Managing Conflict: A Constructivist Grounded Theory Exploring Collaborating Under Conditions of Mandate In English Health and Wellbeing Boards

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Managing Conflict: A Constructivist Grounded Theory Exploring Collaborating Under Conditions of Mandate In English Health and Wellbeing Boards

A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Philosophy in Management at Durham University Business School

By

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Abstract

The focus of this thesis is related to the interactions that occur between people collaborating under conditions of mandate and how these interactions are managed, in a health, social care and public health context in England. In adopting a constructivist approach to Grounded Theory (Charmaz, 2006) the basic social process of *managing conflict* was constructed which is a substantive theory grounded in the data. The substantive grounded theory was developed from the interviews and observations of thirty mandated collaborating members of a North East Health and Wellbeing Board, as they collaborated under conditions of mandate for the organising and provision of local care.

The constant comparison analysis of the data revealed that when collaboratives in a health, social care and public health context are mandated, essential elements of the process are omitted and this allows conflict as a multifaceted issue to manifest within the interactions between individuals. Conflict in relation to this study was conceptualised as being located in, interacting identities, democratising the decision-making practices and coping with the traditions of others. Conflict for these participants developed as a result of health and social care professionals and democratically elected members, being mandated to collaborate for the integration of local care. Decision-making practises that had traditionally been left to the professional members of this group.

The participants in this study were analysed as managing conflict through the three conceptual domains of: interacting orientations, interacting positions and interacting strategies. .These findings represent the first study of mandated collaboration at the micro-sociological level which explores the interactions between people who collaborate under conditions of mandate.

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And finally, to Finn and Reilly. You were both quite young when I started this and have now left school and are leaving. You also probably feel as though I have been studying your whole life and I am sorry that my weekends were always tied up with this thesis. Hopefully, you are not too old to want to hang out with me anymore, now that I should have our weekends back. This is also for you.

And to everyone else who has been there along the way.

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Chapter 1 Introduction

1.1 Background of the Study

I wanted to focus this study on the interactions that take place between individuals who are mandated to collaborate for the organising and provision of care in the health, social and public health sector, in order to understand what really happens. After completing a master's thesis at Durham Business School, 2011 on voluntary forms of collaboration between charities in a region in the North East of England, I noticed that most, but not all, public sector collaborations are mandated. In some cases, this takes place through a policy directive stating that collaboration is now a criterion for funding; in other cases, the mandate is in the form of a policy directive creating a statutory body such as the Health and Wellbeing Boards (Department of Health (DoH), 2012) which provide the context for this study. However, studies that examine the impacts of mandated interorganisational relations, or that explicitly compare mandated with voluntary collaborations, are considerably less common, and a fundamental question that has received only partial attention is whether or not the act of mandating a collaboration has any significant impact on the antecedents, process, outcomes and governance of the collaboration (Aldrich, 1976; Leblebici and Salancik, 1982; Oliver, 1991; Rodríguez *et al.*, 2007; Ivery, 2008; Brummel *et al.*, 2010; Macgill, 2011; Provan and Lemaire, 2012; Vaughan, 2012). It has been suggested that current collaborative mechanisms lack the necessary evidence to be deemed effective and that there is a need to look elsewhere for solutions to the organisation and provision of care. However, is it possible that many of these collaborative mechanisms are framed in voluntary modes which do not fit them well? There is only a relatively small number of published studies that have explored mandated collaboration and, to my knowledge, no detailed micro-sociological study of the interactions that take place exists. This research study represents the first attempt to do so.

At the time of commencing this doctoral study in 2013, I was given the opportunity of gaining access to and studying a North East Health and Wellbeing Board, which is discussed in more detail in Chapter 3. Three years earlier, in 2010, the newly elected coalition government announced its proposals for a major reform of the NHS and public health (Perkins and Hunter, 2014a). Among the changes which were then formalised under the Health and Social Care Act 2012 was the introduction of a new form of mandated collaboration, known as Health and Wellbeing Boards, and on 1st April 2013, 152 boards in England became fully operational (Perkins and Hunter, 2014a). Essentially, Health and Wellbeing Boards are a mandated collaboration/partnership/forum with a prescribed membership of health, social care and public health system leaders with a remit of promoting integrated services through joined-up commissioning. The South Tyneside Health and Wellbeing Board in the North East of England became the subject of interest for this study because I was able to secure access to it; it was as new as any of the other Health and Wellbeing Boards, as all 152 boards were established at the same time; and I lived and studied in the North East of England.

In reviewing existing studies of mandated collaboration, I realised that previous authors had entered the field looking to further knowledge of proven concepts such as governance and power, leadership, institutional theory, and many more as reviewed within the literature section of this study. However, as a researcher, it was a little hard to be excited or take confidence from the possibility that I might (or might not) only be able to advance conceptual knowledge which might not reach the standards necessary at doctoral level. Rather than thinking of the study of mandated collaboration from a conceptual or thematic point of view, I took my point of reference from Ginsberg who defines collaboration as one of ‘the various modes of interactions between individuals or groups, including collaboration, co-operation and conflict, social differentiation and integration, development, arrest, and decay, are all basic social processes (Ginsberg, 1940:436). This helped to shape the focus of the study in that, if I wanted to understand what happens when people have to collaborate under mandated conditions, exploring the interactions that take place between people would be a good place to start.

1.2 Context of the Study

Inequalities in the health of societies around the world have been the trigger for an exhaustive list of collaborations in the health, social care and public health sectors (Evans, 2005; Ottersen et al., 2014; Donkin et al., 2018; Castro et al., 2019). A definition of a collective approach to health was given by the World Health Organization as a ‘state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1946:100). The scope of this definition emphasises a more collective and collaborative approach to health, social care and public health than had previously been considered. At the local level, collaboration and intersectoral working takes place across a wide range of policy areas (health, education, social, housing, for example) and is increasingly recognised as contributing to public health and well-being (Milio, 1987; Nutbeam, 2000; Thomson *et al.*, 2006; Learmonth *et al.*, 2018). Although Baggott (2013) argues that collaboration is not an essential element of local collective action, nor a precondition for a successful outcome, the approach is widely recognised by government as a way of addressing social problems that cross boundaries of policy and budgets. Yet, despite its popularity with past and present governments not only in the UK, local success rates continue to be dogged by the fact that effective collaborative working is often hard to achieve in practice (Gorsky, Lock and Hogarth, 2014).

Despite this challenge, policy makers within England have assumed implicitly that collaborative forms of working are both a necessary and a good thing. From Labour's first post-1997 White Paper, *Saving Lives: Our Healthier Nation* (*Saving Lives: Our Healthier Nation*, no date) to the most recent restructure of the health system by the Coalition Government in the form of the Health and Social Care Act 2012, the emphasis has been on inclusive collective approaches to solving problems of health, social care and public health issues, through initiatives that span sectors and agencies (Neil Perkins *et al.*, 2010; Baggott, 2013) requiring much deeper and closer relationships and a blurring of the boundaries than that of cooperative or coordinated efforts (Keast, Brown and Mandell, 2007). In light of this, policy makers have resorted increasingly to legislation to mandate, or provide a strong stimulus for, collaborative arrangements between sectors and agencies in the health, social care and public health sectors to find solutions to complex and wicked issues (Raab and Kenis, 2009; Hunter and Perkins, 2012; Mandell, Keast and Chamberlain, 2017; Segato and Raab, 2019a).

Common to these collaborative efforts is the concept of mandate and the prominent role it plays in mobilising local collaborative action (Addicott, 2013; Muir and Mullins, 2015; Salvador *et al.*, 2015; Huby, Cook and Kirchhoff, 2018). In the wider organisational literature, mandate has typically been portrayed as a context within which to advance organisational and economic theories, such as transaction cost economics (Müller and Aust, 2011; Schepker *et al.*, 2014; Ebers and Oerlemans, 2016), resource dependency theory (Pfeffer and Nowak, 1976; Hillman, Withers and Collins, 2009; Drees *et al.*, 2013), resource-based theory (Brouthers and Hennart, 2007; Barreto, 2010; Jolink and Niesten, 2012), agency theory (Fayezi, O'Loughlin and Zutshi, 2012; Trahms, Ndofor and Sirmon, 2013; Hanrieder, 2014) and network theory (Kenis and Provan, 2007; McGuire and Agranoff, 2011; Cristofoli, Markovic and Meneguzzo, 2014). However, a number of studies caution that the preconditions of the mandate can have important and notable effects on the motivations, antecedents, processes and outcomes, or the phases of interorganisational relations (Hall, 1977; Gray, 1985; Oliver, 1990; Huxham, 1993; Rodríguez *et al.*, 2007; Concha, 2014).

In the health, social care and public health literature, forms of collaborative working at local level, such as partnerships (Ellins and Glasby, 2011; Hunter *et al.*, 2011; Perkins and Hunter, 2014a), multi-agency working (Sloper, 2004; Richardson and Asthana, 2005; Robinson and Cottrell, 2005), cross-sector collaboration (Glendinning, 2002; Crosby and Bryson, 2005; Selsky and Parker, 2005) and networks (Rhodes, 2006; Varda, Shoup and Miller, 2012) are increasingly mandated to stimulate coordinated working in the implementation of policies to solve public-sector or wicked problems (Baggott, 2013). This increases the potential for public sector organisations to achieve strategic outcomes, such as coordinated working, shared resources, reduced transaction costs, cross-boundary decision-making and a reduction in health inequality indicators (Zahner, 2005; Smith *et al.*, 2009; Petch, Cook and Miller, 2013; Roxby, 2018) . We need, however, to develop our knowledge of local forms of mandated collaboration and, in particular, to deepen our understanding of the interactions that occur between individuals, and the ways in which these are managed as the basis for understanding interorganisational relations (McNamara, 2016).

Despite this momentum for mandated action, and the caution of a number of earlier studies as to the significant effects this carries (Hall, 1977; Gray, 1985; Oliver, 1990; Huxham, 1993; Rodríguez *et al.*, 2007; Concha, 2014), empirical research on collaborative working that conceptually or theoretically considers mandate as an impetus to collaborate in a health, social care and public health context, is still relatively scant and disjointed (McNamara, 2016; Green, Ritman and Chisholm, 2018; Hafer, 2018; Segato and Raab, 2019). The small number of studies that exist have focussed their efforts on the effects of mandate on and within collaborative forms of working from the perspective of interorganisational relations (Vangen and Huxham, 2003; Thomson and Perry, 2006; Ivery, 2008; Vaughan, 2012; Coleman *et al.*, 2014; Concha, 2014; Perkins and Hunter, 2014a). However, if the literature on mandated collaboration is small, smaller still is the number of studies that have considered the dynamics between collaborating individuals and how they interact under conditions of mandate (Bailey and Koney, 1996; Dunlop and Holosko, 2004b). Although the interorganisational relations approach to mandated collaboration is both noteworthy and essential (Gray, 1985; Wood and Gray, 1991; Ring and Van de Ven, 1994; Bryson, Crosby and Stone, 2006; Ansell and Gash, 2007; Rodríguez *et al.*, 2007; Ostrom, 2011; Emerson, Nabatchi and Balogh, 2012) however Williams (2015) notes that it is not clear whether all the learning from the interorganisational relations level applies on the front line, where much of the collaborative interaction takes place. If collaborative interactions on the front line constitute an interorganisational relationship, do we not also need to expand our understanding of the interactions that take place within these interorganisational relations, that is, the ways in which individuals interact and they ways in which they manage these interactions, in relation to how collaborative processes are enacted and how effective the outcomes will be.

1.3 Aim and Significance of the Research

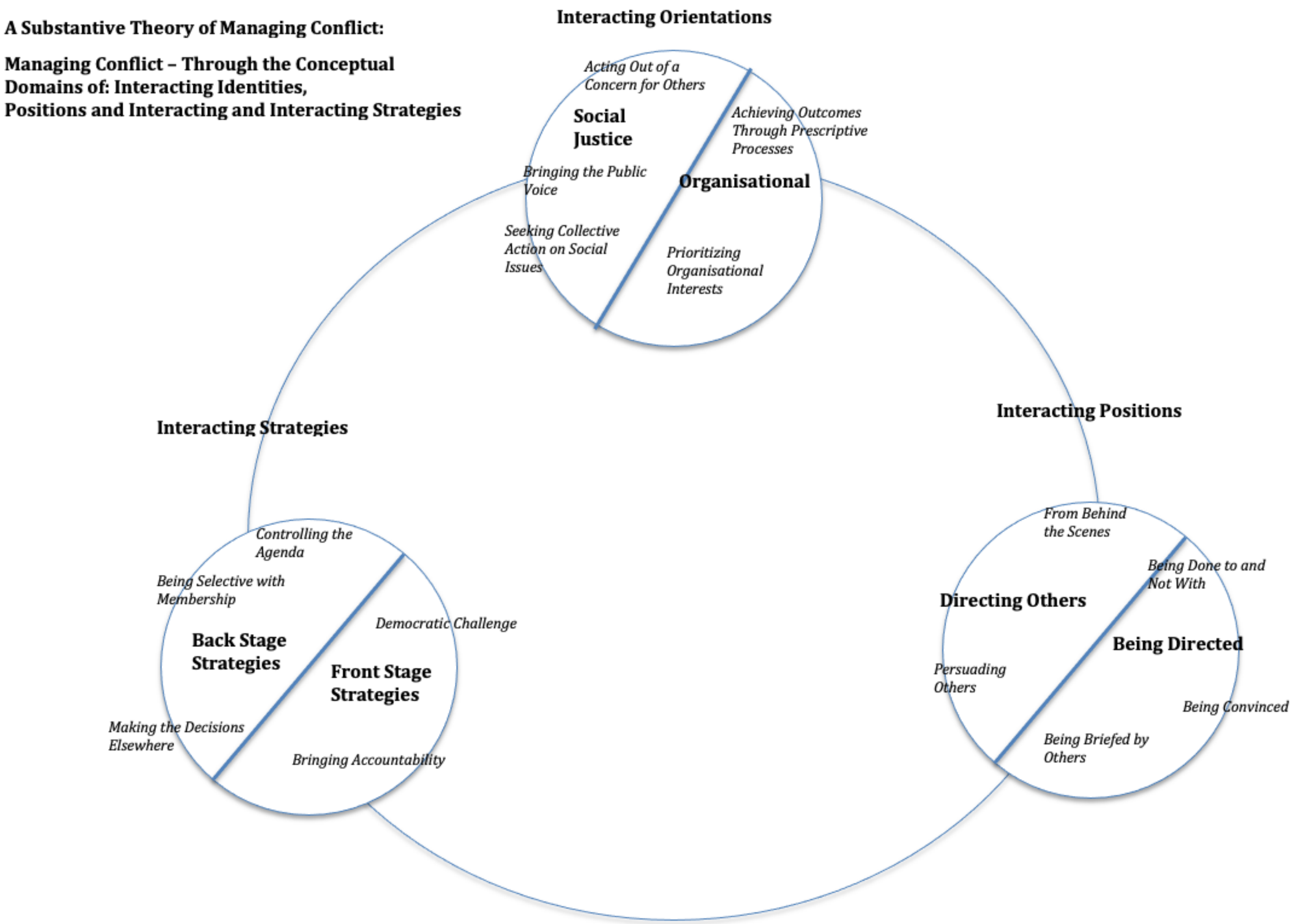
The aim of this research was to develop a theoretical framework from which to understand the interactions between individuals who collaborate under conditions of mandate for the organisation and provision of care. The review of the literature in Chapter 2 reveals not only that there is a paucity of studies on mandated collaboration in this sector and context, but also that there is no detailed sociological study regarding the interactions that occur, the ways in which these occur, and the ways in which individuals manage these interactions so they can fulfil collaborative duties.

The main contribution of the thesis is the construction of a basic social process labelled *managing conflict* which provides a theoretical framework through which to understand interactions between people who collaborate under conditions of mandate and how these interactions are managed. This grounded, substantive theory is constructed from three interwoven conceptual domains that highlight the particular practices, strategies, actions and attitudes developed by individuals to manage the sources of conflict they locate when interacting under conditions of mandate. The three conceptual domains of the theory of managing conflict are constituted as follows:

- *Interacting Orientations* focusses on the orientation of the individual as being either an organisational orientation or one of social justice, which influences the subsequent position from which they manage conflict.
- *Interacting Positions* focusses on the front of stage or backstage position adopted by individuals in managing conflict, determined by their interacting orientation.
- *Interacting Strategies* focusses on the practices, strategies, actions and attitudes developed by individuals to manage sources of conflict, which are dependent on their interacting orientation and interacting position.

The domains are discussed in Chapters 5–7, and Figure 1 provides an illustration of the substantive theory developed from the data known in this study as the basic social process of managing conflict.

Figure 1: A Constructivist Grounded Theory Approach to Exploring Interactions Under Conditions of Mandate



The study is of significance to anyone collaborating under conditions of mandate for the organisation and provision of care. All too often, theorising and research regarding collaborative ways of working translate into little practical guidance for the practitioners who are responsible for collaborating. This study seeks to explore and enable a deeper understanding of collaborating under conditions of mandate and the micro-interactions than can occur between professionals and lay people and they ways in which these can be managed. Rather than focussing on the conceptual or thematic aspects of the antecedents, processes and outcomes of mandated forms of collaboration, this study has shifted the focus to exploring the interactions that occur between individuals and the various practices, strategies, behaviours and attitudes they adopt to manage their way through the process, empirically and theoretically. Combined, these contributions offer new and practical guidance.

1.4 Synopsis of the Chapters

Following this Introduction, Chapter 2 reviews the small but growing number of studies on mandated collaboration in a health and social care context and the micro-interactions that occur between professionals and lay people. This chapter will discuss and review these studies, to make sense of what has been studied so far conceptually, theoretically and empirically and to identify the gaps that still exist in the knowledge. Having identified the key gaps in the literature, Chapter 3 will discuss in more detail the methodological approach that was adopted for this study and the reason why this was chosen. I mentioned earlier in this chapter that departure point for the study of collaboration was Ginsberg's (1940) belief that ‘the various modes of interactions between individuals or groups, including collaboration, co-operation and conflict, social differentiation and integration, development, arrest, and decay, are all basic social processes’ (p. 436). There was also an ethnographic element to the study. The best way to ascertain the interactions and relations between people collaborating under conditions of mandate is to ask them and watch them as they do it (O’Neill, 2002). I observed the collaborative meetings of the group over a period of one year, and followed this with qualitative in-depth interviews with each group member. To this end, I adopted a constructivist approach to grounded theory (Charmaz, 2006). Grounded theory approaches provide the researcher with systematic inductive processes which reveal the basic social processes behind human behaviour and build theories that are grounded empirically in the data. Although many different versions of grounded theory approaches are discussed in this chapter, I adopted a constructivist approach, as this allowed me to acknowledge the role of the participants and myself as a researcher in the construction of the substantive theory of this study, rather than the generation of a theory which already exists, waiting to be discovered. Chapter 4 provides an understanding of the issues as perceived by the people who collaborate under conditions of mandate, and how these issues manifest as conflict within their interactions. Chapters 5–7 reveal and discuss the basic social process of managing conflict, constructed in this study as a way of answering and explaining the interactions between people who collaborate under mandated conditions within a health, social care and public health context. Finally, Chapter 8 summarises the key findings of the study, as they relate to the research aims, questions and the gaps in the knowledge identified in this study. The chapter discusses the contributions to knowledge from this study and how the findings can help those people who are charged with collaborating under conditions of mandate to navigate their way through this process. The chapter concludes with recommendations for future research.

Chapter 2: Review of Literature on Mandated Collaboration in Health, Social Care and Public Health Practice

2.1 Introduction

This chapter begins with a discussion of the approach taken to searching the health literature; the rational for the selection of literature that was reviewed; and the positioning of the literature review within a constructivist grounded theory approach to study. In the first section of this chapter, the literature on mandated collaboration is reviewed to provide the theoretical, conceptual and empirical perspectives through which the research on mandated collaboration so far can be understood, and against which the concepts and categories of the substantive theory developed from the data in this study were critically examined. It concludes with the view that there is a dearth of studies that have taken a micro-sociological approach to the study of mandated collaboration, and that these are insufficient to offer an explanation enabling an understanding of the interactions that occur. In recognising that the available literature on mandated collaboration alone is limited in offering a lens through which to understand the interactions that occur between professionals and lay people in such collaborations, Section 2 focuses in more detail on the interactions that occur between professionals and lay people in health and social care decision making contexts that are not necessarily mandated to allow meaningful insights regarding these interactions to be captured.

Regarding Section 1, the initial literature search involved databases from the health and social sciences literature, and used ASSIA, Cinhal, EBSCO, IBSS, Medline Social Sciences Citation Index, Social Care Online, Sociological Abstracts and Social Services Abstracts. In addition to this, theses and dissertations were searched via Index to These and British Library Ethos Service. Search terms were developed to capture the different ways in which mandated collaboration in the health, social care and public health literature were documented within the literature. Terms such as mandated, collaboration, interactions, social processes, teams, groups, joint working were searched separately and in combination with health, social care and public heath using Boolean search approaches. Studies were only excluded if the publication was not in the English language, or if the focus of the research was not concerned with collaboration for the purpose of the organisation and provision of care under conditions of mandate within a health, social care or public health context. In total, 1351 abstracts/titles were located. Although this might indicate that a substantial number of studies exist on mandated collaboration, the following were excluded from this review: studies that referred to mandate as something an individual body or organisation possessed to progress issues such as family participation in patient care; mandated reporting duties; or the recommendation of processes such as training to be mandated for future successful outcomes. Following a review of the abstracts and the individual reference lists of identified studies, 28 of the original 1351 papers were included.

Regarding Section 2, the initial literature search involved databases from the health and social sciences literature, and used ASSIA, Cinhal, EBSCO, IBSS, Medline Social Sciences Citation Index, Social Care Online, Sociological Abstracts and Social Services Abstracts. In addition to this, theses and dissertations were searched via Index to These and British Library Ethos Service. Search terms were developed to capture the different ways in which the micro-interactions between lay people and professionals were documented in the health, social care and public health literature. Terms such as micro-interactions, collaboration, involvement, engagement, lay people, patients, public participation, citizen, decision-making process, were searched separately and in combination with health, social care and public heath using Boolean search approaches. Studies were only excluded if the publication was not in the English language, or if the focus of the research was not concerned with the micro-interactions between lay people and professionals when collaborating for the purpose of the organisation and provision of care within a health, social care or public health context, in both mandated and non-mandated contexts. In total, 2203 abstracts/titles were located which were reviewed and according to the inclusion and exclusion criteria developed for this review with 116 publications being identified for full-text review. Additionally, the refence lists of the included articles were review for further relevant publications. After screening for eligibility and excluding articles that did not focus on the micro-interactions that occur between lay people and professionals, was not in the context of mandated and non-mandated collaborative forms of health and social care decision making, conference abstracts, full text not found, text not in full English, 42 publications were included.

In adopting a constructivist grounded theory approach to this study, I am aware that grounded theory researchers are encouraged to ignore the related literature until after they have been immersed in the data collection and analysis. Instead, the researcher should move to the point of deriving a substantive theory analysed from the data without pre-judgement or a pre-determined schema of codes from the literature (Glaser and Strauss, 1967; Strauss and Corbin, 1990). In this way, the researcher is not influenced by the work of others but is guided by the data. Convergences and similarities with the literature should only be identified after the core analytic category has emerged (Glaser and Strauss, 1967; Strauss and Corbin, 1994a). This perspective is seen to allow the researcher to deepen their analysis to the level necessary to develop a substantive theory (Charmaz, 2006). However, the extent to which the researcher should, or can realistically, ignore the literature before reaching the point of data collection and analysis is a moot point for Grounded Theory researchers. Charmaz (2006) and Marshall and Rossman (2014) suggest that an initial review of the literature can be both essential and beneficial if the researcher is to develop a basic level of knowledge and contextual understanding and the research questions, if they are to engage with participants in the area under study. (Urquhart, 2007) suggests that researchers should be credited with the ability not allow themselves to be closed off into paths previously well-travelled, should they be exposed to extant literature and theories on their topic of study. The position adopted in this study lies between these two extremes.

2.2 Section 1 - Review of the Literature on Mandated Collaboration

2.2.1 Defining Mandated Collaboration

Although Martz, Mccarthy and Morris (2018) argue that the term ‘mandated collaboration’ is relatively new in the collaboration literature, there is still enough depth to provide a working definition at this point, which is useful in focussing the rest of this review. It is necessary to consider definitions of both mandate and collaboration at this point, as each can be used interchangeably to describe a range of different meaning. Having a mandate, for instance, can mean that the concerned party has the authority to carry out a task or act in a certain way, for example, the Health and Social Care Act (2012) in the UK gave NHS England, an independent organisation, the mandate to manage the budget and the day-to-day operation of the NHS (Glasper, 2014; DoH, 2012). Mandate can alternatively be explained as the external act of forcing others to act in a certain way, which supports the definition provided by (Benson, 1975) and Glendinning, Hudson and Means (2013) of ‘mandated coordination, the exercise of power by an executive authority to enforce relationships upon subsidiary bodies’, and that of Horwath et al., *(*2007) and Horwath and Morrison (2011), ‘the authority or requirement for collaboration’*.*

Defining the noun ‘collaboration’ is also important at this point. Defining and understanding collaboration as the level of effort and joint working needed to pursue complex objectives is important, as it defines collaboration as distinct on the continuum of coordination to collaboration. Drawing on the interorganisational literature, the danger in seeing collaboration as an interchangeable term that can be used to define any level of joint working becomes evident. Most authors view collaboration as being on a continuum that describes the level of joint working between organisations as defined by the level of interdependence required between partners, ranging from cooperation to collaboration. For example, cooperation is used to describe instances of joint working where interdependence is very low, requiring only the sharing of information and/or expertise between the members with very little risk to their own organisational resources, objectives or autonomy (Horwath and Morrison, 2007; Keast, Brown and Mandell, 2007; Mandell, Keast and Chamberlain, 2017). Coordination is used to describe the next level of joint working, where members increase their interactions by sharing information and planning together in order to more closely integrate their individual service delivery (Mandell, Keast and Chamberlain, 2017). At this level, members are willing to accept a further level of risk but only in the way they align their services with others. The next level of joint working is collaboration, which is the focus of this review and study, and denotes a level of joint working where change or innovation is required, as a result of which, the interactions of members are increased to a level of high interdependence, as represented in the studies that are reviewed theoretically, conceptually and empirically later in this section. At this level of joint working, mere alignment of individual interests is not enough; commitment to collaborative goals is needed with the recognition that the actions of each will affect the others, increasing the level of risk to which each member is exposed (Mandell, Keast and Chamberlain, 2017). Failure to recognise these distinctions will not capture the dynamics of the levels of interdependence between members engendered by collaboration, and problematizes their formation and operation (Gray, 1989; Horwath *et al.*, 2007; Keast, Brown and Mandell, 2007; Mandell, Keast and Chamberlain, 2017). Incorporating all of these definitions and for the purpose of the review and this study, mandated collaboration is discussed in the context of the definition offered by Rodríguez *et al.* (2007) McNamara (2016:68) and Hafer (2018): *‘when bureaucratic or hierarchical mechanisms are used by a third party to bring separate organisations together to pursue complex objectives’*. This captures the authority of an external party to enforce interaction; the pursuit of complex goals as is the case in the organisation and provision of care; and the level of joint working and interdependence between participating members needed to achieve these goals.

2.2.2 Why Mandate?

The working definition of mandated collaboration provided above explains the use of bureaucratic or hierarchical mechanisms (discussed further in this section) as the impetus for collaboration in the health, social and public health care sector; however, we might consider why such an impetus is needed when the health of the neediest is at stake? Public sector agencies are a result of the political landscape in which they exist, responding to shifts in governments and policies that can leave a hard to navigate and highly fragmented labyrinth of organisations which are expected to regulate, commission and provide our care (Glendinning and Powell, 2002; Ranade and Hudson, 2004; Hunter *et al.*, 2011; Murphy, 2013d). Working together, crossing the boundaries of their own agencies and organisations, can be complex and time-consuming and, even though there is agreement in the common purpose, public sector cuts in funding and other resources often reduce the capacity to mobilise collaborative or interorganisational efforts, hence the need for these endeavours to be mandated (Lowndes and Squires, 2012a; Addicott, 2013; Muir and Parker, 2014). A more pessimistic view would argue that a policy solution based on mandate allows governments to offload their responsibility and disguise their failure in mitigating the causes of wicked issues whilst appearing to be doing something useful (Popp and Casebeer, 2015; Segato and Raab, 2019). Wicked issues in this sense are defined as:

‘those long-term and seemingly intractable issue that has not been amenable to single-agency resolution or mitigation and therefore has increasingly been approached on a multi-agency basis (Murphy, 2013, p.249).

This view has also been used to describe the efforts of the Health and Social Care Act (2012) which has heightened the approach to localism and transfer of power to local governments (Hunter and Perkins, 2012; Learmonth *et al.*, 2018). This approach to mandate has been described as some as negative policy feedback, explained as the government turning to mandate when its own attempts to effectively organise and provide care repeatedly fail, demanding changes which lead to the emergence and persistence of further instances of mandated ways of working (Hafer, 2018). This more critical view as to why governments mandate collaboration is described by Paton (1999, p.69) as being more consistent with the dogmatism in which seemingly voluntary efforts such as cooperation, partnership and collaboration are now mandated at every turn in what he calls ‘statutory voluntarism’ as a result of government failure rather than of policy imperatives based on sound evidence (Dowling, Powell and Glendinning, 2004). This view is in keeping with the model of collaboration defined by Hudson et al. (2007) where any collaborative efforts are due to the impetus of self-interest on the part of one or more organisations attempting to achieve their own goals through interactions with others. However, if mandating collaboration through legislative means allows governments to mask failures in adequate management of wicked issues, (Davies, 2002) argues that it also allows them to retain ongoing control when mandating collaborations such as partnerships, which denote a seemingly positive and voluntary effort (Glendinning and Powell, 2002; Rees, Mullins and Bovaird, 2012). Dunlop and Holosko (2004) add to this cynical view in what they call the deficit reduction strategy approach to mandated collaboration. They argue that, where governments are incentivised to mandate collaboration for reasons of creating efficiency and if organisers and providers of care perceive that the incentives to collaborate are still weak as a result of the effort and expense for their own organisation, collaboration can then be mandated as requirement of funding, meaning that organisations will struggle financially to survive unless they comply (Ansell and Gash, 2007; Ivery, 2008). In this view, mandated collaboration as a means to support deficit reductions is viewed as the devolving of financial responsibility for the cost of the provision of care from state level to local level, where the level of care must be sustained with decreased resources.

However, even in view of these more critical approaches, there is also the belief that governments mandate collaborative working as it provides the most effective solution available to tackle the complex and wicked issues that dominate health, social and public health care and enhance the delivery of care (Perkins and Hunter, 2010; Lewis, 2004; Perkins et al., 2010; Ellins and Glasby, 2011; Hunter and Perkins, 2012). Mandating collaboration in this way is seen as an attempt to make organisations collaborate with others horizontally across organisational boundaries, instead of vertically up and down the chain within organisational boundaries (Ramadass, Sambasivan and Xavier, 2017). Christensen and Lægreid (2007) also note that governments are prompted to mandate collaboration on account of the synergies that are created in healthcare provision when organisations are forced to think of innovative ways to use scarce resources that can help to reduce the fragmentation in services to users. This also notes the policy shift towards collaborative efforts that are measured on the reduction of health outcomes rather than collaborative efforts (Goodwin *et al.*, 2004; Coleman *et al.*, 2014).

2.2.3 Theoretical Approaches to the Organisation and Provision of Care

Within the academic literature there are broadly three explanatory theories that have been used to conceptualise the organisation and provision of health, social care and public health services that also correspond with the three broad approaches to the governance of these services (Murphy, 2013). Traditionally the provision of care was organised from a public agency or principle agent theory which can be explained as a top-down control approach where central government forms hierarchies of senior managers, and directives and tasks are passed down the chain of command (Rees, Mullins and Bovaird, 2012; Murphy and Murphy, 2013). This is most suited to the definition of mandated collaboration used in this study of 'when bureaucratic or hierarchical mechanisms are used by a third party to bring separate organisations together to pursue complex objectives' (Rodríguez et al., 2007; McNamara, 2016, p.68; Hafer, 2018). This form of organising and providing is one in which the autonomy of public managers to act in ways that suit localised needs s constrained and controlled through finance and legislation (Murphy and Murphy, 2013). This approach is linked to bureaucratic or hierarchical modes of governance where formalised rules and regulation with performance monitoring take the place of authoritative strategies – a full discussion of these governance approaches is provided later in this section (Benson, 1975; Rodríguez *et al.*, 2007). The transition into new public management or public choice theories emphasised New Labour's approach to the provision and organisation of care based on values of equal worth, and opportunity through partnerships between the state and society underpinned by individual self-ownership of health and market-based opportunities (Goodwin *et al.*, 2004). Essentially this emphasised a mix of state-market-voluntary sector provision where individuals are empowered to take responsibility for their own care. Public participation or user involvement in care became synonymous with the term collaborative governance, which can be understood as a more modernised image of public services, in which organisations involve users and local communities in the decision-making process (Newman *et al.*, 2004). In their study on public participation, Newman et al. found that these new forms of governance do not replace the old and interact uncomfortably with the new. Their study found that public participation is frustrated, as participation and co-dependence depend on interaction and relationships with all figures involved, mechanisms with which these new forms of provision and organisation are not equipped. Similarly, Fraser (2014) found that processes of inclusion in public matters are guilty of treating the public as one homogenous group, further alienating certain groups such as and ethnic minorities, the LGBT community and young people. This form of organising is more closely aligned to market-based modes of governance, which emphasised markets and competition for the most cost-effective organisation and health provision as an answer to the perceived failings of bureaucracy and top-down forms of control (Ranade and Hudson, 2004). The third theory, public value and new public service theory, learning from the failings of top-down approaches and the use of markets and competition which moved organisation and provision into public and private sector domains, approached the organisation of care with values of democracy that encouraged the development of policy together with citizens, not for and on behalf of them. In this approach, services are organised with the need of the communities at the centre of prioritising through collective and collaborative processes, rather than an offering as a result of cost efficiencies achieved through market forms. This theoretical approach to the organisation and provision of care is aligned to network modes of governance where coordination is achieved through less formal and egalitarian means, with explicit attention to the way relationships are formed and maintained through cooperation and trust (Ranade and Hudson, 2004). Public value and public choice theories are behind much of the drive towards modern-day collaborative approaches which advocate putting the local community at the centre of care and being citizen-focussed, rather than collaborative approaches that are derived from top-down control or needed to achieve market-driven efficiencies. However, this could cause a dichotomy for understanding modern mandated forms of collaborative working that have been imposed, top down, by an external authority, which speaks of hierarchical mechanisms of governance that advocate organising care with less formal and more egalitarian approaches.

2.2.4 Theoretical Approaches to the Study of Mandated Collaboration

Despite the pervasiveness of mandated collaborative working for the organisation and provision of services from a health, social care and public health perspective, there are several challenges to its study. First, the majority of the current body of literature in this field assumes that participants collaborate on a voluntary basis, which often ignores the nuances that exist between voluntary and mandated forms of collaboration (McNamara, 2016; Hafer, 2018; Martz, Mccarthy and Morris, 2018). To do so can muddle our understanding of the dynamics that can occur when the interactions are mandated, and how a mandate can impact other elements that have long been associated with more voluntary modes of collaboration (McNamara, 2016). Secondly, there is no theory of mandated collaboration but rather a theoretical perspective from which this has been studied (Williams, 2015). The next section reviews those studies that have taken a theoretical perspective, and their findings.

Complex adaptative system theory views any system as open and adaptive in which there are numerous and diverse agents whose interactions contribute to the novel and predictable interaction and events that can occur within it (Tsasis, Evans and Owen, 2012).
In their study of the development of fourteen government-mandated Local Health Integration Networks in Ontario, Canada, Tsasis, Evans and Owen (2012) attempted to reframe the discussion on the organisation and provision of care by challenging previous conceptualizing and arguing for the use of a complex-adaptive systems approach. When viewed from this theoretical perspective, mandated collaboration is seen as a set of diverse figures who self-organise and produce adaptions through dynamic interactions that cannot be predicted or controlled. Complex adaptative system theory can then provide an opportunity to understand more about the agents and their interactions within mandated instances and how these can inform practical recommendations of how to collaborate effectively under these conditions (Holden, 2005; Tsasis, Evans and Owen, 2012b). For these researchers, studies that are unable to approach mandated collaboration from this viewpoint will remain disappointingly unable to grasp what is really happening. An important aspect of this approach, and a reason why the authors argue that results are still poor despite empirical and theoretical studies in mandated health integration, is the understanding that change and integration can only occur through a more hands-off approach at the meso level that allows agents and organisations to self-organise and adapt integration through interactions based over time, an approach which is in direct contrast to the external top-down approach of mandate. This approach is important as, although it may be perceived that the fate of any mandated collaborative efforts are doomed to fail (Kodner, 2009), it does allow researchers and practitioners to understand what is needed to combat the effect of the straightjacket of the mandate, such as fostering facilitative leadership which will allow agents to self-organise and adapt in complex systems despite these barriers (Barnsley, Lemieux-Charles and McKinney, 1998).

Exchange theory has also proved a useful approach when collaboration is mandated as a condition of funding. Exchange theory works on the premise that organisations and agents will choose to apply for or participate in the collaboration based on the reward they can expect to receive in exchange for their collaborative efforts. Even though many of these organisations will enter into a collaboration seeking to maintain and defend their independence, collaborative interorganisational relationships will be developed if the exchange for their efforts offers stability, legitimacy, resources or status (Ivery, 2008). In instances of mandated collaboration where specific agents are not mandated to participate but, should they choose to do so, are mandated to collaborate with others, exchange theory has been used by a number of scholars to gain an understanding of the factors that influence motivation to collaborate. In this way, any benefits and drawbacks of the exchanges in which they take part can be analysed, to identify where this has occurred within the collaborative process and how it can be managed or encouraged in future (Weiss, 1987; Snavely and Tracy, 2002; Dunlop and Holosko, 2004). In a similar vein, Ramadass, Sambasivan and Xavier (2017) used social exchange theory to capture the critical factors that drive mandated collaborations, so we might understand what helps them to succeed. Their study identified the need for transformational leadership, interdependence and community if perceived outcomes are to be achieved. Leadership was seen as essential to build and establish relationships between partners which develop into interdependence. Community, in the form of demands, feedback, accountability and transparency was then essential between the partners as a way of enhancing levels of interdependence. Social exchange theory considers the extent to which agents and organisations recognise they share the central issues for which they have been mandated and begin to exchange mutually rewarding interactions. Over time, these interactions develop into mutually rewarding relationships which contribute towards a solution to their shared issues (Emerson, 1976; Cropanzano and Mitchell, 2005). Using this theory to explore mandated collaboration can identify the critical factors needed to drive these mutually rewarding interactions and relationships, which in turn support the collaboration to achieve their social goals.

Exploring social action within, and as a result of, mandated collaboration has been achieved by some scholars though the use of institutional theory (Grafton, Abernethy and Lillis, 2011a; Forbes, 2012). The institutional theory perspective approaches the mandated collaborative entity or form, such as the partnership or network, as the organisational field, or those organisations or agents that 'constitute a recognised area of institutional life producing a similar product or service' (DiMaggio and Powell, 1983, p.148). The emphasis is on seeing the mandated set of organisations as a field or the totality of the relevant figures that takes into account the connections between agents and organisations, and their structural equivalence (DiMaggio and Powell, 1983). Applying institutional theory to the study of a mandated collaborative entity is useful in explaining the strategic responses of organisations to the new form, or 'mandated collaborative entity' and the design or structure that emerges under the new arrangement or, as the institutional theorists would posit, under the new 'institutional arrangement' (Evans and Forbes, 2009). This theory is useful in illuminating the extent to which the legitimacy of existing practices is continued, adapted or discontinued as a result of the new institutional order or, in this case, the new mandated arrangement. This approach is not unlike the complex adaptive systems theory approach in that the organisations and agents involved in the mandated collaboration are viewed as a whole system or a sum of their parts, rather than as individuals who may be connected in some way.

Institutional theory views the mandated collaborative entity, such as the partnership or network, as the institutional field in which the organisations and agents are connected through their interactions with each other and the level to which they are structurally equivalent, or the extent to which the organisations and agents occupy the same position within the mandated collaboration structure (White, Boorman and Breiger, 1976; Sailer, 1978; DiMaggio and Powell, 1983; Walker, Kogut and Shan, 1997), that is, to what level constraints and opportunities affect all the organisations in the collaboration in the same way, as a result of their structural positions being equal. The extent to which these organisations interact and relate to each other and the patterns of these interactions are said to be the extent to which these organisations reproduce and transform themselves, or the level to which the field (the mandated collaboration) becomes institutionalised as a new form and is developed (DiMaggio and Powell, 1983). In essence, institutional theory aims to explain the level of legitimacy that agents and organisations of the mandated collaboration receive as a consequence of choosing to conform or not conform to their environment, or the level to which they take on the norms, values and ideologies of the mandated collaboration (organisational field). If agents and organisations do not conform, this theory can explore the extent to which they look for innovative ways to solve health inequalities that comply with the mandate and are legitimized despite non-conformity (Evans and Forbes, 2009). In DiMaggio and Powell (1983) well-known metaphor, the coercive pressure and expectation on a government institution to collaborate in the organisation and provision of care under mandatory conditions represents the iron cage and the level to which these figures take on or mimic the actions, processes, behaviours and attitudes of other agents and organisations in this field, instead of seeking innovatory ways to achieve their aims, is the level to which isomorphism is said to occur (DiMaggio and Powell, 1983).

Finally, within the studies identified in this review some authors found it useful to consider policy-mandated collaboration from the theoretical approach of policy implementation theory (Montjoy and O’Toole, 1979; Ovseiko et al., 2014). This approach can be useful as most governments do not come with a manual as to how, with what and with whom mandated collaboration should be implemented. Montjoy and O’Toole (1979) suggest that in cases where organisations are mandated to implement central policy, it is useful to conceptualise the implementation of the mandate as an organisational problem, to which organisation theory can be applied in order to explore and understand the implementation issues that arise. This approach considers how agents and organisations implement mandates from two primary positions: the degree of detail provided, or absent, concerning the implementation of the mandated policy; and whether new resources are provided to support successful implementation of the policy. The aim is to provide practitioners with an understanding of the potential issues when implementing the mandate, so the necessary action to manage these can be developed. Specifically, there are two areas of implementing policy mandates that it can highlight and warn against: firstly, the threat of agents and organisations that may be in a position to use the mandate to further their own ends and dominate the collaboration, and secondly, the extent to which any dominant agents or organisations could impose an interpretation of the mandate to their serve their own needs (Ovseiko *et al.*, 2014).

This section of the review has summarised the theoretical perspectives that have been used to study mandated collaboration and reflects the small but growing amount of academic literature that mandated collaboration is now enjoying. It has shown that different theoretical perspectives have illuminated aspects of what is known on this topic, but it has also revealed a theoretical gap in the literature to explain the interactions that take place between participants and the need for a substantive theory that is grounded in the data. The next section of this chapter discusses the ways in which mandated collaboration in the health, social care and public health sectors is conceptualised within the literature.

2.2.5 Interorganisational Forms of Mandated Interorganisational Collaboration

It would be quite impossible to discuss mandated collaboration in a health, social care and public health context without referring to the organisational forms that these interorganisational relationships most commonly take, i.e. partnerships and networks. Lowndes and Squires (2012) issue an important reminder of the failure to distinguish between organisational manifestations of interorganisational collaboration and their modes of social coordination, more commonly referred to in the literature as modes of governance, as such failure can obscure the fact that theoretical insights that can be gained from effective organisational forms can only be developed when the combination of governance modes best suited to them is identified. Partnerships and networks as interorganisational structures are analytically distinct from the governance modes of network, hierarchies and markets, and it will be useful at this point to provide a definition of these organisational forms before discussing the modes of governance.

Mandated partnerships in the health, social care and public health literature have been described as networks, interorganisational relations, coalitions, strategic alliances, forums and committees (Kirchhoff and Ljunggren, 2016). In defining partnerships as any of these collaborative entities, Lowndes and Squires (2012:314) note that, when manifested as an organisational form, partnerships can be conceptualised as formalised agreements between concerned organisations, ‘given concrete expression through the creation of a partnership or forum’ within which the various strategies, actions, behaviours and attitudes will be governed. Rees, Mullins and Bovaird (2012) define a partnership as ‘at least two agencies with common interests working together in a relationship characterised by some degree of trust, equality and reciprocity’ (p.9). If the partnership involves a higher degree of cooperation, resulting in a bureaucratic partnership, or a deep level of joint working prompted by an external third party, Stoker (1998) identifies this as inter-organisational negotiation and systematic co-ordination. Mandated partnership, as opposed to voluntary partnership, is usually characterised by its ambiguous governance and accountability arrangements; the use of compromise instead of consensus to reach agreement; a vertical-horizontal form of partnership; and objectives imposed by hierarchy (Armistead and Pettigrew, 2008; Muir and Mullins, 2015).

Although at the heart even of mandated partnerships, partners would rarely argue against the creation of efficiencies both for cost and the service user, Hudson (1999) reminds us that, when partnerships are mandated through external controls, the trust base becomes displaced, leaving partnerships that exist on legislative and regulatory mechanisms. A definition of mandated partnerships which would take into account all of these descriptions and caveats is given quite simply by Kirchhoff and Ljunggren (2016) and Sørensen and Torfing (2009) as an externally mandated arrangement, where interdependent but autonomous actors are engaged in the institutionalised processes of common aims, based on negotiated interactions and joint decision-making. Partnerships, as a form of interorganisational collaborative working in health, social and public health, are not new in the UK and, given that some partnerships have been mandated since the Blair government initiated them, there are surprisingly few studies in the literature that focus specifically on the effects that mandating these forms of collaborative entity can have.

Mandated interorganisational networks, as organisational forms, would appear to be a more attractive collaborative entity for research, as the empirical studies identified by the scoping exercise highlighted a greater number of studies on this. Networks are more widely used as a term of governance in the mandated collaboration literature, and a detailed discussion of this is presented in section 2.3.5.7. However, heeding the call of Lowndes and Squires, (2012) the network as an interorganisational form is discussed first. Similar to partnerships, policy-mandated networks can be defined as three or more autonomous organisations that work together to achieve their own goals as well as the collective goals (Provan and Kenis, 2007). They were seen to be emerging as a form of organisation and provision of care later than the explosion of partnerships (Pettigrew and Fenton, 2000). Within the health, social care and public health sector, mandated networks specifically for the organisation and provision of care are usually referred to as goal directed networks, which Kilduff and Tsai (2003) conceptualise as formal mechanisms to achieve multi-organisational outcomes where collective action is required for problem-solving (Provan and Kenis, 2007; McGuire and Agranoff, 2011). Although mandated partnerships and networks are similar in their involvement of multiple agents and organisations working together on complex issues committed to the collective as well as the individual aim, partnerships are seen as hierarchical forms where interactions between participants are at the collaboration point on the continuum, while networks are viewed as being at the coordination point on the continuum, without the benefit of hierarchy (Montjoy and O'Toole, 1979). Although both forms reach across their organisational boundaries to collaborate and behave in similar ways, networks are usually associated with the coordinated efforts of participants to push a collective goal that is the same as their organisational goal, i.e. the daily individual or organisational role differs very little from the network role. In partnerships, collaboration is usually more connected, with levels of hierarchy and a collective goal that is shared, but not usually mirroring the daily organisational goal, meaning participants will have to invest additional effort and resource into a second role to be part of the partnership (Kamensky and Burlin, 2004).

The literature suggests two reasons why these mandated forms of interorganisational relations are used and studied empirically in the literature. The first comes from the perspective of institutional economics, which suggests that fragmentation costs in the organisation and provision of health care are high and can be reduced by collaborative mechanisms (Rees, Mullins and Bovaird, 2012). This point has been touched on earlier in this chapter: the policy shift from the 1990s onwards in addressing wicked issues that could no longer be solved by single agency responses has seen an increase in the use of both mandated interorganisational forms (Clarke and Stewart, 1997). The review of the literature in this study also revealed that the governance of these two interorganisational forms of collaboration are inextricably linked and sometimes used interchangeably in each governance mode. The next section discusses the governance issues associated with these two interorganisational forms as they are evidenced in the literature and how this informs our understanding of mandated collaboration.

2.2.6 The Governance of Mandated Interorganisational Collaboration

Governance, or governing without government, is the organisation and provision of health, social and public health care through the coordination of social action that is not controlled by the state (Rhodes, 1996). Rhodes argues that modes of governance are characterised by the fact that they are self-organising forms of interorganisational relations as a result of the state's failings to manage wicked issues. The starting point, however, is not interorganisational form, but governance, or social coordination and how this is achieved through collaborative interorganisational relationships and their forms. Kooiman (1993) states that it is through these patterns or modes of governance that participants shape their reality, that is, it is through these patterns of governance that the organisation and provision of care will take place.

Although this review has discussed partnerships and networks as a mandated interorganisational collaborative form or entity, they are also distinguished in the literature by the level to which social action across their structure is interconnected and participants are independent or interdependent, that is, the level to which their social action is governed or coordinated. In networks, the level of social action is between independent participants at the level of coordination, where sharing of information and expertise is more common than the exchange of resources and where the network goals closely resemble the individual goals of the networked organisations. The relationships in networks are typically discussed as being informal and horizontal, is between organisations broadly similar in size and structure and with the absence of hierarchy, which is usually replaced by network management.

In partnerships, the level of social action is discussed as being the actions or interactions between participants who are interdependent with each other and at the collaborative level. Sharing of resources, as well as information and expertise, takes place towards a collective goal that is in addition to but connected to the individual goals of each organisation. The relationships in this collaborative form are both vertical and horizontal, in the sense that the relationships are between organisations of varying size and structure with some form of functional split and with the presence of hierarchy (Rees, Mullins and Bovaird, 2012). To simplify, collaborative interorganisational forms such as partnerships can governed by both partnership and network modes of governance. For example, where partnerships as interorganisational forms have a high level of joint working that is developed on mutual understanding and trust, they can be defined as a form of network governance. The emphasis is on viewing the partnership as a mode of governance rather than an entity.

It is clear to see how the terms of mandated collaborative interorganisational forms and their governance modes can become interchangeable in the literature, but it is important to understand the difference between form and governance if we are to understand the benefits and drawbacks of mandating interorganisational relationships in the health, social care and public health sector. A working definition of governance and its different modes is discussed at this point to help navigate this challenge. Network modes of governance can be understood as the combination of mechanisms and institutions enacted to coordinate joint action towards the attainment of network-level goals which can be used as a mode to govern social action in both partnerships and networks as organisational forms (Provan and Kenis, 2008; Salvador *et al.*, 2015). Partnerships as network forms of governance are centred on shared understandings and relationship-building, with the organisation and provision of care and policy coproduced (Lewis, 2009). Hence, some scholars argue that partnerships are the most identifiable form of network governance viewed as formalised networks that are designed as a way of managing collaborative interorganisational relationships (Thompson, 1991; Kickert, Klijn and Koppenjan, 1997). A further key feature of the network as a mode of governance rather than as an organisational form is the coordination of social action that is achieved by less formal and egalitarian means, with explicit attention to the way trust and cooperation are developed as a means of developing and maintaining interorganisational relationships that achieve collaborative goals (Ranade and Hudson, 2004). Within these definitions of network as a mode of governance to coordinate social action, there is an important emphasis on the absence of hierarchy, hence the definition of network modes of governance as horizontal and flat structures where trust, egalitarianism and interorganisational relations based on less formal arrangements are enough to mobilise social action (Macneil, 1985; Rhodes, 1996). However, when these interorganisational relations are mandated, the self-organising characteristic of governance is replaced by this top-down imposition to mobilise action which creates certain dynamics in the way the social action of the collaborative forms is governed.

Therefore, the discussion of the governance of collaborative interorganisational relations and the implications for the coordination of social action when these relationships are mandated are of particular importance. Partnerships and networks are typically seen as voluntary collaborative or coordinated approaches to the organising and provision of care; however, when imposed by an external authority, or mandated, the capability of participants to determine their actions and outcomes by consensus can be reduced (Muir and Mullins, 2015). Davies (2002) argues that government mandates to collaborate might appear to create autonomous entities once the collaboration is formed, but this really only masks the hierarchical power of the state to orchestrate and control. Some researchers would argue that partnerships and networks as interorganisational forms derive from one of three forms or modes of governance: partnerships or hierarchies; networks; and contracts or markets (Thompson, 1991; Ansell and Gash, 2007; Sullivan and Skelcher, 2017). These terms are most commonly expressed in the literature as hierarchies, networks and markets (Powell, 1990). Considine and Lewis (2003) offer a useful way to conceptualise them by the extent to which they control and rationalise the way collective goals should be achieved. Conceptualised in this way, modes of governance as hierarchies coordinate social action with authority; as markets they coordinate social action with competition; and as networks they coordinate social action with collaboration (Lewis, 2009). If we are to understand that partnerships and networks as collaborative interorganisational entities can, once mandated, no longer be conceptualised within the network and partnership modes of governance which with they were once defined, what empirical implications result for mandated collaboration? The following section reviews the empirical studies of mandated collaboration identified in the scoping review of this study.

2.2.7 Empirical Findings of Mandated Collaboration

Of the studies included in the scoping review of this study, only 21 were empirical studies with a specific focus on aspects of collaborative interorganisational relations that had been mandated in the health, social care and public health sector. Of these, nine studies focussed on mandated collaborative interorganisational entities as networks, and thirteen focussed on mandated collaborative interorganisational entities as partnerships. Empirical findings are important as they provide theoretical, conceptual and practical advantages. For researchers of mandated collaboration, they provide evidence through which this phenomenon can be advanced theoretically and conceptually. For practitioners, they can offer a set of assumptions and propositions that highlight the potential benefits and drawbacks of participating in mandated collaborations, and how these can be managed.

The most cited concept discussed in the empirical studies included in this review was the governance of mandated collaborative interorganisational relations. One of the key challenges for mandated collaborations is the need for multiple mechanisms to coordinate social action, as opposed to the governance mechanism that would usually be synonymous with that interorganisational form. The definitions of collaborative interorganisational relations presented so far in this review have identified that when interorganisational relations are collaborative there is no need for reliance on market or hierarchical mechanisms of governance to coordinate social action, as the interdependent participants will negotiate the answers to shared concerns amongst themselves (Gray, 1989; Phillips, Lawrence and Hardy, 2000). However, when these collaborative interorganisational relations are mandated, it appears unclear whether participants should rely on hierarchy, market or network mechanisms to govern their actions, or whether they should rely on elements of all three. This is made by more difficult by the fact that mandated agents and organisations may feel forced to take part in such processes even where the collective goal has a negative effect on their individual goals (Goold, Alexander and Campbell, 1994; Rodríguez et al., 2007). Rodríguez, et al. (2007) noted in their study of a regional health board network that the best possible governance mechanism to apply to mandated collaborative networks is one that incorporates all three modes. Hierarchical or bureaucratic mechanisms (a mandate) can be essential when there is a need to bring partners to the table to collaborate on wicked issues, and market-based mechanisms can incentivise the level of interest participants will have once they are there; however, once these two phases are secured, a network or clan base mechanism or mode of governance should take over, to coordinate action that is developed on shared values and beliefs, trust and reciprocity (Ouchi, 1980).

In practice, where the managing or lead organisation lacks legitimacy with other participants in the network, reliance on bureaucratic modes of governance to formalise the rules and regulations needed at the design stage of the collaboration becomes difficult, and participants resort to clan-based mechanisms (Benson, 1975). However, in instances of mandated collaboration, clan- or network-based modes of governance are ineffectual in the achievement of collaborative goals if there is no incentive to collaborate in the first place. Rodríguez et al., (2007) also found that, if coerced participants are not fully engaged in the mandated purpose as a result of the hierarchical mode of governance not being present in the design stage of the collaboration, they will happily allow themselves to go through the motions of a clan or network mode of governance to coordinate collaborative action, in what Brunsson (1993) calls organisational hypocrisy, giving the appearance of compliance with little change being effected. These findings agree with those of Lowndes and Skelcher (1998) regarding the different modes of governance needed at the different life-cycle stages of interorganisational collaboration. Although their study and findings were based on interorganisational forms of partnership, their interest was in the social action that was to be coordinated, and the reason why lessons of partnerships and networks are transferable.

They also argued that, when applied to instances of mandated collaboration, the creation and consolidation stage of the interorganisational arrangement should be characterised by a hierarchical mode of governance which provides the authority needed for formalisation of rules and engagement of partners who are not participating on a voluntary basis, and the early stages of relationship-building should be characterised by network or clan modes of governance. Although mandated forms of partnerships or networks are seen by some as a genuine shift from optimistic to realistic, regarding the kind of collaboration needed to solve wicked issues, Rees, Mullins and Bovaird (2012) note that the literature has successfully that effective partnerships do not emerge as a result of top-down mandated approaches. This may suggest that the need for mandated interorganisational relations to be characterised by multiple modes of governance through the different stages of the cycle could prove to be the contingency plan that practitioners need to mitigate any unwanted effects.

Some scholars have recognised the importance of what Rees, Mullins and Bovaird (2012) highlight as the need to adopt a governance approach to the study of partnerships in empirical research, as this can alert researchers to the complexities and ambiguities that exist when multiple modes of governance coexist. Using a governance approach to explore mandated partnerships, Lewis (2004) was able to explore the level to which these partnerships reflect network governance ideals and what impact this has for the mandated partnership. Her study was able to identify that that in a mandated collaboration where partners are seen as equal, with the same level of legitimacy, mandated partnerships are able to genuinely reflect network modes of governing where social action is mobilised in trust, reciprocity, shared values, beliefs and norms, even though in reality governance may be a mix of all three modes (hierarchy, market and network). As a result, the partnership was able to influence and coproduce central policy to fit local needs. The findings of these studies would suggest that, if mandated collaboratives are to have a stronger focus on reflecting the network mode of governance to achieve meaningful outcomes, the level of legitimacy which mandated partners perceive each in other is a key issue in achieving this.

Similarly, using a governance approach to explore mandated collaboration, Grafton, Abernethy and Lillis (2011) were able to evidence the extent to which a network's strategic response to the mandate will affect the design choice of mode of governance of that network as an interorganisational form. As the design stage is one of the early stages in the interorganisational life cycle, these authors used Oliver's (1991) framework of organisational strategic responses to institutional pressures. In this case, as in institutional theory, the interorganisational collaborative is viewed as the organisational field and the mandate is the institutional pressure to which the collaborative is responding (DiMaggio and Powell, 1983). Oliver's (1991) framework of strategic responses to institutional pressures is based on the premise that organisations, as a result of external pressures (in this case the mandate), will respond with forms of acquiescence, compromise, avoidance, defiance or manipulation. Where organisations in the network perceive that they can enhance their own legitimacy or gain economic efficiencies as a result of developing relationships with other organisations, this response of acquiescence or complying with the mandate influences the design that characterises a network mode. When agents and organisations within the network have no desire to collaborate, and perceive that working with others threatens their own legitimacy rather than enhancing it, they respond to the mandate with non-acquiescence and disjointed coordination, even though there may be potential for efficiency and social gains.

2.2.8 The Challenges of Mandated Collaboration

The literature included within this scoping review recognises both the need for and the challenges of mandated interorganisational collaboration in the context of the modes in which social action is coordinated and how agents and their organisations must respond to the mandate while negotiating, managing and sustaining their relationships with one another (Rees, Mullins and Bovaird, 2012). The challenges of establishing collaborative relationships with hierarchical governance mechanisms can result in missing links in the stages of developing relations between partners, particularly in those stages where collaborative norms are agreed, which can present a barrier to collaboration or cause resistance to collaboration from partnership or network members.

DiMaggio and Powell (1983) and Tsasis, Evans and Owen (2012) noted that, if the mandated collaboration is not viewed as the institutional field, the awareness of participants is limited to other diverse, independent and semi-autonomous figures who can be said to be structurally equivalent. Tsasis, Evans and Owen (2012) use the concept of Batalden and Mohr (1997) ‘knowledge of the system’ to emphasise the need for agents and their organisations to have an awareness of each other and each other’s roles within the collaboration, to allow them to build relationships of trust. This proves a particular challenge in mandated instances, as trust cannot be mandated and, if participants are not involved in the initial design and creation stage of the collaboration to enable this, there is also a risk of disharmony and demotivation (Goodwin *et al.*, 2004).

Mandating interorganisational collaboration, as noted, can cause a discrepancy between the form of governance and the collaboration, that is, collaborative social action which is usually coordinated or governed by socially constructed shared values and beliefs of network mechanisms being hierarchically imposed (Provan and Kenis, 2008). Van Raaij (2006) and Kenis and Provan (2009) have noted the importance of involving participants in the inception stage, particularly in mandated instances. They note that where there is no shared history between participants of a need to coordinate activities with each other, or where not all participants are convinced of the need for the collaboration, only governance forms that can offer opportunities for legitimacy engage members sufficiently to maintain the collaboration and offer the opportunities for sufficient gains so that participants are willing to balance the needs of their own organisations with the aims of the collaboration (Kenis and Provan, 2009). Tsasis, Evans and Owen (2012) also noted that if the mandated collaboration, or the institutional field, is viewed as a complex adaptive system, hierarchical controls are seen to be intrusive and futile and will slow down the collaborative action. Echoing the principles of network modes of governance and collaborative action based on trust, shared values and reciprocity, mandated collaborations should be seen as systems which foster the capacity for self-organisation and simple rules, which are more conducive when participants are trying to negotiate shared value in complex and fragmented systems such as health, social care and public health.

In addition to the limited trust, collaborative capacity and lack of opportunities for legitimacy that the literature has noted as a result of mandating collaborative interorganisational relations, there is a further challenge in what Rees, Mullins and Bovaird (2012) call this dark side to mandated action: inequality of power. This is aside from the use of collaborative interorganisational forms such as networks and partnerships by central government to mask their own on-going power over and control of apparently devolved responsibilities (Davies, 2002). Rees, Mullins and Bovaird (2012) note that even voluntary forms of collaborative interorganisational relations can be hard to sustain because of the behaviour changes required by participants to share and distribute power equally. Vertical and horizontal relationships can involve multiple organisations of different size and structure. In mandated instances, where there might already be a lack of shared belief in the need to coordinate activities and an unwillingness to commit effort, any asymmetry of power that exists as a result of resources, legitimacy, size and structure can create power inequalities that can lead to hierarchical dynamics led by the dominant participants (Kenis and Provan, 2009). Klijn and Skelcher (2007) note that representations or manifestations of power are rarely at the forefront of analysis in institutional fields that are more strongly associated with collaborative, cooperative and coordinated action. They argue that where power is unequally distributed, dominant participants could use the collaboration to shape and deliver the policy in a way that reinforces their own interests and power base. Hardy and Phillips (1998) conceptualised that dominant figures would leverage formal authority – the right to make decisions; control over critical resources such as money, expertise or information; and discursive legitimacy, which is a participant's ability to act and speak based on the level of legitimacy that they hold outside the boundaries of the collaboration – as power within interorganisational relationships in order to further their own interests. Rodríguez et al., (2007) who explicitly explored power in their study of mandated collaboration in the health sector noted that the absence of presence of power is closely linked to the appropriate or inappropriate governance mechanisms that have characterised the collaboration to coordinate social action. Their study showed that excessive focus on network governance as the only possible mode does not allow for power as formal authority to make decisions, set rules and gain the compliance of those participants who do not share the view that a mandated collaboration is needed. They also found that where there is too much reliance on a network as a single mode of governing which erodes the levels or hierarchy needed, participants resort to symbolic power, or impression management as a way of influencing other participants into a consensus with decisions that have only implied legitimacy. This form of power is conceptualised by impression management theories as the use of power by participants and organisations to protect their organisational legitimacy by managing how actions will be perceived by other participants in the collaboration (Elsbach, 1994).

Challenges in the initial stages of the mandated collaboration relate not only to inappropriate forms of governance, lack of opportunities for legitimacy and efficiencies and unequal power bases. Popp and Casebeer (2015) proposed that there are four essential elements of interorganisational formation that can be affected when collaborations are mandated and are often the reason they fail (Blakely and Dolon, 1991; Neil Perkins *et al.*, 2010): funding of the collaboration, membership, mode of governance and the timing of actions. This last element is further conceptualised by Ring and Van de Ven (1994) as the negotiation stage where initial agreements and rules are set; the commitment stage where the structure is crystalized, modes of governance are applied and the foundations of legitimacy are established; and the execution stage where the interorganisational action takes place.

When this conceptualisation was applied to the formation stages of mandated health networks by Segato and Raab (2019), they found that the absence of an appropriate mix of governance modes to allow sufficient formal authority at the negotiation stage can be managed by a mandate that is very specific as to not only who and what should be mandated but how this should be effected.

2.2.9 Benefits of Mandated Collaboration

The above discussion paints a rather cynical view of mandated collaborative interorganisational relations, fraught with challenges and tensions, which constrain collaborative action rather than facilitate it but there were, however, a smaller number of studies that alluded to some of the benefits that mandated collaboration could bring. The rest of this section discusses the benefits or the more positive outcomes that participants identified as a result of collaborating under conditions of mandate. Although this section on the benefits of collaboration may seem rather sparse, there are two reasons for this: firstly, the size of the literature on mandated collaborative interorganisational relations within the health, social care and public health literature, and secondly, the research perspective of the authors studying the topic – the research aims of most mandated studies are concerned with the challenges, tensions and governance of mandated collaboration, which can miss the benefits that this kind of collaboration could bring.

Local autonomy becomes an important concept when considering the benefits that can be gained as a result of participating in a mandated interorganisational relationship (Siddiki *et al.*, 2015; Hafer, 2018). Hafer (2018) argues that, where collaboration is mandated for the provision and organisation of public services with sufficient levels of local autonomy over the form, governance, structure, goal and process of the collaboration, there is potential for a powerful and successful interorganisational relationship. In a health, social care and public health context, sufficient levels of autonomy in mandated collaborative instances are usually seen when there is an underlying mandate to collaborate to receive government funding. In this way, an element of the collaboration remains emergent as participants are not required to participate and could attempt to secure funding through other mechanisms (Hafer, 2018). Provan and Lemaire's (2012) explanation of the use of underlying mandates in this way adds a further dimension to the definition of mandated collaboration as offered in this study as a concept most commonly described as 'when bureaucratic or hierarchical mechanisms are used by a third party to bring separate organisations together to pursue complex objectives'. In their conceptual review, government pursues the incentivising of emergent collaboration through the use of underlying mandates, which suggests that our definition of mandates should be widened to take account of the voluntary and emergent aspects that exist within this concept.

Studies identified through the search strategy of this scoping review, in particular, those studies that reported significant benefits, were consistent with the views above, that is, those instances of mandated collaboration that offer sufficient levels of local autonomy in which collaboration between voluntary participants can still emerge, enjoy the level of benefits that is worth the effort and costs of participation. Pettigrew et al. (2019) argue that there is a careful balance to be struck between the level of influence the mandate has over the collaboration and the level of autonomy or flexibility participants have at the local level within the collaboration if this level of emergence, or grass roots innovation as they term it, is not to be stifled.

The literature does suggest that, although mandated collaboration can offer some benefits, this appears to be the case when the level to which the mandate influences the collaboration form, structure, governance and goals is low, such as a mandate that stipulates evidence of collaboration with other services to ensure continued government funding. Ivery (2008) study of mandated collaboration for the provision of services for the homeless fits this definition of mandated collaboration, within which there is space for emergent collaboration and local autonomy. In her study of public services, specifically homelessness in the USA, participants experienced more benefits than they did drawbacks. These benefits were described as the enhanced ability to address an important organisational issue, the acquisition of new knowledge and skills, a heightened sense of legitimacy, a more effective and increased use of their own organisation's resources, an awareness of who was in their community and the development of valuable relationships, which were all reported by participants as being among benefits experienced as a result of participating in a mandated collaboration with sufficient levels of collaborative emergence and autonomy. The drawbacks of participating in the mandated collaboration were the diversion from their own organisation's obligations, and the frustrations and tensions that developed as a result of the participation. Ivery (2008) argued that these results hinged on the levels of participation and commitment in the planning stage of the mandated collaboration as, when these levels were high in this stage, the benefits of participating exceeded the drawbacks.

Social legitimacy is seen as both a benefit to collaborators and an incentive to collaborate, and can be defined as the publicly recognised congruence between the values of the health, social care or public health organisation and the values of the larger social system in which it operates (Pfeffer and Nowak, 1976). Social legitimacy theory argues that care organisations exist in a constant state of dependency upon their environments and will only survive if they can convince others in their environment or larger social system that their actions are rightful and proper (Pfeffer and Nowak, 1976; Hearit, 1995). If they are successful in such convincing, organisations can attract the resources necessary for their own survival and goal achievement. The studies included in this scoping review suggest that, whether the collaboration is highly mandated or flexible in its level of local autonomy, social legitimacy can offer a range of benefits. When the collaboration is highly mandated in order to overrule a lack of willingness to collaborate voluntarily, the perceived benefit of enhanced social legitimacy can act as a motivator to genuine action. Grafton, Abernethy and Lillis (2011) define this as 'social fitness' and found that, where a collaboration has been mandated, social fitness or enhanced social legitimacy can be a key driver in participants engaging with the task. For those organisations where levels of resource and authority are not an issue, a willingness to collaborate ensures congruence with the values of the larger social system. For those organisations where resources and level of authority are an issue, enhanced social legitimacy gives access to and attracts the resources that enhance their own organisation and services.

2.2.10 Section 1 - Summary

Policy makers continue to position mandating collaboration for the organisation and provision of health, social care and public health as the solution to the constraints and demands of an under-resourced and overburdened health care system. However, although there are many calls for this type of collaboration, there is a lack of clarity around how participants should interact with each other, the challenges that can exist as a result of mandate, and how these might be managed for more fruitful interactions. This chapter has identified the different ways in which mandated collaboration has been understood so far in the literature, which has revealed certain theoretical, conceptual and empirical perspectives which have influenced and shaped what is known so far. No unified theory has been developed or applied to offer an explanation of the interactions that occur when participants collaborate under conditions of mandate. To date, different theoretical approaches have advanced our understanding by illuminating aspects of mandated collaboration, such as agents as part of a wider complex adaptive system that is not conducive to top-down mandated approaches, and the encouragement of managing strategies such as facilitative leadership to avoid the ‘straightjacket’ of mandate. Through exchange theory we know that mandating collaboration is not enough to guarantee authentic participation; there must be a reward and exchange, whether social or of resources, to give the collaboration a chance at success. By applying institutional theory, we know that mandating participants to collaborate where they might otherwise not could potentially lead to the collaboration becoming an iron cage and, if there is no value of legitimacy, individual organisations will not respond to the pressure to collaborate authentically under conditions of mandate.

Conceptually, mandated collaborations in health, social care and public health are conceptualised as networks or partnerships in an organisational form that rely on a mix of governance modes to self-govern within the top-down approach of mandate. The literature highlights that understandable tensions exist as a direct consequence of mandating social action at the level of collaboration, which suggest a willingness to interact. However, the literature also suggests a conceptual gap regarding the governance of mandated collaborations which lack conceptual fit with the definitions of network and partnership modes by which they have previously been defined.

Empirically, there is a dearth of literature on mandated collaboration in comparison to the practical instances of mandated collaboration through which practitioners of health, social care and public health must organise and provide care. Where studies exist, there is still a tendency within the literature to assume that participants collaborate on a voluntary basis, which often ignores the nuances that exist between voluntary forms and mandated forms of collaboration. This could explain why there is so little literature exploring the dynamics of mandated collaboration in comparison with the number of case studies on mandated collaboration within the literature (McNamara, 2012; 2016). In addition to the governance issues alluded to above, there is strong evidence to suggest that, when the act of mandate removes or constrains the opportunity for participants to engage in the negotiation stage and to agree collaborative norms, a breeding ground for tensions is created that can continue to grow if left unchecked. This can often result in a jostle for positions of authority, usually won by those organisations with the strongest power base, and inappropriate modes of governance which allow these issues to go unchecked.

With regard to the focus of this study, the review of the literature on mandated collaboration in health and social care reveals a partial picture and no theoretical explanation of the interactions that occur when participants collaborate under conditions of mandate or how these interactions are managed. The next section of this chapter will extend this scope and review the literature on the micro-interactions that occur between professional and lay people in mandated and non-mandated collaborative health and social care decision-making contexts to see if this offers any further theoretical, conceptual and empirical perspectives through which the research on mandated collaboration can be understood.

2.3 Section 2 - The Micro-Interactions Between Professionals and Lay People

2.3.1 Introduction

Following the election of the first New Labour Government in 1997 the pace of policy action to secure greater public involvement by citizen, patient or community inclusion or representation increased alongside significant reforms to the health care system to creating new structures that allowed for this participation (Barnes and Coelho, 2009). The Health and Social Care Act 2005 established NHS Foundation Trusts (NHS FTs) as a new type of care provider tailored to local needs which required public representation in its running and oversight. In 2005 Changes to health care commissioning at the local level with the establishment of Primary Care Trusts (abolished by the Health and Social Care Act 2012), Health Action Zones, Commission for Patient and Public Involvement in Health, which were also later abolished and replaced in 2007 by the Local Government and Public Involvement Act by Local Involvement Networks (LINks). Although initiatives to create greater levels of public participation in health planning and service delivery were common place at this time, LINks introduced a statutory duty to include the views of the public to enhance service delivery and accountability rather than be involved in the development of health policy however this level of involvement shifted to greater levels of local and democratic representation in the way services should be shaped and delivered with the statutory creation of Health and Wellbeing Boards which mandated democratic representation to not only represent the views of the public in the way services were responsive to local population needs but to also drive locally driven changes to working relationships, foster collaborative interactions and develop trust (Coultas, Kieslich and Littlejohns, 2019).

2.3.2 The Purpose of Involvement

Government initiatives of partnership forms of working in health and social care have all stressed that the intersection of lay and professional interactions around involvement, representation expertise and knowledge and fundamental to achieving success, but how to achieve the balance of this intersection in partnership forms of working has been perpetually alluring and persistently challenging (Morgan, 2002). The involvement of lay people or the public as citizens and clients in the organisation and provision of care is very much common to most developed developing countries, economically and politically (Martin, 2008). In the English health care system there has been a significant shift from the top down approaches of centralised control and decision-making which have relied on the input of the elite few to more participative forms of local democratic decision-making through increased levels of public involvement and citizen accountability (Hudson, 2018). This shift towards localism has been helped along the way by various initiative and attempts since the New Labour Government of 1997 and more recently with the creation of Health and Wellbeing Boards and the Health and Social Care Act 2012 (DoH, 2012) and Sustainability and Transformation Partnerships which emerged from the ‘Five Year Forward View’ (FYFV) published by NHS England (2014), all of which set out visions as to the way healthcare services need to change to adapt to the needs of local populations in a way that is more efficient and resourceful in meeting the increased demand (Hudson, 2018).

This evolution of public participation in the organisation and provision of care draws on different underlying motivations such as the desire to evidence the democratic ideals of legitimacy and transparency, an attempt to secure public favour in view of unpopular decisions or the need for an overburdened health system to provide solutions to increasingly complex health and social care issues with diminishing financial resources (Abelson *et al.*, 2003; Barratt *et al.*, 2015). One motivation is the belief that further and more effective levels of public participation might become a substitute for social capital through a range of professionals and lay people participating in forms of shared decision-making, providing the necessary capabilities to shift from the rise of individualism in the 1980s towards more collective and co-produced interactions between the government and the people in health and social care matters (Abelson *et al.*, 2003). This call for more participatory approaches to the organisation and provision of health care with the inclusion of lay people emphasizes a two way interaction rather than one party being the passive recipient of information (Allen *et al.*, 2012; Barratt *et al.*, 2015; Barker *et al.*, 2020) is also suggestive of a partnership entity with a network mode of collaborative decision-making governance discussed earlier in this chapter where interactions are both vertical and horizontal and there is a sharing of resources, as well as information and expertise, takes place towards a collective goal.

Martin (2008) notes that lay or public participation in the organising and provision of health care was as a result of the Labour governments of 1997 to 2010 in their attempts to evidence democratic legitimacy at the local level of decision-making and through the modernisation of the welfare state, again with the aim of recognising public pressure for services organised with the need of the communities at the centre of prioritising through collective and collaborative processes, rather than an offering as a result of cost efficiencies achieved through market forms, less formal and egalitarian ways and interactions that are based on cooperation and trust (Abelson *et al.*, 2003; Ranade and Hudson, 2004; Martin, 2008; Murphy, 2013). Further reforms of the Health Service by the coalition government and Health and Social Care Act 2012, which moved towards competency and performance based models of accountability and a new form of enforceable rather than reciprocal trust or ‘new professionalism’ (Speed and Gabe, 2013).

However, these efforts have not always produced the democratic outcomes of citizen engagement hoped for by the wider public and often the inclusion of lay people as active citizens in the decision-making process. Although national policies advocate for the involvement of lay people in healthcare, rationales for this are multiple and often seen as tokenistic with too many efforts still suggestive of definition offered by Hogg and Williamson (2001), bowing to the dominant interest of professionals, rather than the supporters of challenging and repressed interests, in which lay people enter a two way interactive decision-making process supported by other' professional backgrounds and with an acute sense of social justice often from an elected position where they can hope to influence the outcomes with value added rather than tokenistic interactions with professionals in the decision-making process (Speed and Gabe, 2013).

2.3.3 Conceptualisations of Lay People

Although lay member involvement and participation is a strategy in global, national and local healthcare settings, evidence would suggest that it is still seen as peripheral in the decision-making process (Croft, Currie and Staniszewska, 2016). Despite the benefits that the micro-interactions between lay members and professionals can bring to health care organisation and provision and there is strong policy support, this halted due to a lack of understanding and reluctance to accept that lay member participation could contribute appropriately to and influence strategic decisions (Mockford *et al.*, 2012; Baggott, 2013; Croft, Currie and Staniszewska, 2016).

Increasingly, lay people are appointed to health service committees such as Health and Wellbeing Boards (Health and Social Care Act, 2012) however the literature argues that the term 'lay; is used loosely and reasons for their involvement in more deliberate and democratic forms of decision-making in the organising and provision of care and seldom clearly defined (Hogg and Williamson, 2001; Mockford *et al.*, 2012). However, clarifying the ways in which they are conceptualised and explicitly defining the roles that they play, or their participation, can help to realise the contributions that they make to forms of decision-making in health and social care contexts. Since the quickening the pace of public involvement by the New Labour Government and subsequent governments in 1997 there has been a surge in the terms such as such as ‘lay knowledge’, ‘lay expertise’ and even ‘lay epidemiology’ in academic writings (Prior, 2003; Martin, 2008). Similarly (Djellouli *et al.*, 2019) concluded in their review study that a plethora of terms are used when referring to lay or public members and their involvement in these processes lacks clarity and remains poorly defined. Yet, it is still difficult to grasp the extent to which lay people are actively involved and interact with professionals in the democratic decision-making process, they ways in which this is understood and how this is operationalised in practise. As noted by other researchers attempting this task, a plethora of terms are used to refer to lay people in the context of public participation in health can social care decision-making such as: lay people, patients, service users, citizens, public, communities or consumers and elected officials (Djellouli *et al.*, 2019). When reviewing the literature on lay people and the role that they play in local health committees and their micro-interactions with professionals, it is important to understand the ways in which other researchers have positioned ‘lay people’ and identify who is being conceptualised as ‘lay’. Forbat, Hubbard and Kearney (2009) suggest that a reason for this ‘conceptual muddle’ is the ways in which involvement is articulated and understood as participation involves different categories of lay people who will serve different involvement functions across different issues.

Although the term is used loosely and seldom clearly defined however a useful definition is given by Hogg and Williamson (2001) suggesting that lay people in a health care context fall into the three broad categories of: supporters of professional or dominant interests, supporters of challenging and supporters of repressed interests depending of their level of knowledge, professional background and level of their own experience of health care provision. The Collins dictionary defines a ‘lay’ person as ‘non-professional or non-specialist or amateur’. This suggests then that lay people are without that part that constructs a ‘professionals’ identity such as the education, training, qualifications or socialisation into particular professionals such as practitioners or managers in a health and social care context. However as Hogg and Williamson (2001) note, current definitions fail to recognise the transferrable skills and experiences that lay people can bring to their interactions with professionals from their own non-lay backgrounds such as managerial, finance, organisational, educations, and qualifications. There have been many discussions on this point such as the move from viewing a lay persons knowledge and expertise as ‘lay’ to recognising that this there are times when this could actually be defined as technocratic input (Milewa, 2004; Martin, 2008).

From this definition, professionals will construct their beliefs, attitudes, feeling and values systems towards health and social care decision making from their institutional socialisation while lay people will constructs their beliefs towards health and social care decision making from lay knowledge such as their own experience of the health and social care systems and interacting with the views, experiences and perceptions of the wider public who are also users of the same system. Therefore, lay people can be patients, caregivers, service users or those who are most likely to be elected or appointed to positions in which they will advocate for the interests of those who have elected them. Clarifying definition key concepts such as this enables the development of a comprehensive literature search strategy to ensure as much as possible the inclusion of key literature on micro-interactions between professionals and lay people occurring in the collaborative decision-making for local health and social care provision.

2.3.4 Conceptualisations of Lay Peoples Involvement

The literature also revealed ambiguity as to how the role of involvement in understood and interpreted by the relevant lay actors that interact with professionals in a health and social care context. As Beresford and Croft (1990, p.5) participation of public and lay involvement is one that “tends to be long on rhetoric and short on information.”. In a similar review into lay involvement in large scale changes in health, Djellouli *et al.*, (2019) noted that only two publication provided a definition of the terms that are used. Abelson *et al.*, (2003) refers to involvement as participation as the “actions taken with the objective of influencing a decision-making process” and (Rutter *et al.*, 2004) focusing on the term ‘consultation’ and defining this as “a model in which professionals retain control of both the process and outcomes of user involvement”. In a further similar review, Mockford *et al.*, (2012) noted that terms to define involvement are referred to variously as ‘patient and public involvement’, ‘user involvement’, ‘service user involvement’ or ‘lay involvement’ which adds to the ambiguity when ‘lay’ as a starting concept has been shown to lack clarity. Ocloo and Matthews (2016) offered a definition of lay involvement based on the values and purpose of that involvement process such as *“*consultation, engagement, participation, partnership or co-production” but took these definitions further, suggesting the terms can be used to imply the level of lay involvement and a lay persons influence or power level in the decision-making process. However, they also offered some clarity in finding synthesis in these definitions, defining involvement as an activity that is done “with or by” lay people rather than “to them, about them, or for them”. Using this definition would suggest a user involvement at the partnership and collaborative level however as the literature will reveal below, further levels of involvement does not necessarily reduce power imbalances. Boydell and Rugkåsa (2007) extended this definition of lay person involvement in a broader sense as a “growing commitment to public governance’ which fits with the more deliberate, participative and collaborative forms of involvement in which the micro-interactions between professionals and lay people are explored in this research study.

Other authors have sought to define and explain lay person involvement through the use of one of the most commonly used models, Sherry Arnstein’s Ladder of Citizen Participation (Arnstein, 1969). Arnstein used a simple analogy to illustrate the level of involvement that citizens or lay people will have in processes such as decision-making processes for health and social care resources which has consequences as to the extent of the micro-interactions that then take place between lay people and professionals. For Arnstein, participation was really about control and power or having enough of it to make professionals responsive to the local needs that lay people views represent. Just as and Litva *et al.*, (2009) and Ocloo and Matthews (2016) suggest participants are classified as to their level of involvement rather than just ‘being involved’ ranging from non-participation such as education of the public to participation where there is opportunity to influence the process. However, Arnstein defines this level of involvement or interactions are classified or divided as the level of power that is redistributed (Arnstein, 1969; Lonbay, 2015). That is at the bottom of the ladder power in non-participation power is rarely redistributed and held onto by professionals. At the level of involvement such consultation, there is a shifting of power but only the extent that the redistribution is tokenistic. At the top end of the ladder, Arnstein (1969), argues lay or public involvement that is defined as citizen control, delegated power or partnership will now have varying degrees of power. However many empirical studies have argued that even partnership levels of involvement can be a façade where the redistribution of power remains at the tokenistic level (Allen *et al.*, 2012; Kitson *et al.*, 2016; Hudson, 2018; Green, Boaz and Stuttaford, 2020; Perkins *et al.*, 2020).

Other approaches have defined level of lay and public interactions and the extent to which they are characterised by power through the use of consumerist and democratic approaches (Baker *et al.*, 1997 in Crawford, Rutter and Sarah Thelwall, 2003). The consumerist approach views patients as consumers who should be able to consume the health product or service that they want by seeking to include their voice in the decisions made by others. This is a low level of involvement and distribution of power where action is more ‘done too’. Democratic approaches were seen as a way to increase accountability on those who were responsible for organising providing health. Abelson *et al.*, (2003) defines the democratic approach to levels of citizen involvement as emerging in part from the neo-liberal consumerist and customer centered trend of public sector management philosophy of the

1980s and 1990s based on reciprocal and two-way interactions of collection participation – much the same as the partnership and network modes of collaborative governance discussed in first section of this chapter. The key criticism of these models is that power is defined based on the level of involvement in the decision-making process which can often mask what the level of involvement really is, such as the studies alluded to above where lay member involvement has been initiated at the partnership level but the extent of the interactions reveals a consultation and tokenistic level. Hence, they label power differences, but they are limited in their capacity to manage the inequalities that they reveal. These approaches to power are based on the first of Lukes (1974) three dimensions of power. In this first dimension where power is visibly held by one controlling power over another, often facilitated by the dominated forms or structures to which individuals are attached to which refers to the conceptualisation of power by Robert Dahl in *The Concept of Power* (Dahl, 1957). The second dimension of the model refers to those attempts at hidden forms of power, only accessible to certain actor's (usually dominant) and operates behind the scenes such as recruitment of members and selection of agenda items appear with the ulterior motive of making sure dominant interests remain un-threatened. However, at this level these actions can be carried out elsewhere in an attempt to keep them secret but excluded members can still be aware of these actions. Lukes' third dimension refers to power a more hidden psychological level of power, defined as invisible, where the actions and issues are removed by the powerful so far out of the sight of some actors, that they remain invisible, so much so that they influence the epistemological positions of the powerless (Lukes, 1974; Dowding, 2006; Gaventa, 2006). What is common with these scholars of power and others such as Bachrach and Baratz (1962) and Wartenberg (1990) is to reveal power and its constraints on human freedom and conceptualise power as an "instrument that powerful agents use to alter the independent and/or authentic action of the powerless" (Hayward, 1998 p. 9). In this way, Hayward offers a further and interesting concept of power. She proposes to reconceptualise power's mechanisms, "not as instruments powerful agents use to prevent the powerless from acting independently or authentically, but as social boundaries (such as laws, rules, norms, institutional arrangements, and social identities and exclusions) that constrain and enable action for all actors" (Hayward, 2000, p.12). In this sense Hayward is suggesting that power is best conceived as boundaries that define fields of action for all social actors, regardless as to whether they were previously conceptualised as the powerful and the powerless. Rather she is suggesting that even the powerful are just as constrained as the powerless but in different ways and by a different set of social boundaries. Hayward suggests that rather than view power as something A has over B, power should be conceived as mechanisms that consist in, "for example, laws, rules, symbols, norms, customs, social identities, and standards, which constrain and enable inter- and intersubjective action" (Hayward, 2000, p.30). As such, all actors are situated within relations of power. A useful illustration is provided by Hayward in her book De-Facing Power in which she examines the pedagogic practices of a high school in America in an area of concentrated urban poverty and problems of crime, poor health and incarceration where the student population is predominantly black. In this case, key power mechanisms include the racial identities of the school children which constrain the social action of these children in the classroom however this as a mechanism is not something that a powerful teacher of that classroom 'has' 'uses' or directs' (Hayward, 2000, p.97). This offers a further view of power that can help to illuminate and interpretate the interactions that take place between professionals and lay people in health and social care decision-making as although there is a plethora of research that explores the power aspect of these interactions as something A holds over B, there is very little empirical research that has explored the underlying aspects of conflict as a mechanism of power that constrains or enables the interactions that occur under conditions of mandate in a health, social care and public health context (Hayward, 2000).

2.3.5 The Intersections of the Micro Interactions Between Professionals and Lay People

Lay people involvement in the form of collaborative and partnership working is suggestive of what Dryzek (2002) terms democratic deliberation, arguing that democracy itself is now widely taken to be deliberation and is concerned with a more authentic democracy that us substantive of action rather than symbolic. This would seem very much in keeping with the philosophy of public partnership working, engagement and participation (Health, 2000; Act, 2001; Britain, 2001; Parliament, 2003, 2012). Participate decision-making and problem solving that involves a particular sort of discussion involving the carful seriousness and weighing of discussions to take courses of action by individuals with a rage of backgrounds, expertise, knowledge and experiences is the critical element of deliberation (Habermas, 1984; Schudson, 1997; McLeod *et al.*, 1999; Abelson *et al.*, 2003). Although deliberation is defined as a social process in which participants induce reflections to alter views on the organising and provision of health, the assumption that this would necessarily exclude the power inequalities that lie at the intersections of professionals and lay people, or rationalise professional dominance by their lay presence is both supported and challenged by the literature (Abelson *et al.*, 2003; Palmen, 2007; Stewart *et al.*, 2016; Coultas, Kieslich and Littlejohns, 2019).

A central tenant to this challenge is the intersection of professional and lay knowledge and expertise and would suggest that even where there is the inclusion of an informed public, the vast majority of lay participants will defer to the experts or professionals, perceiving a power imbalance in their own level of knowledge or expertise to make those decisions. This can be exacerbated if there are power imbalances that information dissemination to be controlled by some and if the forum in which the information discussion for decision-making takes place is too reminiscent of the hierarchical, central controlled institutional structures from which the deliberative social process is seeking to shift away from. Hudson (2018) cites a very recent example of this in the current NHS Sustainability and Transformation Partnerships in which he noted that the partnership plans were found to consistent of a mixture of jargon and technical language with very few concessions for lay members and those who are unfamiliar with these ways of working. Hodge (2005) discussed this as discursive inequality, highlighting that the language or technical jargon used in the interactions between professionals and lay people serves to reinforced unequal power relations and inhibits future interactions that take place. The power of professionals to limit the extent of lay member involvement and contribution in this way highlights a further intersection in the knowledge, qualifications, and experience between professionals and lay members. Since the increased involvement of lay people in health and social care decision making there has also been much debate regarding what constitutes as lay expertise, experiential expertise, experiential knowledge and lay knowledge (Shaw, 2002; Prior, 2003; Martin, 2008; Weiner, 2009; Thompson *et al.*, 2012).

One of the ways the literature suggests the intersection of knowledge, expertise, qualifications and experience and power in these micro-interactions can be understood is through Kerckhoff's (2001) illustration of social stratification as a condition as opposed to a process. As a condition, social stratification refers to the fact that members of a given population will have differing characteristics that differentiates them into different levels or strata. As a process, this refers to the ways in which those members have been differentiated into those positions (Kerckhoff, 2001; Green, Boaz and Stuttaford, 2020). Kerckhoff’s (2001) illustration of social stratification as a condition allows for a useful illustration of the power imbalances in the micro-interactions between professional and lay people as to the differences in lay member knowledge, expertise, qualifications and experience.

In areas of health decision-making, information, knowledge and expertise resulting from being socialised in to a professional identity certainly holds a place in these decision-making processes however it is also suggestive of the tensions between what Martin (2008) describes as the tension between technocratic and democratic or lay expertise. This tension or hierarchy would suggest that all lay knowledge lacks the necessary knowledge, expertise and experience that would add value to the decision-making process and therefore the legitimacy that technical and scientific knowledge usually attributed to professional members brings (Collins and Evans, 2002). However lay members are known to have crossed the boundary spanning position of technocracy, providing an important source of technocratic input into decisions around the organising and provision of care. Rather than make a blanket assumption that those who have not been socially institutionalised into their professional identity lack the knowledge and expertise to contribute to resource allocation decisions Collins and Evans (2002) suggest that a distinction should rather be made between those possessing the relevant knowledge, expertise and experience, as opposed to distinguishing between professional and lay. This then suggests a new way for lay member involvement, one which is premised on the representation of technocratic rationales or expertise, rather than democratic rationales or democracy (Martin, 2008). Although this might suggest that technocratic rationales as opposed to democratic rationales for representation might go some way to reducing the inequalities in power that exist at the intersection of knowledge, expertise and experiences. Prior (2003) and Martin (2008) and Martin warn that further tension will arise as purely scientific and socially constructed experiences will invariably compete in their contribution to health matters.

Barratt (2015) and colleagues found this to be the case in their study of consultation methods for major changes in health services revealing that methods to involve and engage lay and public members assumed they were merely passive receivers of information, the professionals being the technical experts. They found that ensuring that lay and public members held insufficient and incorrect information about issues presented a form of control but also led to exaggerated fears which presented itself in forms of aggressive and unhelpful challenge. Similarly, Daniels *et al.*, (2018) in their study in lay member and public involvement in decision-making around the disinvestment of health services found that lay members could be intentionally mis-informed about the decisions to be made actions to correct this will fall short if technical and scientific knowledge is still regarded at pre-eminent.

However this particular intersection of knowledge, expertise and information causes a further tension as to the role of participating lay members and what exactly is required of them. O'Shea, Chambers and Boaz (2017) note that lay members are required to be ordinary, representative and understanding to local needs and wants. On the other hand, they are expected to have a good base of technical and health knowledge with the interpersonal skills to influence these understandings on the decision-making process.

The intersection of these concepts allows for a hierarchy in power that enables professional members to control the legitimacy, accountability and credibility of the decision-making process through mechanisms such as agenda setting, institutionalised comfort and recruitment. In the context of partnership working, hierarchies are suggestive of top-down control, where decision-making is held at the individual level which is contradictory of the collectivist aims of two-way interactive and deliberate forms of decision-making.

Intersections of power or power imbalances are noted in the interactions of professional and lay people in several ways such as agenda setting. Control over pre-determining agenda items is seen as way of limiting lay contributions to peripheral issues rather than the strategic decisions affecting the organising and provision of care (Croft, Currie and Staniszewska, 2016) which is contrary to fair and transparent participation which includes participation in agenda setting (Potts and Hunt, 2008). Most notably in the empirical literature of professional and lay people interactions, agenda control as a mechanism of power by allocating a small time slot at the end of agenda items in which lay people can ask questions or express views, which no consideration being given as to the seriousness of the agenda item and the time that might be needed for the lay response this item could provoke.

In their study of lay member involvement of CCG meetings O'Shea, Boaz and Chambers (2019) found that lay members perceived agenda control as a way of limiting the influence or impact they had on CCG decision-making and bringing items into the public domain that only served the interests of the more powerful actors. Croft (2016) and colleagues similarly noted in their study of lay member involvement in CCG meetings that agenda control was seen as 'window dressing', allowing lay members to only have an opinion on topics they were allowed to. In both of these studies lay members were left feeling undervalued and underutilised, wondering what their contribution was which is symptomatic of the power inequalities that can exist in the micro-interactions of professional and lay people. (Clark, 2010) offers an explanation for this professional behaviour suggesting that dominant macro structures can promote dominant behaviours in those individuals who are attached to them, structures which afford them the knowledge and power (Foucault, 1980) to control agendas as a way of protecting their own dominant interests. Although there were isolated instances of empirical studies describing lay people as having adversarial power, in that their presence within the participative processes is more suggestive of holding to account and challenging the actions of others rather than holding power over others to make them take certain actions. This evidence also suggested that where participation is at the level of partnership working and collaboration the institutionalised scripts that structure power asymmetries are enormously difficult to disrupt (Matthews and Papoulias, 2019) and are at odds with the emancipatory and changing goals through which the inclusion of lay interactions, expertise and knowledge is supposed to take place (Rose and Kalathil, 2019).

2.3.6 Section Summary

The review of this literature suggests that there are on-going tensions in the micro-interactions between professionals and lay people who collaborate for the purpose of decision-making in the organisation and provision of care. A key focus of much of this literature is on the power imbalance that exists at the intersection of knowledge, identities, expertise and education, conceptualised as the powerful holding power over the powerless to influence their interactions. However, there are a lack of studies that conceptualise this knowledge, identities, expertise and education intersection as mechanisms of power that constrain and enable action for all actors” (Hayward, 2000, p.12) which suggests that there is an opportunity to advance what is known regarding these interactions that take place in a health and social care decision making context.

Just as the review in the first section of this review on mandated forms of collaboration, policy makers continue to position lay member involvement in collaborative forms of health and social care decision-making even though there is scant evidence of its effective impact on decision-making outcomes and evidence would suggest that the interactions between professional and lay member remain at the level of tokenistic (Daniels *et al.*, 2018; Coultas, Kieslich and Littlejohns, 2019; Djellouli *et al.*, 2019). This would suggest that there is an intention by policy makers to call for more forms of mandated collaboration in which the interactions between professionals and lay people are at are the level of partnership working that extends beyond tokenistic measures and one where the knowledge, expertise and experience influences and shapes the resource allocation decisions that are made in the decision-making process. However, this literature also shows that there is a lack of clarity around the conceptualisations and involvement of lay members which has implications for the power imbalances at play within the decision-making process.

This section has also identified the different ways in which the interactions between professionals and lay people has been understood so far in the health and social care collaborative literature, which has revealed a need for theoretical, conceptual and empirical perspectives to advance what we currently know about this area of study. This further section also revealed no unified theory has been developed or applied to offer an explanation of the interactions that occur when participants collaborate under conditions of mandate. Conceptually, there are gaps in the conceptualisation of the term lay people and their involvement and engagement which leaves questions as to what the extent of their interactions should be. This suggest that there is still outstanding work to fully understand what lay person interactions with professionals in collaborative health and social care decision-making processes mean in practice. Further, although there were a number of studies included in this study on these interactional elements, studies were not fully dedicated to them and this study support the calls of (Coultas, Kieslich and Littlejohns, 2019; Djellouli *et al.*, 2019) that more empirical studies are needed in the relational dynamics that initiate and sustain lay member involvement in the collaborative process as at present the topic is limited and the most informative material is the grey literature which is difficult to scope and locate. Although this section reviewed studies regardless of their mandated nature, empirically, there is a dearth of literature on the micro-interactions that take place between lay members and professionals in mandated. Even if this mandated nature makes no real difference, more studies must be advance if this is to be ruled out.

2.4 Chapter Summary

As explained at the outset of this Chapter, the purpose of presenting a review of the literature on mandated collaboration in health and social care decision-making and the micro-interactions that take place between professionals and lay people was to reveal what is known theoretically, conceptually and empirically regarding the interactions that take place between individuals who are mandated to collaborate for the organising and provision of care in the health, social and public health sector, in order to understand what really happens. In presenting this review I have contextualised the study and provided an understanding of how aspects of this literature were used through the following analysis chapters to provide support and sensitivity to constructs as they arose in the analysis.

The review of the literature reveals a partial picture and no theoretical explanation of the interactions that occur when participants collaborate under conditions of mandate or how these interactions are managed, and this is the departure point for this study. Rather than attempting to build on the previous disjointed efforts to provide such an explanation, the theoretical framework for this study is not provided by or taken from the literature. Rather, this study attempts to fill the theoretical gap in the literature by the adoption of a constructivist approach to grounded theory, to construct a substantive theory that is grounded in the data. Having explored the various literatures that are relevant to this study, the next section details the methodology and methods used to identify the critical issue of conflict in the micro-interactions of professionals and lay people when collaborating under conditions of mandate in a local health and social care context.

Chapter 3: The Methodology

3.1 Introduction

This section discusses the research methodology and methods used to gain an understanding of the interactions that occur when people collaborate under conditions of mandate in a health, social care and public health context and the ways in which these interactions are managed. Corley and Gioia (2011, p. 235) write that theoretical contributions are generally seen as research findings that change, challenge or fundamentally advance our understanding of a phenomena. To explain and justify the choice of research methodology and methods of this study to present a contribution to theory, I begin with reflection on my own intrinsic ontological, epistemological and methodological beliefs and how these lead to the paradigm underpinning and directing the research design, research questions and the interpretations I bring to them (Charmaz, 2006; Denzin and Lincoln, 2008).

Sections 3.2 to 3.4 explore my ontological, epistemological and methodological beliefs to provide a reflective view on my personal research paradigm. Section 3.5 provides a discussion of the study methodology underpinning Constructivist Grounded Theory (Charmaz, 2006, 2009; Clarke and Charmaz, 2014), that is the specific version of Grounded Theory adopted in this study. Section 3.6 presents the data collection methods and the sampling strategy. Section 3.7 discusses the data analysis tools as well as discussing the constructivist grounded theory techniques being used to develop the substantive theory (Glaser and Strauss, 1967; Charmaz, 2006). Lastly, section 3.9 discusses the ethical issues that arose, and how they were acknowledged and managed within the study.

3.2 Theoretical & Research Paradigm

‘A theoretical paradigm is the identification of the underlying basis that is used to construct a scientific investigation' or 'a loose collection of logically held together assumptions, concepts, and propositions that orientates thinking and research' (Biklen and Bogdan, 1982, p. 30; Krauss, 2005). Likewise, 'paradigms are basic belief systems, based on ontological, epistemological and methodological assumptions' (Lincoln and Guba, 1985) or, more simply put by (Richards, 1981), 'The way in which people make sense of their surroundings; make sense of life and the universe' (p.4).

Paradigms are the basic set of beliefs and assumptions that underlie and define the holder's view of the world, their place in it and their relationship with that world and its constituent parts (Lincoln and Guba, 1985). In the context of enquiry, philosophical beliefs and assumptions or theoretical paradigms concerning the nature of reality and truth are crucial in understanding the position from which the research questions are formed, a study is designed and then carried out (Krauss, 2005). In short, our basic belief system, or our world view, becomes the paradigm that guides the study (Lincoln and Guba, 1985). Charmaz, (2012) states that, although it is crucial for a researcher to determine their philosophical position before commencing the enquiry, very few researchers grapple with their own starting and standing points and reflect the way in which positions in society, power, or lack of it, and prestige influence what we see and how we see it.

However, a researcher's conclusion as to their view of the nature of reality and truth is not arrived at instantly or after short deliberation, as we are influenced over time by the historical, cultural and social contexts in which we live, and each researcher brings their own particular way of knowing and seeing the world (Mills, Bonner and Francis, 2006; Schram, 2006). In turn, these contexts influence our belief as to the nature of reality (the ontological position) how we attain knowledge about that reality (the epistemological position) and the collection of strategies and methods we use to attain that knowledge (the methodology) (Trochim, 2000; Krauss, 2005). Mills, Bonner and Francis (2006) suggest that consciously subjecting our beliefs to an ontological interrogation illuminates the epistemological and methodological opportunities to which we might align. Given that a strong research design is one in which the research paradigm is congruent with the researcher's beliefs about the nature of truth and reality (Mills, Bonner and Francis, 2006) I will attempt to bring clarity regarding my own philosophical assumptions in the following section.

3.2.1 Philosophical Self-Reflection and Methodological Self-Consciousness

'*Researchers, who first identify their ontological and epistemological position, will be able to live out their beliefs in the process of inquiry'* (Mills, Bonner and Francis, 2006, p.32).

From the outset of the research study, if not before, the researcher is required to reflect on and acquaint themselves with their inner self and become aware of their basic belief system, reflecting on the nature of what they know and how they have come to know it, that is, their ontological, epistemological and methodological stances, through a process such as philosophical self-reflection (Mills, Bonner and Francis, 2006). In doing so, the researcher arrives at a contribution to knowledge that is imbued with a deeper foundation of certainty, through a confessional and self-critical examination of one's own beliefs and assumptions (Lynch, 2000; Carter and Little, 2007; Mruck and Mey, 2007). The next section offers insights into my ontological, epistemological and methodological positions.

3.2.2 Ontological Position

Ontology, as the philosophy of reality, deals with the nature and structure of reality (Krauss, 2005; Guarino, Oberle and Staab, 2009). In research, it relates to the researcher's belief as to the nature of reality and what can be known about it or what they believe to constitute social reality (Lincoln, Yvonna S and Guba, 1985; Blaikie, 2000). Mills, Bonner and Francis (2006) suggest that consciously subjecting our basic beliefs to ontological interrogation illuminates our epistemological and methodological positions whilst Paul and Marfo (2001) claimed that, without an analysis of this sort, researchers are 'likely to find themselves mired in simplistic conceptions and choices of methodological preferences, informed, at best, by the same tradition that has perpetuated the inquiry-as-technique mindset in quantitative research' (pp. 537–538).

Lincoln and Guba (1985) suggest a researcher can consider their belief system according to their responses to three fundamental questions, the first of which considers the ontological perspective:

> 1) The ontological question - What is the form of nature and reality and what can be known about it? Is one real external world assumed, if so, then only questions relating to real existence and real action will be admissible. (p.108)

My answer to this question refutes its assumption: simply put, I do not believe there is one external universal reality that is generalisable; instead, I believe there are multiple realities and perspectives experienced by the view holder, which are constructed by their own social interactions with structure, culture and people over time. In this stance, no single perspective is the only true view point (Lincoln and Guba, 1985). I view and adopt this position for myself as the author of this research, the research participants informing the research and anyone who reads this research. My own perspective of the concept of mandated collaboration is constructed from my interaction with voluntary collaboration, my limited personal experience of mandated collaboration (group work at university, family activities with my large family when I was younger), the lack of literature on mandated collaboration, and my perceptions as to why this might be different from voluntary forms of collaboration. As I believe there is no one true reality but multiple realities, I acknowledge that my own perspective of this concept is one of many, and the perspectives of those directly interacting in the mandated collaboration will be different (although potentially overlapping), likewise constructed by their own experiences and social interactions. Therefore, my ontological view of the nature of reality necessitates a study that allows for multiple views to exist and be developed into a substantive theory of mandated collaboration (Mcgrath, 2012).

3.2.3 Epistemological Position

Epistemology involves the philosophy of knowledge and relates to how we construct knowledge pertaining to our view of reality and the nature of that knowledge, by asking 'what is the relationship between the knower and what is known, what exactly counts as knowledge?' (Krauss, 2005, p.759). Donmoyer (2006) argues that epistemology trumps ontology if we have embraced an ontological perspective containing multiple realities rather than one true reality. Guba and Lincoln (1994) question pertaining to epistemology is as follows:

> 2) The epistemological question – 'What is the nature of the relationship between the researcher and what can be known?' (p.108)

Just as I reject the assumption of one external true reality, I also reject the assumption that knowledge is objective, discovered and verified through experiments of measure and direct observations. Instead, I believe that knowledge is constructed, or I arrive at the knowledge of what I know, through co-construction, the obtaining of other constructed multiple realities and constructing my interpretation of them (Mills, Bonner and Francis, 2006). Therefore, my epistemological view of how I come to know that which I believe to be real, necessitates a study that allows direct engagement with those who are experiencing and involved in the phenomenon (Mcgrath, 2012; Silverman, 2013).

3.2.4 Methodological Position

Methods are the nuts and bolts of research practice (Carter and Little, 2007). The methodological position of the researcher is built upon their ontological and epistemological perspectives and answers the questions 'How can we go about finding out that which we believe can be known?' or 'Which methods will best answer our research questions and in a way that stays true to our ontological and epistemological assumptions?' (Kaplan, 1964; Schwandt, 2001). This leads to the third question of Guba and Lincoln (1994):

> 3) The methodological question – 'How does the researcher go about finding out that which they believe can be known?' This will be dependent on the answers to questions 1 and 2. (p.108).

Broadly put, the aim of this research is to explore and understand human interactions, or the basic social process of interactions which I do not believe can be achieved through numbers or text converted to numbers for analysis (Ginsberg, 1940; Schwandt, 2001; Carter and Little, 2007). To study mandated collaboration in this way would support a research aim to generalise the research findings so that they might serve as a prediction for others, which would signify an ontological view of one true external and objective reality. I believe there are multiple realities, no single one of which is the only true one. I therefore believe that the aim and questions of this research study are best answered by exploring the multiple realities of those directly involved with the phenomenon as they occur in context. Context is important, as different instances of the same phenomenon with different people will yield different explanations, when multiple realities are believed to exist. Finally, I believe that knowledge is produced through the process of co-construction or, as Kaplan (1964) terms it, reconstructed logic. This takes place when I engage with participants to explore their versions of reality and by default re-interpret (analyse) this with my own reality of what I know and how to understand it (Charmaz, 2006). In this, I acknowledge that my own reality will bias how I understand the realities of others.

Adhering to Kaplan (1964) in that the methodological position is not about the methods themselves but the position, I argue that the methodological position of this study is one which allows for the exploration of multiple realities, without a predefined set of questions, and which will also allow for a variety of questions that can evolve throughout the process and that will be developed by the perspectives of participants and the tensions they highlight (Charmaz, 2006; Mcgrath, 2012).

3.2.5 Theoretical Paradigm

> A paradigm is broadly made up of the following four concepts; ethics (axiology), epistemology, ontology and methodology. When the researcher is able to identify their position relative to that concept, they can assert as much as possible their theoretical paradigm or the basic set of beliefs and assumptions that define their world view (Guba and Lincoln, 1994, p.108).

In the human and social sciences, the two basic paradigms are the positivist and the interpretivist paradigms. The positivist paradigm holds that the laws of the natural sciences should be replicated as much as possible when investigating the human and social sciences, ontologically assuming one external, objective and universal reality. Knowledge is sought by replicating the scientific testing of the natural sciences using quantitative methods (Finlay, 1998). The interpretivist paradigm holds that knowledge concerning the human and social sciences cannot be discovered by applying scientific testing when multiple realities exist. Instead, knowledge should be discovered through qualitative methods. Essentially this continuum can be explained as understanding the way things are (post-positivist) to challenging the status quo (transformative) (Mcgrath, 2012).

My theoretical paradigm or philosophical position as the researcher within this study is that ontologically I believe that there are multiple realities. Epistemologically, I believe that knowledge is constructed through the process of co-construction, through the active engagement between researcher and participant (not restricted to observation) and as such is value laden. Methodologically, I believe the knowledge pertaining to multiple realities is arrived at by exploring the multiple realities and perceptions of those who are experiencing the phenomenon, gaining their qualitative insights through questioning to develop theory that is local and contextual in nature. As the aim of this research is to develop a local theory in order to understand the interactions that occur when people collaborate under conditions of mandate in a heath, social care and public health context and the ways in which they are managed at the local level, I define my theoretical paradigm as being on the social constructivism point of the continuum, as someone who advocates for the existence of multiple realities and the co-construction of knowledge in research (Charmaz, 2006; Mcgrath, 2012).

3.3 Research Approach

Having reflected on my ontological, epistemological and methodological positions, I have adopted a theoretical paradigm of social constructivism, which asserts that there are multiple realities and the viewer is part of that which is being viewed (Charmaz, 2012). The research aim of the study is to develop an understanding of the interactions that occur when people collaborate under conditions of mandate in a heath, social care and public health context that leaves room for multiple voices, perspectives and realities. Therefore, the research questions that underpin this approach are as follows:

- Research Question 1 - What are the interactions that occur between these members when collaborating under conditions of mandate, in a health, social care and public health context?
- Research Question 2 - In which ways do members who collaborate under conditions of mandate manage these interactions, in a health, social care and public health context?

As the aim of this research is to develop a local substantive theory of the interactions that occur under conditions of mandate and the way they are managed in a health, social care and public health context through the exploration of multiple realities, with the acknowledgement that knowledge is co-constructed by the researcher and participants, the approach to research in this study is the social constructivist approach to grounding theory within the data.

Grounded Theory has taken several forms since its conception in 1967, which cross the theoretical perspectives of positivism (Glaser and Strauss, 1967), symbolic interactionism and pragmatism (Strauss and Corbin, 1990), and constructivism (Charmaz, 2000, 2006, 2012). The next section gives a review and a critique of the versions with a rationale for the version adopted for this research study.

3.4 The Paradigms of Grounded Theory Methodologies

3.4.1 Symbolic Interactionism

The intellectual roots of Grounded Theory are founded in the Chicago School of Sociology and the development of Symbolic Interactionism in the period from the 1920s to the 1950s. It was originally born out of the perspective of symbolic interactionism to examine social interactions and is both a theory and an approach to human behaviour. Its aim was to develop an explanatory theory of the meanings and perspectives of social phenomena, and specifically the social processes of human interactions in the historical and social context in which they occur (Glaser, Strauss and Strutzel, 1968; Kendall, 1999; Cutcliffe, 2000). It developed out of a reaction against the grand functional theories and meta-narratives of modern theory (Merton and Merton, 1968; Parsons, 1968) which dominated sociological thought from the end of the nineteenth century through the early to mid-twentieth century (Lyotard, 1984; Kendall, 1999). Functionalist theories conceptualise social action by structure and function, and see the human as part of a greater whole, unable to evolve unless functioning as part of that greater whole and contributing to a greater social system of stability and equilibrium (Swan and Bowers, 1998).

Its key influences can be traced back to Weber and the philosophical school of American

Pragmatism (Barley, 1989), who recognised the need for a methodology capable of *interpretative re-creating* of human experience, coining the term *verstehen*. The Pragmatism school refuted the claims of Descartes that an external reality exists and is only waiting to be discovered, believing instead that reality is constructed or interpreted out of social interactions, dependent upon how they are perceived and the meanings that are attached. The leading proponents of symbolic interactionism, George Herbert Mead, Robert Park and Herbert Blumer, also maintained this need for a *verstehen* for the study of human behaviour, which would emphasise naturalistic, qualitative and interpretive approaches, sensitising concepts to make shared meaning more understandable (Kendall, 1991). Its key principle was ‘that human beings act toward things on the basis of the meanings that these things have for them’ (Blumer, 1969, p. 2). He maintained that we are in a constant process of meaning-making, our interactions constrained but not determined by context, history and social structures (Blumer, 1969; Oliver, 2011).

Symbolic interactionism contested functionalist theory on three main theoretical positions: firstly, it was unable to account for rapid periods of social change; secondly, it portrayed a logical and orderly account of society not supported by empirical observation; and thirdly, the unit of observation was seen as the whole, society or the family, which reduced the individual to a set of structures, functions and mechanisms within a greater whole (Swan and Bowers, 1998). In addition to this, it was highly critical of the positivistic methods that dominated sociological research at that time (Jones and Day, 1977). It viewed society, not as orderly and logical, but as existing in a reciprocating dynamic relationship, interacting with the individual, and reality and meaning created by interactions with others, with a focus on how reactions to circumstances are interpreted (Mead, 1931; Shalin, 1991). Accordingly, it developed an alternative account of social life that viewed society based upon the actions, identities and meanings born out of an individual’s interactions with others and the environments that they live in.

Rooted in relativist ontology, symbolic interactionism acknowledged a reality external to human thoughts, concerned with the generation, persistence and transformation of meaning in the individual's perceptions of reality – meaning only established through communication with others (Stone and Faberman, 1970; Jones and Day, 1977). Communication is the underlying basis for symbolic interactionism, providing the basis by which humans share their experience and perceptions with each other via communication that can be in the form of verbal (language) or non-verbal (signs, gestures, even people not communicating to each other can suggest something) collectively known as symbols. It is interpretative and qualitative in nature due to its ontological (relativism) and epistemological commitments (knowledge is socially constructed through the perception of communicated experiences), and fits with(Lyotard's (1984) definition of a post modernism movement as 'incredulity towards metanarratives in understanding social behaviour'. In contrast to the grand narratives of modern theory, reality is plural and can be viewed and understood from many positions, and any representations of a phenomenon will always be partial as its claims of reality and truth can never be captured in their entirety (Lyotard, 1984; Cheek, 1999; Strathern, 2005). Blumer (1969) argued that interpreting social phenomena in this way required a methodology that immersed the researcher into the participant's situation. The three assumptions inherent in his symbolic interactionism framework are, firstly, that humans are motivated to interact with subjects/objects based on the meaning that they have for them, so reality will be susceptible to many different interpretations. Secondly, meanings are generated over time through interaction and constrained by the social, historical and cultural context of the inter-actor, and the external reality is less important to the individual than their perception of it. Thirdly, meanings become modified through interactions and the inter-actor's interpretive process, which means that an analysis of the external situation only will not be sufficient (Stone and Faberman, 1970; Jones and Day, 1977; Kendall, 1999).

Since the introduction of symbolic interactionism, there have been many methodologies that have been deemed useful in submersing the researcher in the environment of the researched, which has been deemed necessary in the construction of knowledge concerning the reality of others' symbols and interactions (see ethno-methodology and participant observation). Grounded Theory is one such method that has gained momentum from the development of symbolic interactionism. It was from this theoretical basis and need for a methodology to account for an alternative account of social life that Grounded Theory was formulated (Glaser, Strauss and Strutzel, 1968; Chenitz and Swanson, 1986). The following section gives a brief overview of the history of Grounded Theory and its different approaches before defending the approach adopted for this study.

3.4.2 Grounded Theory

Grounded Theory is both a methodology and a set of methods used as an approach to research. It refutes the grand theories and universal truth of social functional theories and looks to study the everyday marginal, local and social processes and human behaviour alongside the socially constructed, emergent and plural realities of human agency (Plummer, 2010). The original version, also known as Classic Grounded Theory or later Glaserian Grounded Theory, grew out of a collaboration between Barney Glaser and Anselm Strauss (1965) in their study of *The Awareness of Dying.* They sought an alternative methodology to the preferred positivistic quantitative methods of studying social and psychosocial processes and the acceptance of grand functionalist theories, which had dominated sociology from the latter part of the nineteenth century up until the mid-twentieth century (Glaser and Strauss, 1967; Kendall, 1999; Fassinger, 2005). Grounded Theory provided a strong rationale for qualitative research to develop theory at a time (1960s) when interpreting participants' meanings was looked upon as anecdotal, value laden and holding no validity (Glaser and Strauss, 1967; Charmaz, 1995, 2006). In essence it married two competing traditions in sociology: Columbia University positivism and the Chicago School development of symbolic interactionism. Strauss was a scholar of the Chicago School of thought, with an emphasis on pragmatism, symbolic interactionism and qualitative research, whilst Glaser studied under Paul Lazarsfeld and Robert Merton, favouring positivism and quantitative research, bringing the methods of multivariate analysis codifying and comparative analysis to give the rigour and validity sought after by positivist advocates (LaRossa, 2005).

Since the original version of Glaser and Strauss, Grounded Theory has been the subject of much debate, in the main due to the epistemological split of Glaser and Strauss resulting with Strauss and Corbin's subsequent version of Grounded Theory: Qualitative Data Analysis (Strauss and Corbin, 1990, 1994, 1997) and the general criticism that the methodology of either version lacked specific methods for those not fortunate enough to be taking graduate classes with either Glaser or Strauss. While Glaser has always dismissed any philosophical or disciplinary position of the original Grounded Theory, as to do so reduced its broad potential (Glaser and Holton, 2007), Charmaz (2006) argued that the original version reflected too strongly Glaser's positivist assumptions of a pre-existing reality, waiting to be discovered through rigorous and systematic techniques. Bryant (2002) maintains that the original version of Grounded Theory saw theory as being induced from the accretion of multiple observations, which is consistent with the positivist assertion that all knowledge of reality is only possible through observations (Bryant, 2002, p.30). Glaser himself (1978) also argued that a grounded theory that worked and had fit could predict what would happen in a formal area of inquiry, which suggests a deductive-inductive approach to the areas where this is tried out. This critique is posited on Glaser's (1978) subscription to the discovery of a truth that emerges from a 'real' reality that is already present, pre-existing and waiting to be discovered, adopting a positivistic position with an objective reality. The 'Strausserian', or Strauss and Corbin (1994) version of Grounded Theory refuted the idea that a pre-existing reality exists waiting to be discovered, and instead subscribed to a relativist pragmatist position, where truth is discovery and enacted. Reality is given meaning when humans interact with their environments and the meaning is then modified through their perception of this environment. They stated that 'theories are embedded 'in history'— historical epochs, eras and moments are to be taken into account in the creation, judgment, revision and reformulation of theories' (Strauss & Corbin, 1994, p. 280).

In answer to the lack of detail in the methodology, Glaser published *Theoretical Sensitivity* (Glaser, 1978) in order to give more detail to the specific approaches of the original version of Grounded Theory. However, when Strauss attempted to do the same and published *Qualitative Analysis for Social Scientists* (Strauss, 1987), and then with Juliet Corbin (1990) *Grounded Theory Methodology: An Overview in Handbook of Qualitative Research,* tensions between the epistemological bases were evident. Strauss departed from the original version on two points: firstly, the shift in the philosophical underpinnings towards symbolic interactionism and secondly, the pedagogical processes. One of the key tenets of the original version of Grounded Theory was that the researcher moved through the data collection and analysis without prejudgement (Glaser, 1978, 1992, 1998; Glaser and Holton, 2007) or any predetermined schema into which data should be organised; instead convergences and similarities with the literature should emerge after the core analytic category has emerged (Glaser and Strauss, 1967). One of the greatest controversies of Strauss and Corbin's version was the introduction of a third coding step: axial coding, a 'paradigm model' with predefined categories that researchers should use to organise the collection and analysis of data, named 'axial' because the organising scheme sat on the axis of all sub-categories and connected them together in one central idea (Strauss and Corbin, 1990). Glaser (1992) criticised this version for resulting in conceptual description by guiding the collection and analysis of data to six predetermined sub categories: conditions, phenomena, context, intervening conditions, actions/strategies, leading theory to be constructed. This contrasts with Glaser's insistence of conceptualisations being driven only by what is seen in the data with a generated theory emerging afterwards. In the original version, Glaser did identify eighteen different coding families that might be used in the same way as axial coding but only to connect sub-categories, not to organise data collection and initial analysis, emphasising that such codes were only possibilities and that conceptualisation emerging from the data should take precedence over any pre-thought out schema in order to assure grounding in the data. Kendall (1999) gives a good account of this methodological dilemma in her study *Living with ADHD*. Using first the Straussian methodology and the paradigm model for organising her data she reflected that the result arrived at was a construction of thick conceptual description, which quickly moved her away from the original focus of the study, leaving the original research questions unanswered. The data was then re-analysed, using the Glaserian methodology without a predefined list for organising data, and resulted in the development of an emergent theory of '*moving on'.*

In 2006, Charmaz further developed the Straussian version of Grounded Theory further with her version of Constructivist Grounded Theory. Building on the symbolic interactionism underpinnings of the Strauss and Corbin (1990) version, (Charmaz, 2000) supported Strauss and Corbin in their challenge to the existing external reality of Glaser's method, and their own assumption that truth is enacted. However, she went further as to the meaning that is attached to reality, stating that this is co-created by the author and participant, the researcher as author presenting their interpreted construction of the phenomena under research. Charmaz (2012) goes further to argue that a social constructionist will give a descriptive rendering of the participants' constructed reality, whereas a social constructivist will acknowledge subjectivity and the researcher's involvement in the construction and interpretation of the participants' constructed reality. In this version, Charmaz (2000, 2006, 2012) adopts relativist ontology and a subjectivist epistemology.

3.5 Complementary Research Strategies and Tools in Inductive Research

Although qualitative data is known for its rich and thick description, perfectly suited to discovery of the processes of a phenomenon lacking empirical research (Geertz, 1973), the criticisms that it lacks scholarly rigour are well noted (Denzin and Lincoln, 2008; Gioia, Corley and Hamilton, 2013). The focus on discovering truth through measures of reliability and validity is replaced by the notion of the trustworthiness of the data in qualitative research (Mishler, 2000). Triangulation in qualitative research has become an important methodological means of finding frequencies across multiple sources of qualitative data (Mathison, 1988). From an epistemic perspective, research that implies an epistemic positioning of multiple constructed realties should therefore use multiple methods of data collection and analysis to acquire these (Johnson, 1997). This calls for the use of triangulation in the constructivist paradigm to demonstrate and evidence validity and trustworthiness in the research findings (Lincoln, Yvonna S and Guba, 1985; Creswell and Miller, 2000; Golafshani, 2003; Leech and Onwuegbuzie, 2007).

In addition to the Grounded Theory analysis of the interview and unstructured observation data, data was collected through observational analysis. In particular, observational fieldwork enables closeness to the data and an understanding of the participants and phenomena that literature reading alone does not offer. Elements from more than one research strategy were adopted for this study to enhance two areas: firstly, the trustworthiness or truth in the data as discussed as above, and secondly, a deeper understanding of the context and the social processes taking place when people collaborate under conditions of mandate. Incorporating elements of ethnography research strategies in a Grounded Theory methodology as advocated by Charmaz (2006) allows the researcher to see the world and social processes of the participants rather than a description of them, using unstructured observation and interviews ‘regarding the life occurring within the given milieu’ (Charmaz 2006, p.31). Grounded Theory analysis situated within partial ethnographic strategies can also enable the eliciting of rich data needed to develop substantive grounded theories that can fit and explain the data (Glaser and Strauss, 1967; Charmaz, 2006, 2014).

3.6 Data Sampling Methods

Qualitative studies allow for a certain degree of flexibility in sampling procedures (Coyne, 1997). Patton (1990) provides a clear and comprehensive taxonomy of qualitative sampling strategies, which serves well in overcoming any sampling confusion that Morse (2015) argues that a researcher may encounter. However, Coyne (1997) critically highlights the point that the sample selection in qualitative research will have a profound effect on the quality of the research and its contribution (or lack of) to theory. Sampling will normally be selective, affected by access, availability and time of the researcher, and focus of the research interests (Schatzman and Strauss, 1973). Patton's (1990) taxonomy of purposeful sampling depicts similar strategies for the selection of information rich cases that allow the phenomena of interest to be studied to such depth that sufficient data will be yielded to answer the research questions. Research that is focused on a single case study requires careful selection, as there must be ample opportunity for the researcher to observe the phenomenon of interest and attain sufficient data when attempting to build theory from case study research (Eisenhardt, 1989). Patton (1990) suggests that information rich cases for in-depth study can provide a great depth of knowledge and learning central to the research questions. This case was selected through theory base or operational construct sampling, which samples incidents, time periods or people as to their manifestation of the theoretical constructs or representation of the phenomenon of interest (Patton, 1990). Although many would argue that multiple case studies are needed to present anything that resembles a theory from qualitative analysis (Neustadt and Ernest, 1992; Dubois and Gadde, 2002; Eisenhardt and Graebner, 2007) a single case can provide context- dependent knowledge (Flyvbjerg, 2006) suitable for the kind of substantive theories of grounded theories which address delimited problems in specific substantive areas (Charmaz 2006). The phenomenon of interest in this study is collaboration under conditions of mandate. The next section describes the physical sample selected.

3.7 The Case Study

As the literature chapter has revealed, the interactions that take place when people collaborate under conditions of mandate are varying, and are shaped by a variety of contexts and factors. Although the literature has shed some light in this topic, there is a paucity of empirical evidence when it comes to truly understanding the interactions that occur under conditions of mandate. The existing literature does suggest that this is a complex landscape in terms of how interactions are shaped, the processes in which they become entwined, their manifestation and how they ultimately influence the effectiveness of collaborative action, when this takes place under conditions of mandate. Therefore, using a data sample which can help to unpack this complexity and build an understanding of the interactions that do occur when people collaborate under conditions of mandate in health, social care and public heath contexts (including the ways in which these interactions are managed) is essential in building an understanding of mandated collaborative processes and the impact they can have on people, policy, process and outcomes. The context for this study was a Health and Wellbeing Board in the north of England, and a radical change in mandated responsibilities for health improvement.

The Health and Social Care Act (2012) is recognised as being one of the most significant reforms of the NHS since its inception in 1948. Under the Act, responsibility for the health improvement of citizens was removed from the Secretary of State, as was the entire super-structure of the NHS (10 regional health authorities and 152 primary care trusts). Health improvement became the responsibility of local authorities, and family doctors were to take over the commissioning of NHS care (Timmins, 2012). To ensure the joined-up commissioning and integrated partnership working of area-wide NHS services, social care and prevention under this new reform, Health and Wellbeing Boards were mandated in all top tier and unitary local authorities. The focus of this research is the South Tyneside Health and Wellbeing Board (STHWB).

In using the STHWB as a case study for this research, I was able to apply the constructivist Grounded Theory approach discussed in detail in the subsequent sections of this chapter (Charmaz, 2006). Using this instance of mandated collaboration in a local health, social care and public health context facilitated the development of the substantive theory from the data of the basic social process of managing conflict that theorises the interactions that took place within this mandated collaboration, and how these interactions were managed. Choosing a case study that offered access to participants who were currently engaged in the development and practice of collaboration allowed timely exploration of key phenomena and processes (Huberman and Miles, 1994; Stake, 2005). As highlighted above, the STHWB was of interest as a case study as its very existence was as a policy-mandated committee (by national government) wherein local stakeholders in health, social care and public health were required to interact with each other for the purpose of more effective decision-making processes regarding the integration of local services. Indeed, the explicit purpose and role of Health and Wellbeing boards is to 2 to ‘act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services’ (Perkins and Hunter, 2014, p. 223).

The STHWB gave me, as the researcher, the opportunity to explore the interactions that occur when people collaborate under conditions of mandate and the ways in which these interactions are managed in a local health, social care and public health context, which was the broad focus of this research. In keeping with the Grounded Theory approach chosen for this study, which allows for the exploration of interactions and social processes, it offers the opportunity of a substantive theory to explain the interactions that occur under conditions of mandate and the way that they are managed, to be constructed from the data. In addition to this, Health and Wellbeing Boards provide a new context for scholars and practitioners to re-examine the challenges of mandated collaboration and, in particular, if attention should be paid to the interactions that occur and how they are managed by participating members. The nascent state of the literature on the interactions that occur under conditions of mandate and how these are managed, and on Health and Wellbeing Boards, gives little guidance as to integrated working under such conditions, and understates the importance of the high functioning relationships needed to underpin flexible local design, and the roles and challenges that the structures of Health and Wellbeing Boards can impose (Dow, 2011;

HARDING and et, 2011; Allen and Rowse, 2013; Humphries, 2013; Coleman *et al.*, 2014).

3.7.1 South Tyneside Health and Wellbeing Board

Under section 194 of the Health and Social Care Act (2012), every upper tier local authority in England was mandated to create and establish a Health and Wellbeing Board effective from April 2013. As a result, the STHWB is a policy-mandated committee of the Council that established it, in this case the South Tyneside Metropolitan Borough Council, and is treated as if appointed under section 102 of the Local Government Act 1972. In addition to mandating the establishment of the Health and Wellbeing Board, the Board was mandated to improve the health and wellbeing of the people of South Tyneside and reduce inequalities in health outcomes. The Board is also tasked with providing whole system leadership for the local health economy and in holding member organisations to account for their part in improving local health and wellbeing outcomes in a local health, social care and public health context.

The main duties and functions of the South Tyneside Health and Wellbeing Board

The STHWB's main functions and duties were mandated as follows:

- To encourage integrated working between members and their organisations with responsibility for the provision of local health, social care and public health provision.
- To assess and understand the health, social care and public health needs of the local population with the statutory Joint Strategic Needs Assessment.
- To support joint commissioning strategies and pooled budgets where this is agreed by all parties as having a positive outcome on the reduction in inequalities in the local health, social care and public health needs of the local people.

The Board's main responsibilities were mandated as follows:

- To provide leadership and drive the vision for the health and wellbeing of adults and children in South Tyneside.

- Using the statutory Joint Strategic Needs Assessment tool, to assess and understand the health and wellbeing needs of the people in South Tyneside.
- To better engage with communities to understand their health and wellbeing needs.

The purpose of the Board was also to build strong and effective relationships between mandated organisations and their representative members to improve services across health, social care and public health provisions in a local context, with the aim of improving the health and wellbeing of local people and reducing the demand for local services.

All Health and Wellbeing Boards have their inception, structure, duties and core membership mandated (determined) by the Health and Social Care Act (2012). The membership of this Health and Wellbeing Board is shown in the following table.

Table 3.1 HWB Mandated Membership

Organisations	Representatives
South Tyneside Council	• Leader of South Tyneside Council • General Councillors
NHS Foundation Trust	• Head of Partnerships, Northumberland, Tyne and Wear NHS Foundation Trust • Director of Corporate and Business Services • Chief Executive South Tyneside Foundation Trust • Chairman South Tyneside Foundation Trust
Children’s, Adults and Families Services	• Corporate Director of South Tyneside Children, Adults and Families
South Tyneside Clinical Commissioning Group	• Director of Public Health • Chief Officer of South Tyneside Clinical

Commissioning Group

- Chair - South Tyneside CCG

Since 2012, this Health and Wellbeing Board has formally operated within its mandated context with meetings between the members taking place every month or as deemed necessary.

3.8 Data Collection Methods

Charmaz (2006, 2014) reminds the researcher of the need to be open and flexible to collecting data from a range of sources, which can also support the trustworthiness of the data when asserting belief in the research answers. This study incorporated data from various sources to develop a deeper and more focussed understanding of the phenomena through different lenses within the same case study (Baxter and Jack, 2008; Clarke and Charmaz, 2014). Patton (1990) and Yin (2003) also advocate the use of multiple data sources in qualitative case study research, as it enhances the credibility of the research, or even more importantly, as Eisenhardt (1989) observes, it can strengthen the grounding of theory in the triangulation of evidence. Two data sources were identified for this study: interviews and unstructured observation.

3.8.1 Unstructured Observation

The starting point of data collection for this study was observational field data from unstructured observations (Mulhall, 2002). Unstructured observation in this study adopted the complete observer approach. Mulhall (2002)states that unstructured observations reflect a paradigm where the researcher cannot be separated from the research. This fits with the social constructivist paradigm of the researcher's interpretation of the participants' constructed reality (Charmaz, 2006, 2014). Unstructured observation was used to capture the whole social setting in which the participants collaborated under mandated conditions. In practical terms, this implies observation of individual and collective action, journal entries, significant processes, and context can be used comparatively to develop or emerge substantive categories in their social context (Charmaz, 2006).

The researcher attended many of the public meetings of the mandated collaboration to study the phenomenon and its processes (Charmaz, 2006). Approximately eighteen hours of meetings were observed between 2013 and 2015, initially as a means of immersing the researcher in the research setting (partial ethnography); however, it became clear that this data was also a rich source of information on the nature of inter-organisational interactions and collaborations that could usefully inform theorising as part of a triangulating approach alongside interview data (Patton, 1990). It is noted here that data and analysis should be carried out simultaneously and my use of this source is retrospective; however, Charmaz (2006) states that Grounded Theory strategies should be flexible and open, and although I draw on this point to argue for their use in the comparative analysis of already constructed emergent categories the main role of the observation data in this study was to confirm or refute the analysis of the interview data.

3.8.2 Interview Method

Interviews are conducive to qualitative understanding of complex social phenomena (McCracken, 1988). Humans symbolise their experience through language, and in-depth interviews can elicit rich detail of multiple realities that have been socially constructed regarding a phenomenon (Rubin and Rubin, 2011). This study uses interview as a method of enquiry rather than merely a data collection method (Hammersley, 2003). In enquiry, the purpose of the interview is to understand the lived experience of people and the meaning that they attach to their experience (Seidman, 2006). From the epistemological stance of social constructivism, the interview as a method takes on the theoretical perspective of localism (Alvesson, 2003). This position holds that complex social phenomena do not exist independently of people's understanding and meaning-making of them, and it is those meaning-makings that are crucial to furthering our understanding of the research topic (Hammersley, 2007). For a constructivist, the interview is not a place where the interviewee is seen as an object from which to generate data for analysis, but a place where the researcher aides the participant in making sense of their socially constructed knowledge which is historically, politically and contextually bound (Holstein and Gubrium, 1995). As conversation is the tool by which knowledge is transferred, there must be a methodological focus on the interplay between the participant and the researcher that takes the interview beyond asking questions and receiving answers (Charmaz, 2006; Qu and Dumay, 2011). Discourse allows interplay of questions and answers and a sense-making of the social constructed reality of the phenomena is co-constructed (Qu and Dumay, 2011). The researcher needs to remain open to qualitative accounts of the phenomena through a focus on themes rather than imposing a prescriptive framework (Kvale, 2008).

Semi-structured interviews provide a context through which participants make and convey sense of their socially constructed understanding about a phenomenon and, when conveyed in language, this allows the researcher to interpret their understanding (Schwartzman, 1993). The emphasis on the role of the interviewer is important, as different interviews will invoke different responses through choice of questions, use of follow-up questions and probes, and the language and style in which they are delivered (Denzin and Lincoln, 1998). Preparation of loose questions or probes to guide conversation on themes and topics of interest, delivered in the appropriate style and pace, can elicit hidden and important facts of organisational and human life, and overcome the participants' use of power and status to influence the direction of the interview, or to not disclose their constructed realities (Charmaz, 2006; Kvale and Brinkmann, 2009; Qu and Dumay, 2011)

Goulding (2002) states that face-to-face, semi-structured, in-depth conversational ethnographic interviews are well suited to Grounded Theory, and these were the choice of interview for this study. Face-to-face, semi-structured interviews were conducted and kept as open as possible to allow the participant to speak freely, with an understanding of the co-construction dialogue process that would take place between the interviewee and the interviewer.

For the reasons given above, semi-structured interviews were adopted, as they are considered well-suited to the exploration of attitudes, values, beliefs and motives needing further development (Richardson, Dohrenwend and Klein, 1965; Smith, 1975; Barriball and While, 1994). They are sufficiently flexible to be adapted to the pace of each individual interview, which may be open for some interviewees or a little more structured for others. There was also a need to be mindful of the value that the researcher and participant would bring to the interview, affecting questions asked and answers given and the construction that takes place (Charmaz, 2006). On a more practical note, the interviewees are leaders in health and social care, and semi-structured interviews would keep the interview within a certain time frame and elicit the data needed to answer the research questions.

A total of 30 participants agreed to be interviewed for this study. Interviewees were either agents of an organisation providing health and social care services or an elected member representing the democratic voice of the public who use the health and social care services. Interviews were kept as open as possible, with a loosely defined structure on relevant topics if prompts were needed, lasting between 45 and 60 minutes. Observational notes and journals were also written during and after the interviews to capture any theoretical ideas or significant instances to be reviewed with the data analysis. As key themes emerged from the data, the last 15 interviews became more focussed (Charmaz, 2006) with particular emphasis on the nature, antecedents, opportunities and challenges of interaction.

The interview schedule for collecting data was prepared with a certain tenet of Grounded

Theory in mind. Glaser (1997) and Charmaz (2006) highlight the danger of forcing data to fit the preconceived concepts of the researcher, a factor that can affect the data collection. Key areas of discussion were identified by the researcher, but posed in a way that would encourage open conversation about the phenomenon if this were needed. One of the early interview questions, 'Tell me about your experience of collaborating under conditions of mandate' was designed to let the interviewee talk freely about their experience which would then allow concepts to emerge, instead of exploring their experience around the preconceived concepts of the literature review. Open questions and probes around the categories of mandated collaboration were used when necessary, but the main focus of the semi-structured interviews was to elicit the participants' experience of collaborating under conditions of mandate. Although an initial interview structure was prepared for the first phase of the data collection, the interviews were designed around the theoretical sampling element of Grounded Theory (Glaser and Strauss, 1967, Charmaz, 2006, 2014). In this way, codes and themes emerging after each interview were used to seek pertinent data from the next interviews to develop the emerging theory and to elaborate and to keep refining the categories and their properties throughout the data collection and analysis (Charmaz, 2006, p.96).

3.8.3 Ethical Considerations

This research and the study were made possible by the participants who shared their experiences of collaborating under conditions of mandate and, in recognition and respect of this, ethical and responsible practices were adhered to at all times throughout the study. In light of this, ethical practices were incorporated into this study to ensure as far as possible that no undue harm or distress was caused to participants who were willing to be involved.

Formal ethical approval was sought from and granted by the University of Durham Ethics Committee in adherence with the university's policy, before any data was collected or participants contacted. A presentation was given to the South Tyneside Health and Wellbeing Board to introduce the study and gain committee-level consent. All participants were then invited to the study via email with a participant information sheet to inform them of the study in more detail, explain the nature of their involvement as a volunteer and give an explanation of their right to withdraw from the study at any time without consequences. All interviews and observations were only carried out after the participant provided a signed consent to say that they understood and agreed with the aims of the study and were willing to participate. Participants were also assured that no identifying data would be included in the study or any other publications. All participants were assured that the data would be held in accordance with the university's policy on holding research data and only the researcher would have access to the interview recordings, which were also stored securely. When the interviews took place, the study was explained again and written consent taken to acknowledge agreement to take part in the study and indicate the participants' understanding of the protocols regarding anonymity, confidentiality, researcher note taking and the recording of the data and its use. Participants were aware and understood that personal data relating to name and role would be anonymised but were happy that names of organisations would not. The location of the interview was chosen by the participant and was generally their place of work, either their office or a common room used for different purposes but without other staff members present to allow participants to talk as freely as possible. After each interview, the process was reflected upon by listening to the digital recording, and initial thoughts and impressions of the conversation topics, participants' attitudes and manner were noted, as well as anything of significance for further exploration. These reflections were recorded as a journal and incorporated into the analysis process. Journal reflections were important as they helped with a limitation of the study regarding this grounded theory methodology. Data collection and analysis should happen simultaneously in a Grounded Theory study; however, due to the tight interview schedule, coupled with the researcher's work and life commitments this was not always possible, but was adhered to as far as possible. Journal notes taken after each interview allowed exploration of key points at the next interview.

3.8.4 Interview Transcription

Glaser (1992) acknowledged that transcribing interviews word for word is time consuming and distracts from the main focus of the study. Whilst it is true that the process is time-consuming, word-for-word transcription allows a further opportunity to reflect and to revisit the scene of the interview, immersing the researcher back into the interview with the participant. The task of transcribing was done in the main by the researcher. The decision was made not to use paid transcription services, as transcribing can be an interpretive process where theoretical, contextual, value- and practice-based decisions are made in the transcriber construct's representations of discourse (Skukauskaite, 2012). This plan was followed until the eighteenth interview and, due to time constraints, the remaining twelve interviews were transcribed by a professional company. These transcripts were read through whilst listening to the original recording to check for errors and allow re-immersion in the data. Paralanguage and silences were included in the word-for-word transcription to make the reconstruction of the interview as accurate as possible (Lapadat and Lindsay, 1999).

The methods of analysing the two sources are explained in the following section.

3.9 Data Analysis Methods

The purpose of this section is to explain the data analysis methods that have and will be used in this study to develop a basic social process, or substantive theory (Glaser, 1968) of collaborating under conditions of mandate. The main analysis method comes from situating the study in the constructivist Grounded Theory approach discussed in 3.4.2 (Charmaz 2000, 2006).

3.9.1 Interview Analysis

Grounded Theory uses a process of coding to build substantive theories of social behaviour and processes (Glaser and Strauss, 1967; Charmaz, 2000, 2006; Corbin and Strauss, 2008). Coding in this sense refrains from fitting the data into themes, and instead codes for actions, behaviours and processes by questioning of the data and making comparisons by going back and forward between the interviews (Charmaz, 2014). Careful reflection needs to be taken on the choice of codes as these will serve to construct the researcher's interpretation of the participants' experience of the phenomenon, which guides the theory around which the data is analysed (Charmaz, 2006). Strauss and Corbin (2008) advocated three levels of coding in their version of Grounded Theory; however, in keeping with the social constructivist methodology, this study adopts two levels of coding, open (initial) and focussed (selective).

3.9.2 Open Coding

Open coding fractures the initial data into concepts and categories by applying a technique known as the 'comparative method' (Glaser and Strauss, 1967). Coding attaches labels to segments of the data, related to what is happening in the scene, and codes it accordingly (Charmaz, 2006). The use of comparative methods moves the researcher to search for, and in the case of data collection explore, similarities in the data so that a sense of the patterns emerging from the data can be understood (Charmaz, 2006). Whilst studying the data and coding comparisons, the researcher writes analytic memos to record ideas of what is emerging from the data or gaps that need further exploration with participants. Open coding is the first stage that moves the data beyond the words and statements of the participants into analytic interpretation (Charmaz, 2014). The general guidelines in this stage are to ensure the codes stay close to the data; to code for gerunds (action words) which helps to detect processes and not themes; and to think which theoretical categories the codes could be representing (Glaser, 1978). The researcher should question the data to encourage coding in this way, Glaser recommends the following questioning of the data:

- What is this data a study of? (Glaser, 1978, p.57; Glaser and Strauss, 1967)
- What does the data suggest? Pronounce?
- From whose point of view?
- What theoretical category does this specific datum indicate? (Glaser, 1978)

Coding in this way is sufficiently provisional that new codes can emerge from the data, but comparative in the sense that codes that fit the data are followed up in subsequent collection and analysis and thus stay grounded in the data (Charmaz, 2014). The data for the interviews included with this chapter were coded manually and managed with NVivo 12, a computer software programme for qualitative data. Each line of text was allocated a number which allowed codes to be traced back to the interview and line in which they had be grounded.

The open coding of the first five interviews built up a progressive list of open codes. The interviews were listened to once more during coding, to reposition the researcher back into the data and bring alive dimensions such as tone, speed and texture of voice. Initial journal entries were made immediately after the interviews took place and added to after the open coding analysis. This was helpful in tentatively elevating the coding process from *open* to *focussed,* a process of looking for the most significant or frequent instances within the data (Charmaz, 2006, p. 2014). Reviewing the journal entries concerning the fourteen interviews (with only five analysed so far) revealed a number of consistencies, either significant, frequent or both.

- It appears that everyone is completely at odds with each other here. Instead of everyone being on the same page and being in it together, everybody seems to have an entirely different construction about what is actually going on and about each other, and each person's construction seems to contradict the others.

- Members construct a definition of mandated collaboration as the existence of a set of properties.
- Although the mandated collaboration is meant to be a partnership, there is a divide between the members as to their orientation or positioning. Members are positioned either as providing health and social care services or as being the ‘public voice’ of those who will be using them, and this seems to divide the group.
- Although nobody seems to acknowledge any instance of overt conflict, they all express examples that point to the fact that they are dealing with implicit conflict. There appear to be three main sources for these instances of implicit conflict – perceptual, contextual or political:
- Perceptual (conflict as perceived): members making negative assumptions about the collaboration or each other.
- Contextual (conflict within the context): conflict arising from any of the interrelated conditions of the collaboration. The interrelated conditions in this sense overlap with definitions in the inter-organisational literature, commonly known as the key dimensions or the antecedents, processes and outcomes.
- Political (conflict from the position of social justice): conflict arising from the wider political context in which decisions regarding social justice, equitable access and its funding are imposed on the electorate.
- Members appear to action numerous existing strategies and processes, or develop new ones as a way managing these sources of conflict.
- Action in the wider network seems to be significant. Externally, the network in action imposes upon the mandated collaboration and, internally, the network is operated by the partners to avoid or manage the conflict from the three sources.

The above observations served as the broad categories and more directly focussed codes under which the open codes were sorted, whilst simultaneously reviewing and developing journal entries.

As mentioned, the analysis process detailed above was carried out manually and then transferred onto NVivo 12, a computer software programme for qualitative data analysis, as the volume of codes became unmanageable manually. Grounded Theory is one of the methodologies that is noted as being incompatible with NVivo, as the software is unable to code for processes, which is one of the central tenets of grounded theory approaches. The software was, however, used to organise and collate the analysis undertaken by the researcher, but not to carry out analysis itself. Using the software ensured that, as a researcher, I was still involved in the construction of the resulting substantive theory and that the data could be managed in a way that would ensure that patterns identified would not be lost. Journal writing and coding enabled me to work more quickly, and allowed my thinking to be as creative and abstract as possible.

Over the course of the analysis, comparison was becoming clear enough to develop some broad categories that were significant in the data. The process of open coding and reviewing and developing journal entries led to the development of the following broad areas:

1) Conceptualising mandate – linked with research question one
2) Integrating or segregating – linked with research question two
3) Dealing with conflict as source – linked with research question two
4) Dealing with conflict as context – linked with research question two
5) Dealing with context as political – linked with research question two
6) Managing processes – linked with research question two
7) Action in the wider network – linked with research question two

This snapshot represents the categories in their initial stages; as such they were broad and emergent. These codes remained and were developed into the substantive theory in the following chapters.

3.9.3 Focus Coding

Focus coding shapes substantive codes and moves the coding from line-by-line and incident coding to coding large segments of the data with those open codes that occur the most frequently or are the most significant (Charmaz, 2006). However, it is the researcher's decision as to which codes make the most analytic sense for categorisation of the data, so careful open coding to detect patterns is essential. Charmaz (2006) warns us that the process is not linear, and involves going back and forward between interview statements to illuminate and make sense of earlier data in a new way. This process is currently being applied to the data using the broad areas developed in the open coding phase.

Theoretical Sampling

Glaser (1978) explains theoretical sampling as a way of conceptualising how the substantive codes related to each other can be integrated into a theory that explains what is happening in the local context. In this phase, relationships between the categories are developed which moves them beyond listing thematic codes. This phase requires careful and thorough exploration of the key categories through further data collection and, once no new properties of the categories emerge, the categories become saturated and can be integrated into the theoretical framework (Charmaz, 2006; McGrath, 2009). In this way, initial categories that were developed from the initial coding stage were explored through further questioning in subsequent interviews and through the use of selective questioning (Charmaz, 2006). This allowed me to focus on the emergent categories in both the data collection and analysis, refining properties until no new properties emerged. As Charmaz (2006) states, this allows the co-construction of a substantive theory that is saturated with rich data.

3.9.4 Memo Writing

Throughout the process of data collection and analysis, memos were used to theorise about the reporting of any ideas regarding the emerging patterns between codes and their relationships. This is advocated by all approaches of grounded theory and is probably carried out in all methodologies. However, in approaches to grounded theory, the process of keeping memos is viewed as vital to the grounded theory process, as this is where the researcher starts the analytical process, defining codes, analysing for patterns between the codes, and conceptualising until the substantive theory has been reached. The memos I kept in this study developed the observations and journal entries (examples given above) to the level of categories. Through the memos for this study, I was able to capture my own thoughts, while analysing the data, with regard to the codes, the generation of the substantive theory and its theoretical framework, and to use these to support the final report stage.

3.10 Theorising

‘When you theorize, you reach down to fundamentals, up to abstractions, and probe into experience’ (Charmaz 2006, p.135).

The above definition of theorising by Charmaz (2006) implies a process that is fluid and dynamic, reaching to all parts to achieve its end. Experience was ‘probed’ through the various methods of interviewing, the observations of people experiencing the concept of mandated collaboration, the re-reading of interview transcripts, observational notes and reflexive memos. Identification of ‘conflict’ and the construction of the substantive theory of ‘managing conflict’ which resulted from this process, did indeed feel as though I had reached down to fundamentals, up to abstractions and probed experience. The constant thought processes and interrogation of the data, checking assumptions and reflecting on observations also accessed new sources of literature which have been interwoven through the analysis chapter to support the developed theory. In this, I have attempted to theorise mandated collaboration as to the interactions that take place and how those interactions are managed by those who collaborate. From the process of open coding, through focus coding, constant comparison of data, theoretical sampling and reflexive memos, the way that mandated collaboration is perceived, and the interactions that take place and behaviours, strategies and practices that are used to manage them, have been constructed as the basic social process of *managing conflict.* This basic social process was acknowledged when the properties of the categories were sufficiently rich and dense that no new properties were yielded (Charmaz, 2006).

The following chapters discuss the substantive theory of the basic social process of managing conflict, constructed through the process discussed above. The following section in this chapter discusses the evaluation of the substantive theory developed by the grounded theory processes.

3.9 Evaluation

There is a great deal of discussion on the rigour of qualitative research and its findings and the criteria that should be used in evaluating it (Guba, 1981; Krefting, 1991; Barbour, 2001; Gioia, Corley and Hamilton, 2013; Morse, 2015). However there is evaluation criterion for grounded theory studies as put forward by Glaser and Strauss (1967), Corbin and Strauss (2008) Charmaz (2006) which are sensitive to the methodologies of the grounded theory approaches. Charmaz (2006) writes that readers of the study who have not been immersed in the study will ultimately judge the finished product, as evaluation criterion should demonstrate rigour in the process and the theory. Throughout this study I have kept in mind the criterion for evaluating grounded theory studies as suggested by Charmaz (2006). While developing the substantive theory I have considered how the process could demonstrate credibility, originality, resonance and usefulness and if this is recognizable by the readers of this study. The following discussion provides a detailed account of the evaluation criteria used for this study and the way in which the process for this study has attempted to interweave this into the study results.

3.9.1 Credibility

For Charmaz (2006) credibility as a criteria within evaluation of grounded theory studies is about demonstrating that the research study has achieved an intimate familiarity with the study setting through an adequate number and range of data collection tools. In this study, thirty in depth qualitative interviews were carried out with the participants of a mandated collaboration as well as observations over a twelve-month period. Being able to draw on the experiences of every participating member of the collaboration facilitated the intimate familiarity that Charmaz (2006) speaks of and demonstrated the range and volume of data collection to argue there was sufficient depth to the data collected from which a local theory could be constructed. Attending the meetings of the collaboration over a twelve month period to carry out unstructured observations added a further dimension to the participants words that allowed further dimensions of properties of the theory to be explored and checked. Keeping the analysis grounded in the data and constructing the theory this way has allowed the discussion of the theory in the next chapters to demonstrate strong links back the data collected which is supported by the use of participants quotes to substantiate this. The discussion of the theory of this study that follows in the next chapter presents a theory with sufficient evidence so the readers of this study can form their own independent assessment and have confidence in the theory that has been constructed.

3.9.2 Originality

Charmaz (2006) writes that for a grounded theory study to be evaluated as original it must offer fresh insights into the area under study and not a remodeling of findings that have gone before. The aim of this study was to explore a phenomenon that is widely used in practice yet receives little attention in the literature. In using a grounded theory approach to explore mandated collaboration I have strived to offer findings that are different from the usual preconditions, process and outcomes that forms of collaboration, mandated or voluntary, that documented in the accessible literature, even though these are arguably necessary and worthy. I have also strived to bring a methodological freshness to studies of collaboration and partnerships in health, social care and public health as to my knowledge and the literature searched there are little, if any studies that have explored the interactions that take place under conditions of mandate in a local setting with a grounded theory approach, which is also demonstrated through the new literature that is introduced in the analysis chapter, which is not from the health social are and public heath literature, which offers a further level of fresh insight. In doing so, this research extended the literature on studies and theories of collaboration and offers new insights as to the way others who study and practice under conditions of mandate might make sense of their experiences.

3.9.3 Resonance

Resonance in grounded theory studies should demonstrate a level of abstract that is sufficient to develop a substantive theory and where readers of the study can understand and identify in some way with findings. Keeping the analysis grounded in the data and applying the constant comparison approach has ensured that the experiences of participating in a mandated collaboration are not lost in the intricate web of the constructed theory. The findings of this study also reveal that what is taken for granted in the day-to-day practices of collaborating under conditions mandate reveal hidden meanings and depth presented in such a way that they still resonate with the data. The participants of this study will offered the opportunity to read the findings of this study, however in the conversations I have had with participants and the presentation of preliminary findings at the South Tyneside Heath and Wellbeing Board, participants feedback suggested that they could identify with the story that was being told in this study.

3.9.4 Usefulness

Grounded theory studies should be at a level of abstract to offer findings that are not apparent without interrogation of the data but with interpretations that people can use in their every day worlds (Charmaz, 2006). This study sought to understand a practice that practioners are having to participate in more and more as a solution to wicked problems in health, social care and public health, but with little guidelines of how this can be done more effectively. These guidelines can also be adopted by those who collaborate under conditions of mandate in a different context. Although the concept of conflict has been identified in the literatures on voluntary and mandated forms of collaboration, deeper exploration of this, specifically in mandated forms and through grounded theory approaches has not been conducted. Originality in this study has also been achieved by drawing on the relevant literature and combining this with the health and social care and organisational literature, which so far have remained relatively separate from each other in this context. Aligning these literatures in this ways also offers further insights to practitioners who must collaborate under conditions of mandate to show the interactions that participate in and the way that they are managed is just as important to the effectiveness of the collaboration as the tangible outcomes such as integrated services.

3.11 Chapter Summary

The purpose of this chapter has been to provide details of and argue for the use of the grounded theory approach to the study of the interactions that occur under conditions of mandate in a health, social care and public health context. The chapter has discussed in detail the stages of the methodology that underpins this study and through which the substantive theory, the basic social process of managing conflict, was constructed. Within this chapter, I have discussed and set out my research paradigm as a researcher and my ontological, epistemological and methodological beliefs, and how these align to the social constructionist grounded theory approach taken and the research aims of this study. I have provided a review and critique of the origins of grounded theory within symbolic interactionism, and the versions of grounded theory available and how they differ in their epistemological underpinnings. The practical stages of choosing the sample, and using interviews and observations to collect the data needed to answer the research questions were detailed. From this, followed an in-depth discussion of grounded theory analysis techniques and stages that were applied to the data, which resulted in the basic social process of managing conflict. I then discussed the evaluation criteria that were applied to the findings of this study with the purpose of giving the reader confidence in the findings of this study. The chapter included the ethical considerations relevant to this study, in particular in relation to the participants who gave their time.

Having discussed and argued the relevance of the Grounded Theory method in achieving the research aims of this study, the following chapter presents and discusses the substantive Grounded Theory constructed through the methods discussed in this chapter. Chapter 4 provides a detailed account of the underlying issue of conflict when interacting under conditions of mandate in a health, social care and public health context, as revealed through the analysis of observational and interview data. Chapters 5, 6 and 7 reveal the basic social process of managing conflict, which is the substantive theory that was developed in this study, and discusses the various processes, practices, behaviours and attitudes used to manage conflict when interacting under conditions of mandate.

Chapter 4 Identification of a Critical Issue

4.1 Introduction

This chapter uncovers the underlying issue of *conflict*, as experienced by the participants of this study whilst interacting to collaborate under conditions of mandate. In doing so, this chapter provides the rationale underpinning the basic social process of *managing conflict* discussed in detail in Chapters 5–7, which is the substantive Grounded Theory constructed within this study.

This discussion of conflict as a critical issue draws on the instances revealed through constant comparison of data collected throughout the study. The issue of social conflict has not previously been revealed in a review of the literature on mandated collaboration. Although the review of the literature identified many tensions and challenges, social conflict as a critical issue in mandated collaboration was not identified in the studies included in the literature review of this study. That is to say, there was no previous examination of the conflict that occurs within the interactions between people, as defined by Dahrendorf (1959):

> All relations between sets of individuals that involve an incompatible difference of objectives i.e., in its most general form, a desire on the part of both contestants to attain what is available only to one, or only in part are, in this sense, relations of social conflict. (p.135)

Further this, of particular significance is the way in which these sources of conflict that constrains or enables the interactions of these group members. Conflict in this study exists in the identities that individuals interact with and the struggle they have with assuming these identities, dealing with decision-making process that have been democratised through the health service reforms (Health and Social Care Act, 2012) as well as grappling with the individual norms and the way of doing things that are brought into the mandated collaborative process. From this perceptive the dimension of power was also revealed as being grounded within the data, specifically mechanisms of power conceptualised as those laws, rules, norms, traditions, institutional arrangements, interacting identities that constrain and enable action for all actors (Hayward, 2000).

The use of direct quotations and extracts from the literature will be used to illustrate my interpretations of the conflict which individuals collaborating under conditions of mandate found in their interactions and how they made sense of these. This will show the richness and complexity of the data generated within the study and allow a comparison of existing literature where relevant. In comparing the data to the literature in this way, the discussion also highlights gaps in the literature. The underlying issue of conflict stems from various conceptualisations of three key domains: *interacting identities*, *democratising decision-making practices* and *coping with the traditions of others*. Conflict is seen, in this study, as an interactive process that resonates with all individuals involved in the collaboration and at different stages of the collaborative process. Within each of these domains there are various perceptions, processes and behaviours that have been conceptualised as conflict that constrains or enables interacting under conditions of mandate in a local health, social care and public health context. Each of these domains will now be considered in turn.

4.2 Interacting identities

The membership of Health and Wellbeing Boards was mandated by the Health and Social Care Act of 2012, which defined a statutory membership through which to represent the areas of care that were to be commissioned and integrated more effectively, with the addition of democratic representatives in the form of locally elected councillors and a patient voice group, in an attempt to democratise the current decision-making processes around health, social care and public health provision. The membership consisted of professionals and practitioners representing health, social and public health organisations, comprising the local National Health Service Foundation Trust, Clinical Commissioning Group, Mental Health National Health Service Foundation Trust and Public Health, referred to as the professional group members for the rest of this study. The locally elected councillors and representatives of the patient service user statutory body (Healthwatch) are referred to as the democratic group members for the rest of this study. Although all group members would admit to agreeing with the ideology of the mandated collaboration, cracks started to appear as they interacted and group members described feeling a 'them and us' mentality. Rather than sharing a group identity, group members perceived two interacting identities at force when individuals were collaborating under conditions of mandate.

> We are the amateurs and they are the professionals. That's how I see it but then I am biased. (Senior Manager, Healthwatch)

> It's strange bringing two extremely different animals together. (Local Councillor)

Although issues of identity formation were not revealed in the literature reviewed in this study, which indicates a gap, there are many studies on the work of identity formation which acknowledge the part that a 'role' plays in shaping an individual's identity. Pratt, Rockmann and Kaufmann (2006) identified three literatures that linked the roles that individuals carry out in an organisational context to identity construction. Their review of these literatures suggested that an individual's identity is shaped or constructed as a result of factors including new roles into which they transition; the socialisation process of interaction with other organisations and their members; and an individual's self-construction process where an individual engages in a process of active construction of their identity as a result of being influenced by social groups or role models. The analysis of the data in this study revealed the process of identity construction as a result of the new role given to group members by mandate. The amateur identity was identified as an identity where there is a perceived a lack of fit between the daily or primary identity and the identity which is seen as most dominant collective identity of the group. The interacting identity of ‘the professional’ was analysed as one, which enabled interaction for the professionals of the group but constrained interaction for the amateurs of the group. This interacting identity of ‘the professional’ was then conceptualized as a source conflict and as a mechanism of power, which enabled or constrained interactions under conditions of mandate. Conflict as a critical issue was seen to weave through the identity construction process of these group members, specifically through the conceptual elements of *perceptions of self* and *perceptions of others*.

4.2.1 Perceptions of Self

Perceptions of self as source of conflict were further revealed in the interviews with the democratic group members. For these members, the process of comparing self to the professional group members conjured feelings of discord with the values, attitudes and behaviours of those from an organisational background. When the Health and Social Care Act (2012) mandated that health, social care and public health professionals would share decision-making processes concerning the integration of local care with democratic representatives through the Health and Wellbeing Board, this brought together a group of members whose knowledge ranged from very little to in-depth experience and trained expertise.

> I keep thinking I am a lay person, but the people on the board are real professionals, so it’s a way of coming together and looking at how we can support a growing population and an ageing population and how can we lift the health of the area as well because that is important as well. Sometimes I am sitting absolutely confused I have to say with the discussions that go on I mean they are fascinating, but they are very high level is taken really seriously. (Local Councillor)

Perceiving themselves as not capable to fulfil the mandated role was a prevalent feeling in the narratives of the democratic group members. This became a common and consistent point when I observed the meetings of the Health and Wellbeing Boards that the democratic members of the group appeared rather, withdrawn or quiet and without the confidence of the professional group members. Within this mandated collaboration, the role of group members was to take a more strategic approach to the organisation and provision of care in a way that achieved more effective integration. Mandating members to advocate the democratic or public voice, in decision-making processes usually reserved for professionals and practitioners, is suggestive of the public value and public choice theory approaches to the organisation and provision of care identified in the literature, that is, an approach which advocates putting the local community at the centre of care and being citizen-focussed (Murphy, 2013). Newman et al., (2004) and Fraser (2014) warn that organising care in these participative ways does not always bring the mechanisms to facilitate these interactions, and the relationships needed to develop them, which can then alienate those who they aim to include. Fraser (2014) called these alienated individuals ‘special groups’, labelled in her study as black and ethnic minorities, LGBT and young people. Groups such as these are often seen to be alienated in the organisation of care in this way, even when the intention is to include them. In this study, the analysis of the data suggests that even citizen representatives become alienated, or like a ‘special group’, where conditions of mandate insist on a membership that lacks a shared identity. This was seen in the following quote from one democratic group member:

> With the health and wellbeing board, you're actually a member of it. And I suppose I don’t feel that – I’m trying to get back to your original question – but I don’t feel an equal member of it. (Local Councillor)

Feeling alienated and unable to fully interact because of the perception of being not as capable as others, is akin to what Barnsley, Lemieux-Charles and McKinney (1998), Kodner (2009), and Tsasis, Evans and Owen (2012) identify as the effects of the 'straightjacket' of mandate. Their view that any collaborative should be reached through a process that allows agents to self-organise and develop their interactions over time, illuminates why the inability to do this in the case of the Health and Wellbeing Board became a source of conflict for the participants in this study. The mandate of a collaboration, specifically by policy or by codified acts as in this study, replaces the initial design and creation stage where collaborative membership would be decided. The exclusion of group members in this study from those initial stages resulted in the democratic group members, for whom decision-making in health matters was not their daily role, perceiving themselves as inadequate. This was highlighted by Batalden and Mohr (1997) with their concept of 'knowledge of the system'. They wrote that there is a need for agents and their organisations to have an awareness of each other if they are to build interactions of trust. Goodwin et al., (2004) similarly noted that, where this is not the case, there is a risk of disharmony and demotivation. These findings also agree with Popp and Casebeer (2015), Blakely and Dolon (1991) and Perkins et al., (2010), who argue that membership is one of the four essential elements of a collaboration and often a reason that collaborations fail when mandated. The observational data collected in the fieldwork of this study also confirmed this perception of self-amongst the lay members of the group. At most if not all of the meetings attended, lay members would take a backseat position and appear to lack the confidence to contribute on the issues that were being discussed.

In addition to the perception of democratic group members that they lack the knowledge required to interact in this mandated process, lack of experience was also noted when comparing themselves to others. Group members representing the democratic voice, specifically local councillors, were analysed as comparing their own previous role experience with that of the practitioners and professionals in the group and finding incompatible differences. In the traditional model of local government, local councillors are elected to advocate on behalf of the electorate. Although one of their official functions is to contribute to the development of local policy, their contribution is often very limited as most have little experience of the detailed policy and budgetary decisions which have to be made (Devis and Grant, 2003), as one democratic group member noted:

> They are professional people who have spent years getting to this level in their profession they feel quite capable of making all these major decisions. They've been used to dealing with all these millions of pounds and now all of a sudden, they are around a board where you have people like myself. (Local Councillor)

and:

> Actually, people who are well versed in a strategic level of health probably took to it a little bit easier than people like myself who got very little experience other than personal experience. (Local Councillor)

One of the key duties of local councillors is to devise and implement local policies. Being elected to such a role requires no formal qualifications or training, in stark contrast to the formal qualifications and level of seniority needed by professionals or practitioners in a care context. Although the system functions when dealing with the daily political issues of the local electorate, faced with strategy and policy decisions it highlights the potential incompatibilities in skills and experience, which constrain just how far these group members can interact in such situations. As noted by one elected local councillor, 'It's [the group role] very daunting' and by another 'I was on [the board] for such a short time and I was so new and I was just feeling my feet anyway and it was a massive amount to learn all of it'. Another elected member added, 'I used to feel quite uncomfortable doing that because I didn't think I was equipped enough.'

And another:

> Another councillor had been lead member for health and well-being, so it was totally new to me, and I felt a little out of my depth with the people who were actually sitting round that table. The likes of the chief executive of the NHS trust, Public Health England, they were all bodies that I hadn't had a great deal to do with. (Local Councillor)

Being democratically elected to a role that requires no formal qualifications or experience may be suited to dealing with daily political issues of the local electorate; however, when faced with strategy and policy decisions, deficits in skills and experience are highlighted in the perception of some group members, who feel ill-equipped to interact under conditions of mandate. Although this is feasible when dealing with daily political issues of the local electorate, faced with strategy and policy decisions it highlights the incompatibilities in skills and experience, which constrains just how far amateurs can interact in such situations. For these members of the group, having to interact in a capacity that goes beyond the boundaries of their daily councillor or third-sector roles, causes perceptions of inadequacy in their own identities:

> You know I'm an elected member who doesn't have as I said necessarily the…., well certainly doesn't have the professional background in it. (Local Councillor)

Even those members who represented the democratic voice but had previously held a recognised public sector role involving training and formal qualifications, perceived themselves inadequate to fulfil the mandated role:

> Yes, you've got professionals, the Clinical Commissioning Group, the National Health Service and so on and in a sense I'm just an ex-teacher, and here I am on the Health and Wellbeing board you know. What do I know? (Local Councillor)

Their preconceived idea of the skills and capabilities needed for the mandated role causes these group members to construct a negative interacting identity. In this study, this had the effect of these members questioning the legitimacy of both their mandated role and their right to interact with the professional group members. This was put by one democratic member:

> How do you put that backbone into somebody's who's like me? Who's like faced with all these people around the table who are paid God knows how many hundreds of thousands of pounds, you know? How do you actually put the backbone into somebody to say, you know, in a public meeting 'Well actually...' 'And when are we going to....' and 'When are you going to.....' and 'Actually have you?' (Local Councillor)

Another stated:

> I used to feel very, very uncomfortable because these were professionals and, who was I to go in, and act again as a bit of a watchdog? I used to feel quite uncomfortable doing that because I didn't think I was equipped enough. (Local Councillor)

Democratic actors in local health and social care are mindful of the traditions in local decision-making regarding care and where the authority to make decisions sits. Within the democratic structures of Local Authorities, these traditions dictate that health and social care organisations such as the Foundation Trust, the Clinical Commissioning Group, and Public Health and their representatives will make decisions regarding the organisation and provision of care for and behalf of others. The Health and Social Act (2012) reforms disrupted that tradition. The Act was intended to democratise the traditionally closed, professional-led decision-making practices of health providers. One way of achieving this was to introduce locally elected politicians to hold professionals to account. And yet, the analysis of the data in this study reveals that, due to a relative lack of experience and context-specific training, they felt ill-equipped to take on the role mandated to them and felt unable and unwilling to question seasoned professionals.

One of the main impacts of the reforms of the Health and Social Care Act (2012) has been to create more complex roles and responsibilities for those that have previously been involved in a different capacity. Humphries *et al.*, (2012) and Humphries and Galea (2013) cite the considerable confusion surrounding roles and responsibilities within Health and Wellbeing Boards as one of the biggest factors impeding their success. The mandate concerning Health and Wellbeing Boards in the Health and Social Care Act (2012) gave some direction as to the functions and duties of the collective; however, the only direction regarding individual roles was that those involved with health, social care and public health work 'more closely together'. When asking one democratic group member about the role that they played in this mandated collaboration, they responded:

> It wasn't blindingly obvious what you were going to do. Actually, you were to some extent, thinking on your feet. (Local Councillor)

Although the local councillors were mandated members and attended every meeting, even towards the end of the period that I observed, their interactions were still noted as being limited. Mandated group roles can often differ from the individual daily roles in which individuals have become socialised. Within this group process, the group role of professionals such as the Director of Adult Social Services, The Director of Public Heath, The Chief Executive of the NHS FT and the CCG Chief Officer became an extension or continuation of their daily professional role and identity. For those group members representing the democratic voice, the mandated role showed little similarity to the functions of their socialised daily roles, which caused further difficulties for these members of the group, as put by one member:

> I think it is sometimes difficult, for me as well, because it's taken me.... you know I don't quite know what my role is. (Local Councillor)

Mandated group roles also become a source of conflict when the duties and functions differed to the extent that they became an extra set of duties in addition to daily roles.

> I'm an elected member who doesn't have as I said necessarily the…., well certainly doesn't have the professional background in it. You know has a portfolio to run and a ward to see to residents. Actually, here I come and how much can I - you know how much energy do I have to do what I think I might be able to do? And also, time and at the expense of things that I'm actually elected to do. (Local Councillor)

The majority of the democratic actors in this mandated process were locally elected councillors, with the exception of one who represented a service user group. The primary role of democratically elected members is to serve and represent the interests of their local community, which involves very separate functions and duties to the mandated group role. For these group members, the lack of a professional identity in health, social care and public health constrained their level of interaction, which became an additional burden. For the professional group members, the mandated objectives aligned with the functions of their daily role. This lack of conflict was identified and explained by one manager as:

> There is a bit of some of my organisation's key objectives and what we are aiming to achieve is a part of the health and well-being board's agenda. So, what we do around, particularly around the quality of health care in the borough, is relevant to the health and wellbeing board. So things like the healthy weight inside South Tyneside and the obesity strategy, does that touch the work that the CCG, yes it does and therefore it is a key part of our business which is tackling some of the obesity issues and that probably feels like it's contributing to the health and well-being board working. (Clinical

> Commissioning Group Manager)

This conflict can also be interpreted through the intersection of ley member knowledge, expertise and experience that socially sratifies members to their skills, knowledge and qualifications resulting in a hierarchy of order which then acts a mechanism to conrstnthe level of interactions action which kay members have in this decision making process (Hayward, 2000; Kerckhoff, 2001). However, the literature also higlights that there is no agreed definition as to what constitutes constitutes as lay expertise, experiential expertise, experiential knowledge and lay knowledge (Shaw, 2002; Prior, 2003; Martin, 2008; Weiner, 2009; Thompson *et al.*, 2012) which can exclude the non-institutionalised contributions that lay members can bring. In this sense, lack of consensus as to what should consituute this contribution acts as a mechanism to constrain lay member action (Hayward, 2000) .

4.2.2 Perceptions of Others

> I don’t think they have really got a full understanding of what health commissioning is all about. It’s taking - well maybe that situation has changed. My colleagues may feel that’s changed. I didn't feel, when I was involved, that the local politicians understood what health commissioning was all about and the role of PCT's particularly and they didn't understand that terribly well. (Clinical Commissioning Group Manager)

Although it could be argued that every group member forms perceptions of self and of others, the analysis of the data revealed that not every group member experienced this in the same way. Where the data revealed perceptions of self as a source of conflict, this was heavily present in the narrative of the democratic group members and perceiving others in this sense was seen as source of conflict that was seen to constrain interaction within the group. When the analysis of the data revealed conflict in the perceptions that members held about others, this was revealed only in the narrative of the professional group members.

These group members perceived that they themselves had high levels of fit between their daily interacting identity and the mandated interacting identity while the democratic members did not. The view that group members representing the democratic voice did not have the necessary skill set to fulfil the mandated role was shared between these members:

> They don’t have sufficient knowledge … they're not equipped … they're not equipped to bring that challenge because they're not …. they don't have sufficient knowledge of service provision to be able to do that … so their skill set, it was limited to challenge. (Foundation Trust Manager)

This perception is linked to the wider culture of decision-making in health and social care. Traditionally, central government has seen a need to restrict decision-making powers in local health, social care and public health to the professionals and practitioners employed within these agencies. Unlike the democratic group members, their position is generally achieved via formal education or a management qualification. The democratic group members were perceived by some as being unqualified to make clinical and managerial decisions, which caused a negative perception of their behaviours and capabilities. As noted by one professional group member:

> I just don’t think they got it, I think they thought - oh Christ we’ve got to do another meeting here and they didn’t really see it as what it was which was a statutory requirement which had to have some statutory outputs from it and they just didn’t utilize it. (Foundation Trust Manager)

There was also a recognition of the challenges caused by not having this clinical and managerial background:

> I think it's been difficult for them, I think a number of them have re-shuffled a number of

> times, so we have gone through quite a lot different councillors discussing at times very technical, very difficult long-standing nuanced problems, for somebody coming in from completely outside the health and social care backgrounds. Coming into that must be incredibly difficult for them and I think they will probably able to contribute more if they were able to stay for more than a year or two around that table. (Clinical Commissioning Group Manager)

Although the professional group members viewed other members as having inadequate skills for the mandated role, they did recognise the challenges that these members faced. Despite the tendency to be negative about the democratic members, there was an acknowledgement that these had been mandated into a collaboration with immediate challenges that would be hard for them to overcome, and empathy towards them. The professional group members recognised the challenges that some were presented with when trying to interact to fulfil their role. The obesevations of the Health and Wellebing Board also supported this. Although I never observed any one expressing this perception of others in the formal meetings, the professional group members were not seen to encourage participation from the others or offer support to help them through the meeting.

There was also a further dilemma for the democratic group members in that they were required to follow the needs and wants of the local population. The focus of their roles could change on a yearly basis, from being attached to adult and children health, to health and wellbeing, or education.

> Right now, I’ve been in all sorts of you know, I was in public health, then I was out of social care, now am transport and housing, now I never built a house in my life, I know nothing about railways or houses. (Local Couoncillor)

Although Local Authorities and their decisions will be managed by civil servants, each area of a Local Authority’s remit, or portfolio, will be represented by an elected member to ensure a democratic voice in decision-making in public services. The impermanent nature of councillors’ positions means they can fail to be re-elected to office or switched to other portfolio areas at relatively short notice. This represents a barrier to learning and knowledge which limits the level of specific knowledge which can be accumulated in each portfolio area (health and wellbeing, adult and children’s services, mental health, public health) and can fragment efforts to interact. This was not only recognised by the professionals and practitioners in the group but also by the democratic members themselves.

Sometimes it appeared that some group members were too quick to gloss over the skills and attributes of elected members, whose primary concern had to be social justice for their electorate. As noted by one health care manager:

> I think that some of the contributions from some of the elected members have been purely heart-based rather than head-based and have not made a great deal of contribution to what has eventually come out that. (Clinical Commissioning Manager)

Professionals in health, social care and public health spend years amassing a high degree of knowledge concerning the practices and processes of health and social care decisions. In perceiving others as not being up to the standard needed for the mandated role, practitioners and professionals misinterpreted the contribution of these members, or the skills and capabilities of these members, as being purely heart-based. This also echoes the findings of Batalden and Mohr (1997), and Tsasis, Evans and Owen (2012), that failure to have awareness of each other’s roles leads to the risk of disharmony and demotivation. In this study, it resulted in some members paying little importance to the skills and contributions of others, whilst perceiving their own skills and attributes as necessary for this mandated role. This kind of thinking creates tensions and challenges between group members that were never vocalized in the interviews but were observed in the Health and Wellbeing Board meetings. Democratic group members were often observed in those meetings as being silent and not contributing very much, which did confirm the perceptions of others that were analysed in the data.

This theme of recognising the self's interacting identity (role, experience, knowledge and skills) as being more suited or better than others was prevalent in the analysis of the data. Professional and practitioners are trained in the process of assessing health, social care and public health needs, based on scientific and objective reasoning. Health, social care and public health systems can be understood as an approach to change which perpetuates the belief that change is linear and predictable, a belief more generally associated with the reductions and deterministic thoughts of scientific management, where change and solutions can be achieved through meticulous planning and control (Tsasis, Evans and Owen, 2012b). As a way of maintaining order and control in complex systems that require solutions to wicked problems, group members revert to the use of sophisticated management tools, concepts and models as a way of 'scientifically, orderly, planned, regulated, programmed and systems that are properly managed' (Greenhalgh et al., 2008, p.593; Karp and Helgø, 2009). In this way, knowledge learnt and skills developed act as a barrier to interacting with others, where some are viewed as falling short if they do not have the same standards of knowledge and experience. There are two interpretations to this. The reluctance to recognise lay knowledge, expertise and experience as anything other than 'lay' when this could span the boundary of technocratic knowledge highlighted by (Martin, 2008) supports the argument that democratic representation is to be treated in this way is neither representation or best fitting to add value to the decision making process. Second, recogning knowledge only as lay knowledge acts as a mechanism to constrain decision-making action within this group.This noted by one professional member:

> Well, some contributed very well some didn't. The cabinet member responsible for social care and health was the principal contributor as you would expect obviously and

> the chairman, the leader of the council steered the meetings, conducted the business but I never felt they made a tremendous actual sort of policy input but I didn't necessarily expect that ... the senior member was fine but I mean once you got past that person there wasn't really a lot of knowledge to be honest. (Clinical Commissioning Manager)

This kind of approach to local health, social care and public health provision and the allocation of resources in which professionals and practitioners were trained, is at odds with the primary or daily role for democratically elected group members. These members do not view the needs of local communities through the scientific and clinical reasoning processes with which health, social care and public health professionals become institutionalised. Although there was an acknowledgement that democratic group members did contribute within the mandated collaborative process, the level of contribution was perceived by others as lacking in a way that attributed any real policy input. Although democratic group members voiced that they were keen to contribute to the mandated collaborative process, observations of their meetings suggested that their self-perception acted as a barrier, in addition to the perceptions that others held about them. This was observed at most meetings that I attended. An awareness of the perceptions of others was analysed in the spoken words of one of the democratic group members:

> I think there is, I have to say, a bit of an inverted snobbery sometimes in some professional groups who perhaps see local government as less of a partner to them and so forth and that they are more professional. They have got better qualifications so I think it's a bit of inverted snobbery further down the food chain. (Local Councillor)

All the members in this group referred to the common view that there is a need to have a certain level of training, experience and knowledge in health care to fulfil the mandated role. Not all group members expressed this view, but their perceptions would suggest that they acknowledged its existence. Professionals and practitioners identify with a body of knowledge that is perceived to generate a professional identity, which then socialises other participants into sharing a similar identity. In local health and social care decision-making, the extent to which participants share a similar professional status has implications for the way they work together and which Loxley (1997, p.1) notes as a source of conflict arising from the deep-rooted social differences in labour developed over the last two hundred years in the health and welfare service.

4.3 Democratising Decision-Making Practices

The Health and Wellbeing Boards were created and mandated as part of the NHS reforms through the Health and Social Care Act (2012) with the particular purposes of, firstly, creating democratic legitimacy in the traditional decision-making processes of local health and social care and, secondly, improving integration levels between public health, local government, the local NHS and the third sector. Previously, decisions concerning local health and social care at this level were made with an exclusive membership of health, social care and public health 'professionals'. The new, more innovative, structure of the Health and Wellbeing Board was created with the purpose of democratising the old forms of traditional and closed decision-making practices, through the unusual features of having locally elected members sitting alongside senior officers of the local authority and the NHS; documented minutes available to the public; and meetings held as a public forum where members of the public and public organisations could attend.

Traditionally, decision-making processes in health, social care and public health have tended to lend themselves to closed forms of decision-making that are often regarded as being shrouded in secrecy, and where decisions are taken for the benefit of individual organisations rather than the wider remit of social justice. This traditional form of closed decision-making derives from the practice of social order, where modernistic and scientific measures are made ‘on behalf of’, not ‘with’, the wider public in an attempt to bring the cost and level of demand for public services within the level of institutional budgets. These approaches can be argued as enduring through processes of isomorphism, that is, not because they have been proved to be effective, but because rightly or wrongly key organisations have adopted them, thus lending legitimacy to the approaches (DiMaggio and Powell, 1983; Dickinson and Glasby, 2010). The newly mandated Health and Wellbeing Board requires and mandates professionals to relinquish their control of decision-making and to allow the input of non-care professionals, the democratic group members, in a forum where the public can view the issues that are being decided on their behalf. This democratising of the decision-making process was intended to enable interactions and decisions to be more transparent and more participative with the wider public and their representatives. However, while many of the group members agreed in principle that more open and transparent forms of decision-making are an admirable ideology, the reality of the democratisation was a mechanism that constrained group interaction and became a source of conflict, leading group members to develop strategies to manage this conflict and find ways to continue making decisions that affected their own organisational interests in the more closed and secretive forms of decision-making to which they were accustomed (these strategies are discussed in Chapters 6-7).

The democratising of decision-making practices was analysed as representing a source of conflict, in the main, for the professional members of the group. For these group members, opening up the decision-making process to include democratic and elected members, and allowing the public to attend, meant relinquishing control and sharing plans that they had not previously been obliged to do. For different reasons, as will be shown below, this source of conflict was analysed as affecting the interactions of all group members, but not always as a source of conflict. Conflict located in democratising decision-making practices took place through the public structuring of the decision-making process and was conceptualised as *meetings in public* and *documenting meetings* and *inclusion of elected members* which acted as mechanisms to constrain interactions between group members when collaborating under conditions of mandate.

4.3.1 Meetings in Public

> It's not that there are things to discuss in secret but I think that when there is an audience it puts a different perception on it. (Clinical Commissioning Group Senior Manager)

> Probably, what I would actually crystalise in three key areas which I think are barriers really, to make it really effective …. I think maybe the public nature of the meeting … the fact that the minutes are taken. I think they're the barriers. I think the public nature of the meeting and the minutes being public and the culture of the of the organisations themselves, this is all said behind closed doors you know. (Local Councillor)

The unusual feature of holding the Health and Wellbeing Board meetings in public aimed to create participative forms of decision-making that would lead to solutions to services that were designed locally and reflected service-user needs. The fact that the group decision-making process took place in an open forum represented a source of conflict for all members.

> I suppose it is the formal public forum and I do think that conducting business in public is an admirable aspiration. I do think it changes the dynamic of the sort of business that is conducted in a public meeting. (Clinical Commissioning Group Senior Manager)

For the professional group members, it was hard to deny that public participation was in keeping with current democratic values and encouraged public participation in care. However, although they could not deny that this is representative of more modern public management theories of organising care (Murphy, 2013), in practice they suggested that this changed the dynamics in a way that was not conducive for constructive interaction.

For some group members, there was a perception that mandating the decision-making process to become a meeting held in the public forum had the effect of making the whole process a ‘set piece’ and constrained group action rather than enabling it. In discussion, one of the professional group members was of the view that:

> ‘There is an element of the health and well-being board being a bit of a set piece. It's a meeting in public for one thing. (Clinical Commissioning Group Senior Manager)

This was also evident in my own observations of the formal meetings. The behaviour of members in the formal meetings was always formal, polite as if rehearsed. Mandating the meetings to be held in public also became a source of conflict for the professional members in that they were always aware of the risk of disclosing sensitive information and, even if the public did not attend, the minutes of every meeting were a public document, and this acted as a mechanism to constrain group discourse and level of real interaction that the group had regarding complex health and social care issues. Ironically, these concerns persisted despite the general absence of the public at open meetings, as one member noted:

> It's a funny thing isn’t it because it's a board in public but there are very rarely any public there. (Senior Mental Health Trust Manager)

However, even though the public meetings rarely attracted the public audience that the mandate intended, the opportunity for this to happen, or the veiled threat, was enough for members of an professional interacting identity to develop interaction strategies of a ‘behind closed doors’ nature, which is discussed in full in Chapters 6 – 8. This form of public participation in the group had the drawback that public opinion was likely to conflict with the professionals' individual organisational policies and would most likely slow down the decision-making process, and make it more bureaucratic rather than democratic. During the observations of the Board, on the rare occasions that that members of the public would turn up, they were asked to take a seat away from the main meeting table and were not interacted with at all by any member of the group. When the meeting finished the member (s) of the public would leave without having had any interaction with anyone. This was a further point that was confirmed in the observation data. On the one occasion that a member of the public did attend the meeting, they were kept at arm's length, no introduction to attempt to welcome them was made by any member of the group and even in an observation capacity this was uncomfortable.

Although formal meetings of the mandated collaboration were to be held as a public forum, public attendance was very rare, but the threat of democratic challenge still represented a source of conflict for those professional members of the group. The mandated public nature of the Health and Wellbeing Board allowed members of the public to attend every meeting but the reality was that the public attended only to lobby and campaign on decisions that affected services in a way which became a source of conflict for service users. One example of this was quite recent at the time of data collection, and group members on all sides referred to it. In 2015, the decision was taken to close a local community hospital and relocate all services to a newly opened centre called the Urgent Care Hub in a nearby area, which was estimated to leave 24,000 service users without access to a hospital in their local town. This was recalled as the only time that members of the public had exercised a democratic challenge to a decision that had been passed through the Health and Wellbeing Board.

> It does meet in public, and of late it has had some interest from the public attendees again due to again the Urgent Care Hub and the walk-in centre. (Clinical Commissioning Group Senior Manager)

> You never get members of the public turning up unless they are demonstrating about the walk-in centre. (Clinical Commissioning Group Senior Manager)

> Occasionally there might have been something of a controversial nature which people would actually come to but generally speaking there was not - there wasn't this public audience, occasionally you might get the odd journalist but no, as a rule. It wasn't attended as a public meeting. They have had one or two occasions where numbers of people have turned up when as we say when there’s some new controversy. (Clinical Commissioning Group Senior Manager)

The sense of conflict that members attached to this level of democratic challenge was noted in that the public was perceived only to attend meetings about controversial issues and to raise challenge rather than participate, which strengthened the view of members that the public structure acted in a way that invited conflict which the group had to manage.

This negative value that members attached to the public meetings was evident in a discussion with an elected member on individual displays of overt power, when the member recalled the democratic challenge exercised by the wider public in relation to the closure of the community hospital:

> I mean XXX chairs it sometimes and he is very good at that. I mean he has had a couple of difficult ones because members of the public have been there about the closure of the walk-in centre and he has handled it very well. (Local Councillor)

One professional member did highlight that there could be a positive element to the public attending the meetings in that they could participate in the decisions made concerning local health and social care services, but even this group member conceded that the wider public did not seem to engage on a positive level with the group but only on issues of conflict.

> Wider members of the public, you know, could be asking those questions and also potentially get something from the meeting as well. I guess what we've seen is that the only time that people have actually come to the health and well-being board have been very specifically about a service change and even in those situations, so I think I recall a meeting where there was, you know quite a number of people who were protesting against the relocation of the working centre, and they asked their questions towards the beginning of the agenda and then left. (Public Health Senior Manager)

The public nature of the meetings was also seen to influence the discourse that took place around the table between the group members, and had the effect of taking important conversations outside the group boundaries. For the democratic group members, the public nature of the meetings stifled the level of transparency regarding decisions that had been made. For these members, what was being said in the public meeting forum was not what had been said out of the room and out of the public domain.

> You know that there's going to be pressures there, you'll know it but how much is that influencing what they're saying around the table and therefore – and it's difficult to actually for them I suppose to say that as well because it's a public meeting although we very rarely have public there, which is another thing … for instance the walk-in centre closed less than half a mile away – the thought was that was based on financials, I don't think there is any doubt about that but actually that was never said in the room. (Local Councillor)

Group members of a democratic interacting identity perceived that mandating the meetings to be held in public did not always ensure the full and frank discussions needed for the complex issues under discussion in a local health social care and public health context.

Locating conflict in the public meetings from this perspective of interaction is caused by some group members having to stay loyal to organisational interests, the functions of their primary role and the wider financial pressures of the health, social care and public health political backdrop. Interactions then become strained when group members of a professional interacting identity are perceived to have made a decision elsewhere, behind closed doors, on key health, social care and public health issues, such as the closure of the local hospital.

This was further confirmed when the democratic group members sought to understand decisions that had been made elsewhere, and to bring decisions already made back into the democratised forum of the Health and Wellbeing Board.

> Well, I'll ask questions and this, that and the other, but actually if I'm told in a public meeting that everything that has been agreed to be in place in order for that closure to happen on the 1st of October is under way and is on target ... what more can I do, you know, what more can I do? (Local Counillor)

For the democratic group members, having the mandated meetings in public was perceived as a mechanism which constrained interaction (Hayward, 2000). It acted as a block to the discussion of sensitive issues which might have been discussed in a non-public meeting, instead of gaining participants' views and being better informed as to the needs of services users when making local decisions. It also acted as a block to the challenges which they had been mandated to bring into this process. The effect was to make the professional group members more intent on ensuring that those items were not brought to open discussion but rather decided elsewhere, so that when they were presented at the public meeting this was only as a token gesture, as it was simply too late for any other action.

When a senior manager from NHS England discussed his views on the meeting being held in public, he also held the view that the democratisation of decision-making practices was needed due to the ‘democratic deficit’ within the NHS, but that the need for transparency was overshadowed by the need to withhold information from those on whose behalf the policies were being made:

> Yes, I think it should. I think it should, because you know, as I said, there are times when you do need to have, to be able to have a closed door discussion to be able to have all the conversations about what potential implications might be that if you had in public could be very harmful if you're talking around scenarios of what might come up and you don’t want to put all of that fear out – but you need transparency, I think especially for the NHS with the democratic deficit that we’ve got. (Senior Manager, NHS England)

Closed-door discussion was a concept that appeared consistently in the narrative of professional group members and will be referred to in the following chapters. For some group members, the suggestion that it would almost be unfair to the public to ‘put the fear out’ on what was really happening in the decision-making of public services became a way of justifying why conversations happened behind closed doors and not in the public forum as they had been mandated to do. The use of a narrative that suggests transparency and democratic deficits, alongside one which speaks of the need to have conversations behind closed doors, gives the perception of an impression being fostered on others by these group members which is referred to as the tokenistic level of lay member and public involvement which is argued to have the lowest level of power and influence but also acts as a mechanism of power to constrain the level of inertacion for the lay members (Hayward, 2000; Martin, 2008; Croft and Currie, 2020)

4.3.2 Including Elected Members

Several of the professionals within the group were also analysed as locating conflict in the *inclusion of elected members*, which was a feature of the mandated Health and Wellbeing Board. Locally elected group members had caused conflict with the professional group members in the way that they confused their role in the group decision-making process with their daily role of democratic challenge (see below). They represented a challenge to the purpose and objectives of the organisations and daily roles of some professionals. The inclusion of elected members was perceived as a mechanism that constrained interaction (Hayward, 2000) and encouraged a reluctance to adopt open and transparent forms of decision-making as a means of fulfilling group requirements or dealing with sensitive funding issues for local health and social care provision.

> I suspect that some of the shortcomings that I have mentioned around health and well-being boards are probably a result of the mandated form of the collaboration rather than the collaborating parties just being allowed to get on and collaborate in the way that they would seem best for them. I think that the most important element to it and the reason why it [decision-making/the meeting] struggles at times is because of the inability to have those difficult conversations around that table. You would have to look at what is it about the form that inhibits those really difficult conversations. Is it the fact that it is publicly minuted and attended by members of the public and journalists, is it the fact that elected councillors are there, is it the fact that providers and commissioners are in the same room and might want to have different conversations with each other? I suspect that it's probably mainly the public element of it with a little bit of the other two that inhibits those difficult conversations and that form where the right people can be in the room to have those difficult conversations, but then the outcome of that can still be publicly accountable and transparent although not necessarily the in-depth content disagreement that may be needed. To remain confidential you would have to do some working out of how you would draw the right balance there. (Clinical Commissioning Group Senior Manager)

Convening the Health and Wellbeing Board in a public setting raised concerns for some group members in that it allowed public access to the mandated collaboration through a number of audience roles, and presented different audiences with the roles of the general public, journalists and elected members. Each of these audience roles represented a different dimension of challenge to the collaborative process and presents a mechanism with the ability to constrain interaction (Hayward, 2000) such as what would be discussed within the formal process and the extent to which this could be discussed for fear of further reprisal. Conceptualising the public by their different roles led the public meetings being conceptualised as to the level of threat, such as the general public as spectators or voicing opinions; journalists who would report proceedings from political angles; and elected members who would become privy to matters concerning their electorate. The analysis of the data in this study revealed that, although there were concerns as to the extent that meetings in public were seen as mechanism constraining the level to which integrated working could be effected (Hayward, 2000) the concerns were also due to a desire to make decisions regarding some key items of provision in secret, out of the view of the public and also out of the view of group members within a democratic interacting identity. The main concern offered above regarding public meetings pertains to the need for ‘in-depth’ discussions over sensitive disagreements and confidential issues; however, analysis of the data in this study revealed the need to retain secrecy and a professional closed shop. (Chapters 6 and 7 provide an in-depth discussion on this.)

This kind of public participation is what Newman *et al.*, (2004) label as ‘representative democracy’, which is seen as too hierarchical, bureaucratic and party-bound to effectively deal with the diverse range and needs of service users today. They argue that one of the reasons for this is that when democratic representation is mainly party-bound, as was the case in the mandated group, their views will be swayed by the local political interests that they represent, or their input will be swayed by the need to protect their political interests.

This was noted by one member:

> I guess the question is, is having an elected councillor really a democratization of decision-making that we do and, whilst the counsellor is or should be the representative of all the people of the borough, when they are at that level at the health and well-being board table, they have always got to have one eye on their electorate which is potentially very local polarized issue driven electorate, so I can see how it is really difficult for them to bring a balanced view of the whole borough, while still being locally accountable to their very local electorate. *(*Clinical Commissioning Group Senior Manager)

> I think you get some people going in who they can't put their representative of their ward or whatever at the door, they can't leave it at the door and that's what they're focused on and that makes it difficult. (Senior Manager NHS England)

Although (as alluded to above) the view that holding the mandated collaboration as meetings in public is admirable and in keeping with public participation theories, the extent to which this really democratised the decision-making process was questioned. Most of the democratic members of this mandated group (except one – Healthwatch) were locally elected councillors. Elected councillors are elected by local constituents, and are defined by their participation in local policy-level decision-making, championing the interests of their constituents and implementing national policy locally (Barron, 1991). The professional group members viewed the inclusion of the democratic members as failing to meet purpose, as their input could be influenced by the need to please their electorate to keep their political seat. In this view, democratising the process becomes ineffective and almost justifies the right to locate conflict in this particular source.

Elected members were also perceived by others as not able to cross the boundaries of their daily councillor role, which was noted when their loyalties to their electorate influenced their decision-making within the Health and Wellbeing Board, even when it was recognised and acknowledged that the decisions being proposed were in the best interests of fulfilling the Health and Wellbeing Board requirements. This was recalled by professional group members when discussing the contentious decision-making around the closure of a local service and the opening of a new Urgent Care Hub:

> I remember showing one of the Councillors around the hospital one day, because they were planning to make some changes to urgent care and he was being really vocal about not doing it. So I said, come in and I will show what we are going to do because when we need you to understand it more in detail. And he was very clear in that discussion where he said that, I can absolutely see what you want to do, I can absolutely see the benefit, but my constituent will not like this and first and foremost I am going to stand beside that. (Senior Manager Foundation Trust)

> So, the things that they … the thing that they would never concede to was actually moving a service from South Tyneside to Sunderland, even where it was absolutely the right thing to do for the patient and finance perspective. So, both for clinical and financially efficiencies and for the best for the patient, the electives members would oppose that regardless if it was the right thing to do. (Senior Manager Foundation Trust)

4.3.3 Bringing Accountability

Bringing accountability as a consequence of the meeting being held in public was analysed as being a source of conflict more for the professional group members. The action of lay members holdind professional members to accounti in the public forums was noted twice in the observational data. Although this was not done in a confrontational way there was a robustness to the questioning which was politely answered until the lay member appeared to defer to the professional argument. The democratic group members were used to and accepted ‘accountability’ as part of their elected councillor roles. They rather welcomed the accountability it brought to the professional group members, who were perceived as having little experience of this in their role of implementing social order. One democratic group member voiced their support of the opportunity for accountability brought by holding the meeting in public, as it was something that they had always had to deal with. In their view, the professional members of the group had enjoyed for too long relatively little public scrutiny when making decisions on behalf of the community:

> They were not used to having public meetings to discuss whether or not a place should be shut or not. (Local Councillor)

There was even a sense of relief amongst those who had always been exposed to public scrutiny as part of their daily democratic role, that the professionals were now subject to this also, and an acknowledgment of the difficulties of being subject to accountability:

> We are used to it. We’re totally used to it. Everything we do is just so open for scrutiny, so it’s like God bless you, I wouldn’t go so far as to say its welcome. It’s the statute that says you have to be but we don’t really want to be. (Local Councillor)

For the group members who represented the voice of democracy as part of their daily role, being elected or re-elected to represent the views of the electorate necessitates being open to a certain level of scrutiny regarding political intentions and achievements. Once elected, their role is to influence policies to satisfy the demands of their electorate and ensure that public officers carry these out, for which they need the help of public officers, some would argue because of the cognitive limitations of elected members (Finer, 1941). As such they are held to account by their electorate as to their record in local office. The analysis of this data suggested that, up until the mandated collaboration, there was sense of inequality when being held to account for the part each played in making and implementing local policy. The democratic group members noted the level of authority and lack of accountability that professional group members were used to, and how little equality there was between this and the level of democratic accountability the democratic group members had to accept as part of their daily role. This was put by one democratic member as:

> They operate right at the top of the food chain to a minister who they will probably never meet and the civil service of London. They don't feel as if they are accountable to the public and the same way as council employees have to be and are on a day-to-day basis. (Local Councillor)

> At the time I think just finding levels and getting used to work with politicians. I think people found that quite difficult – professionals weren't used to being challenged. They would be within their own environment to come to the decisions they would come to and they'd go through the different stages I'm sure. But they weren't used to the vigorous challenges they would get from the local authority because as I said we are used to it. We are used to being completely open and transparent. (Local Counillor)

The view that professional group members were only just starting to be exposed to accountability demonstrates the division in the interacting identities discussed earlier and also links to the difference in role practices that became a dividing source of conflict between them. This also shows the public scrutiny that the elected members were used to: instead of viewing their role as participative, they viewed their role as one of holding other group members to account which became a source of conflict within the group:

> They are professional people who have spent years getting to this level in their profession; they feel quite capable of making all these major decisions. They've been

> used to dealing with all these millions of pounds and now all of a sudden they around a board where you have people like myself who have no – I guess – yes I was a local government officer but quite a middle management role and all of a sudden you are accountable to people like me and if I had been them in their shoes I wouldn't have liked it very much at all, I really wouldn't. (Local Councillor)

Although bringing accountability was perceived as a source of conflict for professional group members, for the democratic group members it was perceived as one of the few areas of overlap between the group mandated role and their daily role. For these members, public scrutiny was seen as difficult and possibly at times unwanted, but it was also seen as legitimate and part of the democratic process that they represented. This differs from the bureaucratic, managerial or 'within organisation' scrutiny that was part of the primary role of those members with a professional interacting identity, that is when scrutiny takes place in the public setting rather than behind organisational closed doors. There were positive outcomes that some members felt were a consequence of the democratic decision-making process, and a result of more open and participative practices, rather than closed or 'silo' ones:

> It allowed it move up a pace and in a different way being a partner around the table so it allowed you to be part of decision making process rather than it be health and wellbeing board coming to a decision about X and requiring the health partners to then be calm about that decision-making and then having to see that, do that negotiation separately because you were actually part of it, it moved at a different pace and it also allowed you take into consideration not just the provider element but actually prevention element, and I think as a provider you do not always appreciate the requirement for that element in the detail that the councils do. So, it gave us a different, it helped development a different mindset I think. (Clinical Commissioning Group Senior Manager)

Another view of accountability within the new democratic decision-making process was that it could encourage bad relations or ‘interactions’ between group members if they had to discuss or challenge key issues concerning local health, social care or public health provision at a public meeting, and that this was best done outside the public meeting and only between the group members who had direct organisational responsibility for that provision:

> It makes it easier to hold people to account if you pick up the phone and say what is going on, rather than having to wait until a meeting in public that you are going to fall out at, so I think that has got to be a positive thing. (Mental Health Trust Manager)

There is a tendency for group members of a professional interacting identity to situate meetings in public as a source of conflict, which leads to poor or negative group interactions. Within the traditional models of health, social care and public health management, social action is achieved by formal rules and processes and holding people to account. This is contrary to the new discourse surrounding local health, social care and public health provision which mandates open and participative forms of decision-making and integrated working. The view of the new, open, democratic, public group space as being non-compatible with the rule and order associated with previous models of working together, is seen as a threat to the impression that the group is dysfunctional and to this effect, being able to interact outside of group boundaries with certain group members can only be a positive and good thing (this is discussed in depth in section 6.2 and 7.2).

4.3.4 Curtailing Frank and Open Discussions

A further issue noted as a result of democratising the decision-making process and analysed as a source of conflict within the data was labelled *curtailing frank and open discussions*.

This represented group members' perceptions that there was an inability to have difficult conversations as a result of *meetings in public*. One of the consequences of this was perceived by some as the limiting of open dialogue. When decisions of a complex nature are mandated to be made openly, sensitive information can suddenly become public, or the underperformance of an individual organisation in providing specific services can be disclosed.

> I think the key issue is that it is a public meeting. That is the most important thing to bear in mind, which then curtails how frank the discussions can be…. most of the time we tend to stick to the generic sort of non-controversial safe issues. It's not just one person, it is almost like we all just default to that place really, there is some hard stuff that needs to be figured out elsewhere and it is not the place of public meeting. (Senior Local Authority Manager)

Health and social care issues are extremely complex, and often discussions need to be of an open nature, disclosing and sharing information that is deemed sensitive, and at times with partners admitting or taking responsibility for failing to implement effective solutions. Locating conflict in frank and challenging conversations as part of the decision-making process became something to be avoided, but there also appeared to be consensus that solutions to social problems are arrived at through 'difficult, frank and challenging' conversations.

A number of professional group members highlighted the press as an element of the public who were able to attend the meeting, and indicated this as a source of potential conflict because of the need to discuss these issues elsewhere, in a place where public access to the discussion on these issues could be contained:

> So you start to think, what if, what would my organisation's relationship be like with this

> organisation if we have that sort of difficult conversation in a publicly limited meeting that journalists … I know they want to read these minutes and put them on the front page of the paper, what is that going to do to our organisation’s relationships? What's that going to do to perceptions? If I am being critical of the chief executive of one of our provider trusts, if it is going on the front page of the paper, lots of staff will read it, there are lots of knock-ons and that does inhibit, I think, the ability to have some of those frank conversations. (Clinical Commissioning Group Senior Manager)

> The CE and Leader of the council and the chair of the CCG are getting together soon to see what is coming down the track, what are the things we need to be aware of, what will be the asks that we want to put on the table, would it just be for example one-way traffic out of South Tyneside and losing services … what would we get in turn, but you necessarily cannot have that played out in public with the press there. (Senior Local Authority Manager)

Generally, it was perceived that although members didn’t want to portray that these meetings should be held in secret, the public element of the meeting altered the dynamics and stifled the level of openness and transparency. Group members were aware that, within the group, there were members whose contributions to the decision-making process would come from the perspective of social justice and those whose contributions would focus on finding financially viable solutions. Often these motivations conflict, as social justice concerns can be perceived as being value-laden and from a lived experience, and thus ill-suited to financial and objective solutions. This discord results in difficult conversations when equality of care is overlooked in favour of financial accountability. For some group members, this kind of conflict becomes heightened when such ‘difficult’ conversations are forced to take place in more open structures than they are used to. There is an awareness that decisions that negatively affect social justice have to be handled sensitively, and having the press present will only carry these decisions to an even wider audience. Traditionally, these kinds of decisions are made out of sight, and publicised only after the event, which tends to lessen the level of mobilised reaction against them.

Several professional members noted that that having meetings which the public, press and elected members could attend affected the extent to which group members could have full and frank discussions regarding the action needed around the provision of local health, social care and public health issues, or curtailed their discussions.

> As I said, it's a public meeting; the challenge that you get from partners is not great. (Clinical Commissioning Group Senior Manager)

> It's still feels like it's a meeting in public and it's a formal subcommittee of the council, so the degree of formality and seniority of people that you get around the table does not lend itself particularly to more open and frank debate. (Clinical Commissioning Group Senior Manager)

This was noted when one of the professional group members was asked about the ability within the new mandated process to have sensitive and difficult conversations when holding others to account, such as, if previously agreed action had been reneged upon or forgotten:

> It could theoretically, it doesn't. It doesn't have those; it hasn’t had those really difficult conversations with itself and its members. (Clinical Commissioning Group Senior Manager)

When asked why he thought this was the case, he explained that the difficult conversations just did not happen, which could suggest that the element of the Health and Wellbeing Board which was designed to enhance public participation failed to influence the decision-making process of local care. This view, that opening issues that might be challenging or sensitive to public participation has the effect of closing down these conversations, shows a contradiction with the mandate of the Health and Social Care Act (2012). It could also be due to the role identity process of professional group members being institutionalised in the traditions of bureaucratic and managerial decision-making, which can prevent an acceptance of the new collaborative process. The analysis of the data in this study has revealed there is a perception that the new mandated way of working is not equipped to allow the frank and open conversations which are needed when making decisions regarding local health, social care and public health provision and that the old regime would have allowed.

4.4 Coping with the Traditions of Others

> Yes, we are interested in better health and well-being for the population of South Tyneside; the CCG is interested in that; the health and well-being board is interested in that; we all want the same things, but we have different lenses of looking at how we get there. (Senior Manager, Foundation Trust)

Coping with the Traditions of Others was constructed to explain the way in which members conceptualize these practices as traditions which act as a source of conflict when they traverse the group boundaries, or which constrain group interaction (Hayward, 2000). It shows the blurring that takes place between the boundaries of group and individual practices and cultures that are so embedded that they impede and act as a mechanism to constrain group interaction (Hayward, 2000). All of the group members in this mandated collaboration belonged to organisations or institutions with their own ingrained traditions and cultures of the way things are done. These practices become imbued with a sense of authority; in that they endure with sufficient longevity to become the way things are done. When these kinds of traditions of others are perceived as mechanism that constrain group interaction and sources of conflict, which members developed interacting strategies to manage. The analysis of the data in this study revealed that, within this mandated collaboration, when the practices of one interacting identity are forced to co-exist with another, these practices can clash and become a source of conflict.

Coping with the Traditions of Others was manifest in the individual approaches to decision-making that group members brought with them into the new mandated process, and which caused tensions and constrained the level of interaction that took place. The analysis of the data revealed that there was a weak commitment to new ways of working, and group members were often reluctant to leave behind their traditional ways and approaches to decision-making regarding the provision of care.

In consequence, incompatibilities started to emerge when these traditions were not left behind at the Health and Wellbeing Board. For the democratic group members, this source of conflict seems to present particular challenges. Traditions for these members could be conceptualised as the processes or way of doing things that are handed down and the process by which they is handed down (Shils, 1981; Feldman, 2007). When old traditions are passed down or brought into a new place, Shuls (1981) explains that these traditions will be adopted by the new recipients, who through a complex process of engagement will reinterpret and adapt the traditions with their own experience and understanding, thus creating a new tradition which will be the new way of doing things (Hibbert and Huxham, 2010). However, Hibbert and Huxham (2010) also note that the extent to which traditions are engaged with and reinterpreted into new traditions, or to which the old tradition continues to endure, is dependent on the level of authority with which traditions endure. For some group members, when the traditions of others carried enough authority to endure into the new mandated process, this became a source of conflict.

When members blurred the lines between their daily decision-making practices and the

Health and Wellbeing Board's decision-making practices, high levels of incompatibility occurred, and these practices were perceived as constraining interaction between group members. The democratisation of the Health and Wellbeing Board had the intention of gravitating away from the traditional closed culture of decision-making, but the reality was to bring together two very different orientations and approaches to the provision of services. Many members of the group found it incompatible when the authority of enduring traditions was not relinquished. As noted by one democratic group member:

> I mean, I am not criticizing them at all, but they have had to change their [group members with a professional group member] outlook to come and work on health and well-being board. (Local Councillor)

This difference in approaches to decision-making was also noted as a barrier, impeding group development. The professional approach of social order and scientific management, and its contrast to the approach of social justice, created the perception of clustering within the group, of people existing within their own 'bubbles' and the need for the authority of this approach to be replaced with a changed outlook, if the new group decision-making process was to work. This was noted by a different democratic member:

> I think there are still areas to be developed because I think that the medical profession, how should I put this, they live in a medical bubble shall we say and the CCG, they are the same, and they do not have contact with people in the street in the way that we do so. Sometimes people get carried away with theory and academia and sometimes they need to have their feet put back on the ground and I think there are still areas about which, I mean I am not criticizing them at all, but they have had to change the outlook to come and work on health and well-being board. (Local Councillor)

The struggle with the concept of being mandated into a group rather than voluntarily coming together was evident in the way that members became territorial about resources that they might have to relinquish, knowledge they might have to disclose and practices to which they might have to commit. In the early days of the decision-making process, the directive of having to take collection action with others created feelings of suspicion and organisational loyalty which made group members guarded against the possibility of relinquishing power in the forms of control they had traditionally enjoyed over the issues at stake or resources they might be required to commit. This was noted by a democratic member:

> I think suspicions at first, that was there you may have heard it … the traditional ones … I think that gets back to the territorial thing. You got a group of people coming, bringing their own power base and their own territory and the thing is you know … you're saying now I've got to watch here … whereas really, you have got to go with that baggage, but you got to be prepared. Compromise, to compromise? (Local Counillor)

When the traditions of some group members were perceived as having the authority to endure and overspill into the new way of doing things, this caused feelings of suspicion among the other group members. Traditions in this sense were conceptualised as another group member's 'territory' or 'power base' that they were reluctant to relinquish. When traditions between group members compete in this way, new traditions are not invented by cycles of repetition and reinterpretation by the group as a whole, but rather they compete with and challenge each other. Friedrich (1972) and Phillips (2004) note that enduring traditions have an element of unchallenged understanding, which is why they endure as traditions. However, in this group, the decision-making practices of some group members endured, not because of a lack of challenge but because of the way these traditions acted as a mechanism of power to constrain levels of interaction.

If the intention of the mandate was to eradicate the authority of enduring traditions and practices and replace them with something new, this was not perceived to have been successfully implemented by all group members. There was a perception that the supposedly new way of doing things, which would lead to a more integrated way of working together, had not really replaced the old way of doing things at all. For these group members the traditional top-down approach was still felt to exist in the group meeting. This was expressed by one democratic group member:

> We have a lot of top-down control and top-down requirements and that can lead to quite a confused system. So, some of things that you to talk about, in terms of the role of the board, you shouldn't do this and you shouldn't do that, and there's a host of confusion around all of that. And as I say I think, many of the levers weren't in place for the Health and Well-being boards to fulfil the theoretical function of the government we're in. I don't think any of them are really doing that. (Senior Manager Foundation Trust)

The purpose of the mandate was to force the traditional approach to decision-making in care to a more open, transparent and democratic approach, to allow the contribution of non-professionals who brought the subjective views of those for whom the decisions had traditionally been made. This could be conceptualised as the forcing of new traditions and became a source of conflict, where the professional group members were perceived as acting in ways that were precious and protective over their traditional practices.

> Not to be deliberately awkward but to make sure we are delivering the best for our residence. I see that as very fundamental, now some people get very precious about that and very kind of you know - I think I get a feeling they do anyway get a little bit kind of protective and a little bit - but actually we all really want the same thing. It's just what we are seeing is, as counsellors, is 'Tell me the reasoning for that,' but actually that's not working because we know this is still at that figure so what else are you

> thinking of? (Local Councillor)

> There was a whole lot of stuff going on there. I think I started at that point on a low level and I found it really hard to have discussions on a one-to-one level with Health and Social Care Manager A and Health and Social Care Manager B. You know because they were very kind of protective really' (Local Councillor)

It was also noted by some group members that there were barriers to information and a reluctance to share knowledge of the individual decision-making practices in keeping with the perception that some members were being territorial. Before the establishment of the Health and Wellbeing Board, the process and culture of decision-making in care was mainly closed and decided by health and social care professionals, practitioners and managers. In this form of decision-making, control of the process is retained and challenge allowed from within the organisation(s) but not necessarily from outside organisations or peers. When health and social care issues became agenda items for the group, many perceived that this traditional culture of barriers to information, and a reluctance to share knowledge, kept the control over decisions outside the group, and acted as a source of conflict which severely constrained group social action.

> I don't know whether I would particularly have thought that I could change the CCG's position or even ask them to reconsider. I think it was a done deal. I think because of their culture, the culture that they have, we know this we know that, we know the background figures for this so, as a token we will commission a consultation. (Local Councillor)

> Very high level, very high level. I just think obviously NHS being a completely different kind of culture which is - perhaps as if not being that kind of outward looking really, a little bit it might have been some of that and politically maybe, similarly, you know,

> that’s their thing, that’s what they do. (Local Councillor)

One of the challenges of mandate identified in the literature and also within this study was the failure to include group members in these initial formations and planning stages of the collaboration, so that group members have an awareness of each other and their roles and build interactions between each other based on trust and respect.

> I do find particularly key figures’, XXX [a professional group member] who’s in my ward and just around the corner actually, attitude really off-putting and really, you know, arrogant. I don’t think he’s probably aware of it, actually. I don’t think he’s aware, and I have tried. I have had actually a discussion with him when a meeting’s finished, and XXX [a professional group member] as well when the meeting’s finished, and I’ve said, ‘What I’d say to you, is you need to take people with you and not dictate. You need to take people with you. As an elected member, you need to take the public with you’. He says ‘Oh, we’ve done this, we’ve done that’ and I think, well, you’re not listening to me. (Local Councillor)

The mandating of the Health and Wellbeing Board saw a group with a lack of time to build relationships or new practices and interactions based on trust and respect. The consequence of this was a struggle between the forging of new decision-making practices against the authority of more mature traditions which were perceived by democratic group members as constraining their level of interaction within the group. Democratic group members expressed the view that the professional group members were not willing to understand or get to know the views of others and this reduced their contribution to the Health and Wellbeing Board.

Traditional approaches to decision-making were also manifested in ‘silo’ ways of working, that is, members working on their own and within their own organisational boundaries when they had previously expressed a commitment to work on issues as a group. For the members who had been part of the decision-making process before the inception of the Health and Wellbeing Board, reverting to silo ways of working represented the lack of accountability and the authority of this tradition was still evident in the new group decision-making process which resulted in group participation being only an outward appearance:

> So I guess you are always going to have, there was always going to be some sort of difference in approach between health and social care and health, and the idea that you can actually do away with silo thinking just by having people sitting round a health and well-being board is not necessarily going to work. (Clinical Commissioning Group Senior Manager)

> I think that I have been in that board where there have been some quite robust discussions, but I think that there is a bit of a temptation for people to bring things to back to their own organisations for the actual decision to be made. (Mental Health Foundation Trust Senior Officer)

These enduring traditions were also noted in group members' individual organisational working practices, which were perceived as rendering contributions to the Health and Wellbeing Board as passive and ineffectual in enabling the outcomes for which they were mandated. This perception that certain group members were approaching the Board as a 'set piece', while making the decisions within their individual organisations, fostered the impression that these group members were acting out the process instead of taking genuine action, which allowed individual traditions to endure.

Bringing together two different approaches to decision-making created an environment in which traditions competed with each other and became sources of conflict. When enduring traditions and individual ways of doing things were not relinquished, new traditions were not able to take their place and this constrained the level of social action within the group. Resistance to the new traditions, in favour of the old, impeded the improvement to health and social care outcomes that members felt they would otherwise be able to make.

4.5 Chapter Summary

In the existing literature, conflict has not been identified as a critical issue in the studies of mandated collaboration. This study has identified that mandating collaboration has the potential to bring together individuals who have incompatible differences and, where this happens, conflict within their interactions will exist. The observations of the Health and Wellbeing Board meetings gave the impression of a very formal collaboration, where tensions rarely surfaced. However, it was observed that there were two different groups with the group. A divide was observed between the professional members who seemed to cluster together and the democratic members who seemed to cluster together, with the latter members always seeming unable to contribute very much within the formal process. However, the analysis of the interview data has shown that conflict in relation to collaborating under conditions of mandate is conceptualised in the identities that individuals construct for their interaction. For the democratic group members, where incompatibilities are perceived to exist between their knowledge, experience and daily role, this constructs an identity in which they must interact under conditions of mandate but in which they perceive themselves to be lacking the necessary skills and experience to fulfil the mandated role. For these members this becomes a source of conflict. For the professional group members, mandating the Health and Wellbeing Board represented a democratising of decision-making processes over which they were used to having control, regarding the organisation and provision of care. It gave them a new audience for their decision-making, by having the meetings in public and the inclusion of elected members. For these group members, having to be open to challenge and relinquish control over the decision-making process became a source of conflict as a result of interacting under conditions of mandate.

Many of the sources conflict analysed in the data of this study refer to issues raised in the review of the literature, which suggest that the issues need to be reconceptualised in the literature as sources of conflict. In this case study, the level of involvement that was suggestive of the partnership form could be classed at the level of consultation using Arnstein's (1969) analogy. This façade of a deliberative structure has consequences for interactions that lay members perceive they should be having and the extent to which their interactions are limited by mechanisms which act in such a way as to constrain their action (Hayward, 2000). When hierarchies of knowledge, expertise and expertise emerge this enables professional members to control the legitimacy, accountability and credibility of the decision-making process through mechanisms such as agenda setting, institutionalised comfort and recruitment. In the context of partnership working, hierarchies are suggestive of top-down control, where decision-making is held at the individual level which is contradictory of the collectivist aims of two-way interactive and deliberate forms of decision-making (Abelson *et al.*, 2003; Hunter *et al.*, 2018).

In the new democratised collaborative processes, they must interact in coping with the individual practices that each group member brings into the new process. The final source of conflict that was identified for all group members was coping with each other’s traditions, or the decision-making practices which each group try to bring into the mandated process, instead of relinquishing these and allowing new practices to be established as part of the new way of doing things when interacting under conditions of mandate. In seeking to understand how these group members manage these sources of conflict so that they can continue to interact under conditions of mandate, the analysis of the group members’ data revealed the various strategies they develop. This has been constructed as the basic social process of managing conflict, which has been constructed from the analysis of the data in this study. Chapter 5 now moves on to start discussing this grounded substantive theory in more detail.

Chapter 5: Interacting Orientations

> *Are we really making a difference? Or are we just saying it as it is a nice thing to do because it scored some points and it made us feel as though we were doing something useful for that sector of society. I just don't know, because all of those individuals around the table, their prime responsibility is to their organisations, it does make it very difficult, particularly when budgets are stretched, when staffing is stretched, when everybody is trying to do more with less and deliver on the must dos for your organisation and the nice to dos for the whole, come second. It is about shifting the nice to dos for the whole and the whole system, against the must dos for the organisation. (Senior Manager, Clinical Commissioning Group)*

5.1 Introduction

The previous chapter illustrated where the group members of this study located sources of conflict when interacting and collaborating under conditions of mandate for the organisation and provision of local care. The analysis of the data also revealed that these group members developed a range of strategies, processes, actions and attitudes as a way of managing these sources of conflict, to enable them to continue to interact under conditions of mandate. This represents the basic social process of *managing conflict* which is a substantive theory that was constructed in this study and grounded in the data. Within the basic social process of managing conflict, these group members move through the three conceptual domains of *interacting orientations* (Chapter 5), *interacting positions* (Chapter 6) and *interacting strategies* (Chapter 7). To assist with the reading and discussion of this basic social process, a diagram of this substantive theory is provided on page 17 at the front of this thesis and in Appendix A.

5.2 The Concept of Interacting Orientations

Interacting orientations is one of the conceptual domains through which the group members manage the sources of conflict that occur under conditions of mandate. The term ‘interacting orientation’ is used to explain and illustrate the idea that group members come from two distinct and opposing orientations which influence what they perceive to be conflict and the strategies they develop in order to continue to collaborate under conditions of mandate. The two key interacting orientations of *social justice interacting orientation* (5.3) and *organisational interacting orientation* (5.4) were analysed within the data and are manifest at different levels and intensities within the mandated process. That is, the literature was not able to provide theories or concepts regarding mandated collaboration able to support the discussion of the analysis of the data in this study.

The analysis of the data in this study revealed that what naturally followed these group members throughout the process of collaborating under conditions of mandate and which was most intimately identified with them was their beliefs, attitudes, feelings and they values systems they leaned towards, the compass which influenced how they perceived things, the position from which they interacted and the action that they took. The analysis of the data in this study suggests that this part of the personal front, which was crucial to the way these individuals collaborated under conditions of mandate.

Orientations are the beliefs, attitudes, feeling and values systems that individuals lean towards, the compass which influences how they perceive things, the position from which they act and the action that they take. In this study, group members interacted from a *social justice orientation* or an *organisational orientation.* Members of the group from a social justice orientation are interested in the provision of health and social care services that advance the inherent human rights of equity, equality and fairness in social, economic, educational and personal dimensions (Goldfarb and Grinberg, 2002). All of the democratic group members of this study were analysed as coming from a social justice interacting orientation. For these group members, the process of health and social care should be built on respect, care, recognition and empathy. Members from a social justice orientation place issues of inclusion and marginalisation in the access and provision of health and social care at the centre of their advocacy, practice and vision, which informs their approach to collaborating under conditions of mandate. The professional group members of this study were analysed as orienting from an *organisational orientation.* Group members from this orientation favour the provision of health and social care via order, control and the prescriptive processes of fixed rules and authority, which are developed from the value and belief system of scientific management. From this orientation, the provision of local health and social care must align with organisational priorities and show financial efficiencies that match levels of organisational funding. Routes to the provision of care from this orientation are found along the prescriptive processes of outcome frameworks, indicators, evidence bases and analysis. Each orientation is now considered below.

5.3 Social Justice Orientation

> It's being champion of the patient and people and it is around signposting people. We have given people advice, finding out the views of people, about GP services or pharmacy services or eye care services, and then ensuring that those views are fed through to planners and decision-makers, working together to try and get the best possible services for everybody. (Senior Manager, Voluntary Sector Organisation)

> So, the little things, things that mean a lot for service users, that's what it's really about. (Senior Manager, Voluntary Sector Organisation)

The commitment to working within the remit of local health, social care and public health, from the motivation of being attentive to the welfare of others and the goal of an equitable system, is identified as interacting from a *social justice orientation*. In using the term social justice, I refer to the disruption and subversion of marginalised and exclusionary processes that exclude the active participation and voice of service users (Gerwirtz, 1998) or, as Young (1990) defines it, ‘the elimination of institutionalized domination and oppression’ (p.15). The democratic group members of this mandated collaboration identify their orientation as stemming from a concern for others. Collaboration under conditions of mandate from a social justice orientation is motivated by the intention of acting out of concern for others, being the voice of the marginalised and subverting the practices of the current processes surrounding the provision of health and social care, that appear (from this perspective) to favour individual organisational concerns rather than the welfare of the service user. The interacting orientation of social justice is explored through the conceptual elements of *interacting out of a concern for others*, *seeking collective action on social issues* and *bringing the public voice*.

5.3.1. Interacting Out of a Concern for Others

Acting out of concern for others is seen by some as the very essence of their daily role. This was voiced by one democratic group member:

> It is our role as the voice of vision-impaired people to campaign for better services. (Chief Executive, Health Watch)

Making decisions in health, social care and public health when orienting from a position of social justice is conceptualised as being the voice of those marginalised groups in society. Group members from this orientation see campaigning on behalf of others as a central component of their role. For these members, campaigning for equitable health, social care and public health provision for groups in society such as the visually impaired is central to their motivation and role. Making decisions from a position that first considers the needs of others, as opposed to institutional gains, is seen as a vocation for these members.

> Things like the Health and Wellbeing board and the Integrated Health board, the voice in the room would say, ‘Hang on a second. Where does the patient fit in this, where does the person fit into this model?’ Because they’ll be talking about integration and joined-up teams in one building, and that sounds good but what’s the benefit for the end user? (Healthwatch Manager 1)

The above quotation clearly juxtaposes organisational imperatives (one building) and user needs (where does the patient fit in this). It is not that organisational priorities should be ignored, but rather that organisational priorities should also be rooted in the needs of the user. Democratic group members are motivated by the plight of the service user in what Prilleltensky and Gonick (1996) have defined as an economically, politically and culturally oppressed system. For these group members, forcing decision-makers within the confines of the professional environment to consider and incorporate the patient perspective is a discourse through which their orientation emerges. This narrative is noticeably consistent with other democratic group members, who also view advocating for the needs of others as a priority in what they do.

> As a Councillor, I have more of an overview. People don't see the full picture; they can only see what is in front of them. So, their ideas tend to be about how it affects them, whereas as the Councillor you have got to think about how it affects the whole of the problem and things like that. (Local Councillor)

The view that decisions regarding local care are made with the organisation rather than the service user in mind, motivates the local councillors in this group and also shows the divide between this group of collaborating individuals, referred to in Chapter 4. In the above quotation, this is framed in terms of being able to see the ‘whole problem’ rather than partisan or immediate concerns. For the democratic group members, taking on a role that advocates for the wider electorate and those who have no influence on the decisions that will affect them, brings the view of the marginalised or absent into the mandated collaborative process, in the hope that the process will be affected.

Coming from a position of wanting to speak out on behalf of those not able to do so, on decisions that will affect the equitableness of the local welfare provision, defines interacting from a social justice orientation. These group members act out of a concern for others within the scope of their daily role. As considered below, this extended to publicising this kind of work and the stakeholders involved:

> It felt as though you were doing some good, like non-smoking work, like breast feeding, that was one of the things when I was Mayor. I got all the breastfeeding mums in the parlour and got their pictures taken and I just felt you – it looked as if you were doing something and felt it as well. (Local Councillor)

Acting out of concern for others is seen as particularly important for those sectors of society where action is needed to increase the health equity of residents, and to ensure that children are given the best possible start from birth (e.g. breast feeding). This shows the connection between advocating for the inclusion of others and orienting from a position of social justice.

Within the discourse of being motivated by a concern for others, there is also recognition of the constraints to interacting under conditions of mandate, when advocating for those who have been oppressed by the political, economic and cultural system. For the democratic group members, advocating for decisions to be made from a service-user perspective requires a recognition that these decisions must also take account of the economic impacts that are perceived as being part of the traditional decision-making systems. For these group members, there is a realisation that this will impose limits on the levels of action which patient advocates are able to take to effect decisions.

While there is a shared belief that a social justice orientation advocates for the welfare of others, campaigning to balance organisational concerns with equality for service users, there is also the realisation that, on some levels, the welfare of others cannot be bargained for when external constraints, such as finance, are too great. This was noted by one democratic group member when discussing the issue of closing a local hospital in favour of a more centralised Urgent Care Hub (referred to in Chapter 4). There was a concerted effort amongst the democratic members of the group to argue against this closure, but without success:

> So Healthwatch went away and did an analysis of what would happen if the hospital was not there, and they came back and said they thought it would be okay [if the local hospital was closed] and that there was enough services to support it [the community] and then we came back and said we want further checks on transport and these other six things and it eventually went back because it was something that had to go back to the NHS nationally, and we were able to say that we wanted these six points in place, because we weren’t sure that they were and only if they were, then we would support it. (Local Councillor)

For these group members, advocating out of a concern for others is often tempered by financial reality, and the fight for social justice has to be limited to issues such as ensuring remaining provision and transport links are adequate. This motivation comes with the knowledge that decisions directly affecting equality of provision can be negotiated even if not overturned. Group members in this instance were able to negotiate social justice through the processes and mechanisms of the NHS Act of 2006, which legally requires NHS bodies to consult with members of the public before making decisions on changes to health services. Negotiations for these members are also constrained in the current climate of squeezed public funding; there is often little room for manoeuvre when acting out of concern for others and also protecting services that will impact the most vulnerable and needy. While there was an understanding that external pressures did not allow for the preferred level of service provision, these group members resorted to more formal channels of engagement to bargain for and negotiate levels of welfare which would minimise the negative effects of decisions made under conditions of mandate.

Acknowledging the struggle that comes from interacting from a social justice orientation was voiced by other democratic members of this group. Several members discussed having to balance their efforts with external pressures which often jeopardised their efforts. As one local councillor explained:

> You know, we try to help our constituents, sometimes we just thought there's not enough money in the pot. So, we can try as hard as you like, but if there's no money there, you can't do it. It's as simple as that, and we have to go back and say, ‘I'm sorry we can’t do it.’ I suppose that was right across the board. There's things that you do, there's things you can't, and you sometimes have to say no. (Local Councillor)

This discourse of social justice is also interwoven with a pragmatic acceptance that, in some instances, preferred outcomes regarding the welfare of others cannot be achieved, and time and energy put into advocating must now shift to being in a state of acceptance. There is an acceptance that acting out a motivation to help others is constrained by the traditional processes of current service provision that is based on scientific rational models that do not support the culture of social justice. In these instances, traditional funding models that support processes over action act as a mechanism to constrain the level of social interaction taken by those advocating for the welfare of others (Hayward, 2000). Local councillors could be perceived as playing a strong role in defining public good and social justice in their localities, so it can be particularly contentious when they have to refuse the requests of service users. This could possibly cause tensions in their orientation, whether that is of social justice or perceived as orienting from a position of rational self-interest, which is often the assumption of local politicians (Pedersen, 2014)

Being motivated to act out of a concern for others can also cause tension, with personal consequences for those who advocate for others, especially if they cannot secure decisions that are in the interests of those who elected them:

> So, when you are – when I get a call saying, ‘hey come have this pothole fixed’ or this tree cut down or whatever – I’ll say, ‘well I’ll do my best’ but there are constraints. The health issue is the same. So, yes, you have to be prepared, prepared to say to the people of Jarrow, oh look, two points. One, clinically it is a better decision – you are in better hands and it is far more cost effective [at a hospital further away]. You have got to be prepared to say that and take the consequences that might be that you get chucked in the next election. (Local Councillor)

There is an awareness that fighting for social justice can come at a personal cost for the democratic group members. The culture of cost effectiveness, efficiency and response to market forces gives authority to decisions where cost savings outweigh the further marginalising of any groups of society. Although there is a need to be transparent and accountable to those for whom they advocate, acting out of a concern for others comes with the realisation that these external pressures can limit their efforts for social justice. In such instances, if social figures cannot convince the community that decisions that have been made are authentic, they can suffer the personal consequence of their motivation, or the orientation from which they collaborate under conditions of mandate, being misperceived.

Acting out of a position of concern for others was also viewed as necessary because of the way decision-making in local care has been managed and prioritised by organisations who still hold much of the authority in these matters. Organisations and their representatives are increasingly forced to make decisions regarding the organisation and provision of care for financial reasons, centrally influenced, which often have consequences for the service user. This was noted by one democratic group member who had been alerted to the fact that shortfalls in care were being supported by other members who also advocated out of concern for others, when this was actually the responsibility of some of the professional members in the mandated group.

> You know the [NHS counselling] waiting lists are through the roof and people are referring to third sector organizations who, out of the goodness of their heart, are doing this counselling actually, but you are not paying them, so there’s bit of a crisis here. (Local Councillor)

Voluntary organisations are known for their efforts to effect social change to empower people marginalised by the structures and institutions of society. These organisations are set up independently of government for the fulfilment of some community good and are often ideally placed to recognise where the needs of the marginalised are overlooked (Schwabenland, 2016). This kind of orientation is referred to as an organisational orientation in this study, where the motivations are not just different but perceived as being almost diametrically opposed by these group members. The analysis of the data in this study showed that collaborative tensions occurred when other group members were perceived as orienting from a position where collective actions were seen to ignore issues such as equity and justice. Democratic group members who orientated from a place of social justice interpreted the mandate as maximising well-being for those who are least well off and most marginal and were analysed as perceiving this as at odds with the priorities of the professional members and their organisations. Interacting orientations, or opposing ones as analysed in this study, were shown to influence what group members perceived to be conflict within these mandated collaborations, and the strategies that they developed to manage conflict so they might continue to collaborate under these conditions.

5.3.2 Seeking Collective Action on Social Issues

Orienting from a position of social justice also comes with the motivation to seek collective action on social issues, including those who prioritise decision-making based on economic control above the welfare of others. Group members from this orientation see the creative opportunities that exist in working with others motivated by a different concern. They also recognise that health and social care systems exist through the shared efforts of professional, political and voluntary cultures that have their own values, beliefs, attitudes and behaviours and should include all orientations, rather than seeing them in opposition. A social justice orientation does not seek to exclude different perspectives but seeks the social justice that can be brought about by cross-sector working. Engaging at an authentic level across cultures and sectors creates an opportunity to ensure that the patient voice and view are fed into health, social care and public health services at the planning level which achieves the social justice agenda.

Members of this mandated group who seek a social justice agenda realise this discourse is supported by a focus on collective action, rather than protectionism over individual cultures or priorities. This orientation places a great deal of emphasis on supportive and collective action that can afford some level of protection to the welfare of others, while also responding to the constraints of market forces.

> I think there is more collaboration going on across the public sector because of the government's austerity measures, which is requiring us to look at all those services to make sure we give thirty percent more and thirty percent less and how do we make sure that the public money we receive is targeted properly and that we don't duplicate service provision to local investments. So at that level, on South Tyneside we have all of the senior officers, Chief Executive of the council, Chief Executive of the Foundation plus others, working together – and looking up their services, [and considering] who is

> best able to provide a particular service, how might we reduce costs and how together might we provide innovative solutions to provide a better service within the tight financial budgets that will be given by government. Is it working? It has to work because otherwise the whole public sector services provision on South Tyneside will collapse, so we have to make it work. (Local Councillor)

The focus on working together instead of separately in times of austerity is viewed as a way to support the welfare of communities affected most by changes to health and social care services and is how the mandate was interpreted for these group members. The awareness that the reduction in public funding would bring about an unavoidable reconfiguration in services opened up opportunities for working together to find innovative solutions that would achieve everyone’s agenda, regardless of orientation. These external pressures brought about an understanding in the local health and social care system that collective action was necessary for survival of the current system. Working with those who are not motivated by a social justice orientation is welcomed, to ensure that better services are not compromised for efficiencies.

Coming together, or seeking collective action, is seen as consistently becoming part of the discourse of orienting from a position of social justice, as one member from a social justice orientation put it:

> It’s a way of coming together and looking at how we can support a growing population and an ageing population, and how can we lift the health of the area as well because that is important as well. (Local Councillor)

Seeking collective action for the welfare of others is perceived by these group members as being opposed to the motivations of an organisational orientation, as it places the concerns of the population before the concerns of the organisation or the professional self.

> The concerns we often share is about the health of children, pregnant women smoking and things like that, and there is no real disagreement between us at all, except people come and put areas of concern of how it could be dealt with and what should we do next so it can be very constructive as well, so I think that has to be said. There are lots of things coming up where people are bringing ideas about how we can support the health and well-being of people in the area. (Local Councillor)

A willingness to collaborate across orientations enables participants to see how different approaches to the same concerns can be constructive and a way to find common ground. This kind of discourse encourages the level of engagement that social figures can have in decisions on local health and social care provision and enables them to act on a more engaged level than the current culture of decision-making has allowed them to do. This form of collective action creates an environment where the views and ideas of social justice figures are invited and listened to in a genuine and constructive way.

5.3.3 Bringing the Public Voice

> *Yes, it does allow you to bring that public voice in because it’s part of what you do. (Local Councillor)*

In addition to acting out of a concern for others and seeking collective action on issues, bringing the public voice is also seen as part of the discourse regarding a social justice orientation. Group members who collaborate under conditions of mandate from a social justice orientation, bring the public voice into decisions made on their behalf as an integral part of their role in advocating for the justice of others.

Health and Wellbeing Boards were mandated by the Health and Social Care Act (2012) with the intention of imbuing the structures of local care with a sense of democratic legitimacy. Executive agencies clinically led statutory NHS bodies and senior officers of local authorities were mandated to share the decision-making on the integration of health and social care commissioning with democratically elected local councillors and the representatives of service user groups who represent the views of local residents. These group members perceive themselves as bringing the public voice to decision-making processes that had previously been without any, or with only limited, public participation. For these members, mandating the collaboration or democratically legitimising health and social care decision-making allowed them the opportunity to influence decisions that were previously made behind closed doors by those with economic and political power, using criteria that ignored any qualitative sensitivities of the service user. Group members who bring the public voice perceive themselves as influencing decisions in a way that is in the interest of the wider public and not for organisational interest. Advocating, campaigning and interjecting on decisions that directly affect the marginalised health and social care service user is perceived as being critical to their orientation. They recognise that their view, that decision-making in health and social care should be founded on a process built on respect, care, recognition and empathy rather than on scientific order and fiscal control, confirms the divide between the orientations in this group. One democratic group member noted:

> Different viewpoints all together. Different, different viewpoints and it’s tradition and traditionally different viewpoints. (Local Councillor)

Having a different point of view was perceived to be the essence of what divided the orientations of these group members. Bringing in the perceptions of the local community and their observations regarding the services that they use is an important element of bringing the public voice.

> I think I bring to it scrutiny and perceptions of what people in the locality are thinking as

> well or what we see in our localities. I think that is quite important, and it is quite different from the professionals' point of view. They are really presented with people who have decided to come for them, and so we are there on behalf of the people in the borough and the reflections and minds of adult and social care. (Local Councillor)

Bringing the perceptions of service users is an important part of advocating on behalf of those unable to do so. Volunteering to bring the views of the local community into the organisations of the professional group members supports the social justice agenda of bringing the voice of the marginalised to those who decide for them based on economic choice rather than their socially constructed needs. The focus on policymakers as a barrier that inhibits the local community from participating in health and social care planning and receiving care that matches their needs, becomes the essence of the need to include the voice and perceptions of the community in local planning decisions.

Consistent with bringing the public voice is the focus on reduced funding as a barrier to the quality and quantity of health and social care that meets local community needs.

> I suppose my job is then representing the people, okay they are cutting budgets and they are saving money but still retaining the quality and quantity of services that people want. (Senior Manager, Voluntary Sector*)*

Policy and planning approaches in local health and social care still lack the flexibility that is needed for more the participative forms of health and social care planning advocated by some (Crawford, Rutter and S Thelwall, 2003). The culture in health and social care planning currently views community participation with a tokenistic attitude. The formality and professionalism of planning processes can cause anxiety and feelings of ambiguity for those involved. Representing and advocating these views enables a social justice agenda to be interwoven in the policy planning process.

The group members who collaborated under conditions of mandate within this study became aware of the different orientations from which group members approached the interaction. The result of democratising the decision-making practices for the organisation and provision of local care made group members acutely aware that the motivations and behaviours that they bring into the collaboration are influenced by orientations that are constructed before any interaction has taken place. In a similar thread to coping with the traditions of others (Chapter 4 Sources of Conflict), these orientations were analysed as being a fixed base which influenced not only what was perceived as a source of conflict but the strategies that were developed to manage this conflict. The nature of the interacting identity of the democratic group members was also due to their orientation. This orientation was defined within their discourses as acting out of a concern for others, seeking collective action and bringing the public voice. This highlights the motivations that will influence the way that they collaborate under conditions of mandate.

The next section of this chapter explores and discusses the other interacting orientation which was analysed within the data and which was found to oppose the motivations and behaviour of the social justice orientation.

5.4 Organisational Orientation

An organisational interacting orientation signifies the commitment to working within the remit of local health, social care and public health from the motivation of being attentive to organisational priorities and financial budgets as a priority. In using the term organisational orientation, I refer to the ‘joined-up government’ values and beliefs in how care should be organised and provided. The emphasis here is on value for money, processes of fiscal discipline, scrutiny and evaluation and ‘what counts is what works’ (Scrutiny and Association, 2015). From this pragmatic orientation, group members of a professional identity collaborate under conditions of mandate. Collaborating under conditions of mandate from an organisational orientation comes from a position that prioritises financial efficiencies and organisational objectives in a way that favours individual organisational concerns rather than the welfare of the service user. The interacting orientation of organisation is explored through the conceptual elements of *prioritising organisational interests* and *achieving outcomes through prescriptive processes*.

5.4.1 Prioritising Organisational Interests

> You've got your own masters to serve, haven't you? Your own governing bodies, etc. So, you know, there was always that – there's always going to be that tension around how do you do all things to all men in these scenarios. (Senior Manager, Foundation Trust)

In contrast with the social justice orientation discussed in section 5.2.1 above, within this instance of mandated collaboration a further orientation from which group members interacted was also revealed within the analysis of the data. Organisational orientation is used to define the beliefs and values of the professional group members concerning the way care should be organised and provided for the local population. This then influences the way that they collaborate under conditions of mandate when making decisions regarding the provision of this care. Local health, social care and public health organisations are imbued with their own cultures regarding the nature of health care provision and how health outcomes for the population are best achieved. Reducing health inequalities in a way that supports and aligns with the organisation's needs and objectives is almost compulsory for these group members. Health, social care and public health professionals are socialised into their professions in such a way that they often assume an identity that mirrors the values, beliefs and attitudes of the for which organisation they work:

> I am just thinking about accountabilities and what and who is accountable to you for what and why. At the end of the day all of the members there have accountability to their own organisations. If you asked me to whom I am accountable, it's not the Health and Wellbeing Board; it is our council of practices, our GP practices, that is who I am accountable to, them. (Senior Manager, Clinical Commissioning Group)

For these group members, being mandated into the structure and processes of the Health and Wellbeing Board did not carry the necessary authority to alter the order in which they perceived they were accountable or who they were accountable to. There was a perception that the exclusive self-perpetuating professional bodies to which these members had always been accountable should still be followed in this decision-making process, regardless of the mandate. This orientation is then seen to cause incompatibilities in the relations between members, as the democratic group members can find it hard to 'break in' and get real access to decisions being made regarding local care.

Orienting from a place that prioritises organisational interests was also evident in the way that the professional group members assessed the mandated collaborative goals to the extent that they did or did not fit with their own organisation's goals.

> The Health and Well-being Board has a broad agenda about focusing on prevention, early intervention, moving care out of hospitals, supporting people in their own homes and enabling people to support themselves, and all of that fits in the general sense with I guess our organization goals. It's how then that's taken forward in a practical way and how it's taken forward in a meaningful way. (Senior Manager, Clinical Commissioning Group)

> No, I don't think the HWBB per se influences the Clinical Commissioning Group's commissioning strategy very strongly. I think Public Health does. So, I think that we

> have a strong relationship and a good connection with XXX and the rest of the public health department, so I think that from our point of view, it is at that level that we feel the influence, which I think, is quite appropriate. I don't see it necessarily happening at the health and well-being board level. (Senior Manager, Clinical Commissioning Group)

All health, social care and public health organisations have their own requirements and objectives which drive their agenda and action for social change. These organisations are legitimately constituted and funded to ensure social change, health, social care and public health outcomes; however, they are frequently perceived as being managed in a way that preserves the needs and interests of their own organisations first. Some of the professional group members assessed the mandated goals as to their fit with organisational goals before deciding the level of commitment that should be invested in the group. Once a good level of fit had been assessed, mandated goals could be reviewed as to how they could be taken forward in more meaningful ways.

The prioritisation of organisational goals was also evident within the interactions of the professional group members when mandated collaborative goals were perceived as having the potential to conflict with organisational goals.

> Yes, I think there is a possibility of having things that conflict with individual organisational goals. I suppose on the surface you might look at reducing non-elective admissions into hospital and equate that that would result in a reduction in income for the foundation trust, and how does that gel with their overall perspective of where they see themselves? (Senior Manager, Clinical Commissioning Group)

It became clear to some group members that reducing non-elective admissions, as a means of fulfilling mandated group objectives, might actually result in an income reduction for some of the organisations in the group. When this was perceived to be the case, consideration was given to these organisations and their perspective within the decision-making process, even if a solution that considered the needs of service users and fulfilled mandated goals had been reached.

Although collaboration under conditions of mandate might appear directly opposed to collaboration from an orientation of social justice, occasionally group members would highlight that the overriding objective of these two orientations was actually the same:

> We are interested in better health and well-being for the population of South Tyneside; the CCG is interested in that; the health and well-being board is interested in that. We all want the same things, but we have different lenses of looking at how we get there. So, from the CCG point of view, we look at how we can get there through the lens of commissioning mainstream health services, health and well-being board will look at the wider public health commissioning of public health services, but also other local services will contribute to health and well-being beyond Public Health. (Senior Manager, Clinical Commissioning Group

Orienting from a position that prioritises the individual organisation's interests recognises that any common agenda to achieve mandated collaborative outcomes is viewed through different lenses. For these group members, these different lenses, or different ways of doing things are how mandated objectives are fulfilled. Arrangements for health and social care provision are co-ordinated between the markets of purchasers, commissioners and providers, where each has its own way of viewing the political, social and economic environments. From this orientation, individual and separate action, rather than collective action, is perceived as being most effective in fulfilling mandated objectives, as the sum of individual action should eventually ensure this. Ranade and Hudson (2004) refer to this as the 'jigsaw model', 'where as long as everyone shares the same picture, they can in time see how all their separate pieces fit together' (p.33).

Bringing only elements of the individual organisation, in a way that ensures the essence of the individual organisation is heard, is also consistent with those that orient from a position of prioritising the individual organisational interests. The perception that health outcomes were better served by the sum of individual efforts or the jigsaw model approach, rather than by the collective action of the social justice approach was also discussed by another professional group member:

> So, we've talked about childhood obesity, we talked about safeguarding, we talked about child sexual exploitation, we talked about cancer outcomes. They're all pretty big, significant issues. We've had challenge about whether we got the right expectation and the right aspiration in those areas. So, I've seen healthy discussions and debates where there would be different views from different members of the health and wellbeing board about how quickly or how slowly we address areas. And also differences in opinion on how big some of these risks are for us. (Senior Manager, Foundation Trust).

Prioritising organisational interests when collaborating under conditions of mandate is coupled with weighing up the individual risk that might be a consequence of collaborative solutions. Whilst still acknowledging the need to address local health needs, this narrative returns to the needs, priorities and risks of the individual organisation that could be perceived as being at odds with the mandated objectives. Another consequence of prioritising organisational interests from this orientation is the pervasive action of silo thinking and individual decision-making. The action of prioritising individual organisational interests supports the behaviour of acting alone or within organisational boundaries.

> So, it comes back to being a partnership. So, we can't require any of the organizations

> to do most of what we need to do. So, if you take the example in the question you asked about, integrated or joined up commissioning. We've got a local authority commissioning function, we've got a CCG commissioning function, and they work together, they influence each other, but they still make their own decisions. (Senior Manager, Foundation Trust)

> I guess you are always going to have, was going to be some sort of inevitably the difference in approach between health and social care and health as commissioners and the idea that you can actually do away with silo thinking just by having people sitting round a health and well-being board is not necessarily going to work. I think it has worked pretty well but it is not the total answer. I think there was a fair bit of lip service paid to it but, if you actually crunched down, I suspect that there was not that much that changed as a consequence of people sitting on the Health and Well-being board. Not initially certainly. (Senior Manager, Clinical Commissioning Group)

Professional group members and their individual organisations were still perceived as maintaining organisational autonomy over decisions that should have been made in partnership with others. The localised framework of health and social care creates separate functions that self-govern as to their own clinical and financial objectives. The need and desire to integrate these functions is limited by the needs and wants of organisations to make their own decisions as a way of prioritising organisational interests. The intention to continue this behaviour in the new mandated structure of the Health and Wellbeing Board is perceived as being part of how these organisations operate. The mandate does not have the mechanisms to facilitate these old and new ways of working co-existing in the same space. Another professional group member noted the lack of mechanisms to cope or manage with the practices of an organisational orientation within the new mandated structure. In addition to the perception that mandated objectives were best achieved by the sum of individual efforts, this was perceived by some professional group members as amounting to nothing more than lip service, giving authority for silo thinking and individual approaches to continue.

5.4.2 Achieving Outcomes Through Prescriptive Processes

Coming from an organisational orientation is also defined as existing in a culture of achieving outcomes through prescriptive processes. Prescriptive processes support the beliefs and values that the health of the population is better achieved through mechanistic forms of control, reporting and monitoring which translate into quantitative evaluation for population assessments. This prescriptive environment continues the tradition of assessing health needs through bureaucratic forms with defined measures and rigid sets of rules which are perceived as the best way of maintaining order and control. From this orientation, improving the quality of life for the local population is about finding efficiencies in local systems. The overall vision of having a healthy population may be the same as in other orientations; however, prescriptive processes favour the use of mechanisms and forms of reporting which are also distinctive features of bureaucracy.

> The work done around smoking will have a bearing and impact in the life expectancy gap. So, I think those things are absolutely about the vision. I think the quality-of-life aspect is another part of that, and some of the work we've been doing around integrating health and social care, to enable people to avoid emergency admission in the hospital and come out of the hospital earlier, isn't just about being more efficient in the system, it's about improving the quality of life for people. So, I can think of a number of examples where the work we've done is absolutely about delivering the vision of the health and wellbeing board. So, I think that we do that well. Yes, we've got the mechanism to do that. We got the reporting and need to wait to do that, so absolutely yes. The challenge will be what every other health and wellbeing board is seeking to address, its outcomes so there isn't a static baseline. (NHS Manager, Foundation Trust)

This perspective comes with the belief that formal reporting and mechanisms to collect data can be used to evaluate how happy and healthy a population is, how long they should live and their quality of life, and assurances that population health has been improved will be confirmed through baseline statistics that show positive upward trends. The areas in which prescriptive process are focussed are the areas that these group members, participants and the individual organisation perceive that they can influence. Opportunities to positively affect health outcomes are assessed by using reporting processes that compare health data to other localities and determine through these processes if population health is underperforming compared to other areas.

> I think there's always more you can do, but in terms of an aspiration to reduce the life expectancy gap, particularly, I think we've focused on the right areas that we can influence. So, leaving aside the economic development question, we know that we got a life expectancy gap in terms of cancer survival rates. We know that part of that is about early or late detection in diagnosis of cancer. So, part of the program work has been working with GPs, primary care, second care, community care, harness other partners to signal and signpost an early intervention. So, that's one of the things that will make a difference in terms of life expectancy and survival rates from cancer. That will shift that life expectancy gap. (Senior Manager, Foundation Trust)

It is often argued that the majority of underlying problems contributing to the gaps in healthy population data, as identified by prescriptive processes, are the wicked issues or ‘messes’ that bridge and permeate jurisdictional, organisational, functional, professional and generational boundaries (Williams, 2002 p. 104). Schön (2017) also argues that these kind of issues are socially constructed, framed as to the individual’s social background, and as such are not amenable to optimal solutions, linear thinking or short-term fixes (Luke and Luke, 1997; Williams, 2002) The adoption of a process orientation can often ignore these underlying problems, in the belief that health inequalities can be rectified by designing intervention programmes that co-ordinate the individual specialisms of each function.

This orientation of reducing health inequalities also views the need for processes that link local and regional functions, such as educational development and education:

> I think what we need to keep coming back to is the health and wellbeing impact of economic development and what is happening elsewhere in South Tyneside and what's happening regionally. I think the answer is, as long as you got a strong enough connection into the economic development work and the educational development work in South Tyneside, I think that's probably sufficient. (Senior Manager, Foundation Trust)

> It might be that, and we could do anything we want to help the health and wellbeing board, but it's economic development in the educational attainment that would shift the health and wellbeing outcomes. On that argument, if we accepted that, the gap on the health and wellbeing board might be the economic development and the educational development components. (Senior Manager, Foundation Trust)

> So, things like the improvement in schools. South Tyneside over the last four or five years has had a really significant change with almost all its schools being good or outstanding. And I think that sort of success, when you see that delivering helps to encourage and create opportunity in other areas. When we start seeing the creation of integrated community teams or the building of integrated care hubs, those sorts of things I think then generate more of that success and people see that, if we all work together, we can achieve outcomes. (Senior Manager, NHS FT)

There is a need to view health solutions as attainable by connecting together the different structures of society, such as health, economy and education. Socialisation processes that link intra- and inter-generational processes become the mechanism through which individuals can occupy a socio-economic position that will lead to a good level of health and wellbeing. This approach focusses on health policies that shape attitudes and behaviours for self-management to avoid preventable illnesses. However, some believe that current prescriptive processes are not flexible enough to include the educational and economic measures that could improve health outcomes.

Although many organisations support the use of prescriptive processes to achieve health outcomes, there is a degree of discord as to which prescriptive processes will reduce demand on services and produce a healthier population:

> I suppose a lot of local authorities, obviously the way they carry out say performance management's totally different to the NHS. So, they don't have a raft of performance indicators or outcome measures to do a lot to sector-led improvement. And obviously, in terms of health and well-being boards, there is a national programme of sector-led improvement in relation to health and well-being boards and having external peer challenging support. Now South Tyneside hasn't gone through that process, which I think is a bit of a gap, because I know a lot of other areas have. They've learnt a lot; they've changed as a result and it's helped them think about where they've positioned themselves strategically. Are they making decisions for their whole population, are they missing things? So that sector-led improvement is another way of measuring it, and we haven't had any of that. (Senior Manager, Public Health)

Prescriptive processes can take a national sector-led approach or a local context approach. Traditionally, prescriptive process approaches to health outcomes have been organisation-led, with little cross-working across sectors. New prescriptive processes favour national programmes of cross-sector approaches that encourage inter-agency and interorganisational ways of working in health. Sector-led approaches are seen as a more valid way of evaluating and measuring the health of populations and can limit the errors that can occur when making decisions for whole populations. The need or desire to maintain the traditional approach to decision-making in care, through the use of local and individual approaches, recognises that these controls are limited in their attempts to improve health outcomes.

> If you look at, obviously, indicators of the public health outcomes framework for example, for some of those, you’re going to need a long time to show any change for some of the, I guess, more service level indicators. So, I guess an example would be overall tobacco prevalence and seeing a reduction in tobacco prevalence. That’s going to take years and years. All we know is, I suppose, using the evidence base and looking at the board supporting all of those interventions and really trying to prioritize them. (Senior Manager, Public Health)

Although there is a national push to improve health outcomes based on sector-led change, a process orientation discourse still favours individual organisation approaches. Scientific approaches to improving health outcomes do not encourage innovative thinking in finding other solutions, and participants from this orientation become institutionalised into using evidence-based approaches. Rigid and prescriptive approaches do not allow flexibility and, where approaches cannot be changed, areas of health inequality become prioritised over others. Despite a recognition that prescriptive processes are slow to effect change, the belief persists that these indicators, the ‘hard’ indicators that are used to measure the areas of health that reflect the greatest inequality, should have an even greater focus placed upon them.

> The hard indicators need to play a bigger part in the Health and Wellbeing Board. So, you could always tick a box very regularly about integrated partnerships working. But

> actually, it says nothing on the KPI, on the solid KPI such as – I don't know – just obesity or levels of smoking or whatever, that are coming through the partnership then actually you have got key measurables for the health and wellbeing aspect. (Senior Manager, Foundation Trust)

Process indicators that are described as hard, or those indicators that measure the 'wicked' health outcomes in an area, are also believed to safeguard against empty partnership working by some group members. Prescriptive processes have a history of using partnership working as a way to reduce health inequalities. These efforts view the old forms of hierarchy as the dominant route to the organisation of care, achieved by bureaucracy and vertical forms of integration. However, such approaches come with a history of failed attempts to co-ordinate the functions of the health and social care system. Using those indicators that highlight the areas of greatest decline in the health status of a population ensures that the process of partnership working itself does not become a tick box exercise or an ineffective action but ensures action. This approach, however, can still be viewed as one that favours rules, routines and standard operating procedures that are also synonymous with bureaucratic perspectives and approaches.

The adoption of prescriptive processes to manage the partnership process also lends itself to accountability, that is, holding others to account. Prescriptive environments must reduce health inequalities but must also minimise the transaction costs those processes bring.

> We did have a performance framework drawn up that is supposed to monitor how we are doing against our priorities. (Senior Manager, Clinical Commissioning Group)

> There is a performance framework that, at least in theory, should hold people to account. I mean, it is down to the whole members whether they raise their concerns or not but there was an example on whatever we have been doing on breastfeeding

> which has not been working, you know, so the public health team or whoever it is, I think its public health, need to sort it out, you need a more robust plan. (Senior Officer, Local Authority)

The need for financial regulation and transparency becomes even more necessary in times of health reform and cuts to health and social care spending. In this case of mandated collaboration, hope of collective action does not assume collective responsibility when targeted outcomes are not achieved. Maintaining an environment that ensures control through prescriptive practices identifies areas of underperformance, and tasks those responsible to construct even more robust processes.

Achieving financial efficiencies in care provision through other routes is another value of those who prioritise prescriptive processes for health outcomes.   Prescriptive processes prepare the way for the reconfiguration of services at a time when the provision of care at a level that matches funding becomes a key priority.

> The scrutiny committee has the statutory power to refer any changes to local health services, things are in the best interests of local people's, to the Secretary of State for Health for review and they did in that case. In this case, they referred the proposed closure of the Jarrow walk-in centre to the Secretary of State. Now, off the record, I don't think that was necessary. I think the reasoning behind the closure of that walk-in centre was entirely justified - the evidence showed that it wasn't really taking the strain off any part of the system as it was meant to do is. People were turning up to the walk-in centre and being assessed as either ‘you’re fine’ or ‘you need to go to accident and emergency’, so why don’t you just cut out the middleman. So, personally speaking, I agree with that analysis, however any closure of the service is always going to be controversial, and elected members understandably reflect the views of some of their more vocal constituents. (Senior Officer, Local Government)

Reconfiguration of services from a place that supports the individual organisational interests usually contradicts the social justice orientation of seeking to provide access to care for the whole of the population in an equitable way. Those coming from an organisational orientation decide levels of care, based on a prescriptive process and financial analysis, whereas a social justice orientation advocates for the provision of care that is equal for all, especially those marginalised sectors of the population. Prescriptive process environments evaluate the need for care through commissioned data collection exercises and analysis that considers whether current access to care is financially viable. UK health systems are designed around process and, as such, arguments based on prescriptive processes carry a level of authority that is able to override those made from a social justice orientation.

5.5 Chapter Summary

In summary, this chapter has discussed two distinct and opposing orientations which show the different values systems in which group members are oriented, and which in turn influence their approach to collaborating under conditions of mandate for the organisation and provision of local care. The emergence of two different orientations within this one group located the different values and beliefs that members held concerning how health and social care provision should be viewed, and the approach that should be taken when collaborating under conditions of mandate for the health and social care provision for the local population. These opposing orientations are influenced by the two interacting identities that were analysed within the data. The more participative and democratic decision-making structure of the Health and Wellbeing Board became a place of division, and opposing orientations were analysed as not collaborating together under conditions of mandate, bringing tensions and challenges that would influence the position they adopted from which to interact (Chapter 6) and the strategies they were able to develop to interact (Chapter 7). Participative and democratic decision-making processes, such as the Health and Wellbeing

Board, are intended to bring into the process the public and/or their representatives. This is explained in the extant literature as collaborative governance, which can be understood as a more modernised image of public services in which organisations involve their users and local communities in the decision-making process (Newman *et al.*, 2004). However just as Newman et al. (2004) and Fraser (2014) argued, these newer forms of participatory and democratic decision-making are not equipped with the mechanisms to cope with the interactions and relationships on which they depend if they are to work. The data in this study showed that collaborating under mandate from two opposing orientations started to frustrate the collaborative process, and interactions became independent rather than interdependent as intended. The extant literature revealed that when mandators and even collaborators do not view the mandated collaboration as the institutional field, the participants' awareness of other diverse, independent and semi-autonomous figures is limited (DiMaggio and Powell, 1983; Tsasis, Evans and Owen, 2012). The members in this group were very aware of the diversity that existed between them, but this awareness frustrated the process further, rather than bringing intended benefits, as suggested by the extant literature. The effects of these opposing orientations are carried over from the group members perceiving conflict to the two interacting identities that were brought together (Chapter 4), which revealed that, as a result of the mandate, group members were excluded from the initial design and creation stage of the collaboration, which risks disharmony and demotivation (Goodwin *et al.*, 2004).

This starts to bring into question the definition of mandated collaboration developed from the extant literature. Mandated collaboration is defined in the literature as 'when bureaucratic or hierarchical mechanisms are used by a third party to bring separate organisations together to pursue complex objectives' *(*Rodrigues, 2007; McNamara, 2016, p.68; Hafer, 2018), and collaboration as 'the level of joint working where change or innovation is required and as a result of this the interactions of members are increased to a level of high interdependence' (Mandell, Keast and Chamberlain, 2017).

The analysis of the data in this study starts to show a definition of mandated collaboration where the interactions of members are not increased to a high level of interdependence, but rather are decreased, which is seen with the forming of two distinct groups within this mandated collaboration. Orienting from different positions as to the organisation care prevents a high level of interaction and interdependence within this mandated collaboration. A social justice orientation advocates for the provision of health and social care services that advance the inherent human rights of equity, equality and fairness in social, economic, educational and personal dimensions. It recognises that decisions need to be influenced by those who are in touch with the local population and by those who prioritise the welfare of people over financial constraints. An organisational orientation believes that the approach to the health and social care of the population should be decided on the scientific and clinical approaches of frameworks, outcomes and evidence bases, in which populations become bid data sets. Viewing populations in this way focusses on the achievement of health outcomes through prescriptive processes that at the same time support organisational priorities. Although participants from an organisational orientation recognise that there are social justice concerns, the need to argue and evidence decisions based on analysis and system efficiencies nevertheless becomes the overriding rhetoric. The two orientations that have been identified and analysed within the data show such levels of incompatibility and disagreement in their values and beliefs surrounding the provision of local health and social care that they become conflicting orientations. In addition to having developed conflicting interaction orientations, local health and social care participants have also developed interacting positions and interacting strategies, relative to the individual orientations and to the perceived source of conflict. The next chapter explains and discusses the conceptual domain of *interacting positions.*

Chapter 6: Managing Conflict – Interacting Positions

6.1 Introduction

> Just because you're round the table it doesn't mean you're really collaborating, so see you can easily have a facade of collaboration when you're in the room, but not really playing an active part. (Senior Manager, Clinical Commissioning Group)

> It always feels like it is a bit of a rehearsal, I think anything where there are elected members it always feels like you have to put a bit of a show on. (Chief Operating Officer, Clinical Commissioning Group)

The concept of interacting positions was adopted as a term to illustrate and explain positions from which group members collaborate under conditions of mandate in this study. Within the context of local care, group members are perceived to interact and manage conflict from two key positioning perspectives. From one position, some group members manage conflict within the decision-making process in a way that suits the individual organisation orientation, which results in the Health and Wellbeing Board becoming a contrived performance. This is revealed in the way that they collaborate under conditions of mandate from a position of *directing others*. The analysis of the data also revealed a further and opposing interacting position from which other group members collaborate under conditions of mandate. From this position, group members manage conflict from a position of genuine interaction, with a degree of naivety, to the extent that the group process is being manipulated, that is, *being directed* although this is revealed as changing over time. The terms 'directing others' and 'being directed' have been constructed to explain these interacting positions. The professional group members manage conflict under conditions of mandate from the position of 'directing others', which enables them to stage the group decision-making process, which then becomes more of a performance then an authentic meeting. The democratic group members are left to assume an interacting position of ‘being directed’, from which interacting can be perceived as genuine and authentic.

The next section of this chapter discusses the interacting position of being directed which is also referred to as the ‘front stage’ position from which the democratic group members who orient from a standpoint of social justice manage conflict under conditions of mandate.

6.2 Being Directed

> It always feels like it is a bit of a rehearsal, I think anything where there are elected members it always feels like you have to put a bit of a show on. (Chief Operating Officer, Clinical Commissioning Group)

Analysis of the data revealed that group members of a democratic interacting identity and social justice orientation collaborate from a position that could be labelled as *being directed*. This label illustrates the way in which the interactions of these group members have been in some way influenced by others when collaborating under conditions of mandate. Although they appear, and at times perceive themselves, to be interacting autonomously, the majority of these interactions have already been staged or scripted for them by members of a professional identity and organisational orientation, and the decision-making process can be perceived to be a rehearsal. In this sense, the mandated collaboration or the Health and Wellbeing Board can be viewed as a socially constructed performance, where group members from a professional interacting identity and an organisational orientation interact from a position where they can contrive the performance in such a way that an impression is fostered of others, and a definition of the situation is maintained. This creates a false reality of the performance that is given in the formal convening of the Health and Wellbeing Board – it has the appearance of decision-making and democracy when in fact most of the decisions have already been taken and the democracy is largely an illusion.

From a social justice orientation, collaborating under mandated conditions, when some of the group members interact from a position of staging the facts, presents the dichotomy of managing conflict from the position of relying on others and having to accept facts with reluctance. Being directed by others is defined and explained through the conceptual labels of *being briefed by others* and *being done too and not with.*

6.2.1 Being Briefed by Others

> We used to have a briefing before each meeting and then they would always bring me up to date completely and they were very, very good. (Local Councillor)

> I have a briefing every Wednesday morning, half past eight with the officers. Sometimes I manage two or three briefings a week actually, because you have to, the officers keep you in touch. (Local Councillor)

Managing conflict from the interacting position of *being briefed by others* is consistent with the position of *being directed*. The democratic group members are defined by their role of advocating on behalf of others. The nature of this role demands that they are at arm's length from the more commercial and organisational interests of local health and social care that are usually associated with the tacit understanding of complex problems and prescriptive process approaches developed by those of a professional identity over a sustained period of time. Consistent with the conceptual label of a democratic identity, members managing conflict from this position are often without the knowledge and experience associated with professional identities and organisational orientations in health and social care, and therefore rely on others to brief them. Lack of knowledge or the access to it creates a reliance on others in order to access the information that others have. Being briefed by others acts as the gateway for information for members of a democratic identity and can influence their actions in the decision-making process. However, this dependency on others for knowledge on complex matters is coupled with the dichotomy that this information must be accepted even if there is an awareness of being briefed from a position of persuading others.

Although the democratic group members in this study accepted the need to be briefed by others if they were to deal with complex social and wicked problems, they were also aware that interacting from this position carried the risk of enabling other group members to take decisions out of the group forum and behind closed doors.

Managing conflict from this position is perceived as being a barrier to access to information, and group members in this position were often left feeling that there was a certain inequity in the knowledge and information at their disposal when interacting in the decision-making process compared to the professional group members.

Lacking knowledge or access to it creates a reliance on others in order to access the information that others have. This also creates a vulnerable position from which to manage conflict, as the group members who are ‘in the know’ may either impart all of knowledge they hold regarding a decision or impart only that which they want other group members to know, so their own interests are furthered. In this way, they are able to manage what they perceive to be sources of conflict.

Although the analysis of the data in this study revealed inequality of access to information and internalisation of knowledge, mainly for the democratic group members of a social justice orientation, there were times when this was analysed as being the case for all group members regardless of their orientation. However, for the professional group members of an organisational orientation, the data revealed that they were prone to withholding information from the democratic members rather than briefing them, which enabled them to manage conflict when collaborating under conditions of mandate. This was evidenced in comments from several of the participants from an organisational orientation, when discussing the way in which commissioning intentions regarding local health and social care plans are shared before the group members come to the Health and Wellbeing Board.

> I think there is some influence, so the principle works, there is a sharing of final commissioning plans. There is a sharing in advance of that about the commissioning intentions, and the delivery of the [local area] vision. There is an influence from the council to the CCG and from the CCG to the council. It could be built on; it could be stronger. One of the conversations we had recently between the three or between the CCG, the council [public health] and ST foundation trust is, do we go beyond where we are now, and have a more structured approach to share commissioning intentions to potentially improve budgets. (Chief Executive Foundation Trust)

This tension was also noted by one of the professional group members from the Local Authority who was involved in facilitating the meetings of the Health and Wellbeing Board.

> The CCG raised the point that as a matter of course the CCG take their commissioning plans into the board for sign off as they should do, but why don't the local authority [Public Health] take their commissioning plans? They never do that and the CCG has noticed this saying ‘well that's a bit one-sided you get to comment on ours but we do not get to comment on what you are doing’. (Local Authority Strategy Officer)

The ability to withhold plans or share information between selected group members shows one of the levels of the conceptual label *being briefed by others.* In this regard, the concern is that the information presented is biased as to what is made known and what is not. When group members have information pertaining to their individual organisations, the tendency is to withhold this even from other professional group members and treat it with confidentiality, withholding it from the public domain. The ability to withhold information or not brief others shows the unequal positions from which the interacting positions manage conflict. However, the analysis of the data showed that professional group members would withhold information from other professional group members as well as democratic members, if this protected organisational interests. This demonstrates that these positions are not fixed but fluid, as group members from either orientation and position can perceive that information is being selectively shared or withheld.

When speaking in this context regarding participants of a social justice orientation, the discourse could be perceived as becoming biased, in that the information that is imparted to others is selectively positioned, to serve the interests of those imparting the knowledge, or the interests of those who are ‘briefing others’ – the professional group members.

The perception that the democratic group members were being briefed by others, and that this professional group members were briefing them, was evident in the narrative of both of these identities. Although the analysis of data showed consistency in this sense, there was inconsistency in the levels of awareness of which information was being briefed or received. The opportunity to brief others was seen as a way to impart information with a level of bias, to persuade others of a certain way of thinking and into a position from which managing conflict then became a position of being directed by others.

> So, they're relying on the Foundation Trust or the care or one of the other providers in giving them the facts and, as a Foundation Trust, what we are doing is presenting the facts, we are persuading the members to our way of thinking. (Senior Manager, Foundation Trust)

Managing conflict from the position of *being briefed by others* can be explained as interacting under conditions of mandate with low levels of awareness, and this was revealed consistently in the analysis of the data of those democratic group members who oriented from a place of social justice. The bureaucratic governance structure of local health and social care systems orders a flow of data that follows a top-down structure, with figures at the top being given uncensored access to data, and access decreasing down the organisation's structure. There is also an internalised level of knowledge due to the professional status of the role and the duration of that role in the sector. Non-professional status roles in the health and social care sector, such as locally elected councillors or lay people who have become involved with the managing of voluntary and third sector organisations, usually lack the same level of internalised knowledge and the access to it. This leaves them in a position of relying on others in the group and they are briefed by others through formal and informal channels of communication.

6.2.2 Being Done To and Not With

> I'm sure some discussion was had and probably at a much higher level about that I would say, but you really do feel, for the rest of us, it's kind of, okay we're a part of this thing, but actually sometimes, you do ... I wouldn't say you wonder what your role is, it just feels it's done to [you], more than you're part of it sometimes, and that's the mandated part of it. (Local Councillor)

Interacting from a position of *being done to and not with* illustrates the position that group members from a social justice orientation find themselves in when collaborating under conditions of mandate. From this interacting position, group members lack full control over the information and decisions to which they have access. Instead, they become passive group members, their actions influenced and directed by those of others. Perceiving that decisions and actions are 'done to you' and not with you emphasises the divide that resonates in each conceptual domain within the basic social process of managing conflict. There is a distinct feeling amongst members of a social justice orientation that they are kept away from the more politically and organisationally sensitive decisions, as a way for other members to manage conflict. Coming from a social justice orientation means advocating on behalf of the more vulnerable and marginalised members of society. Decisions that have the potential to affect the equality of health and social care provision and create instances of public protest, are made ‘behind the scenes’. The effect of ‘being done to and not with’ is to remove the right to control, influence and act from those who have been mandated to exercise these rights.

Interacting from a position of ‘being done to and not with’ is perceived as a position that is a consequence of the action of others. Group members interacting from this position become aware that their actions are now constrained as a result of the actions of others, not as a consequence of their own actions (Hayward, 2000).

> For some things it’s the right place I think, things like the closing of a facility [hospital, ward, home] but that decision was taken by the CCG, so the CCG took that decision not the Health and Wellbeing board and it's actually compromised .... you know I felt quite compromised as a councillor because, whilst I don’t represent this ward, you know, I was asked about what I was doing about that closure. Well, I’ll ask questions and this that and the other, but actually if I’m told in a public meeting that everything that has been agreed to be in place in order for that closure to happen on the 1st of October is under way and is on target ... what more can I do, you know, what more can I do? (Local Councillor)

For members of a social justice orientation, the perception that their ability to interact is constrained through the actions of others highlights the issue of powerlessness among these group members. As such, they become marginalised within the group and their actions become constrained. When group members interact from a position of *directing others*, group decisions are not shared and are instead kept to a select few by those from a professional identity. Being ‘done to and not with’ creates feelings of disempowerment among group members of an amateur identity, and any presumed group norm of sharing knowledge reverts to prioritising individual organisational interests by those in a position to do so. There is a perception amongst group members of a democratic interacting identity that decisions made behind the scenes are purposely revealed in a public setting to constrain any reactions that would be consistent with their social justice orientation. When action on decisions is revealed at this stage in the decision-making process, group members feel *‘done to’* and perceive that their actions, consistent with a role that would advocate against, are constrained to protect the interests of others.

Perceptions that decisions have been made behind closed doors to constrain actions of social justice and to preserve organisational interests are also demonstrated in the way that some participants from a social justice orientation feel that decisions have been foisted upon them.

> I hadn’t been to more than two meetings when the debacle about closing the B wing happened, and we felt – people from the local authority and other organizations who were very accountable bodies; all felt that this had been foisted on us, that there hadn’t been any consultation. The decisions had been made before we got to the health and wellbeing board. The NHS had just made the decision: the B wing was going to close. (Local Councillor)

Perceptions that decisions are ‘foisted upon’ or presented to members of the group from a social justice orientation with an element of surprise support the observation in this study that there was a divide between the group, as a result of members managing conflict according to their own orientation and identities. Foisting decisions upon members of a social justice orientation to constrain their ability to act on certain group issues demonstrates that members within this group are not interacting from the same positions. In this sense, foisting decisions upon others becomes a form of excessive control by organisational members to ensure that the planned performance is the one that is played out in public and that their own sense of legitimacy is maintained. Making decisions behind closed doors demonstrates a temporal aspect to the decision-making process. For those of a professional identity who are responsible for prioritising organisational interests, decisions made early on in the process and behind closed doors can avoid conflict later in the process, particularly when there will be tension around agenda items.

6.2.3 Being Convinced

Managing conflict from an interacting position of *being directed* is also closely linked to the conceptual label of *being convinced*. One feature of having an amateur identity in matters of health and social care was the inability to have the tacit knowledge of complex problems developed by those of a professional identity over a sustained period of service.

Reliance on others illustrates another level of the weak ties and dependencies that group members of an amateur identity form with those who can supplement the specialist knowledge, in an effort to interact in more active, rather than passive, forms of group behaviour. Being briefed by others becomes the lifeline upon which group members of an amateur identity depend, in order to gain a level of knowledge to enable some level of participation in the group interactions. However, the dependency on others to brief knowledge on complex matters is coupled with the dichotomy that this knowledge also has to be reluctantly accepted, even when participants who interact from a position of staging facts are perceived to do so for their own gain. The process of making decisions *behind the scenes* creates the perception that these decisions are now embedded and irreversible:

> It couldn’t have mattered then, because this massive decision had been taken, millions of pounds with a brand-new hospital being built, so it was embedded, but what they

> had to do then, was to convince us that it was the right decision, which they did. (Local Councillor)

The action of making decisions early in the process and behind closed doors gives the perception that decisions are now embedded and cannot be reversed. There is a certain element of ‘acceptance’ in these instances, not only from participants of a social justice orientation, but also by those of an organisational orientation who have also been left out of the decision-making process. The awareness and acknowledgment that decisions which should by legislation be made in a democratic forum have instead been made in secrecy with the exclusion of others produces a passive reaction of needing to be convinced rather than bringing challenge. However, we see that group members from a democratic interacting identity and a social justice orientation adopted a front stage position in both these performances. They resorted to the interacting position of being convinced when they realised a that decision regarding the hospital had been made without them. However, to act out in public that they had not been part of that decision-making would trigger public anger and a lack of confidence, which would not have been in the interests of those on whose behalf they advocate. Being convinced represents taking a front setting, which is a conscious and insincere approach to deceive the audience in order to protect the stage position, in a form of self-defence, rather than to deceive the audience for their own amusement. This was also a position that group members from the interacting position of directing others took, but for different reasons as alluded to above.

When decisions have been made early on and behind closed doors, the level of authority that participants attach to these decisions manifests itself in the level of challenge they bring to these decisions. When a decision made behind the scenes moves from the deciding phase to the action phase, requiring an input of resources, decisions are then perceived as embedded. Participants who have not been involved in the decision-making process see challenging decisions which have this level of authority as pointless and irrevocable. This was typified by one of the local councillors who expressed their feelings about a decision that had been made behind closed doors to close a local hospital, made from the perspective of organisational interests, which heightened the sense of social injustice in the local community:

> Eventually the decision was made to close it. It worries me that it was, but that was the decision and, once the decision is made, I think that that is the decision. I think some people in the community are really angry about it, worried about it and still really concerned about it. (Local Councillor)

Although the democratic group members accept the need to be briefed by others if they are to deal with social problems, they are aware that interacting from this position can take decisions out of the group forum and behind closed doors. There is a general perception from members of this identity that lacking, or being beholden to others for, technical knowledge renders them vulnerable and surrenders any real control over the decision-making process. When members from opposing positions perceive that facts have been staged, there is an awareness that the scene has been set for such decisions and their parts scripted. From this position, members will allow themselves to be convinced for the sake of the wider democratic audience, even if they are not confident about how the decisions have been made.

When decisions have been made without the participation of all members, there is an unconscious agreement among the participants in the group that they will not allow this to play out in public, as elaborated in section 6.3. At this point, a switch is made from the interacting position of being directed to directing others, and actors allow themselves to be convinced until they can also, in public, agree that the right decision has after all been made. That is, there is a perception by members that decisions which have already become embedded should be seen by the wider public as being agreed in the democratised and transparent processes of the Health and Wellbeing Board.

In essence, by allowing themselves to be convinced, members of the public now come into the conceptual label of ‘being directed’. Thus, a staged performance of a critical decision being agreed by all the group is played out to the wider public, and those actors who were originally left outside the group behave in a way that suggests the use of self-presentation to foster the outcome of desired impressions (Archibald and Cohen, 1971; Gardener and Martinko, 1988). For some groups, there was the recognition that preserving the self, and giving the impression that decisions had been taken in agreement for organisational interests, only served to create further instances of social injustice, something which the Health and Wellbeing Boards had been created to deter. One such example was mentioned by a social justice participant, when discussing the inequality in access to services that had been created by the decision to close a service:

> So Healthwatch went away and did an analysis of what would happen if the hospital wasn’t there, and they came back and said they thought it would be okay and that there was enough services to support it, and then we came back and said what we want further checks on transport and six things, and it eventually went back because it was something that had to go back to the NHS nationally and we were able to say that we wanted these 6 points in place, because we weren’t sure that they were in place, and if they were, then we would support it. I don't know whether the six points were really ... but I know that the transport has not been improved because Nexus haven't done anything. It's all about finance really, the state of the area and the country really. (Local Councillor)

‘Being convinced’ as a conceptual label was analysed within the data, showing that when group members are being directed by others, at times this is with high levels of awareness of what is going on, but feeling they have no option but to allow themselves to be convinced to give the appearance that, under conditions of mandate, the interactions that occur give the appearance of integrated working, which was one of the objectives of the mandate. However, at this stage of the process, group members who are being directed and group members who are being directed by others are both aware that there are tensions as a consequence of interactions taking place behind the scenes, as noted by one professional group member:

> There's still a lot that's unsaid. So, there is still a lot that isn't being resolved and there are a lot of tensions beneath the surface that need to be resolved. And I would say in [this health and wellbeing board] in particular, at one level integration looks really good but at another level there are some really difficult relationships that need to be managed through. And I'm not sure that the Health and Well-being board is the place to do that. For real integration to work, it comes back to behaviours, that those tensions need to be resolved. Difficult conversations need to be had or else, underneath this sort of vision of integration, it will work very differently on the ground. (Mental Health Foundation Trust Manager)

This interacting position, where the democratic group members collaborate under conditions from a place of *being briefed by others* and *being done to and not with* can be viewed through the front region or front stage area. Front stage positions are those from which the team will stage a performance that projects the reality they are aiming for on the audience and, in doing so, they maintain a definition of the situation by influencing the perceptions of those that witness it. Both the team and the audience have access to this front space.

However, the analysis of the data also revealed another interacting position, identified in this study as *directing others*, which represents a backstage position. In this space they will interact to rehearse and construct the performance that will be played out on the frontstage.

Within this study, the boundaries of this front stage position are defined by the extent to which the democratic members are allowed to perceive what is really happening, as the analysis of this data revealed a further interacting position or back region, to which they were not allowed access. Not being allowed access to this space acted as a barrier to these group members being able to perceive what was really happening. However, the data revealed that over time, they became more aware of this front stage position they occupied. Although these group members were mandated to be part of the same group, democratic group members were analysed as collaborating under conditions of mandate from a position of the front stage or region. In this position, they occupy a space usually reserved for audience members who will not be privy to how the performance is being contrived from the backstage region. The next section discusses and explains the other interacting position revealed in the analysis of the data: the backstage position of *being directed*.

6.3 Directing Others

The analysis of the interview data also revealed a second interacting position, which has been labelled *directing others,* and is a conceptual label used to illustrate and explain the position in which participants of an organisational orientation locate themselves, in order to collaborate and manage conflict under conditions of mandate. The analysis of the data revealed that group members from an organisational orientation perceived the democratised element of the mandate to be a source of conflict when it exposed decisions motivated by organisational objectives rather than social justice concerns. For these group members, there is a need to safeguard the interests of the organisation within the decision-making process. Collaborating under conditions of mandate with a professional identity and from an organisation orientation allows them to interact from a position that enables them to direct the group interaction in ways that best safeguard these interests, that is *prioritises organisational interests*. Group members from this interacting position are *directing others* from the conceptual labels of *behind the scenes, persuading others* and *retaining control.*

6.3.1 Behind the Scenes

> I would have thought that's something that we should have been discussing as a board. But I think, again, key figures would've had that discussion behind the scenes. (Elected Member)

> Yes, it did go on behind the scenes. The relationship building and the reality of what it all meant went on absolutely behind the scenes. (Senior Manager, Foundation Trust)

From the collaborating position of *behind the scenes*, group members develop strategies to manage issues that could threaten organisational priorities away from both public scrutiny and the democratic group members (*meetings in public)* with the primary aim of protecting their own organisational interests, rather than finding the optimal solution for the mandated objectives of the Health and Wellbeing Board. Their organisational backdrop allows a certain level of influence on the flows of information and knowledge reaching the rest of the group members and limiting the decision-making process in this way is perceived as avoiding potential conflict. In this study, group members who collaborate from a position of *directing others* were able to do so, in part, because of the professional interacting identity they were analysed to have in Chapter 4. Group members analysed as having a professional identity, or being a professional group member, perceived close levels of fit between their daily role and the mandated role. Group members with this identity entered the collaborative process with their organisational background and the resources and institutional authority this brought, resulting in an interacting identity not afforded to the democratic group members. When the organisational group members collaborated under conditions of mandate, the ways in which they interacted enabled them to control who was allowed backstage and who was allowed front stage.

Interacting from a position behind the scenes took issues that required difficult and frank conversations out of the democratised decision-making process and returned it to the practices of more closed decision-making, associated with public sector bureaucracy in decision-making prior to the NHS reforms of 2012 (Health and Social Care Act, 2012).

> Yes, we did some really quite controversial service changes in South Tyneside and the Council were very unhappy about it; the leader of the council was very unhappy about it and so we were on the wrong end of some of that conflict for a little while. It was actually handled very professionally in public and a lot of the difficult stuff happened behind the scenes. (Senior Manager, Clinical Commissioning Group)

The perception that decision-making practices in health and social care take place behind closed doors is well documented within the health, social care and public health discourse. Decision-making is practised within environments that are closed and secret and with select involvement. Making decisions concerning the health and social welfare of others from a position of financial accountability has democratic consequences when the provision becomes inequitable.

In addition to protecting organisational interests, there was a perception that some health and care issues could potentially harm public confidence and cause fear if practices became too transparent. The potential conflict which these issues could represent for group members who interacted from a position of prioritising organisational interests forced these decisions to be made behind locked doors. This was noted by one of the democratic group members:

> These decisions were made behind locked doors to do with budgets and the best ... what they considered to be the best ... which they are professionals and rightly so, but

> they weren’t used to being accountable and haven’t explained why they’ve made these decisions. We have to explain why every single day. (Local Councillor)

There is an acknowledgement that closed forms of decision-making have undermined public trust in the public health service organisations, creating a democratic deficit. Interacting from a position that advocates for discussions to take place behind closed doors alleviates concerns regarding the negative consequences of democratisation. Group members from this position acknowledge that there are opportunities and benefits to having conversations in public spaces; however, the acknowledgement of the need for transparency could equally be perceived as being organisationally motived to enhance legitimacy. Protecting the legitimacy of individual organisations necessitates difficult issues to be kept from public view in order to maintain a charade of public professionalism.

Collaborating from a position of *behind the scenes* was seen as the mechanism which allowed these participants to control which decisions were made behind closed doors and in secret. From this interacting position, the professional group members were able to socially construct the mandated collaboration as a series of staged performances, in which the decision-making around health and social care became a fostered impression which was staged and scripted, as opposed to open and transparent. For some members, operating from a position of behind closed doors was perceived as a mechanism that constrained the level of action that took place within the group. There was a general feeling that having a professional identity acted as the mechanism that allowed some members to take conversations of a group nature behind closed doors. For actors of a social orientation and an amateur identity, this obscured the truth about decisions that had been made and left those members feeling unable to challenge or discuss such decisions in the group forum. In this sense they perceived themselves to become passive participants becoming incompetent to fulfil the purpose to which they have been mandated (Hayward, 2000).

This is also similar to what Ranade and Hudson refer to as ‘insider’ and ‘outsider’ groups within the same partnership or collaboration. The analysis of the data in this study showed that, when individuals collaborate under conditions of mandate, the democratic group members did move between performer and audience, whilst the group members with a professional interacting identify remained. The democratic group members shifted between the spaces of performance and audience. However, in shifting between these spaces, the analysis of the data will show that they were not always aware that they were simultaneously playing the role of performer and the role of audience, which would suggest that the Health and Wellbeing Board became an idealised reality. As a way of managing conflict, those who could do so fostered an impression on others, interacting in ways that maintained a definition of the situation. In this sense power can be seen to operate in the invisible form of Luke’s (1974) third dimension, where others are unaware that their reality is being socially constructed for them (Lukes, 1974)

The perception that protagonists of an organisational orientation and professional identity were making decisions behind the scenes regarding key issues that should have been discussed openly at the Health and Wellbeing Board was noted by another democratic group member. This comment is made with regard to the issue of the local hospital that had been closed, to which the democratic group members referred frequently throughout the interviews:

> So, you know, how many months did that just go into nothing happening. I really don't know. And, again, we haven’t really spoken about it. You know, which is another thing. I would have expected us to have that discussion in the meeting. I mean, I still don't know the reason for it. The absolute truth about why that happened. I don't know. I would have thought that's something that we should have been discussing as a board. But I think, again, key figures would've had that discussion behind the scenes. (Local Councillor)

For some members, operating from a position behind closed doors constrained the level of interacting that took place within the group. There was a general feeling that a professional identity acted as a mechanism that allowed some members to take group conversations behind closed doors. For group members of a social justice orientation and a democratic interacting identity, this obscured the truth about decisions that had been made and left those participants feeling unable to challenge or discuss such decisions. In this sense, they perceived themselves to become passive participants, constrained by others when collaborating to fulfil the purpose to which they had been mandated.

When discussing whether the mandate had actually advanced the position of integrated working and transparency within the group, the perception that a group member's identity enabled or constrained, that is influenced, the positions from which group members collaborated under conditions of mandate, was consistently highlighted by the democratic group members:

> Now, I don't think that was particularly dealt with in that Health and Wellbeing board as an issue which is actually, this is what we are grappling with here. It was dealt with by the CCG and we'll hear about it probably at the Health and Wellbeing board when we hear about the progress that they've made. So, they have made some progress, they've put some new things in place – one of the providers who has been commissioned didn't actually know they were commissioned for certain, for Tier 2, I think. Tier 2 commission hadn't been - I won't say accepted, but the person running that hadn't actually realized. This is all said behind closed doors, you know? It's not going to be said, and certainly not going to be said at the Health and Wellbeing Board and it's hardly being said to a councillor, let alone anywhere else and that's the danger of it. (Local Councillor)

In this quotation, a local councillor was discussing their frustration surrounding a sensitive mental health issue. The level of provision for local mental health services had been a contentious issue for some time. With the reduction in funding for all local services, cuts in mental health provision were perceived as being unfairly prioritised in order to meet demand in other services. The decision regarding the level of funding and choice of provider for mental health services should have been one made by the members of the Health and Wellbeing Board, but it became clear to the democratic group members that these decisions had already been made outside the group meeting and behind closed doors. Moreover, it was recognised that failure to provide adequate care and services for the more vulnerable members of society can threaten organisational legitimacy if this becomes public knowledge. Threats to organisational legitimacy are perceived as being avoided if decisions are kept from public view.

For these professional group members, a democratic identity acts as a mechanism that can threaten public exposure of decisions and bring public challenge. Collaborating under conditions of mandate is therefore carried out behind closed doors as a way of avoiding this. This interacting position allowed the professional group members to operate in a region or space where the democratic group members would not have access. The analysis in this study revealed that group members who interacted from a position of *being directed by others*, or a front stage position, shifted between the space of performer and audience. In the formal setting of the Health and Wellbeing Board, the impression that was fostered was that of an equal group, operating as one group, with all members performers playing together to any audience present. Outside the region or the space of the formal setting, they shifted to the front stage position of being directed by others and occupied this space in the role of the audience. The absence of these group members from the backstage position of *directing others* allowed other group members to develop and conceal strategic secrets, that is manage conflict to collaborate under conditions of mandate.

6.3.2. Persuading Others

The analysis of the data within this study revealed that professional group members were perceived as wanting to keep information relating to their organisations confidential, withholding it from the public domain or *meetings in public,* which was analysed in Chapter 4 as a source of conflict. The ability to withhold information or not brief others showed the unequal positions from which group members across the interacting positions collaborated under conditions of mandate. This was noted when one professional member discussed the way that they had to ‘present facts’ within the decision-making process, in order to gain the agreement of the democratic members, who oriented from a different position when approaching this process.

> So, they're relying on the Foundation Trust or the care or one of the other providers in giving them the facts and, as a Foundation Trust, what we are doing is presenting the facts, we are persuading the members to our way of thinking. (Senior Manager, Foundation Trust)

When speaking in this context, information that is being imparted to others is selectively positioned, to serve the interests of those imparting the knowledge, or the interests of those who are persuading others. The opportunity to persuade others was seen by the professional group members as a way to impart information with a level of bias, to persuade others to a certain way of thinking and into a position from which the professional members can manage the conflict that comes with collaborating under conditions of mandate.

Persuading others was also used to illustrate and explain the position from which those of an organisational orientation and professional identity managed conflict from within the group. Interacting from a position of persuading others is the deliberate attempt by one group identity to organise and influence the interactions of the whole group in a way that suits individual organisational priorities rather than collaborative priorities. In this sense, persuading others can have the effect of excluding participatory practices that have been mandated in order to open up local health and social care decision-making, and influence the strategies that these group members developed to manage conflict.

Interacting from a position of *persuading others* can also be perceived as the effort of shaping and forming the discourse around decision-making that will take place within the group. Although the formal model of local government depicts elected local councillors as making policy, while government officers and professionals advise and carry out, there is a view amongst the professional members that the knowledge required to make policy would be incomprehensible to part-time, amateur and generalist councillors or members of a social justice orientation. Persuading others to conform with the professional's way of thinking takes place and can also be understood as manipulating or moulding the socialisation of the mandated collaborative process.

However, for many of the group members, policy and decision-making is perceived to residing with those of a professional identify and organisational orientation and not with those who represent the democratic voice. For these members, professional identity and its associated knowledge is the mechanism which gives control in these areas and allows the staging of facts in ways that secures agreement and avoids the conflict that would need to be managed should all facts be made available for group and public consumption.

The data also revealed that motives for acting from a position of persuading others were fluid and, rather than acting only to conceal knowledge, members who interacted from this position were also revealed as doing so from a genuine position of wanting to help and support others. An awareness that levels of contextual knowledge were lower amongst members of a social justice orientation was sometimes found to prompt an effort to assist and share genuine facts with those members who were perceived to need this.

> Yes, I mean it was variable, so some of the councillors were very much involved and others had a different level of understanding of what the health and wellbeing board were doing and which is the time that I was there. XXX and the team were trying really hard when they were having their internal forum with the councillors to bring their knowledge on. (Senior Manager, FoundationTrust)

Although there was an acknowledgement that the discourse surrounding facts could be staged in ways that secured the agreement needed to prioritise organisational interests before social justice interests, there was also an effort to cultivate genuine discourse. While a lack of knowledge in others was found to leverage an advantageous position, it also imbued a sense of collective nurturing, and strengthening of elements of socially weak ties between the two differing orientations.

6.4 Chapter Summary

The data in this study revealed an interacting position of *directing others* which represents the backstage or region from which the professional group members collaborate under conditions of mandate. Reforms that are prompted by austerity often seek to make efficiencies by centralising the provision of care through the reconfiguration of services. Professional group members from an organisational orientation who prioritise organisational interests were analysed as doing so from a position of directing others, which allowed them to take decisions behind the scenes which could not be viewed publicly. Interacting from this position enabled the professional group members to constrain as much as possible the disclosure of their secrets to the democratic group members, which would occur should the definition of their situation be revealed. In this way, they interacted from a position which enabled them to prioritise organisational interests.

When the analysis of the data in this study showed the democratic group members as simultaneously interacting from front stage and backstage positions, whilst the professional group members were always able to interact from a backstage position, two interacting positions were revealed. The formal meetings of the Health and Wellbeing Board were revealed as being a front stage area where members of both the democratic and professional groups performed as one team. However, after this performance had been given and the official meeting of the Board was over, a further interacting position was revealed, a backstage position to which only the professional group members had access. In this sense, the Health and Wellbeing Board in the front stage area can be said to be a social construction, where a projected reality of collaborating under conditions of mandate is played out to the public, to foster the impression and maintain the definition of the situation, which is that the group members are collaborating in the organisation and provision of care. The definition of this situation is maintained through the interacting positions of *being directed* and *directing others*. The next chapter discusses the strategies to manage conflict that group members developed as they collaborated under conditions of mandate.

Chapter 7 Interacting Strategies

7.1 Introduction

The conceptual domain of interacting strategies has been adopted as a term to illustrate the way in which these group members perceive they need to manage sources of conflict in order to collaborate under conditions of mandate. Each interacting identity, professional and democratic, was analysed as developing a range of strategies based on its *interacting orientation* and its *interacting position*. The terms *front stage* and *backstage* have been constructed to describe these two differing sets of interacting strategies. The term *front stage* denotes the general orientation as being from the native's or insider's perspective and is used to represent the strategies that the professional members of this group developed to manage conflict. The term *backstage* denotes the outsider perspective who has not had that personal or lived experience of others and is used to represent the strategies that the democratic members of this group developed to manage conflict.

The terms *front stage* and *backstage* in this study are used to signify the interacting strategies developed and adopted by these group members to manage conflict both within the meetings of the Health and Wellbeing Board and outside them. Front and back interacting strategies were developed by group members to manage the sources of conflict that arose as a result of the democratised decision-making processes integrating health, social care and public health provision between disjointed sectors in the local area. Interacting strategies are interwoven with the conceptual domains of *interacting orientation*s and *interacting positions*. That is, these conceptual elements directly influence the interacting strategies that these group members develop to enable them to collaborate under conditions of mandate. The democratic group members who interacted from a position of *being directed* had to resort to managing conflict within the formal meetings of the Health and Wellbeing Board. It was only in these *meetings in public* that they learned of decisions that had been made *behind the scenes*, decisions to which they should have been party and decisions which often caused tensions with their interacting orientation. The professional group members, who interacted from a position of *directing others*, managed conflict inside and outside the formal meetings of the Health and Wellbeing Board. These members were able to use their interacting orientations and positions to take decisions which threatened organisational priorities outside the Health and Wellbeing Board, presenting these decisions in the *meetings in public* when action had already been taken, constraining the ability of others to undo this.

The following section discusses the backstage strategies developed to manage sources of conflict when collaborating under conditions of mandate, by the professional group members, who interacted from an orientation of *organisation* and from a position of *directing others.*

7.2 Backstage Strategies

Backstage strategies enabled the professional group members to manage conflict in a way that manoeuvred the formal meetings of the Health and Wellbeing Board to a position of contrived reality. Collaborating under conditions of mandate through these strategies allowed them to produce a contrived performance that the democratic group members, the audience, would socially construct as a real performance. Although these group members are convinced that their actions are for the best, anchored by their identity and orientation in which decision-making is approached in more traditional ways, they are viewed by others as being insincere. Throughout the mandated process, there appeared to be an unwillingness on the part of the professional group members to depart from *prioritising organisational interests* and *prescriptive processes*. *Back stage strategies* are defined and discussed through the conceptual labels of *controlling the agenda, being selective with the membership* and *making decisions elsewhere* which are discussed in the following section.

7.2.1 Controlling the Agenda

You have to work inside the group to control the agenda. (Manager, HealthWatch)

Agendas create structure and order, listing items by order of priority, including items so they get attention or excluding items so they do not get attention. Agendas are used across most informal and formal health and social care gatherings, as a way of creating order through a flexible structure when people have a range of issues to discuss and a limited time in which they must achieve some level of action on them. In this study, *constructing the agenda* was analysed as an interacting strategy used by the professional members to manage sources of conflict within the decision-making process. The agenda, in this sense, became a gatekeeper for the health and care issues, the arena of the democratised decision-making process. The data from this study also indicated that using the agenda as the gatekeeper of health, social care and public health issues was not an interacting strategy that was available to all members within the group. However, for those members who were able to develop this as one of their interacting strategies, it was used as a way of constraining collaborative action in a way that managed sources of conflict when deciding health and social care issues in the democratised decision-making process.

Health and Wellbeing Boards are unique in the fact that they are a mandated democratised decision-making process, with a mandated core membership but with autonomy to appoint further members. In addition, there is autonomy in managing agenda items within the broad remit of local health and social care integration and commissioning. Agendas become important as a mechanism that decides the structure of the decision-making instances, the tone, items to be discussed and display what is considered worthy and what is not. To this effect they become gatekeepers for the decision-making process, deciding what will be included in the democratised forum, and what will not. In this way, the agenda was used as an interacting strategy to exclude health and social care issues that were perceived as potential sources of conflict or actual sources of conflict. Using the agenda as an interacting strategy and gatekeeper for which issues entered into the group forum and which did not, was in principle an interacting strategy that was open to all members of the collaboration. There was a lead from the local authority because of the nature of Health and Wellbeing Boards and the legislation when they were formed but, in principle, the agenda was supposed to be a mechanism open to all members as a way of influencing the decision-making process in a way that would fulfil the group requirements.

For the democratic group members, the agenda acted as an ethical gatekeeper, to protect genuine issues that were in the interest of the wider public and a way of blocking or holding items that could derail the group's progress or genuine collaborative action.

> There's no other committee in our structure where an officer has a vote. Needless to say, we've never ever had a vote in the Health and Wellbeing Board, and I can't envisage any circumstance ever when we do have a vote. Because once you do that, you don't have a partnership. You end up with cliques and you start having a division in teams and so forth. So, it's far better to try and find consensus through the agenda, which I think we do quite successfully. (Leader of the Council, Elected Member)

Another unusual feature of the mandated Health and Wellbeing Boards was the voting rights that were given to the membership. In recognising that the Board as a democratised process would bring together a range of views, the Act mandated that all members would have equal voting rights. Voting rights were the official mechanism introduced by the mandate to resolve conflicts and tensions at the Board meetings. This was another reason, as discussed later, to restrict the membership as each member comes with a right to vote. Although the democratic members were aware of this right, even with limited access to constructing the agenda, they were hesitant to exercise it, realising the divisions that this could cause. In this sense they viewed the agenda as a mechanism to reach consensus, when collaborating under conditions of mandate, unaware that some were using the same agenda to manage conflict.

Being unaware that the agenda was being used by some to manage conflict outside meetings of the Health and Wellbeing Board was noted by another democratic group member when discussing this from their social justice orientation:

> As it was, Health and Wellbeing Board became very focused on health and equalities on the public health agenda, and how do we do those must shifts, and so on, and so forth. That’s not to say perhaps in the future, or we don’t say that we're going to have to extend this and extend our agenda. Not least because of our report out last week which showed that the multiple indexes of deprivation in South Shields across South Tyneside is actually getting worse. Instead of getting better, it's getting worse. And if it's getting worse then we need to get a hold of that, as partners, to say what factors have made that worse. (Local Councillor)

For the democratic group members, the agenda had potential capacity as well as real capacity for collaborative change. When health and social care issues became a priority or had been missed by the group in other discussions, the agenda had the capacity to capture these and become the mechanism to bring them back into the group forum and, by doing so, add a sense of priority and seniority to the level of attention it should be given. This was also a way of these members disproving the *perceptions of others* (Chapter 4). Having influence over the agenda was a way of proving their worth to the ‘professionals’ of the group who traditionally had been in control of decisions that were now within the remit of the Health and Wellbeing Board.

> There was a general feeling that if we're going to make this work, then we have to demonstrate to other health professionals and other colleagues that we're being serious about this. But my role is very much I think is for all of the partners to feel as if that they can have confidence. That the council, which is the only democratic elected element of the public sector and therefore seen as the civic leader in a given place, that they're helping to really drive this agenda for us, in an open transparent and partnership fashion. (Local Councillor)

This could be perceived as re-enforcing the view of a traditional hierarchy and culture of decision-making in health and social care being made by trained professionals and managers only. For these members, as a mechanism of the Health and Wellbeing Board, the agenda embodied the democratisation principles on which the group had been established, to give health and social care issues that affected the wider public attention, through the open and transparent ways of social justice as opposed to the closed and prescriptive ways of an organisational orientation. The democratic members of the group believed in the ideology of the agenda, and its potential as a mechanism to effect collaborative action within the group and fulfil group requirements.

Although there was acknowledgement of what the agenda could and should be used for, there was also an acknowledgment that, in reality, access to the agenda was not as open and equal as it should have been. When the agenda came up in an interview with some of the democratic group members, and they were asked about their level of input to it, they responded:

> To be honest, I haven’t felt as if that was something that could be possible. (Local Councillor)

And:

> I don't think we're ever asked if there are any agenda items that we would like put on. (Local Councillor)

For the professional group members, the democratising of the agenda represented an intrusion into health and social care matters that had been previously been under their control. The right to decide on issues earned through professional expertise was now being shared with those who had, or were perceived to have, no formal training and very limited knowledge in health and social care matters, which resulted in the professional members being reluctant to participate or give authority to the agenda process. One professional group member acknowledged that the agenda was really something that had to be prepared by an executive group outside the full meeting:

> There is still is a sort of an executive group [professional members] which meets to really prepare the agenda, to prepare papers and all that sort of things so, yes, there was a lot of that, inevitably has to happen. (Senior Manager, Clinical Commissioning Group)

Retaining control of the agenda was one of the ways in which the professional group members were able to construct the agenda, such that items that had the potential to cause conflict as a result of public awareness were kept out of the democratised decision-making process. There was a perception amongst the democratic group members that the agenda had the capacity to trigger action on local issues, but that their own ability to influence this was limited:

> I firmly believe that to make anything happen, it has to be agreed at that level [senior

> level of health care executives]. If it is agreed there and it will happen, but to actually get what you want to happen up there, getting items on the agenda and who controls that agenda. We will try to get things on the agenda if we thought they were important. I don't know if we could but we would try. (Senior Manager, Healthwatch)

For the democratic members, real action on complex issues only happened when and if it was endorsed by professionals at a senior level and getting access to constructing the agenda was a means to make this happen. However, they felt their collaborative action was constrained in being able to access the agenda and find ways to the gatekeeper, and perceived ambiguity in their capabilities of being able to do this.

There was also a perception that being unable to influence the agenda not only constrained collaborative action, but also left some members feeling isolated within the group:

> That's exactly what happened, so the effect you had with that is partners felt isolated, so they weren't included or involved in key decisions within the borough and would just think, well I've got to come to the meeting, I'll just sit through it with them. (Senior Manager, Health Watch)

For these group members, being unable to get items on the agenda left them feeling unable to fully participate in the collaborative process, and able only to 'go through the motions' of collaborating under conditions of mandate. *Controlling the agenda* limited their interaction and participation in the collaborative process to the extent that they became withdrawn from the process. Their experience was of constrained action, instead of a forum where action was supposed to be enabled.

However, the agenda was also seen to constrain collaborative action, not as a deliberatively developed strategy, but by default due to the challenging and complex nature of the organisation and provision of care, which can naturally demand complex agendas. This was noted by one democratic member, when discussing the complexity of the meetings:

> You go to our health and wellbeing board and you have got a two-page agenda, and you're there for two and a half hours and there's every subject under the sun and there's different people having to be accountable for their particular part in it. I think the scrutiny committees, they would just be called in for a specific item and so they would be well versed and well-read and well prepared for that specific item even though they would still get a – but I think coming to a scrutiny wouldn't be as difficult as actually sitting there for two hours and having them be accountable. (Elected Member)

The analysis data in this study did not suggest that agenda were overloaded with items in order to confuse some group members; however, the agenda was noted as constraining the democratic members' capacity for collaborative action by themselves and by the professional group members. This was one of the few instances of the word 'conflict' being used by a participant of this study:

> That's the conflict if I'm honest: they weren't very vocal, and it was probably because there were fairly new councillors coming in the Health and Wellbeing machine, and it's like, you know what the agenda is like? It's like, it's such a range of topics that you're talking about and I cannot remember the contribution of any of the councillors who were there, other than listening and getting the papers and endorsing them. (Senior Manager, Clinical Commissioning Group)

Their lack of the in-depth knowledge of health and social care provision that was analysed as being synonymous with a professional interacting identity made the agenda a natural challenge for some of the democratic group members. In this local health and social care setting, the democratic members have experience of taking part in structures and processes regarding local issues, but in these cases the agenda would have fewer items and they have a sufficient level of knowledge to enable action. In the democratised decision-making forum of the Health and Wellbeing Board, the agenda could be both an organic and a developed interacting strategy to enable the professional group members to take issues of conflict out of the public forum and make decisions on them elsewhere. This is discussed in the interacting strategy *making the decision elsewhere* (section 7.2.3).

Controlling the agenda through the use of ‘confidential items’ was also a way in which the interacting strategy of constructing the agenda was used to constrict social action. Confidential items were perceived to allow some group members to conceal facts by deciding what would, and what would not, be discussed in the public forum of the Health and Wellbeing Board.

> *I think, I guess, I mean there is a slot on the board for confidential items, so I think we would tend to use those items, that slot, if there were things where the board wanted either an early sight of something, or there was something particularly contentious that needed to be discussed. (Senior Manager, Public Health)*

Although the Health and Wellbeing Board was a public meeting, a confidential slot was always put onto the agenda to enable a time for discussion away from public view. When this slot was reached, any individual present who was not a member of the group would be asked to leave, and discussions would be continued. Contentious items to be discussed could include financial planning; restructuring of services that members did not want to be public knowledge or where implementation had begun; information regarding adults’ and children’s service provision which would be too sensitive to allow into the public domain. The agenda in this way allowed management of items that could potentially cause conflict for individual members and their organisations if they were played out in front of members of the public or the press.

Sticking to safe issues was another way in which group members perceived that the agenda was controlled as a way of managing conflict. This was highlighted by one of the professional group members:

> Actually I think that the public health gets a very high profile through the health and well-being boards not least because, at times, I don't know whether this is deliberate or not, but public health issues are seen as uncontroversial - they are the kind of safe issues to take to the health and well-being board, oh let's have a talk about smoking in pregnancy and do the chin-stroking thing again, who could possibly disagree that this is not a bad thing that must be done, so we can all default to having public health default items on the agenda, because they are all the humble apple pie kind of things, whereas if you are going to say, here is a controversial one… national NHS guidance states that certain staffing levels will mean that some hospitals' current service provision will be unsustainable and that there will need to be a reconfiguration of how they are provided across the north-east, so the likes of your smaller district hospitals might lose services like maternity or stroke, now that's the kind of thing that is not straightforward and that the elected members would have a strong view. Any issue where it seems that South Tyneside might miss out; they are the harder issues that are not being taken to the health and well-being board. It was only because the walk-in centre was part of the formal process to the secretary of state that it was forced to come to the health and well-being board as controversial issue. Most of the time we tend to stick to the generic sort of non-controversial safe issues. (Senior Manager, Public Health)

Bringing local health and social care into the public arena not only allowed the public access to local issues albeit with a process to follow if they wanted to voice any concerns, but also brought health and social care organisations into direct decision-making with local councillors and representatives of patient groups, allowing the latter to be privy to and have direct access to issues to which they had previously not been privy. For the professionals who had previously controlled decisions on health and social care, this element of democratisation represented a source of conflict, with potential for public protest against items that caused the greatest social injustice, such as service closures. Focussing on safe issues was a way to manage conflict and constrain social action. Contentious issues that could turn into conflict as a result of the membership of non-professionals, or public involvement, could only be managed if they were kept off the agenda. By constructing the agenda with safe and non-controversial items, items with the potential for conflict because of public reaction could be kept away from the Health and Wellbeing Board, and on the agendas of individual organisations, until the decisions had already been made.

Although there was an 'agenda slot' when the Health and Wellbeing Board could be totally removed from public view, for the remainder of the Board meeting, members of the public could be present. However, although the agenda could not remove the public from all the meeting, it could control the way that they were allowed to present at the Board meetings. This is explained by some of the professional group members:

> I think it's a shame because I think the meeting is held in public and I think that having the public there could be of benefit, you know that members of the public with an interest in health and wellbeing should and could be hearing and asking questions, because there is a slot for questions on the agenda in relation to health, in relation to what's on the agenda. (Senior Manager, Public Health)

> In the last three or four meetings we had campaign groups - the save the Jarrow Walk-In centre campaign group to the last four meetings - and officially you have to submit any question you want to ask within 10 working days before the meeting, and on every occasion no such communication had been received, but nonetheless the leader still

> let them speak on every occasion even though he was within his rights legally to say no. (Senior Manager, Local Authority*)*

For some members, the use of the agenda as a lever to engage with the public on items that were being decided on their behalf was a new approach to a more participative form of providing health and social care, and one that should be encouraged and welcomed by all members of the group. Democratising the decision-making process had allowed public involvement; however, the level of action that could be taken by the public was still managed by the agenda, and by further legislation such as the local council constitution, as all Health and Wellbeing Boards are committees operating under the council which established them. In this local context, the council constitution, the process dictates that a question will be accepted only if notice has been given by delivering it in writing, or by facsimile transmission, or by electronic mail to the Chief Executive no later than midday, eight working days before the day of the meeting. The question will then be put on the agenda with a time slot of 15 – 20 minutes in which it can be asked and answered. Members of the public must thus adhere to a process if they want to ask a question, so that questions can be screened and ruled out of order, illegal, irregular, improper, frivolous, offensive or not in our interest. If this is ruled to be the case, members are instructed not to answer the question; the reason for doing so is documented in the meetings and is not open to debate. Managing public questions through the agenda in this way allowed group members to be forewarned of any public questions that might become sources of conflict and to manage them through *controlling the agenda*.

Controlling the agenda can thus be seen as a way of controlling the performance or manipulating the socialised performance. Control rests on concealing certain facts and giving others a measured level of access by regulating the amount of information acquired by the audience or those who occupy the front stage positions. Although there are references here to Hayward's (2000) mechanisms of power that constrained action for the lay members of this group, the analysis of this data suggests controlling the agenda in this way is also reminiscent of Lukes (1974) second dimension of power and in this way, also becomes a mechanism that constrains action. Regulating the level of information that could be acquired by the audience, who comprised both group members of an amateur identity and the general public, was a means to ensure minimum disruption to the projected performance that was being given in the formal setting of the Health and Wellbeing Board. In this case, the particular combination of circumstances which allowed group members to mystify others was the interacting identity of the professional and interacting position of directing others.

7.2.2 Being Selective with the Membership

The literature concerning the membership of interorganisational groups in the public sector has been well documented and has provided some understanding of the complexities involved in interorganisational working to address wicked and complex social problems. Much of this literature has focussed on the group relations between public sector organisations and their external providers, mainly voluntary and formalised forms, and the part that the concept of membership plays in the overall effectiveness of efforts to provide coordinated solutions to national and local wicked and complex issues (Ranade and Hudson, 2004; Horwath, 2010; Horwath and Morrison, 2011).

Much of the debate surrounding the membership of interorganisational groups is focussed on the tensions of membership governance; the conflict that can arise from issues such as the most effective size and structure; the imbalances that arise from members' status and power; and the lack of group culture and identity resulting from low levels of boundary distinction between the group and individual organisations. However, although issues of conflict and tension in group membership are well documented in the interorganisational literature, using group membership as a tool by which to manage conflict has not been discussed in the literature on interorganisational relations, mandated or otherwise, within the area of health and social care integration.

The analysis of the data from this study revealed that membership, specifically restricting membership, is an interacting strategy used by members who perceive fulfilling group requirements as a source of conflict based on their interacting orientation. This is closely interwoven with their interacting position such that it enables them to restrict the membership of the group as a way of managing those sources of conflict that are perceived as a threat to individual organisational interest. The interacting strategy of restricting the membership is shown to be developed by members whose interacting orientation is organisational and who have an interacting position of directing others. Restricting the group membership is perceived as a necessary interacting strategy to enable members to protect individual organisational interests whilst fulfilling group requirements. Being selective with recruitment is one of the issues that (Green, Boaz and Stuttaford, 2020) refers to as a ways of professional members seeking to protect their own professional identity and legitimacy. (Marent, Forster and Nowak, 2015) highlighted that de-professionalisation occurs when lay members possess the relevant skills, knowledge and expertise to cross the boundary of the professional identity (Martin, 2008) and as such using recruitment into participative processes acts as a way of protecting their legitimacy and credibility.

Restricting the membership was an interacting strategy developed by the professional group members in order to collaborate under conditions of mandate. Having the ability to decide who can and cannot join the membership of the Health and Wellbeing Board enables members to restrict access to knowledge of local health and social care arrangements, and to manage those sources of conflict that can result from the addition of new members and further democratisation of the decision-making process. Some of the democratic members in the group were aware that this was the case:

> I don't know, I really don't know. In South Tyneside the voluntary sector is represented by the CVS, and in South Tyneside the CVS do not understand health and social care so are they the right people to be representing the voluntary sector around health and social care? Probably not. Now HealthNet, which is the voluntary sector hub for health and social care has not got a seat on health and well-being board and it probably should have. It’s got a seat on the integration board but not on the Health and Wellbeing board. They truly represent the voluntary sector. The discussion was held in South Tyneside whether HealthNet should be represented [at the Health and Wellbeing Board] and literally they have gone and done exactly what they were told by the NHS about what the membership should be and there doesn't seem to be much flexibility in it. They don't want any flexibility in it. (Senior Manager, Healthwatch)

The professional group members were perceived by some as using the influence that came with their identity to restrict the membership of the Health and Wellbeing Board to avoid further democratization of the decision-making process, which was already a source of conflict for these members. Reinterpreting the role of policymaking and service delivery prevents this being a one-way process within the remit of professionals and managers, and allows service users or their representatives to play a larger role in the shaping of decisions and outcomes (Bovaird, 2007). The effect of such a policy is to democratise the decision- or policy-making process, which becomes a particular source of conflict for those who have previously held control and made decisions from a stance of order and control rather than the health equity of service users. Efforts to change policymaking from traditional methods to those that are more inclusive of service users need to adopt a coproduction approach which goes beyond the efforts of engagement and participation, enables service users’ access to policymaking, and forces professionals to relinquish control and find new ways to interact with service users or their representatives. Although the literature on coproduction efforts in health and social care initiatives is generally positive, case studies are based on the voluntary sector or extend only to pressure exerted by politicians and local officials.

Within the data of this study, the mandate discouraged coproduction efforts and, whilst a performance of collaboration was played out in public, there was a perception that efforts to include additional representatives of service users were being curtailed where possible. This was noted by a number of democratic group members:

> I really do think the third sector, they really should have a place at the table, no doubt about it. (Local Councillor)

And:

> The voluntary sector aren't formally represented at the board. They're not, and I think there's a missing bit there. (Senior Manager, Healthwatch)

There was a consistent view in the narrative of the democratic group members that the Health and Wellbeing Board, as a democratised decision-making process, should include members who played a key role in providing some of the area's most needed services. Another democratic member expressed a view as to the important role these missing members played:

> They play massive parts. If we lost our voluntary sector, then we would grind to a halt; our whole town runs on volunteers. That was even before these massive cuts. It's worse now, or better whichever way you look at it. The way we look at it, even before we had the massive cuts, our voluntary sector was fantastic. Absolutely. We would grind to a halt if it wasn't for the volunteers. (Local Councillor)

And:

> I suppose perhaps my only concern, and this is me with my voluntary sector hat on, is when integrating health and social care, they should be really looking to include the third sector in this as well because of the third sector is the solution to some of their problems, and they very much should be valuing what the third sector can add to the picture and the model of services. That comes hard to them. (Senior Manager, Healthwatch)

The acknowledgement in this study that the voluntary sector played a major role in the provision of services in this local area yet was excluded from membership of the Health and Wellbeing Board, was seen as a failure to legitimise their role. The voluntary sector is known for its difficult relationship with the budget holders in local care, as it is expected to catch and support the most vulnerable members of society, often with very little financial support and staffed by volunteers. The success of democratic approaches in local issues relies on the engagement of diverse and vested stakeholders who can represent a broader range of views than the traditional views and approaches of professionals. However, empowering all stakeholders in this locality would require a redistribution of the control held by professional members. The extent to which this stakeholder was excluded and the efforts they would have make to be included were noted by another democratic group member and a professional member:

> The voluntary sector isn't formally represented at the board. They're not, and I think there's a missing bit there. I think the only divide that I could see was one that Margaret always wanted to be at the Health and Wellbeing Board, Margaret from HealthNet [voluntary sector] and that was the gap. That was a divide I wasn't going to get involved in. If you wanted to be involved, ask Public Health, or go and lobby, that type of thing. (Senior Manager, Healthwatch)

> If you are inviting your NHS hospital provider then that it one thing, why you would

> then not invite a representative from the voluntary sector, I just don't know because they are such an important player in determining a sustainable future for the NHS. (Senior Manager, NHS England)

If restricting the membership could be viewed as cynical, there was a perception among these group members that a vital player in local care would have to get approval from an organisation, or even lobby if they were to be included in a process which directly affected them. The bureaucratic process of being admitted to the membership was even acknowledged by one of the professional group members:

> I think the bigger gap is our voluntary sector. So, we have Healthwatch but we don't have a representative from our community and voluntary sector. I think we're reviewing the membership as well and I think that will be the one gap that we'll need to kind of agree with the office of the chair of the board and other members. I think it's been a miss, I have to say. (Director of Public Health)

However, the outcome of this interacting strategy of restricting the membership of the group is noted as having a negative effect on the level of group action. This was noted by one of the professional group members:

> You know, so it seems to be, if you have got the CCG there representing the commissioning side and an element of the primary care side, and then you have got your acute provider who may well run the community services following transforming community services, and why you would have that gap - I don't know, it feels like you cannot have a full discussion around all of the individuals. So, part of my other role is to support clinical senates who do reviews of full service changes, you know, so mental health which is based in Newcastle and Gateshead now, it doesn't matter what they do on the service side. You can reduce your number of sites and your number of

> wards, it will all be underpinned by a community infrastructure, the majority of which will be provided for by certain voluntary sectors. So, if you are not focusing on that, it doesn’t matter what you do - it is not going to work anyway. (Senior Manager, NHS England)

This acknowledgement of the effect on group action of excluding the voluntary sector is an acknowledgement that those who should be included in the participation have been excluded. The literature on the relationship between government and the voluntary sector suggests that the independence of this sector and its capacity for critical intervention in civil society has always been questionable, despite the ever-increasing role government relies on them to play in addressing wicked issues (Turner, 2001). Some members noted that the consequence of this interacting strategy is detrimental to the group efforts, that to persist with it renders any group efforts futile.

There is a perception that government policy is pushing responsibility for wicked issues on to the voluntary sector and the citizen with no support from an over-arching authority or a formal system of control (Stoker, 1998, p.21). Voluntary associations can fulfil important democratic functions such as ‘redressing political inequalities’ that exist when politics is materially based; they can act as schools of democracy; they provide alternative governance to markets and public hierarchies that permits society to realize the important benefits of co-operation among citizens (Cohen and Rogers, 1992, 1993). This transformation in the voluntary sector, with it, taking more responsibility for assisting disadvantaged people is said to be a consequence of the decline in the welfare state. These social justice organisations are committed to the redistribution of socio-economic resources, but have been less successful in their claims for recognition, particularly when it comes to decision-making at the service and commissioning level. Although the participants in this study acknowledged the increased undertaking of social justice work in this local area by voluntary organisations, there was still a willingness to recognise this or to share any control or decision-making with them (Ilcan and Basok, 2004). For some members, including voluntary organisations as part of the membership represents a threat to organisational legitimacy, and a source of conflict to be managed, rather than an opportunity to solve wicked issues.

7.2.3 Making the Decisions Elsewhere

The data from this study indicates that *making decisions elsewhere* is used as an interacting strategy by the professional group members to manage some aspects of conflict associated with collaborating under conditions of mandate. Being able to restrict collaborative action by taking and making decisions elsewhere is perceived as necessary to manage the conflict that potential outcomes could bring to those who prioritise organisational interests. *Making decisions elsewhere* is a backstage interacting strategy that is taken outside the group forum and make decisions on collaborative issues without the inclusion of all group members. It is an informal interacting strategy, in that it is not considered to be part of group norms, but rather is developed and implemented by those who interact from a position of directing others, behind the scenes. *Making decisions elsewhere* allows members who perceive the interests of their individual organisations to be under threat from the outcomes of collaborative decisions to make decisions elsewhere that cannot be reversed by the time they reach the group forum.

> It’s one of those groups where I don’t think a decision was ever made. I just saw the Health and Wellbeing Board, but naively when I went into it I thought, right okay, this is a group where you need to go in and say what you think about something, but it was a group where you went in and a group had made this decision and that what was done and that’s the type of group it was. The decision-making took place elsewhere and outside of those groups and it either took place in the silos or collectively on the health and social care integration stuff that fed into it – so there was no decision made really that was the sad thing about it. (Senior Manager, Healthwatch Manager)

Policy initiatives such as the Health and Wellbeing Board can bring both challenges and opportunities to the decision-making processes of group structures. There is an expectation from central government that members who have been mandated to interact will position themselves to capitalise and seize the opportunities that group work can offer to the solutions of wicked and complex issues. Sharing the decision-making between a range of interested stakeholders is said to improve the quality of the decision-making process and the user outcome. However, the data in this study showed that the reality was rather different: attempts by central government to decentralise decision-making are accompanied by simultaneous attempts on the part of some members to centralise it. Centralising and retaining control over the decision-making process prevented decisions being made that could compromise organisational priorities. Managing conflict in this way is perceived by some to create internal barriers within the group which serve to constrain collaborative action rather than enable it.

Making decisions elsewhere is interwoven with the backstage position of *directing others* and also representative of other studies who have also analysed this action as decisions happening in private and behind the scenes (Coultas, Kieslich and Littlejohns, 2019). When the professional group members acted from a *behind the scenes* position, with a desire to misrepresent, the interacting strategy of *making decisions elsewhere* allowed the manipulation of the performance. The awareness of *making decisions elsewhere* was noted by members of both interacting identities. One democratic group member was asked about the decision-making process and commented:

> I got the impression that the decisions were made elsewhere. (Senior Manager, Healthwatch)

A professional group member also agreed with this perception but excused this kind of strategy as necessary for real discussion on complex issues:

> It is almost like we all just default to that place really, that there is some hard stuff that needs to be figured out elsewhere and it is not the place of a public meeting [Health and Wellbeing Board] to figure out what the model is for health and social integration in South Tyneside. (Local Government Officer)

This is closely linked with the analysis in *democratising decision-making practices*, where there is still a reluctance from the professional members to relinquish their exclusive control over decision-making practices, believing that public involvement brings more harm. Concealing certain facts regarding local service provision, while accentuating others, becomes a form of repetitive behaviour to safeguard against any potential sources of conflict and offers an idealised reality for some which is representative of Lukes' (1974) third dimension of power.

The acknowledgment that *decisions are made elsewhere* is in direct contrast to the form of shared and participative decision-making that the policy initiative of the Health and Social Care Act (2012) was designed to create. Efforts to bring complex issues into a more transparent arena are thwarted by the efforts of those who assume illegitimate privileges, and remove those decisions and place them outside the group forum. Although the data from this study showed that shared decision-making was perceived as a source of conflict, it is a method generally advocated because of its potential to improve the quality of decision-making processes and user outcomes (Gravel, Légaré and Graham, 2006). These forms of local governance are intended to add participation and accountability to the usual forms of decentralisation on local arrangements; however, members from an organisational orientation often have to pursue financial and resource efficiencies over health and social care equality and feel this cannot be done in the public gaze.

The perception that members of a professional identity took decision-making back to their own organisations, removing it from the group decision-making forum was consistently evident in the participants' narrative of this study, as one professional group member remarked:

> I think that I have been in that board where there have been some quite robust discussions, but I think that there is a bit of a temptation for things to go back to their own organisations for the actual decision to be made. (Senior Manager, Mental Health Foundation Trust)

And also, by a democratic group member:

> I think massive decisions were made separately. (Local Councillor)

For members of an organisational orientation and professional identity, the tradition of individual organisations being responsible for certain decisions carried a level of authority that was perceived to endure in the new initiative. For members of a social justice orientation and a democratic identity, the motivation in making decisions elsewhere was rooted in the financial control that individual organisations might have to relinquish if decision-making became more transparent. From this perceptive, decisions made elsewhere carried a level of authority such that they were then perceived as done deals, decisions that were now irreversible. This was noted by one democratic member:

> I think it should have been made together, but again it was a done deal before we even came in the arena. I think it was a done deal, I think the budgets had been set. They said it wasn't to do with money; it was all to do with money. (Local Councillor)

And:

> So, I think for me, they got this, they know what they need to do, cut, save, whatever you want, but if they know how much money they going to have less this year than they had last year or previous years and going forward … I think some of the things that have happened, for instance the walk-in centre closed less than half a mile away, the thought was that was based on financials. I don't think there is any doubt about that but actually that was never said in the room. (Local Councillor)

The perception that decisions should be made together but are not, due to financial concerns, is consistent throughout the narrative of democratic members who were of an *interacting orientation of social justice* and an interacting position of *being directed*. Democratising the decision-making process was intended to be an inclusive process that invites others to share in a process previously enjoyed by a select few. Where processes become inclusive for some, they result in a relinquishing of control for others. To fulfil group requirements through the integration of local health and social care, group members must surrender information about financial resources. Consultation strategies are also closely linked with making decisions elsewhere. Members of a social justice orientation, who were in a position of being directed, are perceived to be placated by a demonstration of public consultation that shows a performance of transparent decision-making processes, but in reality, masks and conceals darker practices or strategic secrets.

> I don't know whether I would particularly have thought that I could change the CCG's position or even ask them to reconsider. I think it was a done deal. I think because of their culture, the culture that they have: we know this, we know that we know the background figures for this so, as a token, we will commission a consultation. (Local Councillor)

For members who had to accept decisions made elsewhere, this kind of secondary action confirmed perceptions that some members were unable to relinquish decision-making from the orientation of social order. For these members, decisions made elsewhere were ‘done deals’ and only time would be able to validate whether these closed decisions had been made for the good of the wider public, or the self-interests of the organisation. The opportunity to manage conflict through making decisions elsewhere is also available through the process of consultation. Where making the decisions elsewhere is used to constrain participation rights, consultation serves to give the appearance of participation rights. This is perceived as a form of tokenism or a convenient approach to participation and involvement. Despite the attempts by central government to decentralise decision-making, it becomes once more centralised at local level, perceived as a source of conflict and managed as such. This was noted in a discussion with one of the democratic group members:

> I think it was at times a feeling that the decisions been made, but now we’re going through the consultation and of course I remember XXX talking and – and saying ‘when we talk of consultation in the health service it’s not – it’s not necessarily the consultation as you might see it in another situations’, but I think there definitely was a feeling that the dye was cast and the rest was already planned. (Local Councillor)

Access to information is regarded by some as a fundamental democratic and human right (Naurin, 2007). Using mechanisms such as ‘consultations’ creates an appearance of participation with other members, rather than actual implementation of equal participation. This adds to the perception of members who interact from a position of ‘being directed’ that real decisions are made elsewhere, and the group forum is a scripted performance where the opportunity for social action is restricted by the actions of others.

The perception that the consultation process was a way of staging the performance of a transparent decision-making process was consistent with the narrative of the participants’ data:

> So, members of the public, if they had turned up and wanted transparency and said well, how did you come up with the decision, the one you got from the Health and Wellbeing Board? Because it actually took place over the coffee machine, or one of the other sorts of groups or meetings with the partners type of things. So, they were really just a proof of things that had happened weeks and months ago. (Senior Manager, Healthwatch)

Group members from a social justice orientation are of the view that members of an organisational orientation are keen to restrict the information advantage and room for manoeuvre that transparency in decision-making can bring, that is, the degree to which information is made available about how and why decisions are made (De Fine Licht *et al.*, 2014). Government initiatives such as the Health and Wellbeing Board are intended to bring a greater level of democratic and transparent decision-making to local health and social care provision; however, there is a widespread perception within the group that the rationale behind this policy initiative was only to give a perception of transparency and shared decision-making, rather than fully to implement it.

Backstage strategies are described as withholding information from another group member which limits any further action or influence on that point and in this sense they represent a mechanism which constrains interactions (Hayward, 2000). Many of the empirical studies in this review also revealed that lay members perceived that decisions were being made elsewhere as a way of moving opportunity for action outside the space of the group (Vincent-Jones, 2011; Djellouli *et al.*, 2019; Green, Boaz and Stuttaford, 2020; Perkins *et al.*, 2020). However none of these studies have viewed this either as a mechanism of power that constrains action for some and enables it for others or as a strategy to manage conflict.

The remainder of this chapter discusses the interacting strategies analysed and labelled in this study as *front stage strategies* developed by the democratic group members to manage sources of conflict from the orienting position of *being directed*.

7.3 Front Stage Strategies

Front stage strategies are the interacting strategies that group members of a democratic interacting identity, and interacting position of *being directed*, develop in order to manage the sources of conflict that they locate when collaborating under conditions of mandate. Developing these strategies is analysed as their attempt to disrupt the impression of reality that was fostered in the performance of the Health and Wellbeing Board, where decisions had been made elsewhere, behind the scenes or with misrepresentation. For these group members, not being socialised in the ways of the professional group members moved them into a mandated role that was new to them, where they had to rely on and take their cues from others, which in itself became a source of conflict. Performing in the Health and Wellbeing Board with frontstage strategies allowed these group members to manage their performance in the Health and Wellbeing Board according to the understandings and expectations of the society to which it was being presented, that is, the professional group members and the members of the public.

7.3.1 Holding to Account

> To them it was a massive culture shock, because they were not used to being accountable and, all of sudden, they’ve got these people who are holding them to account and asking why did this happen without any proper consultation? So, immediately it went into consultation mode and it was quite heated, as you can imagine. (Local Councillor)

Holding to Account was one of the strategies developed by democratic group members to resist and manage the professional group members' backstage strategies of *controlling the agenda*, *being selective with the membership* and *making decisions elsewhere*. The mandate of the group to take over the decision-making in local health and social care integration took control of those decisions traditionally made by the professional group members and forced them to become more open about the health and social care plans surrounding their remit. For example, the Clinical Commissioning Group was responsible for ensuring the efficient running of the Palmer Community Hospital, but the decisions on the action to be taken to tackle its underperformance were to be influenced and decided by the group, with the outcome of those decisions taken back to their organisations by the Clinical Commissioning Group and put into place. The democratisation of decisions such as these were analysed within the data as being a source of conflict which members managed by making the decisions elsewhere (7.2.3). The result of making a decision elsewhere was that it entered the group forum not in its nascent stage, but in its mature stage as a decision already made, rendering any group discussion on the matter futile. When a decision was presented as a mature decision, this became a source of conflict for the other members, who realised, nevertheless, that any efforts to influence the decision and its outcome were fruitless. Instead, when democratic group members located conflict in mature decisions that had been made elsewhere, holding members to account in the public forum of the Health and Wellbeing Board was perceived as the only way to attempt to resist these decisions, by challenging others to be open and transparent about how decisions had been made, and the true outcomes for local health and social care provision:

> Yes, and the same with the closure of the walk-in centre at Jarrow. I mean the Clinical Commissioning Group got a really rough ride over that one. And again, I think they had not been used to being accountable, and then all of a sudden, they met with these politicians who are totally accountable. We are on our backsides if we don't please our electorate, so we are used to being totally accountable. These other people are not. And rightly so, the professionals, they are not used to working in an atmosphere like

> that, in a political arena. So why should they have to be accountable? Then all of a sudden, they are chucked in this arena where we are totally accountable, everything is double stamped because it's public money. (Local Councillor)

Health and Wellbeing Boards were created as safe spaces where professionals and democratically elected representatives could interact on equal terms with a shared understanding, where all perspectives were valued. When democratic group members interact from an orientation of social justice, and from a position of being directed, they perceive a failure to meaningfully include them in the decision-making process. By *holding other members to account*, they interact to shift their level of participation away from 'could have been' tokenism and towards authentic participation. The realisation that decisions have been made elsewhere, and not in the ringfenced space of equal terms, according to the mandate, results in members having to resort to strategies that will still have some influence on the decision-making process. Holding the professional members who have made decisions elsewhere to account, in the public and an open space of the group forum, means that those members who interacted from a behind the scenes position now have to justify those decisions or revise them.

Resisting and holding members to account about mature decisions had the effect of producing secondary action on some decisions that had been made elsewhere. Secondary action occurred when evidence to support a decision through processes such as consultation took place after the decision had been made instead of before. However, as some members noted, this kind of secondary action was also seen as futile and 'token', acted out for the purpose of complying with democratisation:

> I don't know whether I would particularly have thought that I could change the Clinical Commissioning Group's position or even ask them to reconsider. I think it was a done deal. I think because of their culture, the culture that they have: we know this, we know

> that, we know the background figures for this so, as a token, we will commission a consultation. (Local Councillor)

For members who had to accept decisions made elsewhere, this kind of secondary action confirmed perceptions that some members were unable to relinquish decision-making from the *organisational orientation* that *prioritises organisational objectives*. This was put by one democratic group member as:

> I think it was at times a feeling that the decisions been made but now we're going through the consultation, and of course I remember XX [Senior CCG Manager] talking and – and saying 'when we talk of consultation in the health service it's not – it's not necessarily the consultation as you might see it in another situations', but I think there definitely was a feeling that the dye was cast and the rest was already planned. (Local Councillor)

For these members, decisions made elsewhere were 'done deals' and only time would be able to validate whether these closed decisions had been made for the good of the wider public or the self-interests of the organisation.

> I think it should have been made together, but again it was a done deal before we even came in the arena. I think it was a done deal; I think the budgets had been set. They said it wasn't to do with money; it was all to do with money. It was a hand on heart could have said it could be better service if everything was launched at the hospital. And time will tell. (Local Councillor)

Having a done deal or deals that are done before the democratic group members re-enter the arena or the Health and Wellbeing Board, pushes the level of contrivance that group members must interact with in the formal setting. These kinds of deals are a source of conflict that must be managed with backstage strategies, to give the impression that there is an idealised performance of dramaturgical cooperation. Rather than giving the show away, backstage interacting strategies allowed these group members an opportunity of influencing the mandated collaboration to take a particular turn, or a turn away from what these group members located as sources of conflict.

7.3.2 Bringing Democratic Challenge

Having to revert to the front stage strategy of *holding members to account* as a way of dealing with decisions that had been made elsewhere was itself a source of conflict. Within complex issues such as health and social care, challenge can be a positive mechanism that can force a new solution; however, when challenge is a reaction to a source of conflict, members were noted to attach a negative value to it. In this sense it was seen as forcing members to take action they were trying to avoid, and an opportunity to avoid this kind of challenge was explicitly welcomed.

> When I finished, when I stepped down from Healthwatch, some of the strategic partners were really shocked and couldn't believe it. One of the partners said, 'In a way, it's going to give us an easy time. I know I shouldn't say that, but it's going to give us an easier time because I know what we've got left; people who will not challenge our services.' I think that was a bit sad because that's exactly where I placed Healthwatch, as a credible partner, so we could challenge. (Senior Manager, Healthwatch)

> And it's sort of good and bad, because generally Health and Wellbeing Board, what I've noticed when I was there for like about a year and a half, two years: there weren't challenge enough of each other, there was all very nice and sort of nice, nice but not

> really getting the difficult conversations. (Senior Manager, Healthwatch)

Bringing democratic challenge was a front stage strategy developed from an interacting position of *being directed* by the democratic group members. These strategies were developed in response to the more dominant group of backstage actors and, as such, did not yield as much authority in enabling the interaction they wanted at a level where the performance of the Health and Wellbeing Board could be disrupted. When conflict was managed in this way, group members still remained respectful, not willing to disrupt the performance of the Health and Wellbeing Board, knowing that this must be kept professional and appear without conflict.

Some democratic members resorted to ‘making a fuss’ about decisions that had been made elsewhere when they realised that this had happened:

> And because we made such a loud voice and made such a fuss about it, we got things like promises of transport. We got a lot of things that I think, had it just been NHS in the past, it wouldn’t have happened. But because they had the local authority, and not just the local authority, other organizations as well who were making their mouths go. I think it pulled them into line and made them give us a lot of things that we wouldn’t have got, so I think it was a good learning curve for all of us’ (Local Councillor).

When democratic members realised that they were dealing with what has been labelled ‘mature’ decisions that had been made elsewhere, bringing democratic challenge allowed these members to challenge these decisions in the public forum without triggering public anger or votes of no confidence from those on whose behalf they advocated.

7.4 Chapter Summary

This section has explained and discussed the two interacting strategies that group members develop to manage the sources of conflict that they locate, dependent on their interacting identities, orientations and positions. The sources of conflict identified and discussed in Chapter 4 revealed that mandating this group of individuals with opposing interacting identities results in conflict being perceived in different ways. Group members will then develop opposing strategies to manage this conflict which are influenced by their interacting orientations and positions.

Backstage strategies represent the strategies developed by the professional group members which are underpinned by a desire to protect organisational priorities by carrying out the decision-making behind closed doors. Controlling the agenda, being selective with the membership and making decisions elsewhere are strategies that manage conflict that threatens their organisational priorities and allows them to perform in the Health and Wellbeing Board in a manner fitting with the inward view of reality, presenting a constructed reality of what is in keeping with the expectation of the mandate and the wider public. *Controlling the agenda* allows discourses around the decision-making process to be constructed so that contentious issues, or those that threaten individual boundary enforcing, are kept away from the audience and the public arena as much as possible. Similarly, *being selective with the membership* and *making the decisions elsewhere* allows the old practices to endure with a certain level of authority and enables these group members to take key decisions out of the audience arena and make these decisions elsewhere. This results in the Health and Wellbeing Board being a reality that is constructed by others, before the audience participates in their own socially constructed process.

Front stage strategies are underpinned by a desire to resist the backstage strategies that manage conflict from an organisational orientation. These strategies attempt to bring the decision-making process back into the democratised forum that the Health and Wellbeing Board was mandated to be. For these group members, who have a growing awareness that decisions are being made elsewhere and that the democratisation process of the Health and Wellbeing Board is being circumvented, front stage strategies can bring a level of transparency and participation that should have been embedded in the decisions already made. Coupled with the realisation that information regarding decisions about care is being withheld, and acting out of a concern for others, these group members are aware that the strategies that they develop to manage conflict must also retain a performance of the Health and Wellbeing Board in keeping with what is expected by the society to which it is presented. That is, these group members are not taken in by their own performance, or the performance that is being presented in the formal meeting of the Health and Wellbeing Board but believe in the impression being fostered on the wider audience or the general public, seeking to hold other group members to account and bring democratic challenge.

In this Health and Wellbeing Board, there were times when the democratic group members who had to assume an interacting position of being directed, or a front stage position, would be aware that the performance being presented was a manipulated reality, in that what was being presented via the agenda had either been decided elsewhere or was masking some other critical issue. In this way, front stage group members resisted maintained levels of expressive control as a way of managing conflict. Although it was noted that tools such as these can be divisive, as there was a real hesitancy to interact from a position such as this, to refrain helped to achieve a level of consensus amongst the group and safeguard against issues that could cause divisions and cliques within the group.

The extant literature on mandated collaboration did not reveal any previous studies that had considered the strategies that people develop to enable them to collaborate under conditions of mandate when facing conflict. Elements such as membership and agenda were noted as being essential elements but had not been explored as to the ways in which these can actually be used as mechanisms to control the collaborative action that is being played out (Blakely and Dolon, 1991; Perkins and Hunter, 2014; Popp and Casebeer, 2015). The findings of this study did touch the extant literature in those studies in which previous authors had used institutional theory to explore the reactions of those who collaborate under conditions of mandate (DiMaggio and Powell, 1982; Grafton, Abernethy and Lillis, 2011; Forbes, 2012). Institutional theory is useful in illuminating the extent to which the legitimacy of existing practices is continued, adapted or discontinued as a result of the new mandated arrangement. In this study, under the new institutional arrangement of the Health and Wellbeing Board, existing practices of decision-making in health, social care and public health were not discontinued and replaced by a new institutional order. The intention of the Health and Wellbeing Board was to transform the old ways of organising and providing care into participative and democratised decision-making practices through patterns of interactions that would reproduce over time (Forbes, 2011). However, the professional members were able to interact in ways that gave legitimacy to their old practices, enabling these practices to be developed as backstage strategies facilitated by an interacting position of *directing others*. From an institutional theory perspective, under conditions of mandate existing practices are challenged, but their legitimacy continues, rather than being discontinued as the theory suggests.

This chapter concludes the explanation and discussion of the substantive theory of *managing conflict*. This study has revealed that people who collaborate under conditions of mandate for the organisation and provision of care manage conflict through the three conceptual domains of: interacting orientation, interacting positions and interacting strategies. These domains interweave with each other to show the strategies, practices actions and attitudes that construct the basic social process of *managing conflict.* The next chapter summarises the key findings of this study, the contribution to knowledge, the application of these findings for people who collaborate under conditions of mandate, and areas for further research that can be developed from the findings of this study.

Chapter 8: Conclusion

8.1 Introduction

The purpose of this study was to explore the interactions that occur when people collaborate under conditions of mandate, and the ways in which those interactions are managed in respect of the organisation and provision of local care. Exploring this using a social constructivist approach to Grounded Theory (Charmaz, 2006) I have demonstrated that these interactions are underpinned with conflict. I also revealed the orientations, positions and strategies from which this conflict is managed. In doing so, I have constructed the basic social process of *managing conflict* which is a substantive theory that is grounded in the data. This study brings an entirely new aspect to our existing knowledge about collaborating under conditions of mandate.

This chapter begins with the summary of the research findings of this study, which are central to understanding how people collaborate under conditions of mandate. These findings will be discussed in relation to the existing literature on mandated collaboration and the micro-interactions between professional and lay people in chapter 2. However, where recent reviews have noted this as limited (Djellouli *et al.*, 2019; Green, Boaz and Stuttaford, 2020) the study will aim to show where it has contributed to the gaps highlighted in that literature.

The chapter concludes with an examination of the contribution of this study to knowledge, the way in which these research findings could be useful to those people who have to collaborate under conditions of mandate in a care context, and avenues for further research that build on the findings of this study.

8.2 Summary of the Research Findings

The findings from this study have revealed that, when people collaborate under conditions of mandate for the integration of local health, social care and public health provision, conflict, or social conflict, as a multifaced issue occurs within those interactions. The findings also revealed that people manage these sources of conflict through the basic social process of *managing conflict*, which is the substantive theory constructed from the data in this study and grounded in the data.

Previous literature had focussed on the challenges and tensions caused by mandated collaboration rather than the conflict between people, or 'social conflict' as it was identified in this study. One of the key tensions noted in the literature concerns the governance modes of mandated collaborations. The literature reviewed in this study revealed that the act of 'mandating' a collaboration can cause inherent tensions between the approach taken to organise care and the governance mode. This issue arises when collaborations, which are usually characterised by egalitarianism, less formal arrangements and self-organisation, are subject to a top-down imposition to mobilise social action (Macneil, 1985; Rhodes, 1996).

Lowndes and Squires (2012), noted that these tensions arise because of the failure to distinguish between manifestations of collaboration (i.e., partnership) and their modes of social coordination or modes of governance, such as hierarchical, market or network. Previous literature highlighted that, where instances of mandated collaboration are not governed by modes that combine hierarchy, market and networks, they will not be equipped with the mechanisms needed to need to bring partners to the table to collaborate on wicked issues, incentivise shared commitment and coordinate collaborative action developed on shared values and beliefs, and thus trust and reciprocity will be absent (Ouchi, 1980; Goold, Alexander and Campbell, 1994; Rodríguez *et al.*, 2007). In this was, if collaborative and deliberative forms of collaboration and imposed and initiated by top down hierarchical structures that go against the network modes with which these collaborative forms should be governed, this will continue to remain a source of conflict and detract from collaborative outcomes.

Previous literature also highlighted a notable tension in what Rees, Mullins and Bovaird (2012) call the dark side to mandated action, which lies in inequalities of power. This relates to the tensions that are created through the asymmetries resulting from a participant's resources, legitimacy, size and structure, tensions which can lead to hierarchical dynamics between the dominant participants (Provan and Kenis, 2009). Findings from this study found that, where asymmetries exist in the interacting identities of group members, this allowed the professional members to give legitimacy to their existing closed practices of decision-making in the new institutional field of the Health and Wellbeing Board. Institutional theory would argue that, under a new arrangement, existing practices will be susceptible to challenge, rejection or replacement and discontinued by the new institutional order, but the findings of this study indicated that, under condition of mandate, existing practices can be given the legitimacy needed for them to endure (DiMaggio and Powell, 1983).

The findings of this study indicated that tensions pervade much deeper than indicated by the extant literature. The tensions in this mandated collaboration could be defined as conflict (Dahrendorf, 1959) revealed as existing in the identities through which individuals collaborate, the democratic and participative structure of the Health and Wellbeing Board and the individual traditions and practices that crossed individual and group boundaries and persisted within the mandated process. Within each of these areas, collaborating individuals face opposing positions which they must manage, in order to be able to continue to collaborate under conditions of mandate. In essence, the findings from this study indicate that 1) the extant literature on collaboration underestimates the persistence of legacy tensions among those who may be forced to collaborate, and 2) the depth of those tensions as revealed in the analysis of this data should, more correctly be characterised as conflicts.

The causes of such conflict are found to be multiple and interwoven.

8.2.1 Conflict in Interacting Identities

Evidence from the participants in this study revealed that conflict develops when individuals who are mandated to work together lack a shared identity. The data revealed that, when individuals are mandated to collaborate, they omit an essential element of collaboration: the negotiation stage, where membership along with other norms and ground rules will be decided (Ring and Van de Ven, 1994; Popp and Casebeer, 2015). Although Segato and Raab (2019) suggest that, in the absence of appropriate governance modes, mandates which are highly specific as to who should collaborate and how this should be done can manage this ambiguity, the findings of this study and the data collected suggested otherwise. The highly specific nature of the mandated Health and Wellbeing Board in this study created what could be likened to a straightjacket of mandate (Barnsley, Lemieux-Charles and McKinney, 1998). Highly specific mandates can deny individuals the opportunity to arrive at a collaborative membership that is socially constructed, based on shared values and beliefs as is the case in voluntary collaborations. The data in this study showed that the removal of this element results in individuals going through a process of identity formation to determine whether that socially constructed position of shared values and beliefs can be reached. In this study, individuals gravitated towards a socially constructed position of shared values and beliefs, based on their interacting identities of a professional or a democratic type. Identities in this study were formed through the process of assessing self and others on the basis of the knowledge, skills and experience perceived to be necessary to fulfil the mandated role. This led to an awareness that, within this group, a shared identity did not exist, creating an ‘insider’ and ‘outsider’ mentality which participants identified as a source of conflict. This led to the awareness that mandating collaboration was not enough to enable a shared identity creating an ‘insider’ and ‘outsider’ mentality which participants identified as a source of conflict which constrained collective action.

8.2.2 Conflict in Democratising Decision-Making Practices

Evidence from the participants in this study also revealed that the mandated collaborative process itself represented a source of conflict. The extant literature highlighted tensions that can exist when modern day approaches to the organisation and provision of care, which advocate for less formal and egalitarian approaches, are subjected to a top-down structure imposed by an external authority, which could suggest an almost oxymoronic nature to mandated collaboration. The literature suggests that governance modes can be defined as to the way in which social action is coordinated. In this study, a democratic and participative approach to local care was hierarchically imposed (or mandated). For the professional group members, mandating the decision-making process regarding local care to become more democratic and participative represented a source of conflict when interacting with others within the group. When these democratic and participative approaches to care are pushed as being the solution to more integrated way of working across care, those who impose the mandate, too often conceptualise collaboration at the interorganisational level rather than as a group of socially interacting individuals (Hunter and Perkins, 2014). Failure to explore or consider the individual ignores action at the front line or the ‘street level’, where much of the collaborative interaction takes place. The findings of this study suggest that, at this level, participative and democratic approaches to care under conditions of mandate can manifest as conflict between individuals, constraining collaborative action. At the interacting level, the imposition of rules to share previously closed decision-making practices can result in an individual having to prioritise organisational priorities over mandated priorities, which then becomes a source of conflict. The findings from this study agree with Newman *et al.*, (2004) and (Fraser, 2014) that these democratic and participative forms of organising and providing care are dependent on the interactions and relationships between all participants, and these new processes are not equipped with the necessary mechanisms to achieve this. However, I would add to and develop this argument, the reason that these mechanisms are not present, thus frustrating the collaborative process, is that the approach to integrating care is conceptualised at the interorganizational level and ignores the front line where much of the collaborative action takes place (Williams, 2015). For example, while mandate specifies a more integrated and democratic approach to the decision-making processes that underpin approaches to the integration of local care, by bringing together key leaders from the health and care organisations and democratic representative, it does not account for the social element, that is, how dependant the collaboration will be on the interactions and relationships between the people collaborating. Simply putting structures in place without a contextually and professionally sensitive consideration of the needs and working practices of those who must enact joint working on a daily basis is, essentially, flawed. Without paying attention to the realpolitik and needs of individuals on the ground, pronouncement that collaboration 'ought' or 'will' happen are at best naive and at worst counterproductive. This can be seen when we consider the traditions of different stakeholders.

8.2.3 Coping with the Traditions of Others

A further way in which the participants in this study revealed conflict in the interactions that take place between people who collaborate under conditions of mandate is the through the traditions, or the practices and ways of doing things, that individuals brought into the ringfenced space of the mandated collaboration. The traditions of others were conceptualised in this study as the long-lasting ways in which individuals become institutionalised as to the practices and processes of their daily role which then cross the boundaries of the new mandated process. These practices and processes become conceptualised as sources of conflict when they carry sufficient authority to endure in the mandated process. For example, this was seen by the reluctance or a weak commitment by the professional group members to relinquish the ways and with who they had made decision regarding local care prior to the mandate which became a source of conflict which constrained collective action. The perception that 'mandate' carries sufficient authority to ensure integrated and new ways of working was seen to be a misconception in this study. The extant literature showed that highly specific mandates manage the absence of appropriate governance modes and the presence of ambiguities. The Health and Social Care Act (2012) was a highly specific mandate as to the structure, membership and objectives of the collaboration. However, this did not ensure a level of authority sufficient to ensure that group members relinquished the old way of operating to a level that really allowed effective collaborative working. In this sense, mandate failed to account for impeded cultures, professional socialisation and, as already noted, realpolitik.

8.2.4 Managing Conflict – The Basic Social Process

In developing an understanding of the interactions between people, and the conflict that occurs in these interactions as a result of collaborating under conditions of mandate, the basic social process of *managing conflict* has been constructed. Within the substantive theory of *managing conflict*, people who collaborate under conditions of mandate manage conflict from three conceptual domains. These domains are: *Interacting Orientation*, *Interacting Positions* and *Interacting Strategies.* Each of these conceptual domains was constructed to show the various strategies, practices behaviours and attitudes developed by the participants of this study to manage conflict and to enable them to collaborate under conditions of mandate.

The conceptual domain of *interacting* orientations contains the various strategies, practices, behaviours and attitudes that individuals develop to manage conflict. It establishes their beliefs, attitudes, feelings and values systems; the compass which influences how they perceive things; the position from which they act and the action that they take. The orientation of these group members influences the other conceptual domains through which they also manage conflict. Within this study, group members were analysed as being rooted in an *organisational orientation* or a *social justice orientation.* Within a social justice orientation, a group member’s value system is rooted in a place that acts out of concern for others. When these group members collaborate under conditions of mandate for the organisation and provision of care, they do this by seeking collective action on social issues and bringing the public voice, which is representative of the participative and democratic approach to care that was the intention of the mandate. However, the data also indicated that there is a second opposing orientation: the organisational orientation. Within this orientation, a group member’s value system is rooted in a place where organisational interests need to be prioritised ahead of mandated priorities and approaches to the organisation and provision of care should be achieved through prescriptive processes. Within an organisational orientation, a group member’s values system is rooted in a place where organisation interests are prioritised. When these group members collaborate under conditions of mandate for the organising and provision of care, they do this through prescriptive and formal processes that enable them to prioritise organisational interests whilst giving a performance of collaborating for collective goals.

The second conceptual domain of *interacting positions* incorporates two positions from which the participants in this study managed conflict when collaborating under conditions of mandate. These two positions were constructed as *being directed* and *directing others*. Group members who manage conflict from a position of being directed orient from a place of social justice and through a democratic interacting identity. When interacting under conditions of mandate, these group members need to rely on others to brief them to obtain the information they need to participate in the collaborate process. For those in a position of relying on others, although an impression is fostered that they are equal members of the collaborative process, in reality, processes are ‘being done to them’ and not with them. The second position from which group members manage conflict under conditions of mandate is from the opposing position of directing others.

Group members who orient from an organisational orientation manage conflict under conditions of mandate from a position of directing others. From this position they can ensure that the priorities of the organisation are prioritised from a behind the scenes position, whereby they persuade others to their way of thinking. These two interacting positions can also be explained through front stage and backstage positions. The position a participant interacted from was greatly influenced by their interacting identity. In this study, having a professional group identity enabled interaction from a position of directing others, or a backstage position. Those group members who were analysed as interacting from this position with a professional identity included the Chief Executive of the NHS, the Director of Public Health, the Director Adult and Children's Social Services, The Chair of the Clinical Commissioning Groups, the Chief Officer of South Tyneside Clinical Commissioning Group, the Director of Corporate and Business Services, the Chairman South Tyneside Foundation Trust, the Corporate Director of South Tyneside Children, Adults and Families. The remaining group members which included the Local Councilor's and Healthwatch managers, were in effect outside and interacting from a position of being directed. This latter group became performers within the formal meetings of the Health and Wellbeing Board but outside of this space, their interactions were constrained by others sufficiently enough, so they effectively became the audience. They had to manage the outcomes of decisions that were as a result of made being made behind the scenes enabled by the agenda setting by those used to directing others.

Another consequence of this position was that the democratic group members become the audience. They are not given access to the backstage position or to the decision-making carried out here. Instead, they become as an audience member and are forced to interact outside of the formal space. This causes tensions, and constrains their ability to collaborate, as key issues of the Health and Wellbeing Board are perceived to be taken behind closed doors and behind the scenes, out of view of this interacting identity. This is a fluid interacting position for these group members, as they must simultaneously interact as a performer when in the formal Health and Wellbeing Board meetings and then as an audience member when they are backstage. Although there is some awareness that decisions are being made elsewhere, in the formal meetings of the Health and Wellbeing Board where the democratic group members revert back to being performers, they ‘maintain the line’, keeping the secret that decisions have been made elsewhere and collaborating in a manner that maintains the contrived performance. From this position, all members act as one team in the space of the formal Health and Wellbeing Board and then as two separate teams outside this space.

The third conceptual domain of *interacting strategies* represents the strategies that individuals develop to manage conflict when collaborating under conditions of mandate. Two sets of opposing strategies were developed by the participants in this study. Group members who collaborated under conditions of mandate from a social justice orientation and a place of being directed, developed *frontstage strategies* to manage conflict. These include holding others to account and bringing democratic challenge to manage the consequences of other group members taking the decision-making process out of the Health and Wellbeing Board and into backstage areas where only members with a professional interacting identity are granted access. In this way, when decisions have already been made, they can at least be publicly challenged if not reversed. The second set of strategies developed to manage conflict were *backstage strategies*, developed by group members who came from an organisational orientation and a backstage position. Conflict is managed by controlling the agenda, being selective with the membership and making decisions elsewhere. These strategies are developed as a way of prioritising organisational interests even when collaborating for mandated interest and perpetuate prescriptive processes for the provision of care. For the democratic group members, front stage strategies enabled them to maintain expressive control and act in a way that their audience would expect of them at the formal meetings of the Health and Wellbeing Board. However, these strategies were not developed to help them maintain expressive control, but to enable them to manage conflict and bring challenge, presenting a performance where a consistent impression was maintained.

8.3 Contributions to Knowledge

The main contribution of this study is the construction of the basic social process of managing conflict, which is a substantive theory that is grounded in the data to enable understanding of the interactions that take place when people collaborate under conditions of mandate. This also answered the research question of this study which previous studies had been unable to answer.

This contribution was arrived at by adopting a constructivist grounded theory approach (Charmaz, 2006) which enabled the construction of the basic social process. Previous studies also revealed that this methodological approach to the study of mandated collaboration has not been considered.

This research also offered a further conceptualisation of conflict and power when professionals and lay members collaborate under conditions of mandate in a way that has not yet been done based on the studies included in this review. This study attempted to do what (Hayward, 2000) calls de-facing power. Rather than viewing power as something that the professionals had over the lay members used to alter their independent action, this study illustrated the way in which the sources of conflict analysed in this study acted to enable or constrain collaborative action as a way of illuminating the social action they can take to overcome these mechanisms, that is sources of conflict.

8.4 Reflections on the Study

How useful are these findings for the people who actually collaborate under conditions of mandate for the organisation and provision of care? They reveal that, where a mandate results in a membership of diverse identities, time and action must be acknowledged to resolve these tensions at the beginning of the collaborative journey. This study has revealed that diverse identities that are formed on account of the knowledge, experience and skills needed for the mandated role have the potential to become a source of conflict if they are too diverse, and this conflict will influence the way the collaborating action is managed throughout the rest of the process. Although additional sources of conflict were identified in this study, these particular sources will not be the same for every mandated collaboration; however, it may be useful for collaborators to be aware of and accepting of conflict, to acknowledge that it does exist and will emerge, and thought should be given to how this is managed, to avoid it being managed elsewhere, behind the scenes. Through identifying the various sources of concept that can occur when individuals collaborate under conditions of mandate, provides the opportunity for those who will participate in futures instances of mandated collaboration in a care context to acknowledge and appreciate that manifestations of conflict as analysed in this study can or will occur. This acknowledgement provides the opportunity for current and future collaborators to discuss and explore the identities, traditional ways of doing things and changes to decision making practises that will need to be resolved within the new mandated space.

Understanding and acknowledging the manifestations of conflict that can occur within instances of mandate collaboration can enable collaborators to view the mandated collaboration as something different and new, or the institutional field as this is put by (DiMaggio and Powell, 1983; Batalden and Mohr, 1997; Tsasis, Evans and Owen, 2012). These authors note that viewing the new mandated collaboration in this way can help collaborators to have a new awareness to the other diverse, independent and semi-autonomous which will allow them to build relationships of trust.

Using the basic social process constructed in this study as a tool through which to understand and perceive future instances of mandated collaboration could help collaborators to develop collaborative strategies to manage conflict in a way that enables collective and inclusive action and that constrains some from making decision behind closed doors. Consideration could be given to the time needed to develop as a team in addition to the time that is needed for formal mandated meetings. Working with each other to understand the different orientations and needs of organisations at the beginning and with transparency could encourage collaborators to be more creative and innovative as to how this is done in ways that suits their own context and the extent to which collaborative structures and process are mandated.

All research studies, no matter how well planned and executed, will have shortcomings that cannot be avoided but are useful to acknowledge. Due work commitments and access to other Health and Wellbeing Boards, I had to limit this study to one instance of mandated collaboration, resulting in research findings that are focussed on a particular context and locality, and there may be other patterns and interactions in other instances of mandated collaboration in a health context. Carrying out studies on other Health and Wellbeing Boards in different geographical areas, and on mandated collaborations other than Health and Wellbeing Boards, would be able to explore this.

Using a different sample could also verify or develop the findings of this study. To understand the interactions between people under conditions of mandate, the study drew upon the experiences of thirty participants interacting within the same mandated collaboration, and observations of these interactions over a twelve-month period. Using a comparatively small local sample and range of data could be perceived by some as limiting, when the aim of the research is to contribute towards theories on mandated collaboration. Theorising locally, through an approach of constructivist grounded theory, leaves the theory open to refinement so that others may build on this theory in further studies (Charmaz, 2006).

Also, this study primarily focused on the mandated membership to elicit information and perceptions as to the interactions under conditions of mandate. As such, wider stakeholders such as the public or the press, invited organisations to some of the meetings, or the civil officers who will underpin some of the work of the Health and Wellbeing Board were not included. A key question for further research then might be: In which ways do other stakeholders interact with mandated collaborators and how do they manage their interactions. Further grounded theory approaches or appropriate qualitative methodologies could be with conducted with these other Health and Wellbeing Boards and stakeholders to help answer this question which could assist in refining or substantive theory constructed from the data in this study.

A further research question could be in relation to the interactions that compare under voluntary conditions of collaboration and how this compares to the interactions that occur under conditions of mandate. Although this study highlighted a gap in the knowledge concerning what is known regarding the interactions that occur under conditions of mandate and how they are managed. It did not explore the interactions that occur under voluntary modes and if these interactions are different, and if so how?

A further avenue for research that was raised in the study concerns the different levels of public sector though which mandate is shaped. Mandate was shaped and explored in this study at the ‘street level’, however the development of the mandated originated much higher up. This could prompt the research question of: What understanding do individuals at the level of policy formation have in regard to the issues that occur when mandated collaboration is enacted at the street level and in which ways could policy at the formation level consider this at the policy implementation level? The literature in this study highlighted that the mandate was developed to encourage more participative and democratic ways of decision making. However, the Health and Social Care Act (2012) only enabled this at the street level and omitted this participate and democratic approach at the more senior level. Then perhaps conclude that in policy terms it is clear that simple demanding that diverse groups collaborate is no guarantee that better organising, provision and care will result. Much work is required to get this message across at local and national levels

Finally, although this study developed a substantive theory from a constructivist grounded theory approach which previous authors had not been identified as utilising, the theory of managing conflict could also be studied from a positivistic perspective. This could be used to test and measure the levels to which conflict and its management occur across instances of mandated collaboration in a range of health care settings and could also assist in seeing the level to which the findings in this study can be generalized.

Finally, a point must be made regarding my position as a researcher in this study and the implications this has for the research findings. In adopting the constructivist grounded theory approach, knowledge in this study was arrived at through the co-construction of meaning. As the researcher in the study, I am aware that the data collected from the observation of participants and their shared experiences was interpreted through my own interpretations and understanding to arrive at the substantive theory that was grounded in the data. This has been acknowledged throughout the study; however, the use of the Grounded Theory techniques, such as the constant comparison of the data, sought to minimise my researcher bias in that properties that were developed around the conceptual domains of the substantive theory were developed as a result of theoretical sampling, which is discussed in Chapter 3. However, understanding the boundaries allows further studies to take these into account when using such studies as a base for building theory (Marshall and Rossman, 2014).

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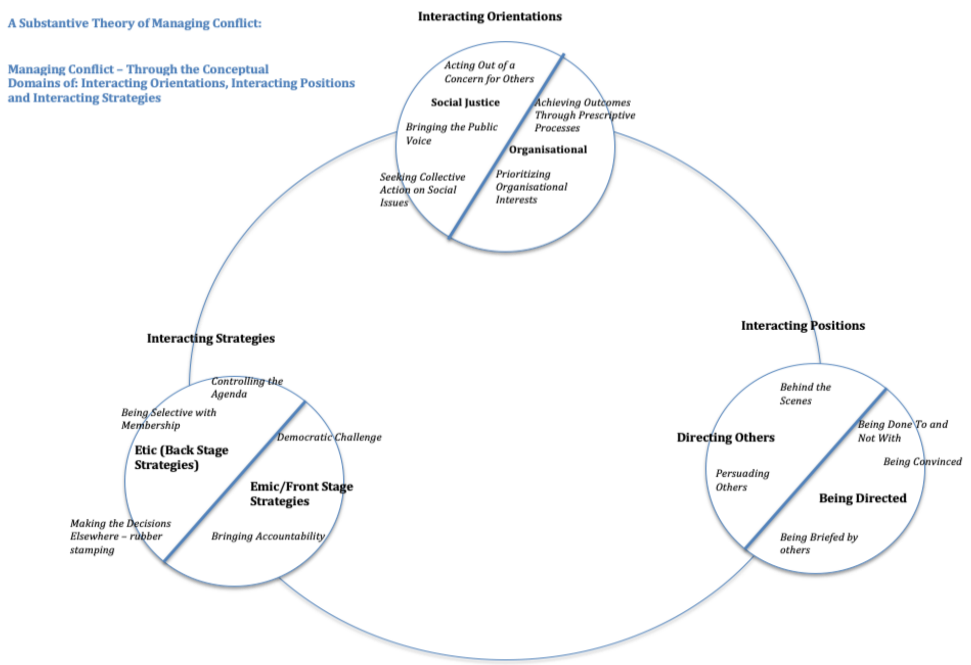
Appendices

Appendix A: The Basic Social Process of Managing Conflict

Figure 1: A Constructivist Grounded Theory Approach to Exploring Interactions Under Conditions of Mandate



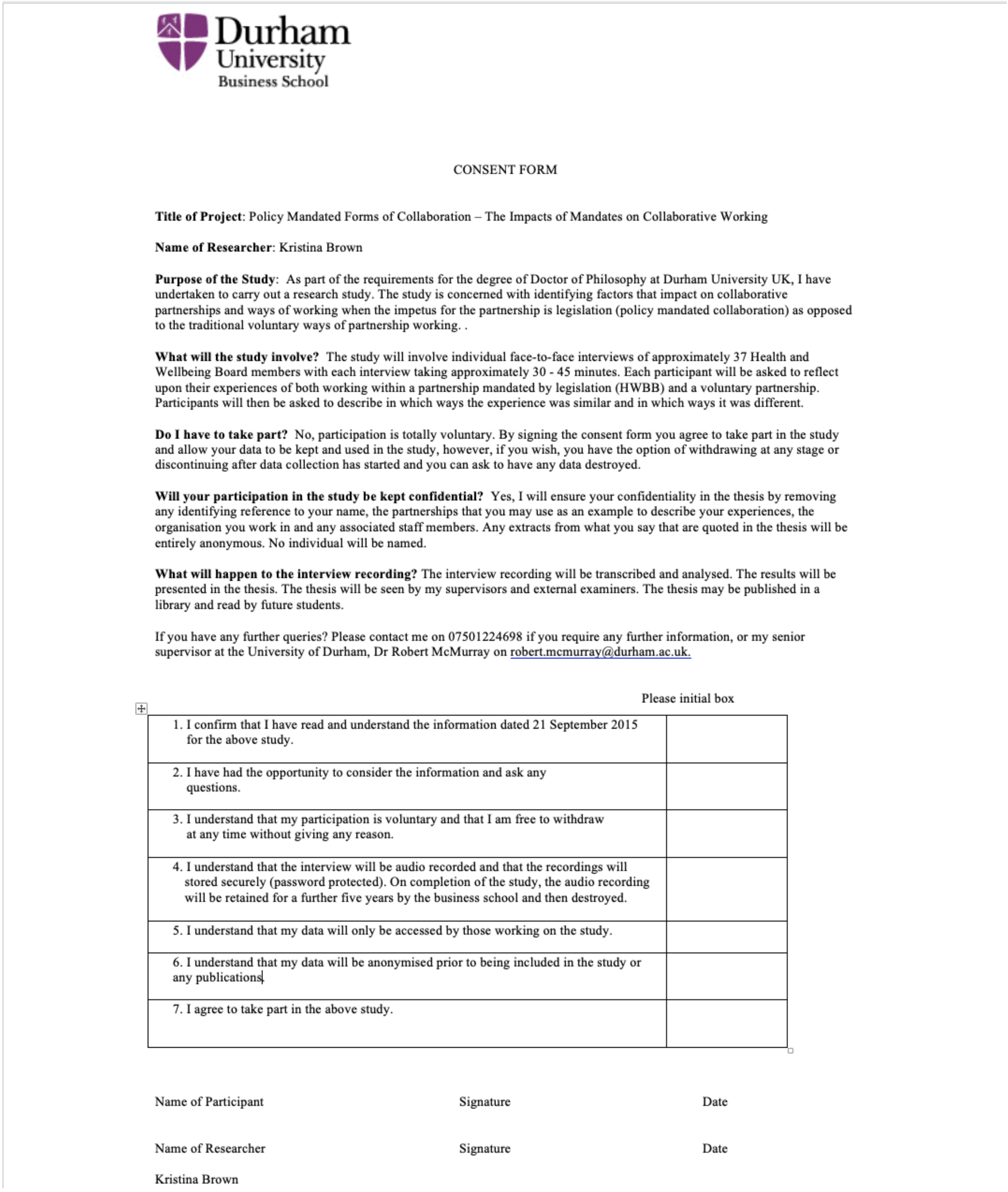
Appendix B: Publication from the Thesis – Book Chapter

During the write up of this thesis I was asked to write a booked chapter to contribute to the following book: The Management of Wicked Problems in Health and Social Care

Edited ByWill Thomas, Anneli Hujala, Sanna Laulainen, Robert McMurray. I applied social identity theory to illuminate a different side collaborating under conditions of mandate which is different to the approach taken in this thesis.

The link to the chapter in the book can be found here: https://books.google.co.uk/books?id=eUNvDwAAQBAJ&pg=PT216&lpg=PT216&dq=kristina+brown+a+darker+side+to+interorganizational+relations&source=bl&ots=PLz5FfXOyF&sig=ACfU3U3P8AXgwXp2-NdUNJOEWYuZPRed2g&hl=en&sa=X&ved=2ahUKEwjVrNv6psrmAhWzmFwKHch7Cj8Q6AEwAXoECAkQAQ#v=onepage&q=kristina%20brown%20a%20darker%20side%20to%20interorganizational%20relations&f=false

Appendix C: Interview Consent Form



Durham
University
Business School

CONSENT FORM

Title of Project: Policy Mandated Forms of Collaboration – The Impacts of Mandates on Collaborative Working

Name of Researcher: Kristina Brown

Purpose of the Study: As part of the requirements for the degree of Doctor of Philosophy at Durham University UK, I have undertaken to carry out a research study. The study is concerned with identifying factors that impact on collaborative partnerships and ways of working when the impetus for the partnership is legislation (policy mandated collaboration) as opposed to the traditional voluntary ways of partnership working. .

What will the study involve? The study will involve individual face-to-face interviews of approximately 37 Health and Wellbeing Board members with each interview taking approximately 30 - 45 minutes. Each participant will be asked to reflect upon their experiences of both working within a partnership mandated by legislation (HWBB) and a voluntary partnership. Participants will then be asked to describe in which ways the experience was similar and in which ways it was different.

Do I have to take part? No, participation is totally voluntary. By signing the consent form you agree to take part in the study and allow your data to be kept and used in the study, however, if you wish, you have the option of withdrawing at any stage or discontinuing after data collection has started and you can ask to have any data destroyed.

Will your participation in the study be kept confidential? Yes, I will ensure your confidentiality in the thesis by removing any identifying reference to your name, the partnerships that you may use as an example to describe your experiences, the organisation you work in and any associated staff members. Any extracts from what you say that are quoted in the thesis will be entirely anonymous. No individual will be named.

What will happen to the interview recording? The interview recording will be transcribed and analysed. The results will be presented in the thesis. The thesis will be seen by my supervisors and external examiners. The thesis may be published in a library and read by future students.

If you have any further queries? Please contact me on 07501224698 if you require any further information, or my senior supervisor at the University of Durham, Dr Robert McMurray on robert.mcmurray@durham.ac.uk.

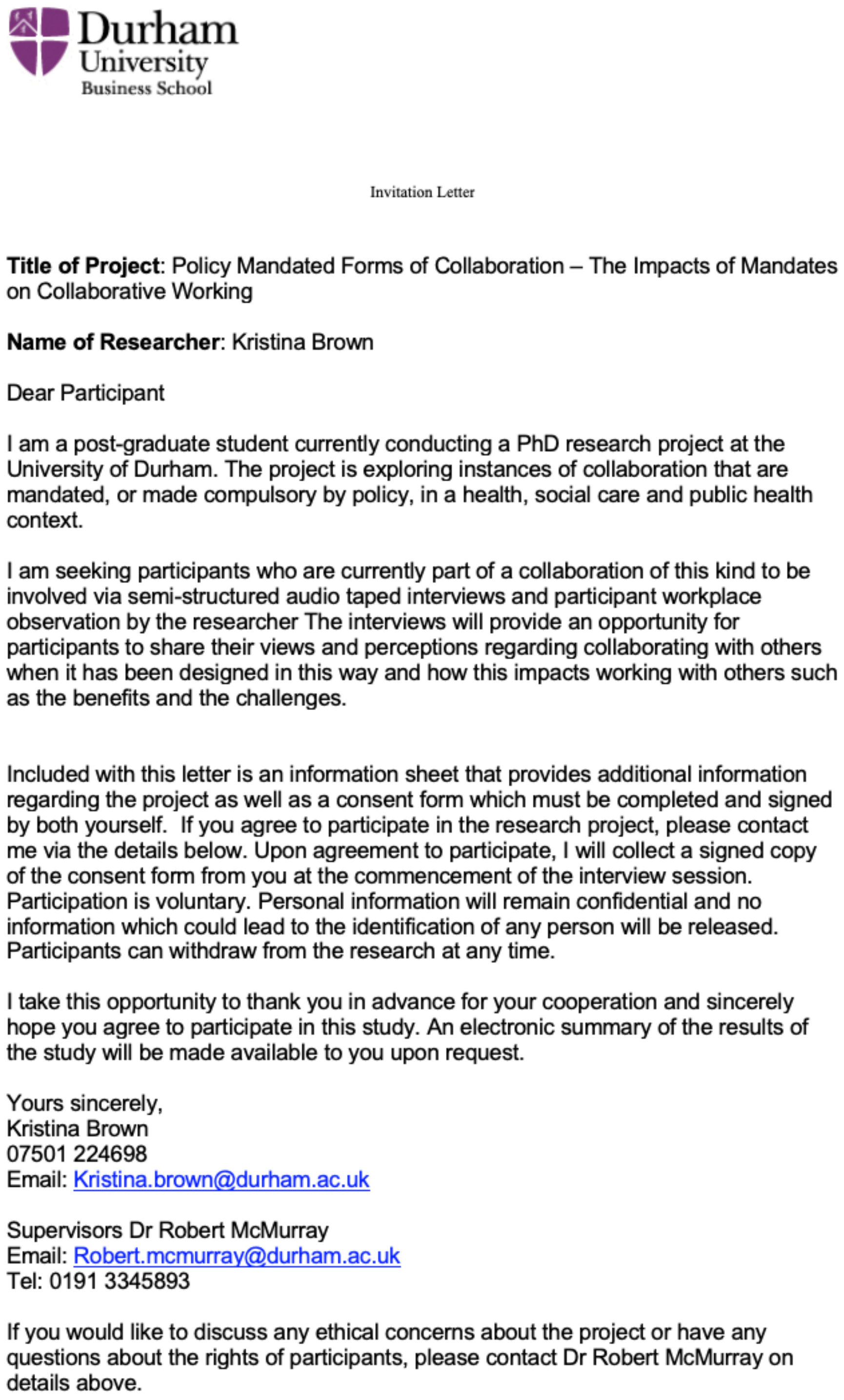
	Please initial box
1. I confirm that I have read and understand the information dated 21 September 2015 for the above study.	
2. I have had the opportunity to consider the information and ask any questions.	
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
4. I understand that the interview will be audio recorded and that the recordings will stored securely (password protected). On completion of the study, the audio recording will be retained for a further five years by the business school and then destroyed.	
5. I understand that my data will only be accessed by those working on the study.	
6. I understand that my data will be anonymised prior to being included in the study or any publications	
7. I agree to take part in the above study.	

Name of Participant Signature Date

Name of Researcher Signature Date

Kristina Brown

Appendix D: Study Invitation Letter



Durham
University
Business School

Invitation Letter

Title of Project: Policy Mandated Forms of Collaboration – The Impacts of Mandates on Collaborative Working

Name of Researcher: Kristina Brown

Dear Participant

I am a post-graduate student currently conducting a PhD research project at the University of Durham. The project is exploring instances of collaboration that are mandated, or made compulsory by policy, in a health, social care and public health context.

I am seeking participants who are currently part of a collaboration of this kind to be involved via semi-structured audio taped interviews and participant workplace observation by the researcher The interviews will provide an opportunity for participants to share their views and perceptions regarding collaborating with others when it has been designed in this way and how this impacts working with others such as the benefits and the challenges.

Included with this letter is an information sheet that provides additional information regarding the project as well as a consent form which must be completed and signed by both yourself. If you agree to participate in the research project, please contact me via the details below. Upon agreement to participate, I will collect a signed copy of the consent form from you at the commencement of the interview session. Participation is voluntary. Personal information will remain confidential and no information which could lead to the identification of any person will be released. Participants can withdraw from the research at any time.

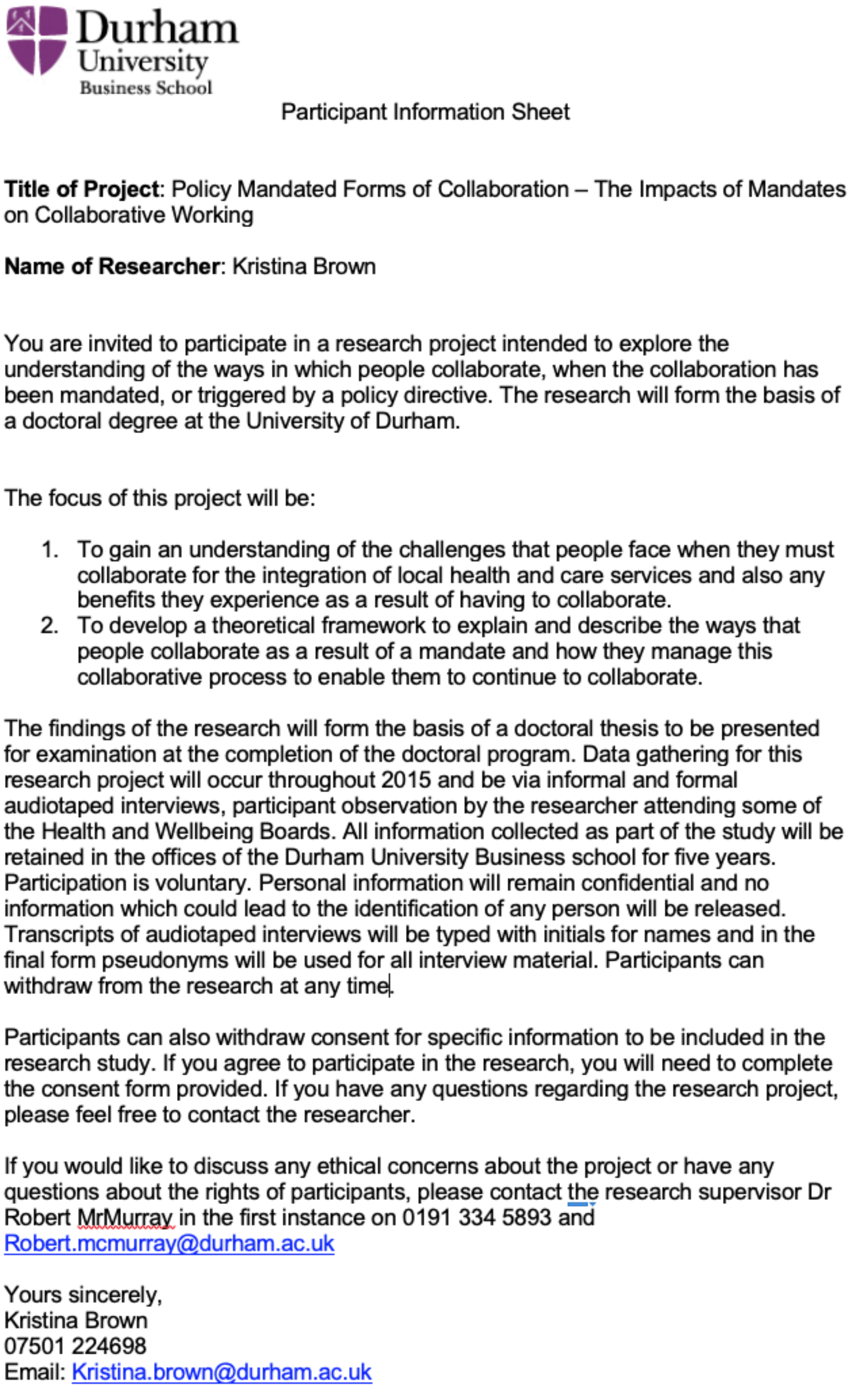
I take this opportunity to thank you in advance for your cooperation and sincerely hope you agree to participate in this study. An electronic summary of the results of the study will be made available to you upon request.

Yours sincerely,
Kristina Brown
07501 224698
Email: Kristina.brown@durham.ac.uk

Supervisors Dr Robert McMurray
Email: Robert.mcmurray@durham.ac.uk
Tel: 0191 3345893

If you would like to discuss any ethical concerns about the project or have any questions about the rights of participants, please contact Dr Robert McMurray on details above.

Appendix E: Particpant Information Sheet



Durham University Business School

Participant Information Sheet

Title of Project: Policy Mandated Forms of Collaboration – The Impacts of Mandates on Collaborative Working

Name of Researcher: Kristina Brown

You are invited to participate in a research project intended to explore the understanding of the ways in which people collaborate, when the collaboration has been mandated, or triggered by a policy directive. The research will form the basis of a doctoral degree at the University of Durham.

The focus of this project will be:

1. To gain an understanding of the challenges that people face when they must collaborate for the integration of local health and care services and also any benefits they experience as a result of having to collaborate.
2. To develop a theoretical framework to explain and describe the ways that people collaborate as a result of a mandate and how they manage this collaborative process to enable them to continue to collaborate.

The findings of the research will form the basis of a doctoral thesis to be presented for examination at the completion of the doctoral program. Data gathering for this research project will occur throughout 2015 and be via informal and formal audiotaped interviews, participant observation by the researcher attending some of the Health and Wellbeing Boards. All information collected as part of the study will be retained in the offices of the Durham University Business school for five years. Participation is voluntary. Personal information will remain confidential and no information which could lead to the identification of any person will be released. Transcripts of audiotaped interviews will be typed with initials for names and in the final form pseudonyms will be used for all interview material. Participants can withdraw from the research at any time.

Participants can also withdraw consent for specific information to be included in the research study. If you agree to participate in the research, you will need to complete the consent form provided. If you have any questions regarding the research project, please feel free to contact the researcher.

If you would like to discuss any ethical concerns about the project or have any questions about the rights of participants, please contact the research supervisor Dr Robert MrMurray in the first instance on 0191 334 5893 and Robert.mcmurray@durham.ac.uk

Yours sincerely,
Kristina Brown
07501 224698
Email: Kristina.brown@durham.ac.uk