Moving from rational to normative ideologies of control over public involvement: A case of continued managerial dominance

Abstract

Public Involvement (PI) is a strategic priority in global healthcare settings, yet can be seen as peripheral during decision making processes. Whilst extant research acknowledges variations in how policy is translated into practice, the majority attribute it to the limiting influence of professional hierarchies on the perceived 'legitimacy' of PI. Drawing on examples of three commissioning organisations within the English NHS, we outline how the variance in policy implementation for PI can be attributed to influence from the managers rather than professionals. In doing so we explore how rational ideologies of managerial control negatively impact PI. However, we also illustrate how PI alluded to in policy can be more successfully realised when organisational managers enact normative ideologies of control. Notwithstanding this assertion, we argue managerial domination exists even in the case of normative ideologies of control, to the detriment of more radical PI in service development.

Keywords: England NHS; public involvement; policy implementation; commissioning; managers

Introduction

Public involvement (PI) is a global priority in healthcare settings and is assumed to empower communities, improve service decisions, provide democratic accountability and contribute to higher quality services (Barnes et al, 2003; Gustafsson & Driver, 2005). Despite the benefits of PI for health and social care services (Mockford et al 2011), much existing research suggests that, while there is strong policy support, its potential contribution is stymied by contested terminology, limitations in the underpinning evidence base, different attitudes to PI, and variable attempts at implementation (Staniszewska et al 2011, Baggott, 2005; Contandriopoulos, 2004). Commentators note the impact of professional hierarchies on the translation of PI policy into practice in public sector organisations (Boivin et al, 2014; Litva et al., 2002; Martin, 2011; Rutter et al, 2004), but neglect the impact of managerial influences on PI (Renedo et al, 2015). This is surprising, considering recent research highlights how PI representatives attempt to increase their influence by working more closely with managers (El Enany et al, 2013), suggesting changes in managerial context may represent a means by which to enhance involvement.

In this paper, we outline three cases from healthcare commissioning organisations which reflect variation in managerial influences on PI, and highlight the positive, or negative, impacts on involvement from each case. Our analysis suggests organisational managers should refrain from attempting to

implement policy recommendations by actively creating PI roles and structures for involvement, as such rational ideologies of control (Barley and Kunda, 1992) limit PI contributions. However, we also outline how normative ideologies of managerial control enhance PI when groups are encouraged to work outside of managerially framed roles, increasing their contribution and influence over service design and delivery. While PI contributions are still subject to the dominance of managerial influence, we discuss how normative approaches may enhance the potential for the collaborative nature of PI alluded to in policy. In doing so, our paper responds to calls for an exploration of PI in different health settings, particularly in relation to how managers influence PI (El Enany et al., 2013; Renedo et al., 2015).

Public Involvement

In the context of healthcare, multiple policy documents emphasise the need for representative, comprehensive involvement of 'the public' (HSCA, 2014; DOH, 2010; NHS England, 2013). In this paper we consider examples from the English National Health Service (NHS), but the need for PI in healthcare is evident globally (Barnes, 1999; Church et al., 2002).

Despite a political focus on the need for PI, definitions of PI are vague, with little consensus over who should be involved in public decision making processes, at what level, and what form that involvement should take. While involvement in healthcare research settings has developed with a clear architecture and policy support (Staniszewska et al, 2011), development of PI in health service development has been more diverse. In health service development, a lack of

consensus of terminology, and overlapping structures (Mockford et al, 2011), potentially undermine PI, limiting the ability of the public to influence, or contribute appropriately to, strategic discussions (Baggott, 2005). However, others suggest that limitations of PI, such as perceived lack of impact on organisational outcomes (Contandriopoulos, 2004), cannot be associated entirely with the coherence of policy or the structures in place to encourage PI. Indeed, Martin (2008a) argues there is no need for comprehensive policy recommendations, as guidance is coherent but allows flexibility for interpretive involvement in different settings. The ambiguity of policy allows PI to be framed in different ways, encompassing multiple definitions of the 'public' as patients, carers, service users, communities, tax payers and citizens (Martin, 2008b), opening different avenues of interpretation of the meaning of 'involvement'. In this paper we follow Martin's definition, and use the term 'public involvement' to encompass multiple definitions of participants and their contributions.

Despite the flexibility of policy, and the potential for interpretation in different settings, research situated across multiple healthcare organisational contexts criticises the way PI is operationalised as tokenistic, not central to decision making processes, and even constructed as a mechanism for manipulating the public, rather than empowering them (Baggott, 2005). Considering the problematic translation of policy into practice, many attribute limitations of PI to the influence of professional hierarchies on the involvement, or exclusion, of members of the public during decision making processes (Litva et al., 2002; Rutter et al., 2004). The influence of professionals within healthcare organisations frames institutionalised assumptions about types of 'legitimate'

knowledge, undermining the perceived legitimacy of PI (Boivin et al., 2014; Learmonth et al., 2009; Martin & Finn, 2011).

Whilst the influence of professionals on PI is well documented, there is little exploration of how managerially defined contexts influence involvement in professionalised settings. Recent work has suggested that managerial involvement in PI, for example creating managerially defined structures through which involvement occurs, may enhance PI influence or credibility within healthcare organisations by reframing their role as 'experts in layity' (El Enany et al., 2013; Martin, 2008a). However, the influence of what Barley and Kunda (1992) term 'rational' ideologies of control, whereby systems are tightly structured by managers, and the consequences of constraining involvement to managerially framed positions, are unclear. On the one hand, rational ideologies of control may realise the aims of policy by providing structure and meaning to PI groups, encouraging outputs relating to institutional priorities, which could be positive for PI contributions (Martin, 2011). On the other hand, framing PI roles in managerial structures as partners, rather than independent critical voices, could risk a loss of the distinctiveness of the PI, limiting contributions to self-legitimisation strategies for managerial agendas (Boivin et al., 2014; Learmonth et al., 2009). In other words, PI representatives run the risk of being co-opted towards managerial interests during decision making processes, which counters policy aims for their involvement. To explore this issue further, we consider PI in healthcare commissioning organisations.

Public Involvement in Commissioning

In this paper we consider three illuminating cases from commissioning organisations (who plan and contract for healthcare provision) in England. Whilst the following explanation of organisational arrangements is specific to the English NHS, similar approaches to PI are seen globally in healthcare settings where provider, purchaser and consumer are separated (Barnes et al., 2003; Church et al., 2002).

In the English NHS, PI is reflected in policy advocating patient choice and shared decision making, from the individual level of care to the development and improvement of health services (DoH, 2010; NHS England, 2013). The importance of PI is also reflected in recent organisational reforms that have seen the introduction of Clinical Commissioning Groups (CCGs), which lead commissioning networks (DoH, 2011). CCGs have a central focus on the involvement of community physicians (General Practitioners or GPs) and service users in commissioning decisions, driving patient-focused decision-making, theoretically autonomous from top-down control.

The new commissioning arrangements, in particular the renewed focus on public and clinical involvement, distinguishes CCGs from their commissioning predecessors, which were criticised for being managerially focused, with limited, tokenistic engagement with the public (Callaghan & Wistow, 2006; Martin, 2011). This is reflected in the new legal requirements for commissioning organisations to engage with the public at multiple stages of the commissioning

process (HSCA, 2014). However, reflecting other policies relating to PI, the interpretation of what PI 'is', or how the public should be integrated into commissioning decisions, is vague. Commentators suggest this ambiguity is key to the new organisations, as they theoretically have more autonomy and flexibility from top-down control, creating contexts which have the potential to develop PI according to their local needs and organisational cultures (Hudson, 2014).

Commissioning organisations offer insight into the varying managerial influences on PI, as policy will be interpreted and implemented within an organisational context influenced by local managerial structures and priorities. As such, they offer a context from which to explore the research question: What are the consequences of co-opting PI representatives into managerially defined roles?

Methods

The overarching study was concerned with enhancing decision making processes for commissioning organisations, specifically related to interventions to reduce avoidable admissions of older people into hospital. The three cases presented in this study are illuminating for research into PI, as senior managers in each organisation were explicit about the commitment of their organisation to implementing PI policy. Despite this, over the course of the study, distinct variations in managerial interventions shaping PI involvement were noted, leading to different outcomes for PI influence on service development at each site.

The three cases offer insight into influences on PI, as they have similar organisational and professional structures framing involvement processes. All three commissioning organisations had formalised structures for public engagement at four levels. Each community physician's surgery had a patient reference group, one representative of which attended the PI group at the commissioning organisation. In addition to the PI group, each commissioning organisation appointed at least one lay member to the governing body. Alongside internal PI structures, the 3 organisations also engaged in wider consultation with the general public in their local geographical area. The four mechanisms supporting PI are outlined in Table 1.

Table 1 here

In other words, structural, professional or political influences did not vary between the cases. As such, and in the context of extant research, the research team inductively concluded the potential for variation might stem from local managerial influences on the implementation of PI policy. To explore these influences, the team conducted semi-structured interviews with individuals from the commissioning organisations, including: managers, clinicians, lay members of the board, and PI representatives from level 2 of the PI structure illustrated in Table 1. We asked participants to describe how information or opinions were acquired from the public, and through what structures this took place; how feedback was used with other forms of data to determine the needs of the local community; how information from PI was used to design services; and what the

influences on PI were. Interviews lasted between 45 minutes and 1 hour and were audio recorded and transcribed. Interview numbers and job types of those interviewed are outlined in Table 2. In addition, the team attended two PI meetings at each site, to observe how meetings were conducted and explore the level of managerial control over meetings. Extensive hand-written field notes were taken during observations.

Table 2 here

Coding of interviews and field notes was guided by searching for in-vivo codes related to managerial attitudes towards PI, examples of the way PI influenced service design or delivery, and indications and implications of co-option of PI representatives into managerially determined roles. Over successive rounds our coding became more theoretical and we induced themes of rational and normative ideologies of managerial control (Barley & Kunda, 1992), as empirically illustrated below.

Findings

We present the findings for each case, within which we highlight variation in managerial interventions for involvement, and the consequences for PI influence in decision-making processes around service development.

Case 1: Rational ideologies of managerial control

The following extract is taken from field notes taken at the second PI group meeting attended by the research team

> *The group was asked by the lay chair to identify what they feel their contribution to the CCG should represent. There was a lot of confusion amongst members about their potential contribution… The chair had difficulty keeping the group on point… Two general managers attended the meeting, and they were responsible for setting the agenda. By the end of the meeting the managers had taken over the running of the session to ensure all the agenda items were discussed in a more structured manner* (Field Notes: 11/04/2014)

This observation of the PI group at this site highlights two influences on PI: confusion amongst public representatives about their role and potential contribution to the organisation; and the dominance of managerial control over the group. The management team took over the running of the PI meeting as the group was not seen to be conforming to the agenda pre-determined by the managers. When interviewed about the PI group, a general manager said:

> *It is hard work… We've spent countless hours doing terms of reference, loads of time explaining what their role is… they don't necessarily understand how the NHS works so that's part of the problem… people's understanding of the health system is actually really quite minimal and*

they don't understand all the inter-organisational arrangements (Interview 5 - General Manager)

The perception on behalf of the management team, reflected above, seemed to be that the PI group was not informed enough about the NHS to contribute in a meaningful way to decisions made by the commissioning organisation. Indeed, the manager notes how they spent time 'explaining what their role is' to the group, limiting PI contribution to a managerially determined role, rather than encouraging the group to determine a role for themselves. In addition, the perception that they had 'minimal' understanding of the issues in the health service often led to derisive comments from managers during discussions about PI:

They'll randomly email me going "Oh (manager's name), have you seen this thing about telehealth?" and I'm like "Oh god."… they don't understand the priorities or the organisation, so it's really difficult to manage them (Interview 7 – General Manager)

Again, the suggestion above is that the PI group need to be 'managed', associated with which managers did not accommodate PI contributions outside those considered to be managerially defined organisational priority. The influence of the hierarchical organisational context in encouraging rational ideologies of control was illuminated by many of the managers interviewed, who suggested they often limited PI to smaller, peripheral discussions, rather than involvement in strategic decision making. Consequently, there was relative diminishing

potential for the PI group to influence decision making processes. This sentiment was also voiced by doctors involved in the commissioning organisation, suggesting the hierarchical organisational context encouraged rational ideologies of control across professional groups, as well as managers:

> *I think them feeling involved is probably the best that we can do. They don't necessarily have all the information or the knowledge and experience to make the decisions that we would make as health professionals and they do make some really valid points but it's really peripheral stuff to be honest (Interview 9 – General Practitioner)*

Consequently, PI involvement in decision making processes was marginalised, and the management team characterised PI in a way which suggested they did not see much strategic value in any PI contribution:

> *They want better plates or something ridiculous... But then again, you see, if you're a member of the public and you know nothing, like a lot of them don't really about how the NHS works, then why shouldn't they bring these things up? It's not really that helpful for us though, it doesn't change the way we work (Interview 3 – General Manager)*

As noted by the manager interviewed above, PI contributions were not viewed as changing organisational processes. During interviews, none of the managers or PI representatives could give examples of the way ideas from the PI groups influenced development of services. In addition, there was little capacity for new

ideas to be generated from the PI groups, as the management team set the agenda, constraining PI contributions to managerially determined issues. As such, the potential for new, or different, ideas to emerge from the PI group was limited:

> *There aren't many things that come up that don't really fit with the main themes because we set the agenda to make sure that what they're discussing fits with the main themes (Interview 3 – General Manager)*

On the one hand, organisational managers were aware of the need to engage in PI in line with national policy. However, their interpretation of policy led them to engage in rational ideologies of control, which constrained the PI group, only allowing them to contribute through formally determined, and managerially led, discussions. For many PI representatives the lack of flexibility for their involvement led to feelings of frustration, and questions about their potential for strategic influence:

> *It's difficult to see how you make a difference really. I think a lot of the time the managers just sit there and nod their heads, they don't hear us. And we're not supposed to talk about a lot of things, just stick to the agenda or you get into trouble! (Interview 10 – PI representative)*

However, the chair of the group, who also represented the PI group as a lay representative of the commissioning board, described how he felt he was involved in strategic level discussions. An experienced manager in the private

sector, he had been appointed as chair of the group by commissioning managers, who identified him as 'our champion for public and patient involvement' (Interview 1 – General Manager). As such, the chair felt he could use his professional background, and the influence afforded to him by his managerially appointed position, to contribute to managerial decisions:

> *I have some skills from a professional management point of view… So as a non-exec sitting on the board I'm able to say "Well, why do you do it that way? Have you thought of…?" So I'm able to put constructive challenge into the system (Interview 2 –Lay member)*

Therefore, by drawing on previous experience of management within different organisational contexts, the PI representative achieved more strategic influence by working within a managerially framed role. However, he was also aware that to retain this influence and his position given to him by managers, he had to behave in a way that aligned with managerial interests or accepted behaviours, influencing the way he communicated information from other PI representatives to commissioning managers. In this way, he could be seen to replicate forms of rational control over his PI group members:

> *If I go to that board with a proposal which is unrealistic, then I've failed… I have to go back to the (PI group) and say is "It's all very well coming up with these ideas. How do we fund it?" They have a responsibility as well. They can't just say "We want a cancer consultant on our doorstep every day of the week" like sometimes they do… So if I take it into the board I*

have to make sure it is credible. If it's not, then I'm going to get thrown out and rightly so. I'll have a fight and I won't be taken seriously (Interview 2 – Lay member)

In summary, case 1 represents an organisational context in which PI is influenced by the constraints of rational ideologies of managerial control, which framed opportunities for PI. An organisational context, which did not prioritise the potential for PI outside of formal structures, meant that managers set the agenda to limit PI contributions to peripheral issues, rather than strategic decision making processes. Consequently, there were no examples of the PI group influencing the commissioning organisation at a strategic level. Whilst the managerially appointed chair of the group felt they had influence, this was related to their ability to work in a way consistent with managerial expectations, due to their professional background, previous experience, and a position bestowed on them by the commissioning managers. The need to act in a way aligned with managerial interest, through channels determined by rational ideologies of control, subsequently influenced the type of information the lay member communicated between the PI group and the management team, as the chair himself replicated forms of managerial dominance.

Case 2 – Increasing recognition of the potential of public involvement

In case 2, characterising their attitude towards PI as a 'supportive culture', managers were keen to communicate the importance of PI within the

organisation, highlighting that their organisational context encouraged and recognised potential benefits of PI in service design and delivery:

> *If we actually end up designing services or commissioning services that have got strong, local backing it's going to make it ten times easier to actually put those services in place because you can say "Well actually, we've got the backing of the general public here and this has all been informed." Yes, we've been influenced by our clinicians and the GPs, but particularly the public. (Interview 7 – General Manager)*

However, whilst all managers claimed they valued PI, some voiced concerns over the level of understanding of PI representatives about the commissioning organisation, and the context of the wider health system. Similar to case 1, some managers acknowledged that a lack of awareness of the wider organisational landscape could limit PI:

> *What's practically quite hard is having to go over things that we've already talked about, and so something maybe you talked about three weeks ago you then spend half the meeting going through it again. It's quite time consuming and can be quite frustrating (Interview 13 – General Manager)*

Despite what was characterised as a more supportive managerial culture, managers resorted to rational ideologies of control, and limited PI to topics or contributions determined by the management team. However, the chief

executive of this organisation suggested that such control was not due to a reluctance to involve the public in strategic decisions, but about identifying the most relevant opportunities for involvement, arguably enhancing their contribution towards decision-making:

> *There is always a line to be drawn between what is operational detail that we sort out every day, kind of day to day stuff, and what is really important, relevant stuff that the public ought to know about… So sometimes it's not conducive to ask them about it (Interview 11 – Chief Executive)*

Whilst managers acknowledged that their dominance could limit the involvement of PI, trying to focus the contribution by involving them in 'relevant' discussions, they suggested their organisational culture was one which valued PI. Diverging from the findings in case 1, where organisational approaches to control trivialised PI, leading to concerns from PI representatives that they had no real involvement, PI representatives in case 2 seemed more satisfied with their contribution. In particular, they suggested that they were able to challenge managerial decisions, and raise issues outside of the managerially determined agenda:

> *I think they've realised that we are a real asset so, you know, I think we've got a good working relationship… they're very welcoming and, you know, we can be very challenging and raise some really difficult questions, but*

then they do try and seek the answers. We can ask about anything really (Interview 4 –PI Representative)

However, despite positive attitudes towards PI in case 2, which might have engendered more normative forms of control, the way in which PI influenced structure and recruitment to the PI group was tightly controlled by commissioning managers. PI representatives were not able to offer contributions to the commissioners outside of the boundaries of managerially controlled mechanisms for involvement:

I was appointed by the commissioners to the committee…. So the public interact with (PI) committee; the (PI) committee collates the information and then we transmit this in one way or another to the clinical commissioning group (Interview 2 – PI representative).

This was particularly frustrating for one PI representative, who acknowledged the organisational context was supportive of PI when occurring within controlled strictures, but questioned the extent to which he could contribute to wider issues:

They didn't discourage me from doing research, but they couldn't say if a layman like myself could carry out something… so now as an active member, quite active and outspoken, I'm still feeling somewhat tagged on… Are we really important or is it all window dressing? I'm allowed to

have an opinion but only on topics they allow me to. So I just wonder what my contribution is (Interview 1 –PI Representative)

Therefore, whilst more anecdotally committed to PI than case 1, PI was still influenced through rational ideologies of control from management, limiting involvement to a small number of pre-selected topics. Whilst some PI representatives were satisfied with their involvement, perceiving the organisational context as one which supported and valued PI, others felt limited in their contribution. As such, whilst the managers in this organisation were attempted to enhance PI, facilitating involvement where it could have the most impact, continuing managerial dominance through rational ideologies of control had the potential to exclude PI representatives from involvement in more strategic issues. This led to some members feeling 'tagged on' and not integral to the commissioning process.

Case 3 – The potential of normative control

Case 3 is notable due to the different approach to the implementation of PI policy taken by the management team. At this site, the managerial culture encouraged a more normative approach to the organisation and control of the PI group. Managers were significantly less controlling in a formal sense and described themselves as holding a greater commitment towards the diverse viewpoints that PI potentially brought in to decision-making. They thus claimed a 'hands off' approach to PI, although we later note such an approach may merely represent a more subtle form of managerial dominance.

The management team was not actively involved in the development of agenda or running of meetings, and the PI group had a small budget provided by the commissioning organization, which they could use for their own purposes (such as room bookings, transport, small research projects). In addition, the PI group themselves elected a chair and determined their recruitment strategy independently from managerial control:

> *We decided to try and have a representative body and my original thought was that we'd have a group with one representative from each of the patient participation groups and any special interest groups would bring in a representative… The other thing we did, we decided that if people showed a strong enough interest that we'd take on a few independent members. So we have about three or four independent members who are there because they've got a great interest in the health service and wanted to do something (Interview 2 - PI Representative)*

Despite the apparent lack of direct involvement from the commissioning managers, the PI representatives reported excellent relationships with management. Some representatives had been involved under previous organisational structures, and noted the difference under the new commissioning arrangements:

> *(Previous organisations) were very much management led… they tended to do things on business lines rather than on patient need lines….*

everything was organised because that seemed like the right way to make it easy for somebody who was organising it rather than "What actually are we trying to get out of this? What does the patient really need?"…. So I have seen a major shift, yeah (Interview 1 – PI Representative)

Rather than determining the topics the PI group should be involved in, the management staff allowed the group to discuss issues they felt were important. This encouraged the generation of new ideas for service development:

We don't tell the PI group what to discuss, they come up with the ideas and set their own agenda, arrange their own meetings. And sometimes they're used as a sounding board, so they will often come up with ideas, very good ideas which we will use in commissioning design (Interview 7 – General Manager)

During interviews, managers noted that their normative approaches to control, claiming they set aside organisational hierarchy and encouraged a collaborative ethos, not only enhanced the PI contribution, but developed a sense of organisational belonging or ownership amongst PI representatives. This subsequently influenced the implementation of the services in a wider public setting:

If you use patients to help in the design you may still end up with the same result, but because you've taken patients along with you they will go out and defend it themselves… at a public meeting somebody was having a go

at our CCG over something and one of the guys from the patient group stood up and defended it because he'd been in on the inside and said "You've totally got this wrong. They're doing it this way." So it shows it does work (Interview 13 – General Manager)

In contrast with cases 1 and 2, both managers and PI representatives interviewed in this case could give explicit examples of episodes when PI had influenced service design, or had been clearly involved in strategic decision making processes. As noted above, this encouraged a sense of organisational commitment, ownership of services, and instilled a feeling amongst PI representatives that they were able to contribute at all levels of commissioning processes. This was reflected in an example from one of the PI representatives who was concerned with the local ambulance service, and as a result undertook their own research, independent of the commissioning organisation. After developing a paper, and arguing a case for change in the way services were being delivered, the PI representative distributed it to the PI group, the board of the commissioning organisation, and the board of the local ambulance service:

I sent a paper off to the chief executives because I've been concerned about the lack of data transparency from the ambulance service… So I wrote a paper and it's very challenging potentially… but I'm not constrained from doing that and if I've chosen to do that that's fine… I've pursued it, asked questions… My objective would be that people can make informed decisions about whether they think they're getting quality out of

the ambulance service and I think that will help the CCG (Interview 10 –PI Representative)

The above example illustrates how a the more collaborative ethos towards PI encouraged representatives to become more actively involved in strategic issues outside of formalised, managerially determined roles. As a result, ideas or opinions evolve, which may not otherwise have been facilitated. A second example of the positive influence of PI was illustrated in design for a respiratory (COPD) service:

One of the chief executives came to me and said they'd been looking at the plans I'd sent them for a project on COPD, and they wanted my input in developing the service… it's now showing something like a 17% reduction in unplanned admissions. Well, if you add up £3,000 or £4,000 a time that's a lot of money we're saving… So the patients are benefiting and the CCG are benefiting because the patients are benefiting (Interview 4 –PI Representative)

By having the confidence (and managerial encouragement) to send ideas or project proposals, which may not be managerial priorities, to the management team of the organisation, PI encouraged the development of a new service, subsequently resulting in patient benefit and cost savings. If the PI representative in this case had been constrained by managerial priorities, reflected in cases 1 and 2 that were characterised by rational control, the service

would have been unlikely to be developed, as it was not part of the immediate managerial agenda.

PI representatives in case 3 seemed aware that their potential influence within the CCG was not reflective of the types of involvement in other areas. As a result, some members within the PI group were reluctant to work with other 'less credible' PI groups, in case that undermined their influence. This aversion to actions that may reduce their level of influence within the commissioning process was noted in field notes, during a discussion at a PI group meeting about the potential for collaboration with a neighbouring organisation:

> *Discussion about collaboration with (neighbouring organisation). Everyone becomes very animated and derogatory about the PI reps in neighbouring area. Many people appear concerned that the other group have less 'credibility' as patient representatives, and that they do not take their role as seriously. A number of people suggest that they are "not the same as us" an "don't know how to work with their CCG in the best way'" Someone says they are just "yes men" and will not challenge managers (Field Notes 09/11/13)*

The PI group seemed aware that their influence came from their ability to work alongside commissioning managers, but remain outside of managerially determined roles. Working in an organisation with a more normative approach from managers towards their contribution did not require PI representatives to

work within rationally controlled involvement structures, and afforded them freedom to think more innovatively about service design, as they were not constrained to managerial priorities or visions. The distinction with the neighbouring group was the latter were seen as being particularly influenced by an more hierarchical that privileged managerial priorities:

> *In (the other organisation) they're appointed by management…. there's a completely different culture and the people will all be yes men… The thing is when you suggest something the people from (the other organisation) will put all the obstacles in the way and the people from here will say "Well why can't we do it? What's stopping us?"… You see, I wouldn't hear "We can't do that" from us, but I would from them (Interview 6 –PI Representative)*

The PI representatives were aware of the unique freedom afforded to them by commissioning management team, enhancing their influence and potential contribution. Their aversion to working with managerially controlled groups was due to concerns that they may find their influence lessened by increased pressure to conform to managerial priorities. However, the PI group were also keen to help educate others, and encourage them to work independently of managerial agenda. This was highlighted during interviews by an awareness of their role in developing influential PI representatives for the future:

> *I've been to meetings and I've asked questions and I've heard somebody say afterwards "He shouldn't have asked that question. He knew the*

answer." Yes, I did know the answer, but half of the people there didn't which is why I asked the question and they wouldn't have known to ask the question… So that's where I see my role. I see my role now bringing those people along, helping them along so we've got some people who can question things in the future (Interview 10 –PI Representative)

In conclusion, case 3 illustrates the potential for innovative PI when it is subject to normative, rather than rational, ideologies of control, meaning it is not constrained by managerially determined ways of working, realising the aims of PI policy. By being able to work outside of rationally controlled roles, whilst maintaining supportive relationships with commissioning managers due to normative control, PI representatives could inform commissioning processes at a strategic level and had a clear influence on the development of services. In addition to encouraging organisational commitment, and ownership of services within the wider public, normative control of the PI group enhanced the ability of the commissioning organisation to design responsive services, resulting in positive outcomes, such as the COPD service.

Discussion

The three cases outlined in this paper reflect a variance in the interpretation of PI policy in commissioning organisations. In our findings, we outlined how this variance was related to managerial influences on the way policy was interpreted in practice, reflected by rational or normative ideologies of control (Barley & Kunda, 1992), which shaped the PI agenda and topics of contribution. We now explore these findings in the context of existing research.

In case 1, PI was limited by the organisational context, which encouraged rational ideologies of managerial control. Often suggesting PI was a peripheral element of commissioning processes, managers attempted to implement policy through a directive and constraining approach, meaning that PI was not integrated into strategic decision making. By determining the agenda for the PI group, and taking over meetings that deviated from their agenda, these managers parallel research findings about limiting actions of professionals towards PI (Baggott, 2005; Boivin et al., 2014; Callaghan & Wistow, 2006). Whilst one PI representative, also involved as a lay member of the organisation board, suggested they had some level of influence with managerial staff, this was only achieved by co-option into a managerially framed role. By drawing on previous managerial experience, the lay member conformed to managerial control in ways that made him seem 'credible' to managers. However, as a result, the ideas he communicated from the PI group to the governing body were tempered by a desire to retain that credibility. Our analysis supports previous research that argues incorporation of PI into managerially controlled governance structures undermines the distinctiveness of public engagement, as representatives become co-opted towards managerial interests, replicating forms of rational control, rather than acting as critical challengers to managerial decision-making (Martin, 2011).

Case 2 represented a more complex picture of the implementation of PI policy, in which commissioning managers stated their organisation had a commitment to PI, but where they struggled to move away from rational ideologies of control. In

case 2, managers determined the nature of PI, and the way representatives were 'allowed' to work into the organisation. For some PI representatives, the positive organisational attitude towards PI, and the feeling that their opinions and ideas were taken on board to some extent, resulted in feelings of satisfaction with their level of involvement. Litva et al (2002) term this type of PI 'accountable consultation', in which PI contributions continue to be influenced by managerial priorities and agendas, but through which public opinion is expressed and the rationale for managerial decisions is fed back to the PI group. Such accountable consultation appears to be the most dominant model through which PI policy is implemented in the public sector (see Martin, 2011; Rutter et al, 2004), where managerial structures can give structure and meaning to PI groups and encourage involvement where it would be most appropriate (as defined by the management team). In a sense, the managerial approach in case 2 was moving toward a more normative form of control, encouraging a sense of ownership and commitment to organisational goals.

However, whilst some PI representatives in case 2 were satisfied with accountable consultation, more active or outspoken members were frustrated by their inability to contribute outside of managerially determined topics. As noted by one respondent, who desired to take on independent research, this undermined the potential contribution of PI, limiting the empowerment of representatives, which is a political aim of PI (Barnes et al., 2003; Gustafsson & Driver, 2005). Therefore, whilst there was an awareness of the need for a normative approach to integrate PI, rational managerial control continued to manipulate PI outputs, encouraging conformity, rather than innovation, through

engagement. In these settings, despite rhetoric of normative control, managers continued to engage in rational control to determine who is involved in PI, what contribution they can make, and how that contribution is interpreted within decisions that align with managerial priorities (Baggott, 2005; Rutter et al., 2004). This contrasts with contexts such as health research, where a more normative approach encourages a focus on active collaboration and co-production of knowledge, and where PI representatives define the research agenda (INVOLVE 2012).

In contrast to cases 1 and 2, managers in case 3 demonstrated a more normative approach to the implementation of PI policy. Rather than determining the agenda, or distinguishing appropriate structures for involvement, the managerial staff offered support for the group to develop a context which facilitated involvement on their own terms, and subsequently worked to integrate the outputs of the group into service design. As a result of this normative control, and a relative absence of rational control, we found examples of two occasions on which PI involvement led to the design, or evaluation, of a service. In one case, related to the development of a respiratory service, this resulted in a decrease in urgent admissions, enhancing cost effectiveness and patient experience.

The PI representatives in case 3 could be conceptualised as becoming 'expert' representatives. Previous research suggests that experienced PI representatives undergo a process of professionalisation, enhancing their credibility and ability to influence at a strategic level of decision-making around service development (El Enany et al., 2013; Martin, 2008a). However, El Enany et al (2013) suggest

this professionalisation process requires PI representatives to align with managerial influence, becoming co-opted into rationally controlled managerial structures to gain influence. Whilst this is reflective of our findings in case 1 and 2, the representatives in case 3 were distinct due to their *lack* of co-option into managerially framed roles, enabling them to influence topics which were not necessarily part of the managerial agenda (such as the ambulance service), and developing service in domains that may not otherwise have been addressed (such as COPD interventions).

The importance of an organisational context that supports normative control was highlighted by the reluctance of the group in case 3 to work with a neighbouring PI group, who they believed were rationally controlled by their respective managers. On the surface, our findings could support conclusions of El Enany et al (2013) that professionalised PI experts become complicit in the active selection of the 'right' participants for PI, whilst excluding others to protect their jurisdiction. In this sense one could argue that professionalised PI experts replicate forms of rational managerial control to limit others' involvement. However, we also highlighted that the PI representatives in case 3 wanted to help develop inexperienced individuals in normative ways, guiding them through meetings which may be unfamiliar, and encouraging them to continue to ask questions rather than become co-opted into managerial ways of thinking. Therefore, we argue that, rather than replicating forms of rational control, the PI representatives in case 3 were not distancing themselves from individuals who did not possess the 'right' types of knowledge, as suggested by El Enany et al (2013), but rather replicating forms of normative control.

The difference in organisational contexts encouraging rational or normative managerial control is an important factor in explaining the variance between the 3 cases, highlighted by the potential for PI influence over service design as illustrated in case 3. However, it is also important to acknowledge the potential inhibitory influence of normative control. In all 3 cases, PI was framed by forms of managerial dominance. Whilst normative control fostered an environment that supported the collaborative PI alluded to in policy, the management team were still arguably shaping the nature of PI involvement and recruitment, albeit in a less directive way. This resonates with the work of Alvesson and Willmott (2002), who argue that normative managerial control works to influence employee commitment and reduce distinctiveness, encouraging them to work in ways congruent with managerial priorities. Therefore, whilst this paper highlights the importance of normative, rather than rational, control for realising innovative PI, we acknowledge the continuance of managerial dominance in shaping the nature of that contribution.

Finally, whilst the organisational culture at the time of data collection supported normative control in case 3, the findings in this paper only offer a temporal snapshot in the turbulent, dynamic context of healthcare commissioning. Normative control, in the face of continuing pressures in healthcare to conform to performance management and governance structures, is unusual (Martin, 2011), despite the potential for increased innovation in the commissioning and delivery of care. Indeed, one participant from case 3 highlighted the ongoing

spectre of rational control, suggesting that the organisational context had the potential to shape and constrain the nature of PI in the future:

> *So we have arrived now in recent meetings where we now get copies of board meetings and highlight papers and god knows what, and frankly I think it's a negative move, because whenever you end up with an agenda in a meeting that's got umpteen items that are about somebody else's meetings you end up with your own time being curtailed… the more you have to stick to the agenda, the more you have to constrain that freedom to move about (Interview 3 – PI Representative)*

Whilst it may be difficult to sustain organisational cultures promoting normative control of PI structures in the context of top-down performance pressures in healthcare, the three cases outlined in this paper demonstrate that a move away from rational control is necessary for the realisation of PI alluded to in policy documents. Our findings emphasise that managerial dominance means that managers are responsible for creating organisational contexts that maximise the potential for PI influence during decision making processes. Supportive contexts offer the opportunity for PI representatives to replicate normative, rather than rational, control mechanisms with other, less expert, groups, further enhancing the potential for innovative PI.

Conclusion

This paper has considered three interpretations of PI within the English NHS. Reflecting current policy, limited guidance on the operationalisation of PI, and the ability of commissioning organisations to determine their own organisational processes (HSCA, 2014; Hudson, 2014), we have shown how variance amongst policy implementation in commissioning groups can be attributed to the use of rational or normative ideologies of managerial control over PI. By demonstrating the potential benefits associated with normative control, we highlight the importance of developing an organisational context, which supports more normative approaches, and warn against the limitations of co-opting PI representatives into managerially determined processes through rational control.

On the one hand, findings from case 3 offer prescriptions for the implementation of policy in healthcare organisations towards development of more innovative PI. In particular, we identify the need to encourage the development of 'expert' PI representatives, who can in turn teach others about the complexities of the organisational context through normative processes, without replicating rational control mechanisms to co-opt them into managerially dominated roles. Whilst previous research suggests that professionalised PI representatives may work to exclude others from involvement (El Enany et al., 2013), we argue that in organisational contexts, which support normative control, expert representatives will encourage others to become involved in more challenging ways, perpetuating future innovation.

However, our findings also highlight the continuing managerial dominance perpetuated by normative control. This is indicated by an absence of the potential case 4, that of more radical PI, which has been seen in the HIV/AIDS (Epstein, 1995) and anti-psychiatry (Crossley, 1998) social movements. By amassing different forms of credibility outside of managerially dominated structures, radical PI movements have the potential to become genuine participants in the development of health services, whilst at the same time advancing their own strategic goals (Epstein, 1995). The findings in this study do not reflect this type of PI. However, the commissioning context may be relatively distinctive in that it is removed from direct experience of healthcare delivery that most engages PI representatives. Epstein (1995) argues that radical PI, taking the form of social movements, occurs when a group constructs identities associated with a particular disease category, becoming experts to exert political influence. In the context of commissioning, the PI groups represent individuals with diverse healthcare experiences or identities tied with variable medical conditions. As such, without a strong collective identity, PI in commissioning may be more susceptible to managerial dominance.

Our conclusions support the argument of (Martin, 2008a), who advocates for flexible policy guidance, leaving the nature of PI open to interpretation. Whilst UK commissioning organisations are now legally required to engage in PI (HSCA, 2014), the nature of that involvement can be determined locally, reflecting the needs and skills available in the local community. Again, this relies on PI not

being co-opted into managerial governance structures, but allowed to develop normatively.

Regarding further research, researchers may wish to draw on some of the normative approaches adopted in health services research (INVOLVE 2012), to explore how to encourage organisational cultures, such as those described in Cases 1 and 2, to develop from rational to more normative approaches behaviours to enhance PI. Notwithstanding our explanation for absence of more radical forms of PI free of managerial influence, we encourage future research to seek out such forms in commissioning structures and analyse its antecedents. In addition, this paper focuses on managerial influences on policy implementation, but future research should also consider the interplay between managers and PI representatives, and the reciprocal influence of PI representatives on managerial structures, where they themselves may replicate forms of managerial control over others.

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