the degree of discomfort or distress likely to be entailed.**

Interview sessions that explore changes in functioning over different periods of time, i.e. changes in social, relational, career and general functioning before onset of illness and in the present day, could create discomfort for people whose lives are not meeting their expectations. I will undertake a number of practices to mitigate distress. These have been described in the ethical self-evaluation.

12. **State how the participant(s) will be recruited. (Please attach copies of any recruiting materials if used).**

The first cohort of participants will be recruited via initial and unrecorded conversations that I have had with individuals who have experience of collective co-production. From this I will use snowball sampling to gain further participants.

13. **State if the participant(s) will be paid, and if so, provide details and state reasons for payment.**

N/A

14. **State the manner in which the participant(s) consent will be obtained (if written, please include a copy of the intended consent form).**

The participants consent will be obtained in two parts. The first part will ensure that their consent is informed. This will be achieved through the provision of an information sheet that gives participant's an easy to understand description of the research objectives and the means through which these objectives will be met. Within this they will be given an understanding of what the research wants from them i.e. involvement in interviews. It will also include a statement regarding confidentiality and security of information that details who will be able to see the information that they provide and how they will be identified within the thesis. Furthermore, the information sheet will explain that there are few risks associated with participation, as well as the details of the lead researcher and the ethics coordinator at the university. Finally, the information sheet will explain that participation in the research is entirely voluntary and that participants can withdraw at any time.
The second part will focus on obtaining consent. This will be achieved through the provision of a standard consent form. This form will ask potential participants to confirm that they have been informed of and understand the purposes of the study, that they have had opportunities to ask questions to the researcher, that they know that they can withdraw at any point, that they understand that their information will be kept private and that they agree to participate in the research.
Finally, consent will be continually gained at every juncture of a participant's involvement. Thus, I will ask participants to re-consent before every interviews. In doing this I will be able to inform them about any developments or changes to my research and they can, subsequently, decide whether they still want to take part.

14a. Will the participant(s) be fully informed about the nature of the project and of what they will be required to do?

Participants will be fully informed about the goals of the research and the methodology through which these goals will be met. This will be achieved through the informed consent form that will both explain the nature of the research and test participant understanding of the research. For example, I will explicitly ask them if they know what the study is about. If they cannot answer this then they will not participate in the research.

14b. Is there any deception involved?

There is no deception involved in the research. Participants will be informed of all methods and practices throughout the research.

14c. Will the participant(s) be told they can withdraw from participation at any time, if they wish?

They will be told this at the beginning of the study and in the information sheet of the informed consent form. Furthermore, their understanding of this should be confirmed in the consent form, as well as before every one-to-one session in which they are involved

14d. Will data be treated confidentially regarding personal information, and what will the participant(s) be told about this?

Identifying data that could lead to participants being identified will be treated in the strictest confidence. I will not be using personal data so confidentially in this regard will not be a problem. Data gained through narrative investigation will be anonymised. Participants will be aware of these safeguards, as well as of their power to remove their data from the research at any point.

14e. If the participant(s) are young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), how will consent be given (i.e. from the participant themselves or from a third party such as a parent or guardian) and how will assent to the research be asked for?

N/A

15. Will the data be confidential?

15a. Will the data be anonymous?
Yes

15b. How will the data remain confidential?

The names of all subjects taking part in the research and the names of those people that are mentioned within the participant's narratives will not be used. Furthermore, any narrative details that provide strong indications as to whom the interviewee is will also be removed. This has been described in greater detail in the researches Ethical Self-Evaluation.

15c. How long will the data be stored? And how will it be eventually destroyed?

Medical data is not being collected. However, the qualitative understanding, gained through the research's various methodologies, will be stored for a minimum of three years in accordance with *UK Research Integrity Office: Code of Practice for*

Research (2009, p.17) guidelines. Thus, I will keep the data in an easily retrievable format so that it can be deleted if necessary.

16. Will the research involve the investigation of illegal conduct? If yes, give details and say how you will be protected from harm or suspicion of illegal conduct?

N/A

17. Is it possible that the research might disclose information regarding child sexual abuse or neglect? If yes, indicate how such information will be passed to the relevant authorities (e.g. social workers, police), but also indicate how participants will be informed about the handling of such information were disclosure of this kind to occur. A warning to this effect must be included in the consent form if such disclosure is likely to occur.

N/A

18. State what kind of feedback, if any, will be offered to participants.

Participants will be kept fully informed of all findings after the research is finished. They will be sent an executive summary of the research and its findings.

19. State the expertise of the applicant for conducting the research proposed.

I have developed a significant amount of expertise regarding co-production, particularly collective co-production, from my years of studying it from an academic perspective. This has occurred alongside a developing expertise in the NHS, again gained through research. This expertise is not clinical. Rather, it is an expertise in respect to the way that people with chronic illness live and manage their lives and the extent to which they have control over the way that their condition is treated. I will be working with and constantly consulting with healthcare professionals who can guide and provide me with advice, should any clinical issues occur.

20. In cases of research with young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), or with those in legal custody, will face-to-face interviews or observations or experiments be overseen by a third party (such as a teacher, care worker or prison officer)?

N/A

21. If data is collected from an institutional location (such as a school, prison, hospital), has agreement been obtained by the relevant authority (e.g. Head Teacher, Local Education Authority, Home Office)?

N/A

22. **For those conducting research with young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), do the investigators have Criminal Records Bureau clearance? (Ordinarily unsupervised research with minors would require such clearance. Please see College *Code of Practice on Research Ethics*, 2005).**

N/A

23. **Will research place the investigators in situations of harm, injury or criminality?**

No

24. **Will the research cause harm or damage to bystanders or the immediate environment?**

No

25. **Are there any conflicts of interest regarding the investigation and dissemination of the research (e.g. with regard to compromising independence or objectivity due to financial gain)?**

No

26. **Is the research likely to have any negative impact on the academic status or reputation of the College?**

No

–

ALL APPLICANTS

Please note that the Committee should be notified of any adverse or unforeseen circumstances arising out of this study.

Signature of Applicant **Date 12/4/2017**

Thomas Kerridge

TO BE COMPLETED BY HEAD OF DEPARTMENT

Please note that the College Research Ethics Committee should be notified of any adverse or unforeseen circumstances arising out of this study or of any emerging ethical concerns that the Head of Department may have about the research once it has commenced.

Has there been appropriate peer review and discussion of the ethical implications of the research in the department (i.e. with yourself as Head of Department or the Departmental Research Ethics Committee or Research Committee)?

Yes (Please circle)

Are the ethical implications of the proposed research adequately described in this application?

Yes (Please circle)

Signature of Head of Department **Date 12/4/2017**

Appendix 3: Ethical self-assessment

This document was provided as an addendum to the document in the previous appendix.

1. **Who is Involved**
    - My proposed research involves human participants. They will be adult volunteers who have the capacity to give their informed consent to take part. As such, participants will not be comprised of children, the very old or those with mental illnesses. This means that my choice of participant does not correspond to the *Department for Health: Research Governance Framework for Social Care* definition of vulnerable (2nd Ed, 2005, p.7).
    - Participants will comprised of NHS patients who have a long term/chronic illness, as well as service provider figures. This should not impact on their capability to give informed consent.
    - If I believe that an individual cannot give informed consent then they will not be asked to take part. However, before research begins it is to be assumed that individuals have capacity, unless it has previously been established otherwise (Mental Capacity Act, 2005, Part 1).
    - I will provide evidence that informed consent has been given by asking all potential participants to sign an agreement that states that they understand and want to take part in the study. Prior to this, potential participants will receive an information pack that explains, in clear and easy to understand language, the researches aims, objectives and methods. This should provide an understanding of what I want from them, as well as their rights as participants. An example of a World Health Organisation template Informed Consent Form for qualitative studies can be viewed by following this link. [100]
    - In addition to these measures, individuals can communicate with me at any point before and after deciding whether to provide consent. This will give potential and actual participants the opportunity to ask questions that may not have been covered within the information pack or consent form.
    - To assess whether informed understanding has been achieved by participants, I will scrutinize whether potential participants:
        - Understand the information relevant to deciding whether they should give consent.
        - Can retain that information.
        - Can use that information to make their decision.
        - Can communicate the decision to others (Ibid).

[100] Please follow this web link to find the template: https://www.who.int/ethics/review-committee/informed_consent/en/

2. Physical Harm and Risk for Participants

- The research does not involve physical interventions. Thus, medically invasive techniques such as collecting tissue will not be used. This means that it is highly unlikely that participants will be exposed to physical risk.

3. Other Types of Harm

- I will collect qualitative data through narrative interviews. This methodological tool may expose participants to distress, as they will be invited to discuss how illness has altered their capacity to behave in certain ways.
- I will also inform all potential participants before agreeing to take part and all actual participants before every interview session that this methodology could result in distress and that it is their right to, at any point, stop the interviews for a short period of time or in its entirety.

4. Participant Personal Data and Privacy

- Personal Data is defined here according to *Article 2(a) of EU Directive 95/46/EC* as any information, private or professional, which relates to an identified or identifiable natural person. This includes name (real or pseudonyms), address, email, phone number, occupation and medical records.
    - I will seek to gain some forms of personal data such as name, age, medical history and occupational history.
    - Such information will be gained through a combination of audio-recording and field-notation. The research will seek participants consent before recording any personal data. They will be informed, before every instance of recording that it is taking place and that it is their right to not participate.
    - Personal data will be anonymized in the final report. This will be done by reducing detail in regards to identifiable personal information. For example, participants will be identified through the use of pseudonyms rather than their real names.
    - Information stored electronically, as a result of audio recording, and in written form, through field-notation, which does contain personal data will be kept for a minimum of three years, subject to any legal, ethical or other requirements, from the end of the project, as per *UK Research Integrity Office: Code of Practice for Research* (2009, p.17) guidelines.
    - Other types of personal data that are of no relevance to the research, but are in and of themselves important such as information relating to criminal activities or abuse will not be included in the research. Instead the researcher will seek to understand the context surrounding the given information and in doing so will either assess whether the relevant authorities should be directly informed or if the participant should be encouraged to do so (Department for Health, 2005, p.11)

5. **Health and Safety**
    - I will only conduct my research within environments that are considered to be safe.
    - My one-to-one interviews will either occur within a setting provided for by the institution, and will thus again have been risk assessed, or in a setting of the participants choosing. If this latter environment is used then the research will undertake these practices to mitigate risk:
        - It will, keep careful notes of all of these types of engagements.
        - Undertake debriefing after field research with an assessment of fieldwork safety and report any health and safety incidents (European Commission, H2020 Guidance, 2016, pp.29-30).
        - Furthermore, should interviews take place over the phone, then I will aim to ensure that I have arranged an appropriate time to get in contact with the participant.

Appendix 4: Informed consent form

Name of Principle Investigator and Researcher: Thomas Kerridge
Name of Organisation: Goldsmiths College University of London
Name of Sponsor: Goldsmiths College University of London

This Informed Consent Form has two parts:
- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction
I am Thomas Kerridge, a PhD candidate and researcher at Goldsmiths College, University of London. I am doing research on the way that users of healthcare services and service provider figures, like health care professionals, peer leaders and wellbeing coaches, work together to co-produce outcomes such as learning or changes to services.
In this pack you will be given information about the research and also be invited to become a participant. You do not have to decide today whether you will participate in the research.
This consent form may contain words that you do not understand. If you feel like something could be better explained or if you need something to be clarified then please do not hesitate to contact me via phone or email. I am happy to help.

Purpose of the research
Co-production is a process where people who use services and people who provide and deliver services interact and decide together on the best way to deliver a service. Collective co-production is similar, but occurs within a group setting wherein people with similar issues or concerns meet with service providers. I want to look at how collective co-production happens in UK healthcare. This involves an exploration of your experiences, understanding and perceptions of why and how phenomenon have occurred.

Participant Selection
You are invited to take part in this research because you have relevant experiences related to groups where collective co-production may have taken place. As such, I would be very interested in interviewing you about these experiences.

Voluntary Participation
Your participation in this research is entirely voluntary. It is your choice whether to participate.
If you choose to participate and then change your mind at any point during the research process then you will immediately be able to stop participation. You can also request that all information previously gathered from you not be used in the research.
You will be asked, before each interaction with the researcher, whether you want to continue to participate. If you do not want to continue then you simply need to say no.

It is your right to decline.

Procedures: Introduction
I am asking you to participate in a study that will examine how service users and provider figures work together in groups and co-produce outcomes. I am inviting you to take part in this research project. If you accept, you will be asked to participate in one research stage*:

- An expert interview, in which I will ask about your personal experiences of taking part in, conducting, leading, facilitating and/or researching a group related to health care.

*There may be a point in the future where you might be asked to participate in another stage of the research.

Procedures in Detail: the expert interview
This is a one-to-one interview with the researcher, Thomas Kerridge. At the beginning of the interview the researcher will briefly describe the research and its aims, as well as your rights as a participant. You will then be able to ask any questions about the research that you might have. You will also be able to withdraw your consent if you want.
After this, you will be asked questions about your experiences of healthcare groups where collective co-production may have occurred.
To do this, you will be asked to reflect on how the group/groups was/were characterized, as explicitly using collective co-production or simply encouraging open and deliberative dialogue. You will be asked to think about why the group/groups was/were characterized in this way. You will also be asked to reflect on how such a characterization compared to the reality within the group.
Furthermore, you will be asked to discuss the technical and procedural aspects of the group in question. This will include questions about room geography, who was involved, how decision-making occurred, how often the group meets and opportunities to prepare. You may also be asked about your impression of the power structures and hierarchies evident within the group.
In addition, you might be asked to reflect on your role within the group and how this influenced your behavior, as well as how your professional culture and history may have impacted on your role within the group. You may also be asked about the level of engagement of other group members.
The interview can take place on the phone or in person. You may have already made plans to participate in the interview. However, if you wish to change to a different means of communication please feel free to contact the researcher.
The entire telephone or face-to-face interview will be audio-recorded. However, no-one will be identified by name and all personal information will be anonymized in interview transcripts. The recording will be kept by the researcher and will be stored securely. The information recorded is confidential and no one else will have access to the recording. If you feel uncomfortable about being audio recorded you do not have to participate in the research. If you have any questions about the recording process or confidentiality please feel free to contact the researcher.

How Long will the Research Take?
The expert interview phase will take place over one session and will last for around 1 hour.

Risks
If you choose to participate in the research you will be asked to share with us your experiences. This might mean that you share personal and confidential matters such as why you attended a group related to NHS services. Some people may feel uncomfortable talking about some of these topics.
You do not have to answer any question or take part in an interview if you do not wish to do so. You do not have to give any reason for not responding to any question or for refusing to take part in the interview.

Benefits
There will be no direct benefit to you but your participation is likely to help us find out more about collective co-production.

Reimbursements
The research cannot pay you back for travel costs or time lost while taking part. The research will, therefore, work with you to make participation as easy as possible.

Confidentiality
The information that we collect from this research project will be kept private until publication. Any information that you have shared that is published within the research will be anonymized. This means that no one will be able to know that the information came from you. For example, your name will be replaced with a number or pseudonym. Only the researcher will know your name. Any personal information that you share with the researcher that is not relevant to the study will not be included in the research. Anything that you do share and is relevant will not be shared with, or given to, anyone except:

- Thomas Kerridge-Principal Investigator and Researcher

Sharing the Results
The results of the research will be shared with you before it is made widely available to the public. Each person who takes part will receive a summary of the results. You will be able to contact me if you have any issues with the study or if something needs to be clarified. If there are any issues the researcher will try to work with you to resolve the problem.

Who to Contact
If you have any questions you can contact Thomas Kerridge at any time on Thomas.kerridge@gold.ac.uk
This proposal has been reviewed and approved by the Goldsmiths Research Ethics and Integrity Sub-Committee. You can contact them at S.Newman@gold.ac.uk

Part II: Certificate of Consent for ~
I have been invited to participate in research about collective co-production in UK healthcare. I understand what being involved means and confirm this by providing short answers to the questions below.

Questions	Answers
Do you know why I am asking you to take part in this study?	
Do you know what the study is about?	
Do you have to take part in this research study?	
If you decide to take part, can you choose to withdraw your consent at any point during the research?	
Do you have to answer questions that you do not want to respond to?	
How can the interviews take place?	

Will I receive any benefits from taking part in this study?	
Will the research be paying you for taking part in this study?	
Will the information that the research collects about you be confidential?	
Will you receive a summary of the results before the research is published?	
Can you ask the researcher any questions about the research study? If so, when can you ask these questions?	
Where can you find the contact details of the person who can give you more information about this research study?	

[FOR PEOPLE WHO HAVE READ THE INFORMATION SHEET AND CONSENT FORM THEMSELVES]
I have read the information sheet, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to take part in this study

Print Name of Participant_____
Signature of Participant _____
Date _____
Day/month/year

[FOR PEOPLE WHO HAVE HAD THE INFORMATION SHEET AND CONSENT FORM READ TO THEM]
I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____

Signature of witness _____

Date _____
Day/month/year

Statement by the researcher/person taking consent

I have given the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:
1. By giving consent they understand that they will be voluntarily taking part in a research study wherein they will participate in 1 interview.
2.They understand that personal information relating to the research will be recorded and stored safely until the publication of the research wherein it will be anonymised.
3.They understand that there are inherent risks associated with taking part in the research, that they will not be reimbursed for taking part and that they will not receive any direct and individual benefit from involvement in the research.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced in to giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.
Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/month/year

Appendix 5: List of respondents and method of communication

- Original telephone interviews are delineated in this thesis by the name of the participants. Thus, my interview with participant 1 is simply referred to as ('Jackie' Interview) in the text.
- Second telephone interviews (denoted by the x2 symbol below) are referred to as ('Jackie.1' Interview) in the text.
- Email correspondence are referred to as ('Jackie.2' Email Correspondence) in the text.

1. Participant 1 ('Jackie')-Telephone Interview x2
2. Participant 2 ('Linda')-Telephone Interview
3. Participant 3 ('Beth')-Telephone Interview
4. Participant 4 ('Angelina')-Telephone Interview
5. Participant 5 ('Teresa')-Telephone Interview
6. Participant 6 ('Michela')-Telephone Interview
7. Participant 7 ('Rachel')-Telephone Interview
8. Participant 8 ('Nina')-Telephone Interview & Email Correspondence
9. Participant 9 ('Paul')-Telephone Interview x2
10. Participant 10 ('Gareth')-Telephone Interview & Email Correspondence
11. Participant 11 ('Roxy')-Telephone Interview
12. Participant 12 ('Holly')-Telephone Interview
13. Participant 13 ('Keira')-Telephone Interview
14. Participant 14 ('Nigel')-Telephone Interview x2 & Email Correspondence
15. Participant 15 ('Karlee')-Telephone Interview
16. Participant 16 ('Karen')-Telephone Interview x2
17. Participant 17 ('Mary')-Telephone Interview x2
18. Participant 18 ('Martin')-Telephone Interview
19. Participant 19 ('Sonia')-Telephone Interview & Email Correspondence
20. Participant 20 ('Christie')-Telephone Interview & Email Correspondence
21. Participant 21 ('Cher')-Telephone Interview
22. Participant 22 ('Samira')-Telephone Interview
23. Participant 23 ('Liv')-Telephone Interview
24. Participant 24 ('Imogen')-Telephone Interview x2
25. Participant 25 ('Amelia')-Telephone Interview & Email Correspondence x2
26. Participant 26 ('Renata')-Telephone Interview

Appendix 6: Participant biographies and interview details

In this section I provide a short description of the respondents who participated in my research. As such, I describe their organisational and/or social background, delineate how they have experienced co-production and provide details of the co-production initiatives in which they have been involved. To access full interviews and correspondence please see the documents stored in the memory stick that accompanies my thesis.

Participant 1, 'Jackie': This respondent works in the third sector and supports people who suffer from long-term illnesses. In this role the respondent facilitates programmes wherein people are empowered to become independent and self-manage their condition. In our interviews we discussed the process of collective co-production by examining how she has created groups within the NHS. Furthermore, we spoke about what could help the reproduction of co-production within the institution, and explored the constitution of her organisation.

Participant 2, 'Linda': This respondent is a leading HCP within the NHS. This status has enabled the respondent to take on an active position within her department and implement co-productive processes. In these processes she invites a number of people who suffer from long-term conditions to participate in collective consultation. In our interview we discussed her understanding of co-production, examined the form and dimensions of collective co-production, spoke about how deliberation transpired and considered the outcomes that occurred as a result of her group work.

Participant 3, 'Beth': This respondent works in the third sector for an organisation that supports people with disabilities in the UK. The participant organises groups within and outside of the NHS. In our interview we discussed how the respondent had experienced the organisation of collective co-production and examined how her organisation partnered with NHS trusts and practices. Moreover, we looked at her experiences of participating in groups organised by the NHS and explored the reasons why these incidences had been difficult for her.

Participant 4, 'Angelina': This respondent works for a company that supports the organisation of co-production. She facilitates groups that empower people with long-term conditions. Furthermore, the participant runs 'coaching' courses wherein she supports individuals to manage their conditions. In our interview we discussed how her role as a 'coach' supplemented, and ran parallel to, notions of co-production. Moreover, we looked at coaching techniques and explored how these could be used to manifest equality between communities.

Participant 5, 'Teresa': This respondent works in the NHS as a therapist with a particular interest in art therapy. Furthermore, she has recently become involved in the facilitation of collective co-production. In our interview she suggested that professional her role has helped her to work as a facilitator of collective co-production. Moreover, her interest in art therapy has provided her with a means through which to introduce visual media as a tool in facilitation.

Participant 6, Michela: This respondent is an NHS patient and a carer for a family member. The participant has taken part in a number of different collective co-

production groups wherein she has been asked to act as a patient representative. These experiences have been difficult for her, as she has often felt ignored whilst participating. In our interview we discussed how her lived experience enabled her to become involved in collective co-production within the NHS. We also examined differences between groups in which she had felt alienated and empowered.

Participant 7, 'Rachel': This respondent works as a private consultant who supports public sector organisations to facilitate co-production. In this role the respondent helps NHS organisations to improve their representation and accessibility. Furthermore, the respondent supports governments in attempts to create co-production legislation. In our interview we discussed how she became a consultant, and the way in which she works alongside government. Furthermore, we examined her understanding of co-production and discussed how this can be realised practically.

Participant 8, 'Nina': This respondent works in the third sector as an advisor who helps implement co-production within the public sector. In this role the respondent creates accessible groups that include people from different communities. In our discussions we explored how she began facilitating co-production alongside public sector actors. Furthermore, we talked about how these processes can be equal by examining the utility of pre-events, facilitation and representative recruitment. Finally, the respondent provided information regarding her understanding of co-production, as well as how people could take on her role within other parts of the UK.

Participant 9, 'Paul': This respondent works in the third sector and as an academic interested in healthcare participation. In the former role the respondent promotes the empowerment of people who suffer from disabilities by involving them in advocacy. In the latter role the respondent examines collective co-production: focusing on notions of empowerment. In our interviews we discussed co-production as a normative process, the constitution of his third sector organisation, the outcomes of co-production and how academics are perpetuating understanding of participation. Furthermore, we examined the state of the NHS and discussed how co-production can occur within it.

Participant 10, 'Gareth': This respondent works as an advisor in the public sector and as an academic interested in healthcare participation. These roles are related to one another as he often conducts research within healthcare organisations. This research is frequently orientated around the production of public engagement in the NHS. In our interview we discussed how his background in sociology enabled him to research co-production within public services. Furthermore, we talked about the processes that he had researched, as well as how co-production groups can be equal.

Participant 11, 'Roxy': This respondent works for a Welsh third sector organisation that facilitates co-production in health and social care. In this role the respondent trains people for involvement in co-production and advocates for equal participation between communities. In our interview we discussed how processes of collective co-production are instituted within public services, as well as the normative values that underscore her organisation. Furthermore, we examined her experiences of collective co-production groups.

Participant 12, 'Holly': This respondent works for a third sector organisation that organises co-production within the NHS. In this role the respondent organises strategic co-production wherein different communities come together to influence aspects of the service. In doing this she works as an organiser and facilitator. In our interview we discussed how she works alongside NHS organisations, as well as the difficulties she faces in producing co-production within the institution. Furthermore, we examined her experiences of co-production groups and spoke about how she had facilitated them.

Participant 13, 'Keira': This respondent works within the NHS as someone who supports people who have learning difficulties. In doing this the respondent empowers SUs to engage in processes of participation. In our interview we discussed how she worked as a facilitator within groups to promote inter-community equality. We also looked at the dimensions of these groups, as well as the processes that transpired within them. Furthermore, we examined how outcomes are sustained within NHS environments.

Participant 14, 'Nigel': This respondent is a healthcare professional in the NHS. In this role the respondent works as a practitioner and as a supporter of a standing group of SUs. In our interviews we discussed how his medical expertise supplemented his role in the standing group. We also looked at how standing groups occur and the roles that SUs perform within them. Furthermore, we talked about his understanding of co-production and explored how co-production could occur within the NHS.

Participant 15, 'Karlee': This respondent works as a researcher and as a person who facilitates public participation in the NHS. In this role the respondent has helped produce forms of collective co-production that are accessible and representative. This occurs through preparatory work with participants. In our interview we looked at her identity and talked about how this had helped her in implementing groups. We also discussed the processes through which she prepared people to participate in groups and explored how these groups transpired within NHS institutions.

Participant 16, 'Karen': This respondent is a SU who also works in the third sector. In this role the respondent organises processes of co-production that generate strategic outcomes within the NHS. In our interviews we discussed how she operated within peer networks of SUs and how this enabled her to become empowered. Furthermore, we examined how she partnered with NHS organisations and explored how this relationship transpired. Finally, we talked about her personal life and considered how this had impinged on her work.

Participant 17, 'Mary': This respondent is a HCP within the NHS. In this role the respondent has engaged in the facilitation of processes of co-design within a number of NHS environments. In our interviews we discussed how her clinical identity had supported her transition in to participation research. Furthermore, we looked at how the respondent formed participation groups related to different clinical areas. Moreover, we examined how co-production occurs within the NHS and looked at how different institutional cultures might impinge on implementation. Finally, we

talked about facilitation and the importance of having support from experts when creating a group.

Participant 18, 'Martin': This respondent is a SU who also has a role in an NHS research body. In this role the respondent assesses the validity of NHS research in respect of patient participation. In our interview we discussed how research within the NHS can be made to be participatory. In doing this we examined how the respondent had experienced research that could be deemed to be co-productive. Furthermore, we looked at how the respondent has participated in the empowerment of SUs.

Participant 19, 'Sonia': This respondent works for a research organisation that has partnered with NHS trusts in producing co-production. The respondent has, thus, worked on a number of health related research projects many of which are orientated around increasing understanding of participation. In our interview we discussed the respondent's professional experience and how this related to research in co-production. We also looked at the respondent's notion of ideal co-production and how this is practically realised. In our email correspondence we talked about the NHS as an institution and whether the respondent felt that co-production could become a major form of decision-making within it.

Participant 20, 'Christie': This respondent works in the third sector and is also a SU. In this role the respondent facilitates the creation of co-production groups within NHS environments. These groups aim to increase and improve the generation of co-production within strategic NHS environments. In our interview we talked about the respondent's role within the third sector by examining how co-production is produced within NHS environments. Moreover, we examined the respondent's notion of ideal co-production and discussed whether this had occurred within practical settings. Finally, we examined the limitations of co-production within the NHS.

Participant 21, 'Cher': This respondent works for a third sector organisation that empowers SUs by engaging them in training and enabling them to participate in decision-making. In this role she often works as a facilitator who promotes equality in groups comprising of SUs and professionals. In our interview we discussed her experiences of collective co-production by examining the forms in which it occurred, how she facilitated groups, examples of good practice and how co-production was understood and referred to within the NHS.

Participant 22, 'Samira': This respondent works in the third sector. In doing this she helps organise groups that empower people with disabilities. Moreover, the respondent works as an advocate for improved co-production by engaging communities in co-production training sessions. In our interview we discussed how her professional role had helped her to work in co-production, looked at how her specific co-production work was instituted in the NHS and explored how institutional culture impinged on participation.

Participant 23, Liv: This respondent works as a HCP in an NHS trust. The respondent has also had the opportunity to train as an organiser of participation processes. As such, the respondent has organised a number of co-design events that

have changed NHS practices. In our interview we discussed how the respondent's professional history has enabled her to organise co-production and examined how she has created and facilitated groups within NHS settings. Furthermore, we examined the different processes through which co-production has been generated (e.g. sampling, preparation) and the types of interaction that transpired between communities.

Participant 24, 'Imogen': This respondent is a SU who also organises a standing group. In this role the respondent helps produce participation projects within an NHS trust. In our interviews we discussed how her lived experience enabled her to become involved in a standing group that organised co-production within the NHS. Furthermore, we examined the types of groups in which she had been involved by considering how they were organised and the difficulties faced when trying to institute change within the NHS.

Participant 25, 'Amelia': This respondent is a HCP with an interest in understanding experiences of child birth. As such, the respondent trained to engage in processes of co-design wherein she could harness SU experiences of childbirth. In our interview we discussed how her professional expertise supported her transition in to co-production, as well as the lack of satisfactory participation processes within the contemporary NHS. We also discussed difficulties in involving professionals in these participation processes and how ingrained institutional culture blocks greater involvement.

Participant 26, 'Renata': This respondent is a HCP within the NHS. The respondent has also taken on a research role and helped to organise processes of collective co-production wherein professionals and SUs engage together to improve services. In our interview we discussed how the respondent's professional role enabled her to transition in to research and patient participation. We also talked about the dimensions of the respondents groups and the way in which these groups had been instituted within the NHS.

Appendix 7: Example of interview plan

16th of February 2017

Plan for interview with ‘Linda’.

1. What is your understanding of collaborative decision-making?
2. Can you paint me a picture of the structure of the groups that you have been involved in?
3. As you know, I’m particularly interested in the deliberative phases of the group consultations. How did these deliberative moments occur?
4. How did different communities cope with interaction?
5. What were your impressions of their freedom to participate?
6. How did participants react to other members?
7. What are the effects of participation on service users?
8. Was there an impact on their ability to live in a way that suits them?
9. Would you be able to say, in your experience, how collaboration came about?
10. What is the role of the organiser?
11. What needs to happen for health care trusts and other bodies in charge to agree to do this?
12. How did you decide where collaborative decision-making was to take place?