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Power dynamics and collaborative mechanisms in co-production and co-design processes

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Abstract

Co-production and co-design practices are increasingly being promoted to develop user-centred public services. Analysing these practices with literature on power, participation and realist social theory this paper explores the power dynamics, mechanisms and impacts within co-production and co-design processes. Two case studies were evaluated using qualitative longitudinal methods: an experience-based co-design project within hospital-based breast cancer services was followed from initiation to completion, alongside a local government innovation team that used co-production and co-design techniques to enable person-centred policies and services. The two cases illustrate how co-production and co-design techniques involve facilitating, managing and co-ordinating a complex set of psychological, social, cultural and institutional interactions. Whilst existing power relations can be challenged in different ways, constant critical reflective practice and dialogue is essential to facilitate more equal relational processes within these techniques, and to institute changes at individual, local community, and organisational levels.

Keywords

Co-design, collaboration, collective reflexivity, co-production, participation, power, user involvement

Introduction

Co-production, understood as a process by which 'citizens can play an active role in producing public goods and services of consequence to them' (Ostrom, 1996: 1073) has been gaining prominence within public policy and practice debates. Co-design and co-creation are based on the principles of co-production (Durose and Richardson, 2016), and utilise user-centred and participatory design techniques to develop more person-centred public services and implement improvements and innovations (Bason, 2010; Bate and Robert, 2007; Parker and Heapy, 2006; Voorberg et al., 2015). Internationally, the World Health Organisation (WHO, 2015) promotes the development of health service models that are based on co-production. There is considerable interest in co-design techniques, including the United Nations Development Programme Public Service Innovation Lab, alongside initiatives in Europe such as MindLab in Denmark and the European Design Innovation Initiative. In the UK, where this study is set, the NHS Five Year Forward View (NHS England, 2014) advocates the importance of local co-design in the implementation of new care models, working with local communities and leaders. The Care Act (2014) also highlights the importance of co-production within social care, defining it as when individuals or groups influence the support and services that they receive, or influence how services are designed, delivered or commissioned.

Co-production is a contested concept. In practitioner and policy literature co-production is often promoted as a 'normative policy good' (Osborne et al. 2016: 644) endorsing a partnership approach and equal relations between staff and citizens that can facilitate innovation and improvement within public services (National Endowment for Science, Technology and the Arts [Nesta], 2012). In contrast, at a discursive level co-production has been analysed as an

extension of neo-liberal free market economics and a fix for austerity (McGimpsey, 2016), where citizens may be substituted for paid personnel within public services (Fotaki, 2015). Radical perspectives see that 'real co-production', where alliances are forged between practitioners, service users and carers, may offer the best route to challenge 'damaging policies' and promote 'genuinely user-led services' (Beresford, 2016). This article examines these debates by exploring the power dynamics within co-production and co-design processes, which has been highlighted as needed (Boaz et al., 2016; Donetto et al., 2015; Ocloo and Matthews, 2016). Theoretical perspectives on power and participation are used to analyse the policy and practice of co-production and co-design. The research question focussed upon is: How can staff and citizens collaboratively change public services, what power dynamics affect this, and with what outcomes? Two public service case studies are analysed. One case was set within National Health Service (NHS) hospital based breast cancer services, and used the process of experience-based co-design (EBCD) (Bate and Robert, 2007). The second case was a small-scale innovation team in local government that used co-production and co-design techniques to develop person-centred policies and services. This comparison between health services and local government community-based interventions is distinct, as empirical studies of co-production and co-design processes usually occur within similar service contexts (Voorberg et al., 2015; Donetto et al., 2014). This enables a comparative analysis of the mechanisms and power dynamics within these collaborative processes across different contexts.

The article begins by overviewing co-production and co-design literature and policy, using a multi-dimensional approach to understand power (Haugaard, 2012) and realist social theory (Archer 1995, 2013). Methods are detailed before the analysis of the two cases. The processes of these are described separately before the discussion comparatively analyses them, drawing out key power dynamics within co-production and co-design practices. Drawing on this

theoretical and empirical analysis, a series of critical questions are presented, that practitioners can reflect on to consider different power relations within these processes.

Dimensions of power within co-production and co-design

Recent co-production literature (often practitioner and policy based) develops key features of co-production, including building on: people's capabilities, assets and skills; mutuality and reciprocity; more equal partnerships between professionals and citizens; and moving from a service delivery model to a facilitative one (WHO, 2015; Nesta, 2012: 5; Social Care Institute for Excellence (SCIE), 2015: 5). A transformative model of co-production involves service users in all aspects of a service from planning to delivery, transferring power and resources from organisations to people who use services and carers (SCIE, 2015: 7). However, the theoretical roots of these concepts of co-production and co-design are distinct from other radical participatory literatures that have politically emancipatory aims such as feminist, post-colonial, indigenous knowledges, and critical theory (Facer and Enright, 2016).

Co-design techniques explore people's experiences, focusing upon subjective and emotional elements to enable connection between service users and staff (Bason, 2010). Techniques include understanding people's interaction with services through touchpoints, stakeholder maps, and service prototyping (Parker and Heapy, 2006). Experience-based co-design (EBCD) is a participatory action research method that uses design techniques to develop improvements in healthcare (Bate and Robert, 2007). It has been used in a range of acute, primary care, and mental health services and has resulted in a range of incremental quality improvements (Donetto et al., 2014). Both co-design and co-creation advocate the importance of developing equal relations between service users and professionals (Bason, 2010: 173; Bate and Robert, 2007: 9). However, the extent to which power relations are altered within these processes needs further in-depth analysis (Boaz et al., 2016; Donetto et al., 2015). Is co-production 'legitimating and deepening' managerialism and neo-liberalism, giving 'a false

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impression of citizen power' (Dahl and Soss, 2014, p.502)? Or does co-production support small scale service improvement, or have the potential to transform power relations and structures?

This question of whether co-production leads to empowerment, or may further engrain inequalities, is a matter of empirical investigation; rather than its intrinsic nature being either empowering or dominating (Farr, forthcoming). When analysing co-production different theoretical dimensions of power can be used to understand these power dynamics in policy and practice. This article uses a 'bridge-building' approach to understand power. Haugaard (2012) uses Lukes (2005) three dimensions of power and Digeser's (1992) fourth dimension of power developed through a Foucauldian approach to develop his analysis. But rather than focussing just on power as domination, Haugaard (2012) illustrates how these different aspects of power can also enable emancipation. This enables an analysis that is sensitive to the different aspects of power within co-production in policy and practice, and how they may reproduce relations of domination (McGimpsey, 2016) or be potentially emancipatory.

Focusing initially on power as domination, Lukes (2005) first dimension of power concerns observable conflicts of interests. Rooted in a Weberian analysis of power (Haugaard, 2012) this is about the ability of a person to achieve their own will against others' resistance. Weber developed the concept of 'legitimate domination' and power as authority, with bureaucracy being based formal rationality, expertise and discipline. Exploring this element of power in relation to public services, their 'legitimate domination' has often been challenged by independent welfare service user movements who have created politicised collective challenges to professional dominance, highlighting some practices as oppressive or paternalistic. Service user movements may create more disruptive innovations that challenge institutions, whereas co-production and co-design processes tend to work within institutions (Farr, 2013). The emphasis on partnership with public service institutions may overlook the

importance of observable conflict, agonism and contentious opposition; as Dahl and Soss (2014: 500) note 'democracy depends on conflict as much as cooperation'. The EBCD approach has been critiqued for its lack of recognition of existent welfare service user movements (Williamson, 2010: 184). Whilst co-production has been promoted by the Trades Union Congress (TUC, 2013), there has often been less substantial roles for trade unions within co-design and co-production processes. Trade unions have been one of the few groups to use co-production to overtly contest market based mechanisms within public services (TUC, 2013).

Lukes (2005) second dimension of power is a more hidden omission of possible alternatives, a 'mobilisation of bias' where choices and agendas are narrowed in favour of more powerful parties' interests. This dimension relates to the critique that managed participatory mechanisms such as co-design and co-creation may subordinate democratic contestation to specific ends such as 'service improvement' as opposed to challenging wider structural inequalities (Dahl and Soss, 2014) or austerity (Fotaki, 2015). For example, within EBCD projects they have initiated more small-scale service improvements (Donetto et al., 2014; Boaz et al., 2016; Clarke et al., 2017) than wider structural changes. Decision making powers in complex organisations may have a significant influence on whether specific improvements are realised (Bowen et al., 2013). Co-production and co-design techniques may be critiqued as 'grafting deliberative processes onto a neoliberal framework' (Dahl and Soss, 2014: 502), where service improvements are made, yet at the same time wider structural issues within public services, generated through austerity measures and neoliberal marketisation may not be challenged.

The third dimension relates to power's deceptive and indiscernible characteristics where a more powerful person's interests may be internalised and sought after as one's own (Lukes, 2005). A critique of co-production with respect to this dimension may concern how co-production under financial crisis and austerity may take the form of unpaid volunteers being

substituted for those who are paid, with some costs being paid by the co-producers themselves (Fotaki, 2015).

The fourth dimension of power builds on a Foucauldian perspective highlighting how power can be 'constitutive of social life' (Haugaard, 2012: 33) and be both productive and repressive. A Foucauldian governmentality approach to power highlights how subjectivities are shaped and mobilised through discourse and particular modes of governing (McKee, 2009). Within co-production, there are contradictions between 'the rhetoric of empowerment and reductions in state safeguards and funding' (TUC, 2013: 50). At a discursive level co-production may only be an extension of neoliberalism and a sticking plaster for service cuts, where 'civil society' is used to maintain cohesive relations, closely regulating subjectivity and reproducing relations of domination (McGimpsey, 2016: 8). Does co-production's discursive emphasis on equal partnerships hide wider increasing social inequalities, displacing social justice and rights based approaches?

Analysing co-production and co-design processes in this way highlights their potentially dominating effects. However, power can be positive sum where both parties can benefit from its exercise (Haugaard, 2012), and can be 'productive, transformative, authoritative and compatible with dignity' (Lukes, 2005: 109). Social interactions, the people involved, and the structures within which participatory processes are set, all influence power relations and whether co-production may empower participants, or, conversely, embed existing power inequalities (Bates, 2010; Haugaard, 2012; Allen et al., 2014). To understand these dynamics, realist social theory can support this analysis of power to explore the actual practices and outcomes in co-production and co-design processes.

Using realist social theory to analyse co-production and co-design

Realist social theory conceptualises how people (agents) are conditioned by their structural and cultural contexts, but their actions are not determined (Archer, 1995). Within realist social

theory both structures and agents have power, which may be used to dominate or emancipate (Bates, 2010). Through reflexivity and social interactions, people have the potential to instigate changes within themselves or others, or instigate cultural or structural changes (Archer 1995, 2003, 2007). Social interactions can facilitate shared understandings of common concerns, making people reflect and act differently, which can lead to changes in people, cultures or structures (Donati and Archer, 2015). These external effects of interaction can be associated with *power with* (Allen et al., 2014); the collective power that can emerge through the human ability to act together. The emergent power created through social interaction may be a force for emancipatory change, or domination may continue (Archer 2013). Using Archer's (1995, 2003, 2007, 2013) realist social theory as a framework, literature on participation and power highlights key issues to take account of within co-production processes.

1. The **people (agents)** involved:

   o Do professional attitudes model mutual recognition and respect, non-hierarchical collaboration and a commitment to improvement and learning (Renedo et al., 2015)?

   o Are public participants middle class (Faulkner et al., 2015; Renedo et al., 2015) and more 'articulate and managerially experienced' (El Enany et al., 2013: 29) or are a diversity of groups involved (Gibson et al., 2012)?

   o Are volunteers taking on previously paid staff roles (Lukes third dimension of power)?

   o Do participants have independence and security to participate equally (Pateman, 1970)?

2. The **structures** within which participation is set:

   o At what level does involvement occur at (e.g. at board or service provision) (Faulkner et al., 2015)?

    o Is there access to organisational resources? (Clarke et al. 2017)

3. **Social interaction.**

    o Are service users expected to 'fit into formal meetings' within institutions (Rutter et al., 2004: 1978)?

    o How are conflicting priorities managed (Carr, 2007) (Lukes first dimension of power)?

    o Do professionals retain control (Rutter et al., 2004)? Are participants drawn into managerial agendas (Renedo et al., 2015) (Lukes second dimension of power)?

    o What language is used (Morrison and Dearden, 2013; Beresford, 2013)? Are emotional and expressive contributions included (Barnes, 2008; Gibson et al., 2012)?

    o How do different deliberative styles include and exclude different participants (Donetto et al., 2015; Martin, 2012; Ocloo and Matthews, 2016)?

    o How can professionals engage in dialogues 'outside their traditional terrains' (Gibson et al., 2012: 542)?

4. What type of solutions are proposed and **outcomes achieved** (Faulkner et al., 2015; Gibson et al., 2012)?

    o Are senior staff and managers supportive and enabling of the processes, and involved in implementing solutions (Clarke et al., 2017)?

    o Is co-production more of a rhetorical device with little transfer of power, or impact (Lukes fourth dimension of power)?

These different elements all affect the extent to which service users can have power within co-production and influence social change. With these theoretical ideas in mind, this article now

moves to the empirical examples of co-production and co-design processes within public services.

Methods

The data used in this article consists of two realist evaluations (Pawson and Tilley, 1997) that were comparatively analysed using realist synthesis (Pawson, 2006) and realist social theory outlined above. The two cases were purposively sampled because both projects used similar co-production and co-design processes in different contexts (health services and local government) to understand context-mechanism-outcome patterns (Pawson, 2006). My role within both case studies was as an independent evaluator of the projects. The research was ethically reviewed via the University of Bath, specific ethics and governance procedures were followed within the two case organisations. Within the NHS case I attended meetings and events (n=33) of the EBCD project (Bate and Robert, 2007) from initiation to completion within breast cancer services at two large hospitals in an urban area over a period of 22 months, to understand the implementation process. Within this 71 feedback sheets from staff (n=46) and patients (n=25) were collated through co-design events. At the completion of the co-design project, I conducted 25 interviews with seven patients and 17 different staff (a project co-ordinator was interviewed twice), purposively sampled because they had taken part in some aspect of the co-design process. Staff were from both hospitals and had either had management, co-ordination and facilitation roles (six staff); or were staff participants within ongoing co-design groups (11 staff), including clinicians, managers and support staff. Within the local government case (covering both rural and urban areas) the implementation pathway of a small-scale innovation programme based on co-production and co-design principles was followed. This had begun before the research started and its initial projects were tracked through organisational documents and reports (n=24). Data collection took place over a 19-month period and people who had worked collaboratively with the programme were purposively

sampled to be invited to be interviewed. I attended eight meetings and events to meet participants and familiarise myself with the project's work, conducted 18 interviews with 17 different staff (a project co-ordinator was interviewed twice), alongside two focus groups: one with three community participants and two members of staff; and a focus group with three members of staff. Staff who were interviewed consisted of policy managers, senior managers, service managers, project co-ordinators and front-line staff, and were either employed by the local government organisation or third sector organisations. Community participants were all involved in projects facilitated by the programme.

In both cases I was reliant upon project managers who were gatekeepers to initially contact, gain access to and recruit potential interviewees. Participant information sheets and invitations to take part were emailed to potential participants by project managers. Although emailed to invite to participate, I found it harder to arrange interviews with staff who had dropped out of the co-design processes. Interviews were mainly conducted face to face, and following the written informed consent process, open ended questions were then asked about: people's motivation to get involved in the projects; what it was like to take part in the co-design process, working alongside other service users and staff; whether people felt heard and influential within the process; and what was achieved through the process. Interviews lasted between 30 to 85 minutes and were transcribed verbatim and analysed through the use of NVivo qualitative data analysis software. Interview transcripts were returned to interviewees so that they could review them and withdraw any data that they did not want used. Realist evaluation (Pawson and Tilley, 1997) techniques were used initially to understand how outcomes emerged through specific processes and contexts. This analysis was theoretically extended using realist social theory and literature on power and participation, as detailed above. Interpretive validity was discussed and confirmed through the development of separate evaluation reports for the two case studies. The following data analysis focuses first on the NHS case, then the local government case.

EBCD in breast cancer services

Project implementers (independent from the hospitals) interviewed staff about service provision, and interviewed and filmed patients about their service experiences, which was made into an edited film (Bate and Robert, 2007). This patient film created a visual, emotional portrayal of people's experiences. Patients consented to the film being shown at a co-design event where staff and patients came together to deliberate improvement priorities. The film put patients' experiences centre stage in a powerfully emotive way:

> I was absolutely shocked that patients coming into my department, I am managing the staff, and this is how [the patients'] felt. And I felt so bad, and I thought, "no, this has to be improved". So that was the impact watching that video (NHS Staff 18).

Lukes' (2005) first dimension of overt conflict was not observed, but these emotions were unpredictable and some staff did disengage with the later co-design process, who were said to have felt 'criticised' (NHS Staff 09). Patients were very aware of not wanting staff 'to feel demoralised' (NHS Patient 12) and wanted to ensure that the positive aspects of the services were clearly emphasised. Following the film, service improvement priorities were discussed and voted on, with staff and patients choosing to participate in specific co-design groups to action improvements. Through interviews professionals spoke of their own values, motivations and professional identity as being the catalyst to commit to these collaborative processes: 'It touches your own values and beliefs about what you are there to do' (NHS Staff 13). Unfortunately, no staff who withdrew from the process were able to be interviewed to discern why.

Ongoing co-design groups with patients and staff were held on a hospital site, following a traditional meeting structure, discussing and implementing service improvements. Service

users who participated tended to be professionally experienced and articulate, and this could enable them to engage and effect change:

> I think we had the benefit of having extremely, women in high ranking positions, very vocal, very able to present themselves and very coherent (NHS Staff 23).

Where co-design groups were successfully set up facilitators held a crucial role in creating space to identify common goals and the means to achieve these. The co-design groups enabled a different kind of dialogue between staff and patients:

> Well people come out of roles don't they. You are not sitting there as a surgeon, you are not sitting there as a clinical nurse specialist or a modern matron or whatever else. You are sitting there as [Name, name, name, name] and you are having conversations with people but you are having real conversations with people. It is not a directive conversation, it is not an advisory conversation as it normally would be with a health care professional. It is a conversation between one human being and another. So it is very different, it is very powerful, very powerful (NHS Staff 13).

Staff came out of Weberian bureaucratic structural roles to interact from the basis of a more personal identity, a finding echoed in other EBCD projects where staff developed more 'humanistic connections' with patients through the co-design process (Locock et al., 2014; Boaz et al., 2016). Some patients felt that there was a 'partnership' (NHS Patient 12) with staff, with a sense of being 'equals' (NHS Patient 02). Another found the initial experience of meeting staff in the first co-design event 'terrifying' but that staff were 'really kind and did their best to put you at ease' (NHS Patient 01). Where patients were still receiving treatment

they were dependent upon clinical relationships, sometimes with the clinicians they were co-designing services with:

> The power relation didn't really come into it. The only thing that I used to laugh about was how we would feel when we sat across the table from our surgeon, having conversations … we were thinking, how would it be when we are next in clinic and we have to take our clothes off (NHS Patient 12)?

Partnerships and space for change could develop where there were several patients in a co-design group, there was strong and skilful facilitation and where staff engaged warmly, openly and committedly in the process. Where staff disengaged with the co-design process, this could lead to an adverse experience for patients:

> By the end I was worried that they just thought I was this critical person…. So from my perspective, there was nothing good at all, I was really worried about blotting my copy book and being seen as a difficult person (NHS Patient 05).

Whilst staff could participate voluntarily in the process, patients had less 'independence and security necessary for (equal) participation' (Pateman, 1970: 43) as they could be dependent on ongoing clinical relationships, according to their treatment stage. Staff had to be positively and openly engaged for a sense of an 'equal partnership' to develop, welcoming and acknowledging critiques of service provision. However some staff withdrew from the process, which meant that patients could no longer engage with the co-design groups, nor were changes instituted.

The collective element of co-design groups enabled interdepartmental issues to be addressed: 'what we did in that project was to look at the whole system together; we are just fire-fighting individually' (NHS Staff 21). People could see and tackle everyday working problems from a wider systemic perspective. Patient and staff collectives could generate a new sense of *power with*: 'The power is in the room, you can choose to use it or not as you may see fit' (NHS Staff 13). Dialogue with patients about improvements could enhance feelings of staff accountability. Staff knew that they had to report back to patients about improvement work. One staff member spoke of how there were less blaming dynamics between different staff groups, because of the presence of patients at discussions.

Bureaucratic and professional hierarchies were experienced as both enabling and constraining in how improvements could be implemented: 'I still would have to go through the necessary lines to make changes, regardless of this project really' (NHS Staff 22). One interviewee spoke of the importance in involving more senior managers so that changes could be instigated at a higher institutional level. Others saw that collaboration with patients enabled a different sense of power:

> Nobody quite knows where decisions get made, so everybody thinks that someone else is making decisions to be honest…. People can think … "doesn't this have to go through some committee?" And you are like, "well we are a committee" and there is a massive power in saying we have consulted with patients on this (NHS Staff 09).

Where the EBCD project implemented most changes, there was often a groundswell of other improvement activity taking place:

> Our unit was in huge change, we were trying to change things that had not been changed for 10-15 years before…. So this came at a very opportune moment …. This came bang at the right time, saying, "right let's get the users of the service involved and design the service around them so for us it worked great" (NHS Staff 23).

From over 36 different issues that patients had discussed with staff, 29 of these were acted upon. Outcomes included improvements to some appointments systems, increased privacy and dignity in specific areas, stronger continuity of care practices, improved systems through surgery and day surgery, and improved patient information. Some staff felt that communications had improved within teams and between different staff groups:

> I think there is probably less pointing of fingers and maybe more of a jointness of this is our problem rather than it's your problem. There is definitely more thought about the impact of problems on patients (NHS Staff 25).

Issues such as waiting times and some care issues on ward environments appeared to be more difficult to tackle. Structural pressures enabled and constrained particular forms of change, aligning with wider policy trajectories. For example, more patient-centred changes occurred in day surgery, aligning with priorities to reduce hospital length of stay. Culturally, interviewees observed a shift toward more patient involvement through the organisation where patients were becoming more involved in a wider variety of decisions through different areas of the organisation, including in major hospital building developments. Within the time frame of the research less change had occurred at a strategic level, with wider institutional pressures constraining the degree of *power with*. Policy changes affected the ability of managers to focus on this collaborative work: 'I think, day to day business, the change in the NHS, the finances,

everything got in the way' (NHS Staff 16). Financial and resource constraints provided clear boundaries in the degree to which some systemic issues could be tackled.

Co-production in local government

The local government case was based on the concept of an 'innovation lab' (Bason, 2010) and used co-production and co-design principles to develop person-centred policies and services through the organisation. The team developed collaborative projects with staff and service users in areas including housing, public health, and social services, for example working with local communities, families on low incomes and people leaving prison. In contrast to the breast cancer services project that followed a specific EBCD process (Bate and Robert, 2007), this case used a variety of co-design and co-production techniques in different projects. Ethnographic and visualisation techniques were often used at the beginnings of projects, including participatory film and community mapping to engage both service users and staff. In a project with a small rural community, community relations with the local council had broken down and people voiced their concerns around intergenerational divides. Here participatory film was used to bridge these rifts. Young people created a film about the local area and its history, interviewing the older community members, showing this film at an event in the community centre. As in the EBCD case the film helped to initiate dialogue and reflection, acting as a bridge to connect people: 'Conversations wouldn't have happened without the film'; 'It helped everyone to open up and talk honestly' (Quotes from case study project report). This enabled a sense of *power with* where stronger relationships with the local council started to develop, leading to further collaborative projects and successful funding bids.

Within different project workshops, both contestation and collaboration occurred within deliberative processes:

Are there arguments? Yeah, hundreds of arguments and I think that's fantastic that it's done in such a way that your views are respected and appreciated… and challenged, to a degree…. It's been very, very constructive (Local government interview 10).

These facilitated processes could contest people's preconceptions of different groups, creating spaces for dialogue. In this way, perceived differences between groups were broken down, shared interests and perspectives were explored, and connections developed. In addition to facilitating these bridging relationships the local government project aimed to engage directly with professionals' personal identity, building a 'coalition of the willing' (Staff focus group) and encouraging people to bring more of their personal ways of being into their job:

I think it is about bringing your weekend self to your job, it's about seeing what you do as not just, you come to work, you do it, you leave it behind, its caring about what you do and liking what you do (Local government staff 03).

The project attempted to tap into staff's personal values and concerns, where their working relations were connected to personal identity, as opposed to Weberian bureaucratic roles with work constituted by rules and procedures.

The project worked with citizens in community settings and successfully engaged people from diverse backgrounds, addressing potential exclusions through creating inviting spaces where participants could easily interact. In the Fathers' project, the team invited people through a 'pizza and beer' night which was popular with fathers, but less so some staff:

Now this had all sorts of horrible ramifications here. Staff were very upset, some staff, about the fact that they were dealing with mums who were suffering from the effects of

dads who were drinking too much and here was us offering a free beer to blokes who were coming in. I respect that view. We never did it again, but we did get quite a lot of dads come in (Local government interview 10).

In a separate community shop project, meetings were informal get togethers held in a local café where 'people are having cups of tea and toast, children are pulling chairs and climbing and falling off things' (Local government interview in Farr, 2013). In developing the community shop, project staff gave control and direction of the project to community members: "You can come up with an idea and they just turn round and say, 'yep, if you think that works'" (Community participant, focus group). Not only did professionals yield control of the process and content of the meetings, they also worked with community members in a much more personal rather than professionalised manner: 'They have become our friends' (Community participant, focus group). Bridging relationships across class and institutions were facilitated, where one community member compared project staff who were 'human people', with other council staff that she had previously met:

I wouldn't want to approach some of the people, they are just so… so up their own backsides it's unbelievable… (Community participant, focus group).

Trust was important in forming relationships between staff and local residents, especially where residents had historically less positive relationships with the council. In this case community participants seemed to have more 'equality of power' and 'independence and security necessary for (equal) participation' (Pateman, 1970: 43) within the processes, despite clear structural inequalities. The way in which participative forums were designed and situated in the community had an important influence on this. However in comparison with the EBCD

case, less service-based local government staff seemed to regularly participate in these community based groups.

The project worked to ensure that community participants had resources and links to instigate events within the community. Participants were empowered to co-create new community assets; a community shop and time bank were successfully launched:

> To me what has made the change is having the real people, the people who just live on (the estate) and the professionals, so between them everybody, whatever skill is needed somebody within the group has got that, but they do it in a really relaxed way' (Local government interview 14).

The social relations that developed between project staff and community members generated *power with* that had effects at a personal and community level. The work empowered participants in their own feelings of equality and status. Personal confidence of community members grew, with one speaking at a conference about the project:

> It was pretty nerve wracking, considering that was my first speech, I did walk away buzzing. It was like going in there, it was like Pretty Woman going down Rodeo Drive. You walk in there and you have got all the suited and booted all on the side with their phones and that (Community participant, focus group).

Another community member set up their own parents' group that provided peer support in an area of deprivation and health inequalities. Greater access to public services was facilitated through stronger community networks: '… rather than them bricking themselves about contacting them [council staff] they'll go through and speak to them' (Community participant,

focus group). As a result of the Fathers' project a new Fathers' worker was employed, who developed more creative and community-based approaches to work with young dads.

The local government project encouraged the adoption of participatory techniques into policy work and the wider organisation, informing organisational policies on poverty, children and families, and housing. Some policy team members used a wider range of participatory methods in their day to day work, but they also cited problems of timing, resources, and the nature of the work as potential issues in adopting more collaborative work practices. Similarly to the NHS case, top-down pressures from financial constraints and government policy impacted on the extent to which more senior figures were themselves empowered within organisations, facing both significant top-down directives and bottom-up operational pressures.

Discussion

Co-production and co-design techniques can facilitate different stakeholders to work collaboratively across and within institutional structures. This involves facilitating, managing and co-ordinating a complex set of psychological, social, cultural and institutional interactions. Comparatively analysing these two cases illustrates how existing power relations can be challenged in different ways.

Co-design techniques acknowledge the emotional aspects of experience, which can be used to facilitate connections between diverse groups of people. Connecting different people on an emotional and relational level and touching on people's values and concerns, could facilitate the discussion of shared interests and concerns. This could build new relationships across different social groups and cultures. Collaboration centred upon finding issues of mutual concern and interest that different participants could identify with and effectively sign up to. These concerns were carefully drawn out through understanding different people's perspectives, finding commonalities and generating broad consensus from different participants on ways forward. Both the NHS and local government projects challenged

objectifying and disconnecting bureaucratic processes, reconnecting staff with their own values and other's humanity and experiences, to support greater personal meaning within staff's working lives. This reconnection and collaboration could generate *power with,* which facilitated people to undertake new situated actions and instigate forms of social change. In both cases there were many examples of where the processes improved local services and participants' lived experiences. The process was potentially emancipatory for those taking part, with a significant number of both service user and staff participants expressing that the process had positively impacted them personally.

Co-production actively used service users' tacit knowledge, skills and experiences. However, the ideal of creating 'equal partnerships' between staff and service users can obscure an intricate web of power dynamics that operate in practice. Relations and involvement processes between staff and service users/ community members may be dynamically affected by different forms of social inequality; such as class, hierarchy, skills, language use, participatory environments within which people may feel comfortable to attend and contribute, and the focus of co-productive activity. Constantly reflecting upon how different power dynamics are manifesting themselves through co-production processes can support a greater understanding of how to minimise the effects of different inequalities (see Figure 1). For example, how and where participatory processes took place had an important impact upon power relations and potential outcomes. Where local government forums were held within local community spaces, using a personal and informal approach alongside creative and less conventional techniques, this encouraged people that may be deemed 'hard to reach' (Beresford, 2013) to get involved and contribute their experiences, skills and resources. In the local government project more community-based developments were initiated where citizens used their own resources and those that institutions provided, to better support people in their local communities. In the EBCD project within breast cancer services, service users were more

involved in organisational decision-making. This seemed to attract service users that felt more comfortable within this institutional context. Here, service improvements could be limited in line with staff's decision-making powers (Bowen et al., 2013). Encouraging more senior leaders to be involved may support changes at a wider level (Clarke et al., 2017), as participants needed to draw on institutional resources, networks and relationships to instigate wider structural changes. Cultural level organisational changes were noted by participants within both case studies, where public involvement processes were becoming more embedded within institutional systems. However, whilst collaborative processes supported a new sense of *power with;* wider policy, economic and political contexts set the rationales and conditions within which changes were instituted.

The two case studies were successful in instituting changes at individual, local community, organisational service and organisational cultural levels. The extent to which staff and service users could critique, challenge and change institutions and policy trajectories was a contingent process where people needed to 'rock the organisational boat without falling out' (Meyerson, 2001: 8). Combining this article's theoretical analysis with case comparative analysis, has enabled a series of questions to be developed to support practitioners who want to use co-production processes to consider different power dynamics within these processes.

Figure 1. Understanding power dynamics in co-production and co-design processes HERE

Wider strategic actions may be needed to create opportunities for change at a broader structural level, as the institutional context of these processes may limit the extent to which they can create wider political contestation. This helps to explain critiques of co-production at a discursive level of analysis (e.g. McGimpsey, 2016), as collaborative mechanisms tended to operate at a level where participants held some power to be able to instigate social changes.

The participants involved had little power to be able to challenge or change policy, neoliberal economic structures or austerity drives. Here, the involvement of national social movements, trade unions and policy makers may support a wider force for change, illuminating different possible paths for the development of public services that are based on more equitable relations between service users and staff.

Conclusion

This article has critically reflected on the consequences of the mainstreaming of co-production in policy and how this links to practice. It has analysed co-production and co-design processes and outcomes using a multi-dimensional understanding of power. Realist social theory has supported an analysis of the complex interplay between structures, people and social interactions within co-production processes, illustrating how different dimensions of power may operate within co-production.

When asking people about their own experiences of co-production processes, there is clear potential for empowerment and transformative agency. However, truly equalising power was difficult to achieve within uneven hierarchical structures, social inequalities and service users' dependence on organisational services. People's lived experiences were mostly positively impacted, however structural changes were generally small scale (Donetto et al. 2014; Clarke et al, 2017). The processes did not challenge political inequalities at a structural level; focusing on more specific ends of service and community-based improvements.

Adopting co-production and co-design techniques provides no guarantee that equal partnerships will be enabled between staff and service users. Constant critical reflective practice and dialogue is essential to facilitate relational processes that can empower and enable, and challenge dominating relations and practices.

Disclaimer

The views expressed are those of the author and not necessarily those of the case organisations, the National Health Service (NHS), the National Institute for Health Research (NIHR) or the Department of Health.

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Figure 1. Understanding power dynamics in co-production and co-design processes

WHO IS INVOLVED IN CO-PRODUCTION?
Involving public participants
o Are a diversity of public participants involved? Who may be excluded from conversations? How can their perspectives be included and accounted for?
o Are volunteers taking on previously paid staff roles?
o Are participants being paid appropriately for their time and skills?
Involving staff
o Are a range of hierarchical levels of staff involved?
o Are staff given time to get involved or are they expected to contribute in their own time?
o Which senior leaders can promote these co-production practices? Which key people can help to facilitate change? How can their own interests catalyse their involvement?
Involving other organisations
o Could trade unions be involved as partners?
o What service user organisations and movements could be involved?
o Who else may have skills, resources or knowledge in the area of interest to support collaborative goals (e.g. research, policy, third sector organisations)?
SOCIAL INTERACTION
o Can staff and service users speak freely about their experiences?
o What techniques can be used to help see others' perspectives and values?
o Are involvement methods accessible?
• What language is used? Can people express themselves in their own ways? Are diverse forms of knowledge included?
• How are agendas agreed? Do professionals cede control? How are conflicting priorities managed? Can common ground be identified?
• Are a range of venues and types of activity used to involve different people? Can different activities facilitate connections between different people?
• What barriers to involvement exist and how might they be reduced?
• Who is disengaging with the process and why?
o How is trust developing between different partners?
o How can people's skills be developed? To what extent are the processes empowering people?
o How does collaboration enable challenging of wider structural inequalities?
WORKING WITHIN AND ACROSS INSTITUTIONAL STRUCTURES
o Where can collaborative processes build bridges to connect people from different contexts and institutions, to work together to achieve shared goals?
o What organisational or policy priorities and resources can be harnessed to promote changes?
o How can bureaucratic structures, resources and roles be used to enable and empower people, as opposed to constrain action?
o How can hierarchical positions be used to share power and enact changes?
o At what institutional levels is co-production working at? (e.g. community/ service/ policy)
WHAT CHANGES DO PEOPLE MAKE BECAUSE OF CO-PRODUCTION?
o How are people's values and motivations connected with to generate a sense of personal agency to create changes?
o Do processes enable collaboration and *power with*, so people can instigate change?
o Are actions challenging oppressive or paternalistic practices?
o Are senior staff/ managers/ policy makers involved in implementing solutions?
o Is co-production more rhetorical with little transfer of power, or impact?
o What wider political and structural issues may be setting the conditions of possibility for change? Can any actions bear pressure on these?
o Are power and resources being transferred from organisations to people who use services?
o How can co-production and co-design be embedded into everyday practice and systems?