Patient and Public Participation in the English NHS: An assessment of experimental implementation processes

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Abstract

This article analyses the impact of the implementation of a set of policies introduced after 1997 in the English National Health Service aimed at increasing patient and public involvement in organizational decision-making processes. Adopting the ambiguity/conflict policy implementation model and based on a year-long research project, it shows that patient and public engagement can be more effectively achieved when there is room for interpretation and discretion in selecting the means for involvement. Local initiatives, based on effective leadership governance mechanisms and organizational learning processes, are more likely to generate inclusiveness, shared ownership, and user-centredness than a top-down framework for involvement.

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INTRODUCTION

Over the past twenty years, policy networks and academics have stressed the importance of increasing democratic legitimacy in health care by placing patient and public involvement at the centre of the decision-making processes of service providers (Baggott 2005; Edelenbos and Klijn 2006; Roberts 2004). Great prominence has been given to the introduction of reforms aimed at increasing the effectiveness, efficiency, and user-centredness of service provision (Martin 2011; Newman et al. 2004), with a progressive drive to engage the health-care system on a collective level with its public – an umbrella concept which traditionally includes patients, local communities, taxpayers, and citizens (Martin 2008). In this study, 'patients' identifies service users and their families, whereas 'public' is associated with the local communities of the areas where service providers operate; substantially all those stakeholders with a direct interest in the strategic orientation of local health-care providers.

On a parallel level, the public policy discourse has increasingly promoted competition and choice in health care by shifting the idea of citizenship and coproduction of services from partnerships and collaborative arrangements towards markets and the power of the consumer (Dixon and Le Grand 2006; Fotaki 2007). According to this perspective and mainly focusing on individual patient decisions over health-care treatment options (Fotaki 2011), service users are to be given the power of exit against unresponsive providers while maintaining the relevance of voice in the system (Hirschman 1970). Although of general interest and relevance in the context of health-care reforms, the implications of the consumerist agenda for public involvement as a form of participation in organizational decision-making are beyond the scope of this article.

In the United Kingdom, following the Conservative reforms of the early 1990s, the New Labour governments heavily emphasized the involvement of patients and the public in the design of health-care services (Newman 2001; Pickard et al. 2006), as enhanced public participation was seen capable of improving the quality and legitimacy of providers' decisions (Barnes et al. 2003). Active engagement was identified as one of the means to 'modernize' the delivery of public services by making them more capable of meeting local needs and allowing greater identification with providers (Hyde and Davies 2004; McNulty and Ferlie 2002; Newman et al. 2004). Specifically, the adoption of non-bureaucratic/participative models was perceived as instrumental for achieving a patient-led National Health Service (NHS) (Hyde and Davies 2004; McNulty and Ferlie 2002; Rowe and Shepherd 2002), ideally characterized by freedom from central control, greater distance from politicians, and capable of finding solutions to complex problems in health-care provision (King's Fund 2002).

The present study draws from a number of policies introduced since 1997 within the English NHS during the New Labour governments and, specifically, focuses on the declared goal of policymakers to revolutionize the provision of health care through the involvement and active participation at the collective level of service users and local communities in health services management. Applying Richard Matland's (henceforth

RM) ambiguity/conflict policy model (Matland 1995), this article aims to answer the following research questions: Have policy attempts based on general principles and open forms of guidance been successful in facilitating the involvement of patients and the public in the planning and design of services at the local level? Can we identify any explanatory factors justifying the implementation processes outcomes?

In essence, the purpose is to offer a theoretically and empirically based explanation rather than a mere description of the antecedents of implementation of success/failure and, in the process, provide insights into the effectiveness of patient and public involvement mechanisms. Issues of representativeness, legitimacy, and ex-post control have been excluded as they do not explicitly investigate the level of participation (and influence) granted to patients and the general public in the determination and pursuit of local priorities (Baggott 2005). Moreover, we have concentrated on instances where patients and the public are directly engaged in decision-making processes and do not just exercise advisory/consulting functions (Ansell and Gash 2008). As mentioned, the unit of analysis has been at the strategic level and from a collective perspective, i.e. not on individual patients decisions over their own health care (Fudge et al. 2008).

METHODOLOGY

The study was conducted as a year-long research project using a range of qualitative methods (focus groups, semi-structured interviews, and document analysis). Qualitative approaches have been considered particularly relevant especially where the policy environment is complex (Spencer et al. 2004), specifically within 'modernization' programmes of health and social care. The semi-structured interviews have provided the main body of data. Every participant (in total twenty seven – twelve executive directors, eleven non-executive directors, and four senior executives) was interviewed twice, in the first instance to gather the initial data that were then coded and classified into themes of analysis, and the second time to stimulate sensemaking, general observations, and to delve into those factors which seemed to be more relevant in explaining public involvement. The interviews followed a plan of general ideas, but questions were intentionally kept open to avoid leading the interviewees (Silverman 2004). Within each theme the evidence was investigated and interpreted according to Matland's framework as well as using an inductive approach. Through the process of synthesizing the findings and referring back to the raw data, the explanatory factors progressively emerged and offered clarification of the outcomes of the implementation efforts. All the quotes reported in the article are verbatim transcripts from the interviews.

The first round of focus groups was used to generate ideas for the researchers and to stimulate reflections and discussion amongst participants. The second round served the purpose of gathering opinions/comments on the interpretative activity and to further question, in a collective manner, the significance of the evidence gathered. At each stage of the research process, field observations and the authors' sensemaking were circulated amongst participants and within their organizations (and, thus, making them available for

comments for members not directly involved in the research) to confirm the validity of our understanding and to encourage participants to validate and expand our thoughts (Bryman and Burgess 1994). This interaction between the whole range of the participating subjects was, thus, aimed at reducing researchers' bias (Miles and Huberman 1994). Narratives of the case studies were written, summarized, and sent to the respective participants' organization for validation and to gather further comments from individuals who had not taken part in the study (Yin 1994). Additionally, with a lag from the first period of field work, we sought the views of some of the patient and public representatives to test our findings and to assess the effectiveness of their involvement across time.

Document analysis was adopted for the examination of the content of policies to collect data on trusts' activities and to triangulate the views of the participants. In particular, the analysis of the minutes of the board of directors helped us to clarify how the strategic proposals had been generated, the drivers of their discussion in the boardroom and the extent of any changes made. Fundamentally, the minutes represented a traceable account of the strategic decision-making processes and outcomes in boards. Local press reports were also consulted as they, usually, contain insightful views from outside the organization, e.g. comments from service users and patient representatives. We intentionally concentrated our investigation on senior executives and board of directors because of their privileged position within the internal governance structure and their primary involvement in strategy formulation.

Fifteen trusts (four mental health trusts and ten acute care trusts – of these two types seven were foundation trusts (FTs), the new form of public benefit corporation introduced by the Health and Social Care Act in 2003 – and one ambulance service trust) were involved as they represent the main service providers and, therefore, principal instruments for giving prominence to the interests and needs of the local populations. Although mental health trusts have a history of more accentuated patient and public involvement, this has been mainly confined to the operational and middle-tier management levels rather than the strategic apex of service providers. In this sense, the evidence from this study does not highlight any clear difference between acute and mental care providers. The fifteen trusts were part of a larger project focused on investigating issues related to changes in the organizational structures, processes, and governance arrangements.

A multiple case studies approach was used to develop a more comprehensive interpretative framework (Denis et al. 2001) and, following Eisenhardt (1989), organizations were chosen for opportunistic (location proximity, existing contacts with participants, and familiarity with the history and characteristics of the trusts) and theoretical reasons (targeting organizations that are at the forefront of the patient interface). We decided against including primary care trusts (PCTs) – officially abolished from 1 April 2013 – for a variety of reasons. Firstly, these trusts have had a dual commissioner and provider role which puts them in a scarcely comparable position with trusts that perform exclusively a provider role. Secondly, PCTs have been established, ideally, with a strong community base and with an explicit mandate to give

patients and the public a direct influence on commissioning (Baggott 2005; Green et al. 2007). Thirdly, there already exists a body of literature on patient and public involvement in these organizations (see Rowe and Shepherd 2002).

RM'S AMBIGUITY/ CONFLICT POLICY MODEL

RM's ambiguity/conflict policy implementation model offers a parsimonious approach for the assessment of policy implementation efforts (deLeon and deLeon 2002). The model is based on a four-cell matrix framework in which the interactions between conflict and ambiguity dimensions are counterposed (see Table 1). It explains which approach is more appropriate depending on the contingent situation (Perry et al. 1999). Accordingly, the framework has been employed as an analytical tool to, initially, classify and, then, assess a specific typology of policy attempts aimed at enhancing the role of patient and public voice in organizational decision-making.

Firstly, policy conflicts are originated in the implementation process when divergent views exist on the policy goals and/or the means for their achievement (Perry et al. 1999); basically conflict 'characterized by dissension over the virtues of its implementation' (McCreadie et al. 2008, p. 249). The evidence collected suggests that the principle of increasing patient and public involvement in decision-making processes seems, in the main, to have been largely accepted by service providers and seen as an important shift towards the democratization of the health-care provision. We have heard of trusts committed to 'fully embrace the policies' ethos' and board members emphasizing the 'virtues of the policy makers' mandate'; essentially, the rhetoric of the respondents has been in support of an increased role of patient and public involvement in organizational decision-making processes. Furthermore, we did not gather any specific issues of contested representativeness and/or legitimacy of patient and public representatives which, according to published evidence (Fudge et al. 2008; Martin 2008), are more likely to surface at the operational level rather than strategic level. In RM's model, a general agreement on the policy goals indicates a low-conflict level in the policy implementation (Hill and Hupe 2002).

Historically, nonetheless, this has not always been the case (Lupton et al. 1998). Board members with long-term experience in the NHS have recognized how conceptually similar pre-Labour initiatives such as Community Health Councils, the engagement of the public in service commissioning, and the creation of public juries/panels suffered from a lack of support and at times open opposition at the implementation point. Additionally, within the policy framework under investigation, the absence of clear lines of accountability for responsibilities and tasks can generate formal acceptance of the policy mandate but does not ensure a corresponding commitment at the implementation point (Matland 1995). Although 'ambiguous policies with a good deal of local leeway are unlikely to lead to significant conflict' (McCreadie et al.

2008, p. 250), generally favourable responses for the policymakers' goal always require careful evaluation. Nevertheless, the analysis of the trusts' internal documents has further confirmed the existence of a 'degree of goal congruence' (Matland 1995, p. 156) with the objective to foster the involvement of patients and the public at the local level. The extent to which this could be opportunistic tokenism rather than real commitment lies in the evidence discussed in the following sections.

The second dimension of the model is centred around policy ambiguity; i.e. the uncertainty surrounding policy means (actions) and the consequences of the implementation processes for everyday practice (deLeon and deLeon 2002; Hill and Hupe 2002). RM suggests that conflict levels might be kept to a minimum if the policy initiative counterbalances 'the dysfunctional effects of clarity and the positive effects of ambiguity' (p. 158). Essentially, it might be more beneficial from a policy effectiveness perspective to provide 'an organisational headroom that enables the transformation of meanings and creates new frames' (p. 78). Several policies have stated that patients and the public are in a privileged position to exercise their health-care decisions and should be able to shape services at the local level (Allen 2006; Greener and Powell 2008; McMurray 2007) but, following the ambiguity/conflict dichotomy, the overall policy-umbrella can be divided into two different groups.

In the first group, falling in the category of administrative processes and characterized by both low levels of conflict and ambiguity of means in the implementation (Matland 1995), there are a number of policy approaches (e.g. patient and public involvement forums, stakeholder membership, and the appointment of patient and public representatives on the governing board of hospital FTs) that have specifically introduced implementation mechanisms targeting final users and the role of the local population in localized decision-making processes. In principle, policymakers have here opted for the introduction of specific frameworks, based on clear inputs and formalized processes, targeting patient and public involvement in local health. They imply a high

Table 1: The ambiguity-conflict matrix

	Low conflict	High conflict
Low ambiguity	Administrative implementation Policy environment: goals and means are known and therefore solutions for outstanding/emerging issues are clear	Political implementation Policy environment: goals are clear but also incompatible, generating dissent, and resistance amongst/between implementing agencies
High ambiguity	Experimental implementation Policy environment: goals/values of the policy not contested and hence the contextual conditions become crucial for a successful implementation	Symbolic implementation Policy environment: outcome(s) determined by the degree of power or the coalitional strength of implementing agencies

Source: Adapted from Richard Matland (1995).

degree of consensus and shared knowledge of the means necessary to achieve pre-determined goals, mainly requiring compliance with set activities rather than autonomous decision-making (deLeon and deLeon 2002).

In the second group – the focus of this article – a wide range of policymakers' initiatives can be included (see Table 2). These, building on and reforming previous governance

Table 2: Health policies

Year	Policy	Extracts
1997	The New NHS: Modern, dependable (White Paper)	The needs of patients will be central to the new system.
		'Integrated care' system based on partnership and driven by performance centred on the needs of the patients.
1999	Saving lives: Our healthier nation (White Paper)	People, communities, local authorities to work together in partnership to improve health.
		People improving their own health supported by communities working through local organizations.
1999	Modernising government (White Paper)	Making sure that public service users, not providers, are the focus, by matching services more closely to people's lives.
		Public services to meet the needs of citizens.
1999	Patient and public involvement in the new NHS (NHS Executive Communication)	Building a health service…responsive and sensitive to the needs of patients and the wider public.
		People…fully involved in decisions both on their own care and on the way services are provided.
		Every part of the NHS…to work in partnership…to ensure that it systematically engages with, and listens to, its local communities.
2000	NHS Plan: A plan for investment and plan for reform (White Paper)	NHS to be responsive to different needs of different populations throughout regions and localities.
		NHS to develop partnerships and co-operation at all levels of care to ensure a patient-centred service.
2003	Building on the best: Choice, responsiveness, and equity (White Paper)	Establish a process of decentralization to pass power outwards and downwards to put patients in control.
		Local health services…to involve patients and the public in the overall modernization of the NHS.
		Patients, the public and their representatives…fully involved in both the planning and the development of services, and fully consulted on decisions that affect the operation of the services.

Table 2: (*Continued*)

Year	Policy	Extracts
2004	Choosing health: Making healthier choices easier (White Paper)	Real progress depending on effective partnership across communities.
		Involvement will enable NHS organizations…to meet the needs of changing local populations.
2004	The NHS improvement plan – Putting people at the heart of public services (White Paper)	Communities to be given greater influence over the way that local resources are spent and the way local services are run.
		Greater readiness…to seek and listen to the views of patients, and to act on them.
		Statutory duty…to involve and consult patients and the public in service planning, service operation, and the development of proposals for change.
2006	Our health, our care, our say: A new direction for community services (White Paper)	Give people a louder voice… at a local level where…key priorities are.
		Patients will be in the driving seat of reform…to shape care pathways which are most appropriate to local people.
		Strong voice for people using services and for local communities in the way in which the whole health and care system is designed and work.

Source: Department of Health Publication library.

arrangements, have promoted the active participation of patients and the public in the provision of health care by setting general principles and open forms of guidance. This policy approach corresponds to an experimental type of implementation process, characterized by low-conflict levels but high ambiguity of the means of implementation (Matland 1995). Usually, these looser forms of guidance are incorporated in wider, agenda-setting policymaking documents, i.e. White Papers. Thus, one main characteristic of this policy approach entails the absence of detailed implementation mechanisms/ processes (McCreadie et al. 2008), indicating, for instance, the preferred way to facilitate patient and public engagement and who should be specifically targeted.

EXPERIMENTAL IMPLEMENTATION PROCESSES: FLEXIBILITY, DISCRETION, AND LOCALIZATION

In experimental implementation processes, the absence of clearly stated means of implementation confers experimental character to the whole process (Perry et al.

1999), allowing the moulding of the policy content to the reality and multiplicity of local needs (Matland 1995, p. 166); environmental influences are, therefore, more likely to be reflected into the process (deLeon and deLeon 2002; McCreadie et al. 2008). In line with RM's model, we expect contextual conditions to dominate policy implementation. We do not dwell on the mechanisms and techniques adopted which have taken different forms/routes across the cases – although of generic interest, it is believed more worthwhile to investigate the factors behind the positive outcomes of these processes; in essence, the content rather than the formal elements.

In this section, we discuss the evidence gathered in relation to three of the fifteen trusts involved in the study. The reasons behind the choice of these three cases are as follows. Firstly, the three cases provide the more in-depth level of evidence from primary and secondary sources, allowing us to deepen our understanding, to triangulate between verbatim transcript of interviews, notes from focus groups and narratives of organizational documents and to, ultimately, reach a more complete and unbiased interpretation of the data. Furthermore, the fifteen trusts shared similarities in relation to FT actors involved, the processes adopted, and the underlying objectives of greater patient and public involvement. The three case studies reported were, therefore, satisfactorily representative of the issues faced, choices made, and resources involved in the implementation processes in the other organizations. Finally, the fifteen trusts were at different stages in their attempts to incorporate the voice of patients and the public in their strategic decision-making processes. We decided that it would have been more informative for the reader to concentrate on the cases that had a more con-solidated evidence of successful implementation attempts; i.e. tangible, concrete engagement at the strategic level.

Case 1: Organizational cultural shift

The first case study concentrates on a mental health trust in need of a radical 'revamping' after a series of issues had progressively started to emerge. The trust's overall performance had been traditionally in line with those of comparable organiza-tions, but slip-ups in the service quality had increasingly become the norm rather than the exception. According to an internal inquiry, this was understood to be the result of excessive complacency (the trust was lagging behind in terms of the adoption of some mandatory statutory changes) as well as a phase of internal slack (the trust had been struggling to optimize the use of the resources available) after the successful acquisition of FT status a couple of years earlier. Many of the senior executives who had been involved in the application process had for different, unrelated reasons left the organization and, thus, the appointment of a new CEO coincided with the decision of the revitalized board of directors to address once and for all the existing problems.

The organizational culture, passive and inward looking, was identified as one of the more pressing issues to be tackled. For some time, representatives of patients and the local

community had been asking to have more of a meaningful role in the trust decision-making; nevertheless, their involvement had been kept marginal, leading to a general dissatisfaction and resentment. This negative attitude towards challenging the status quo had been accentuated by the underlying ineffectiveness of the FT formal engagement mechanisms. Despite an initial, minor resistance from within the organization, the board set as one of the priorities of the new strategy the improvement in patient and public involvement, partially as a response to what was seen as a rightful request from the organizational stakeholders but also to generate momentum for the targeted cultural shift in the trust. Furthermore, the board directors were conscious that failing once again to effectively engage service users and local communities (i.e. obtaining external support in exchange for mere 'token' participation) would have, perhaps irremediably, adversely affected the relationship between the trust and its constituencies.

The means chosen to give prominence to patient and public views were threefold: broad upfront consultation aimed at all potentially interested parties, open discussion with key stakeholders (staff, representatives of patients and local population, and members of local authorities and voluntary organizations), and, once decisions were taken, a feedback questionnaire submitted to the wider stakeholder base. As suggested by these interviewees, patient and public engagement was sought from the beginning of the decision-making process:

> We wanted to involve from the beginning the people. In the past we had sat down and decided what to do, without really listening to those who were the target of the changes. (Executive director)

> We wanted people to take ownership of the process…we wanted to make a statement to our stakeholders that we're complaining with their indications. (Non-executive director)

The increased role of patient and public voice was to be achieved through strategic working groups of mixed membership, made up of a blend of trust insiders and patient and public representatives. The groups were asked to meet regularly, discuss any relevant strategic matter arising, and focus on finding innovative ways to deliver the service, either through partnership agreements with other service providers or by redesigning and rearranging the internal processes.

The outcome of the novel joint approach was significant in many ways. The overall attitude towards the trust management registered a marked improvement, which transpired in positive comments reported in the local media and was implicitly confirmed by the durability of the working groups. Patient and public representatives expressed their approval of the changes implemented once it became clear that these were having a positive effect in terms of increasing their role. Furthermore, the board of directors, which under the previous CEO was frequently left at the margin of the trust activity, became more involved with the internal matters, simultaneously growing in visibility outside the organization. The trust management also acquired a

greater in-depth knowledge of the problems affecting the local community, particularly in relation to the booming number of ethnic minorities:

> We managed to be very effective and created a process that was very powerful in terms of bringing out existing issues and involving people. (Non-executive director)

The organization was, as a result, in a better position to rebalance the allocation of its resources in line with the new environmental contingencies:

> We could finally benchmark ourselves, we could understand where we were at and where we needed to go. And this was achieved in the public eye! (Executive director)

Finally, new partnerships were established with third sector providers which allowed a further realignment of the health-care provision to the emerging needs of a growing number of patients.

Case 2: Expansion of trust facilities

The second case study centres on a trust that, in spite of a relatively troublesome history of financial management, was looking to radically improve the quality of the health care provided through a significant capital expenditure project. Care was almost entirely offered from two neighbouring Victorian facilities which, due to a rapid increase in the population served, had become critically inadequate. The trust was in the difficult position of having to commit a large amount of resources to face the increased demand for its services. After an initial evaluation round, two feasible options were left on the table: on the one hand, following a marginal redevelopment project initiated a decade earlier, one possibility entailed undertaking a general renovation of the facilities mostly in need and adding a new state-of-the-art wing to the main hospital site; on the other hand, the second proposal was suggesting to embark on a completely new expansion strategy that would have seen the trust providing its services from its core central sites in conjunction with 'lighter' facilities scattered through the catchment area. Essentially, the choice was between keep providing the large majority of the service from the two adjacent sites or creating a less monolithic structure with service points distributed according to local needs.

The supporters of the first option were pointing out that offering a large portion of the health-care provision from the neighbouring locations would have strengthened the existing synergies across medical divisions, helped to maintain under control the bureaucratic burden and the administrative costs of the project, and, ultimately, generated greater research funding opportunities due to the increased 'body-mass' of the trust. Additionally, the local authorities, which had previously committed to support part of the expansion plan, were keen on leaving a longstanding legacy – a

flagship project – to the local community. Conversely, the backers of the second option were highlighting how there had been a clear demand from patients, their families, and local groups for more accessible and less congested facilities in particular for ambulatory services. Furthermore, it was pointed out that the second option was giving the trust the opportunity to convert some inner city public buildings and, therefore, to suffer less disruption to the service during the expansion works, with the collateral benefit of keeping the costs and the overall demands of the project down to a more manageable size and complexity.

The engagement process saw a first preliminary round-table with key stakeholders (elected local politicians, service delivery partners, and members of staff), followed by a series of meetings with the wider stakeholder community that were then fed into board discussions. A closing round of consultation with the initial group of key stakeholders and representatives of patients and the local population was, then, held. According to the interviewees, the process dramatically improved the form and, especially, substance of stakeholder interaction with organizational matters:

> They [the stakeholders] prepared a list of all the things they considered a priority, which were then used to inform the boards, and it really engaged executives and non-executive directors. And one of the things they really wanted to have was more interaction with the organisation. (Governance director)

> A lot of people have been engaged by giving them important functions, and empowering them to formulate proposals in their groups. (Chair)

Eventually, after a prolonged debate at the board level and several breakdowns in the mediation process, the final version of the plan scaled down the expansion of the Victorian sites by concentrating the capital investment on those parts of the facilities where specialties with a greater potential for shared treatments and common research activities were operating. The remaining funding was, then, used to purchase and renovate the off-site facilities and, thus, decongestion of the overall activity undergoing in the two neighbouring sites was achieved.

Specifically, it was decided to concentrate the Accident and Emergency department and specialist services for maternity and children in one of the hospitals managed by the trust, allowing the other to focus on traumatic surgery and rehabilitation. This helped the organization to achieve better recovery times, increased the number of beds available for patients, and boosted admission volumes. Moreover, the representatives of patients and the local community obtained the opening of one walk-in centre and the relocation of one already planned in a different area. It was also determined to forego some of the initial changes as it was felt that these were representing a serious threat to the financial viability of the FT while offering limited benefits in terms of service quality improvements. Finally, the adoption of a more decentralized organizational structure offered the chance to achieve greater integration of the health-care provision with some local charities situated in the more challenging neighbourhoods of the catchment area.

Perhaps more significantly, the FT saw a marked improvement in the approval ratings from patients and their families:

> It [the engagement process] really helped to create a sense of commonality, to bring people together, to find a sense of being on the same side. At the end of the day we're going to be a different organisation, we're leaving our world to go into the unknown. (Governance director)

> They [the stakeholders] can understand better the process whereby the board goes through its decision, what it can achieve and the information that directors need for the decision making. (Chair)

Case 3: Structural and governance reorganization

The third case study focuses on the reorganization of an acute care trust, which had been investigated by central authorities for the state of its finances and the chronic inability to meet the required quality standards. To solve these problems, the trust senior management decided to fundamentally reengineer its internal structure (traditionally based on clinical divisions) to one organized around clinical processes centred on typologies of illness. Accordingly, this would have facilitated collaboration between different specialties and, thus, potentially enhanced innovation in the health-care provision. As the strategy was taking shape, the top management realized that one of the most urgent challenges was to generate sufficient support throughout the organization in response to predictable resistance from the clinical workforce. The move from clinical directorates based on medical specialties to clinical pathways was naturally bound to generate opposition.

Firstly, some of the clinicians were criticizing the idea of revolutionizing the status quo as their divisions were performing within the set standards of quality and in accordance with the agreed targets. A few of the senior consultants were particularly vocal for what they felt as an attack on their professional independence and autonomy, whereas others were simply more concerned with the loss of control over their divisional budget. Conversely, the move had been positively welcomed by the representatives of patients and the local population as it was perceived like an opportunity for a decisive shift in the trust's modus operandi. A less publicized but nevertheless tangible pressure was exercised by the relevant commissioning and monitoring bodies, which had been threatening to put the trust under external administration if its performance had not been urgently improved.

The first step in the engagement process was to make the general public aware of the outstanding issues in the trust:

> I used the report to identify key issues, key pressures, the real problems the organisation was facing, and everything ended up in the public domain. (Chief Executive)

Once a public interest report had been circulated, stakeholders were openly invited to come up with suggestions for the turnaround plan and indicate where the improvements could have come from – the locus of the change process:

> I made them [the participants] responsible for cross-cutting piece of work inside the trust. So, there was a sort of dependence between each other. (Chief Executive)

The trust management was particularly keen on making the whole processes as visible as possible, given that the organizational decision-making had been previously criticized for not being sufficiently accessible and externally auditable. The early involvement of patient and local community representatives was seen as instrumental to overcome the internal resistance and to support the development of a reengineering plan. By being involved since the early stages of the change activity, the trust stakeholders were made aware of the financial challenges faced by the organization and, consequently, the trust management was avoiding creating unrealistic expectations on what was achievable through the reorganization project. In terms of their specific role within the decision-making process, service users and local communities representatives were asked to formulate proposals (and, thus, acting as a driver for change) as well as to contribute to the ex-post assessment of the effectiveness of the changes implemented.

The more tangible results of the reorganization were a progressive improvement in the clinical targets, with a noticeable reduction in waiting times and an increase in the number of patients treated. Moreover, a successful financial turnaround brought a redirection of resources towards areas of the service previously underfunded. In addition, representatives of patients and their families convinced the trust board to institutionalize a simplified and more direct feedback process in order to improve the existing communication channels. The overall outcome was particularly positive in certain areas of the trust, with a general, more positive attitude towards a wider participation in the decision-making processes, and more problematic in others, as symbolized by some remaining resistance to a collective involvement in strategic decisions from some of the senior consultants. The greater recipient of these improvements was effectively the board of directors, which gained a more comprehensive understanding of the organizational activities:

> The rigour brought a better understanding of the health care needs and what the organisation was trying to achieve, which has helped to understand different areas and consequently broadened the horizons of the board itself. (Executive director)

> What was critical was to change the mindset of people, was to make people aware of what should have been going on and how should have happened, and part of doing that was to tell them that external stakeholders can provide a big help in terms of suggestions but also criticism. (Non-executive director)

Nevertheless, there was full awareness at the board level that the changes would have needed more time to become effective and, consequently, should have been properly re-evaluated in the medium or long term.

Explanatory factors

In this section, we describe the explanatory factors that have contributed to increasing the role of patient and public views in trusts' decision-making, linking each factor with the drivers of the experimental implementation processes at the organizational level. Table 3 provides a summary of the analysis.

RM suggests that in experimental implementation processes the contextual conditions have to be given priority as 'outcomes depend heavily on the resources and actors

Table 3: Explanatory factors and implementation drivers

Factor	Case	Implementation driver
1. Flexibility and discretionary power to capture contextual conditions	1	Using patient and public engagement as a benchmark for strategizing
	2	Transforming rigid, bureaucratic approaches into more flexible, ground-based actions
	3	Bringing organizational issues in the public domain
2. Variations in the allocation and use of resources	1	Giving patient and citizen involvement a breakaway function from the status quo
	2	Allowing stakeholders to initiate strategic proposals
	3	Creating decision-makers' interdependence in strategy formulation
3. Top management leadership moulding the policy mandate	1	Providing more accurate information, time, and preparation for board strategizing
	2	Securing board centrality in consensus-oriented processes
	3	Changing top management mindset in relation to patient and public involvement
4. Crisis as a change agent	1	Overcoming a deteriorating service performance record
	2	Solving longstanding issues of congestion and cooperation within the trust
	3	Complying with pressures from commissioning and regulatory bodies
5. Organizational learning	1	Allocating more efforts and resources to the planning phase Seeking active participation not ex-post agreement
	2	Linking participation with accountability and performance
	3	Designing a more structurally coordinated decision-making process
6. Responsiveness to increased patient and citizen awareness	1	Actively listening, reporting, and complying with stakeholders' concerns
	2	Transferring stakeholders' priorities into board agenda
	3	Using patient and public participation as a strategic driver and a means for change

present in the microimplementing environment' (p. 166). Accordingly, the first explanatory factor is identified with the flexibility and room for interpretation given to local bodies under the policy-umbrella, essentially giving freedom and discretionary power to trusts to effectively adapt the policy mandate to local contingencies and specificities. Many participants saw this as a precondition for effective patient and public involvement in the delivery of health care, a source of context-specific knowledge against the shortcomings of centrally mandated structures deemed to be ineffective in supporting the emergence of local interests. Thus, the trusts focused on the breakdown of the ingrained barriers which were originated by inward-looking modus operandi and characterized by rigidity and detachment from the external environment (see Table 3: *1*), as highlighted by this quote:

> If we'd carry on doing what we were doing what we had got would have always been what we were already getting, which is the same kind of nonsense most trusts get from the NHS, an illusion of comfort and reassurance that everything is under control, when the reality is that nobody knows if anything is under control, there are only a few things that you really know. We all needed to make a concerted effort to communicate with our stakeholders. (Chair, FT)

Moreover, the increased influence of patient and public views in trusts' decision-making seems to have been made possible by the variety of actors and resources committed to the implementation processes (similarly Ansell and Gash 2008; Edelenbos and Klijn 2006). Variations between implementing sites are an embedded feature of experimental implementation processes as the resources available can differ from trust to trust (Matland 1995). Therefore, differences between the width of stakeholder participation – i.e. the number of interested parties actively engaged – and the depth of their involvement – i.e. the extent of their role in the strategic decision-making – amongst the case studies reported (and the ones not included in this article) should not be seen as a failure but as normal characteristics of these types of processes. The broad policy mandate has been translated into different implementation plans which, although dictated by the same principles, have employed different approaches to ensure greater participation and interconnectedness in strategizing (see Table 3: *2*). The importance of not having to fit rigid implementation frameworks is made clear by this board director:

> We did realise that this could only be achieved through a planned action…The new openness in the decision making process allowed everybody to discuss properly the plan, what this restructuring was about and the impact of the changes. (Non-executive director, FT)

A further factor that appears to have facilitated the increased influence of service users and the local population in trusts' decision-making consists of the direct involvement of senior managers and, in particular, the board of directors from the early stages of the implementation activity, providing a higher profile and immediateness to the whole process. RM highlights how the policy ambiguity typical of experimental

implementation creates ideal opportunities for 'bureaucratic entrepreneurs' to mould the policy mandate in accordance with local needs, leaving the process more open to environmental influences than other forms of implementation (p. 166). Thus, a strong leadership presence throughout the implementation process, supported by more accurate and timely information and increased control, seems to have ensured a deeper, more effective role for patient and public involvement in organizational decision-making (see Table 3: *3*).

Furthermore, all three case studies centred on organizations that, for various reasons (fragmented service provision, weak performance, pressures from regulators, and so on) had been facing a 'crisis-point' (see Table 3: *4*). The improvements in patient and public participation have, therefore, largely benefited from the initial momentum originated by the need to overcome critical issues for the trusts. According to RM, experimental implementation processes generate 'outcomes that are hard to predict' (p. 166) and, as in the 'garbage can' process (Cohen et al. 1972), different factors can trigger different reactions. Implementers perform formative evaluations of the surrounding environment in order to build sufficient knowledge of the strategic context before deciding on the required course of actions. In the presence of a crisis, these assessments are made more crucial by the urgency of the moment which forces the trust leadership to take a more direct control of the organizational activity and, eventually, to rely on other sources of local knowledge to enhance its decision-making. The knowledge-sharing function of these interactions is fittingly reiterated by this participant:

> As a director, I have really enjoyed the opportunity to attend and participate in these open meetings, to really engage the board with things that matter to the organisation and to the local population. (Non-executive director, Trust)

In addition, it should not be underestimated that hospital trusts had been previously exposed to several policymakers' attempts to achieve a wider patient and public involvement within the health-care sector. This has given them the opportunity to come to terms with their failures and explore the reasons behind the unsatisfactory outcomes of previous implementation efforts. Indeed, RM stresses how the learning process at the organizational level is, perhaps, the most important aspect of experimental implementation, even more than random successful outcomes. Given the ambiguity characterizing the policy mandate, implementers have had the chance to learn from their mistakes and not be forced into 'artificially constrained form[s]' (p. 167). Accordingly, trusts seemed to have taken into consideration their previous failures by modifying the timing, locus, and modus of patient and public involvement in their strategic decision-making processes, especially in relation to resource allocation, accountability concerns, and structural coordination (see Table 3: *5*). As shown in the following quote, it also reinforced the sense of belonging and common intent with the local community:

> It felt much more robust than the process that was used in the past. It really seemed that people would take ownership of the process. The real difference was that people were really involved in it, really involved throughout the process. (Executive director, Trust)

Finally, trusts have been required to deliver in an environment characterized by mounting pressures for involvement from patients, the local population, and the vast number of private and third-sector organizations operating in the health sector (see Table 3: 6). These interest groups have, in different ways and with different motives, supported the policy mandate goals even if the means of implementation have been ambiguous. In spite of the historic indifference towards institutionalized forms of involvement and the relative lack of interest of the population at large in taking an active role in health-related matters, patient and public engagement has been, in recent times, driven forward by the activities of user and advocacy movements which have proliferated especially when specific issues have been in the public debate, e.g. women's reproductive rights (Milewa 2004). Thus, service users and the wider public have become more aware of their rights and have progressively improved the skills necessary to exert influence over policymakers and service providers (Baggott 2005), simultaneously mounting pressure for cooperation and coproduction on service providers. This has been clearly felt at the trust level:

> We did perceive that one thing our stakeholders really wanted was to have more integration with the organisation. They considered this a priority, they wanted to flag us all the things that really mattered to them, to fundamentally engage executive and non-executive directors. (Chair, FT)

DISCUSSION

The NHS has a long history of targeting the increase in the role of patients and the public through hierarchical and highly structured implementation processes; from the Community Health Councils of the 1970s up to the establishment of patient and public involvement forums in 2003 or the mandatory procedural requirements of stakeholder membership and the appointment of representatives of patients and the public on the governing board of FTs. This form of implementation, defined as *administrative* in RM's model, requires implementers to exercise limited discretion and compliance and, hence, should yield almost by default the intended results (deLeon and deLeon 2002; Matland 1995). Instead, published evidence suggests that these top-down policy efforts have generally shown a poor fit with the contingent situation at the local level and, therefore, have, in the main, failed to produce the expected outcomes (Allen 2006; Baggott 2005; Wright et al. 2012).

Clearly, there have been instances in which patient and public involvement forums, FT members or board governors have been able to actively participate in the decision-

making processes of trusts. Nonetheless, this has happened in an unpredictable, unsystematic fashion; i.e. following a random pattern and not for the totality of the cases as expected for administrative implementation. Effectively, there is an inherent tension in trying to dictate detailed implementation processes for democratic participation, as policymakers cannot be absolutely prescriptive on matters that, by definition, need to be adapted to the local contingencies. The mandated uniformity of the implementation mechanisms stands at odds with the task of catering for a wide range of interests at the local level as it fails to take into adequate consideration the context-specific complexity. Indeed, as pointed out by RM, 'top-down models emphasize command, control and uniformity and fail to take into account the diversity inherent in much implementation that occurs' (p. 167).

On the other hand, patient and public engagement requires individual and collective skills to operate with inclusive approaches, the presence of effective leadership governance mechanisms and active organizational learning processes, factors that have been duly highlighted in our analysis. Not by chance, these skill-based, process-type and consensus-oriented factors have underpinned the success of the experimental implementation processes examined here. At the same time, there is some merit in suggesting that the previous top-down approaches, although without achieving systematic implementation success, might have been able to raise the profile of patient and public involvement amongst NHS managers and to change the expectations of the public in itself, therefore creating space for experimental implementation processes.

Evidently, participants' claims of a positive outcome of their experimental implementation attempts have not been accepted uncritically. By looking at trusts' internal documents and, in particular, at the minutes of the board of directors' meetings, we have been able to discern between those cases where the implementation of the policy mandate was still more formal from those where it was substantive (i.e. at the core of the strategizing process). Accordingly, a positive assessment in relation to patient and public engagement at the local level has not been made for all the trusts included in the study, as experimental implementation might well produce 'broad variations' in relation to its outcomes from case to case (p. 166).

Admittedly, the ambiguity in the policy mandate can result in marked variations in how it is translated across sites (McCreadie et al. 2008). Implementers need to have the right level of skills and competence, but these resources are likely to be acquired over time as organizational actors become familiar with the causal connections in the environment. As explained by RM, 'this process is more open to environmental influences than are other forms of implementation' (p. 166), and, therefore, even more than a *successful* – italics in original – outcome based on uniformity is one that 'produces learning' (p. 167). Essentially, learning is the standard for success and, specifically, the benefits of learning through experimentation (Perry et al. 1999). Furthermore, the pressures on trusts coming from increasingly intrusive performance management systems cannot be ignored. With a growing level of scrutiny on the quality

of services and use of resources, NHS managers have been asked to juggle between different policies priorities, which not unusually are, at their core, mutually exclusive. This form of conflict at the policy level is not considered in the RM model but poses some severe barriers towards successful policy implementation.

Finally, a point that requires further elaboration is related to the role of internal crisis in giving relevance to patient and public involvement. The importance of a crisis situation lies in the fact that, in order to tackle the issue at hand, trusts were forced to change their traditional patterns of behaviour, to find a different modus operandi. Trusts were made more receptive to the pressures from patients and the public to have a say in the way local services were provided. The complexity of the engagement process was simplified by the contextualization – i.e. the existence of tangible issues – of the 'negotiation' between organizational insiders and outsiders (Barnes et al. 2003). Of course, this raises the fundamental question if implementation achieved through this channel could be classified as successful implementation according to the spirit of the policy. In the introduction, we have provided a working definition of success in increasing patient and public involvement centred on greater engagement in organizational strategizing, but uncertainty still characterizes the understanding of what this means in more general terms. Additionally, these examples of experimental implementation have been gathered in a cash-rich period for the NHS as a whole. The outcomes could well be radically different in periods of austerity where conflicting logics become more imperative for managers.

CONCLUSION

Reinforcing the views of Exworthy et al. (2002), the findings support the idea that policies emphasizing the importance of capturing context-specific contingencies, as driven by localized voice, can be more effectively implemented when room for interpretation and discretion is given to implementing bodies. Therefore, local initiatives in increasing patient and public participation, for specific purposes, are likely to generate more inclusiveness, shared ownership, and user-centredness than a general national initiative, expecting comparatively uniform implementation at the local level. Essentially, the micro-dynamics of interaction are more significant than the macro-abstractions of organizational engagement (Barnes et al. 2003). The study participants have highlighted the advantages of autonomous decision-making and independence in terms of selecting the more appropriate means for patient and public involvement in the activity of trusts. In this way, the overall aims/purposes of health policies can be locally reshaped by allowing the adoption of flexible strategies within the implementation process (Pope et al. 2006).

The implications of our findings for policymakers are insightful in the sense that forcing implementers to adopt formal policy mechanisms for patient and public engagement seems to diminish at the outset the possibility for valuable organizational

learning processes. It might well be the case that local initiatives are formally carried out only to meet statutory requirements to involve and consult but, due to their greater flexibility, they potentially offer the opportunity to understand where the process can be shaped and made to fit the local needs. Changes in institutional arrangements and practices require time and effort. Negotiations between the participating actors are to be considered an integral part of the implementation activity. The inherent tensions and competing rationales have to be solved pragmatically and not, as for hierarchical approaches, on the basis of normative mandates (Martin 2008). Ultimately, implementation is a process and, as such, setbacks and conflicts have to be expected in the settlement of particular, local means. As highlighted by RM, the key point stands in understanding that 'the process requires a conscious realization that learning is the goal…and is likely to occur in a random pattern' (p. 167).

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