GOVERNING THE HEALTH COMMONS:

AN INSTITUTIONAL ANALYSIS AND DEVELOPMENT (IAD) FRAMEWORK ON HEALTH DEVOLUTION IN GREATER MANCHESTER

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GOVERNING THE HEALTH COMMONS: AN INSTITUTIONAL ANALYSIS AND DEVELOPMENT (IAD) FRAMEWORK ON HEALTH DEVOLUTION IN GREATER MANCHESTER

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“The NHS will last as long as there are folk with the faith to fight for it.”

- Aneurin Bevan, founder of the NHS

Abstract

In 2015, Greater Manchester (GM) has landed a landmark devolution deal in health with the government. National Health Services (NHS) England agreed to delegate some functions to the city-region, including strategic planning and administrative responsibilities. The GM Health and Social Care (GMHSC) Partnership was established in order to bring together local authorities, NHS organisations, and community-based institutions and to provide strategic direction and make collective decisions on behalf of the overall GM health and care economy. Using collective action, common property regimes, and collaborative governance as theoretical lens, this research argues that health systems leaders of a regional can come together as a collective unit and act as stewards of their health commons. They can devise institutional arrangements and use collaborative mechanisms in order to address collective action dilemmas and address the sustainability issue of the health commons.

This research proposes an alternative solution in managing and sustaining the NHS. It aims to explore how formal and informal institutions emerged as a response to collective action dilemmas in the context of the Health Devolution policy and GMHSC Partnership. Using a qualitative approach, we used the Institutional Analysis and Development (IAD) framework to explore the role of rules and how they emerge as a response to collective action dilemmas, and how the (in)formal institutional arrangements facilitate and influence the interaction of the actors. Our findings suggest that the Partnership demonstrated that with the right combination of leadership, trust, and collective intention to resolve joint problems, then it is possible to overcome the political barriers of Devolution. They were able to successfully craft, enforce, and monitor their own institutional arrangements to overcome the limitations of the formal rules and to use them as countermeasures to self-seeking behaviour.

Abbreviations

A&E	Ambulance and Emergency
ACO	Accountable Care Organisations
AGMA	Association of Greater Manchester Authorities
CCG	Clinical Commissioning Groups
CPR	Common Pool Resources
CQC	Care Quality Commission
CSR	Comprehensive Spending Review
CVO	Centre for Voluntary Organisations
Devo Health	Health Devolution
Devo Manc	GM Devolution Agreement
Executive	Partnership Executive Board
FEG	Finance Executive Group
FT	Foundation Trusts
FYFW	Five Year Forward View
GDP	Gross Domestic Product
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
GMCC	Greater Manchester City Councils
GMHSC	Greater Manchester Health and Social Care
GP	General Practitioners
HCB	Health and Care Board
HEE	Health Education England
HSC	Health and Social Care
HSCA	Health and Social Care Act
HWB	Health and Wellbeing Boards
IAD	Institutional Analysis and Development
ICS	Integrated Care Systems
JCB	Joint Commissioning Board
LA	Local Authorities
LCO	Local Care Organisations
LEP	Local Enterprise Partnership
LMC	Local Medical Committees
MoU	Memorandum of Agreement
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NSF	National Service Frameworks
Partnership	Greater Manchester Health and Social Care Partnership
PCAG	Primary Care Advisory Group
PCG	Primary Care Groups

PCT	Primary Care Trusts
PFB	Provider Federation Board
PHE	Public Health England
PMO	Project Management Office
QSG	Quality Surveillance Group
SCN	Strategic Clinical Networks
SHA	Strategic Health Authorities
SPB	Strategic Partnership Board
SPBE	Strategic Partnership Board Executive
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Partnerships
Taking Charge	GM Strategic Plan
TF	Transformation Fund
TFOG	Transformation Fund Oversight Group
ToR	Terms of Reference
UK	United Kingdom
VCSE	Voluntary, Community and Social Enterprise

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1 Introduction

1.1 Introduction

This chapter outlines the background of the study and why it is important in the policy context, followed by the supporting theoretical assumptions that will guide the thesis. We then highlight the rationale of the study and enumerate the research objectives needed to be addressed. The chapter concludes with a section on the summary of each chapter in the thesis.

1.2 Background of the study

This thesis investigates how formal and informal institutions emerged as a response to collective action dilemmas in the health policy context. We apply this in the Health Devolution (Devo Health) context in Greater Manchester (GM), where we posit that health system actors, such as local authority (LA) leaders, local National Health Service (NHS) providers, voluntary and community groups, etc., can come together and act as stewards of their own local health and social care (HSC) economy as a response to the need for sustaining their resources.

Analogous to the conceptualisation of the commons, we recognise that health resources can be devised as a shared property between those who benefit from it, where those said individuals (or organisations) can function as semi-autonomous communities and craft their own rules to monitor who, what, and how to appropriate from it. This research suggests that we can compare these conditions similar to that of governing common pool resources (CPR), where self-organising communities formulated institutional arrangements in order to limit free-riding behaviour and to shape the incentives of those who benefit from the shared resource. McGinnis and Brink (2012) demonstrated in a pioneering study in the health commons that a health care community in Grand Junction, Colorado was able to generate positive health outcomes by managing

their own resources, exerting influence over collective decisions on how to allocate their shared resources, and creating parameters and governing structures to moderate multisectoral relationships. These group of leaders formed a collaborative governance, where they have a collective responsibility of overseeing the health commons and make decisions on behalf of its population to ensure that the resource will be sustained for later use.

Following the success of this study, we aim to replicate the findings of McGinnis and Brink's (2012) study and apply it in the United Kingdom (UK) health context, which has never been explored before. Whilst there has been a wide amount of research addressing how and why we should sustain the health resources in the UK through a plethora of state-led policies, place-based approaches, and/or partnership working (Alderwick, 2015; Ham and Alderwick, 2015; Ham, 2018a), empirical evidence using a collective action and institutional approach to regional stewardship of managing a particular segment of the NHS remains unexplored.

There are several reasons why we should examine these conditions and why we are interested in exploring this phenomenon. This is outlined as follows.

1.2.1 Sustainability of the NHS: not enough fish in the sea

When the NHS was established in 1948, it advocated for free (at the point of use) comprehensive health care services to all UK citizens funded primarily by general taxation (Gorsky, 2008). For as long as we know, it has been a universally admired institution that offers “one of the best and most cost-effective health services in the world” (British Medical Association, 2018b:2). However, this has not been the case over the last two decades. It has been well-documented that the top-down centralised and hospital-based model of care established in 1948 is no longer adequate to fit the fast-growing population and ever-changing needs of the UK population (Department of Health, 2016; NHS England, 2017; The King’s Fund, 2017; British Medical Association, 2018b).

The NHS has been under enormous financial pressure to sustain quality care and keep up with the rising demands. Recent figures indicate that it is predicted from 2019-2020 to 2023-204 that health spending will increase by 3.4% a year on average as a result of the growing ageing population, increasing prevalence of chronic conditions, and the rising costs of delivery of care (National Audit Office and Department of Health & Social Care, 2019). However, over the last decade, there has been an overall slowdown in the growth of NHS funding as a proportion of the UK's Gross Domestic Product (GDP) dropping from 7.6% in 2009-2010 to 7.2% in 2018-2019 (The Health Foundation, 2019). As the NHS budget continues to tighten due to austerity measures, this resulted in a negative impact on access to services and quality care. NHS trusts and CCGs are spending more than their income, whilst Accident and Emergency (A&E) departments continue to miss their targets (National Audit Office and Department of Health & Social Care, 2019). These narratives posed unprecedented risks to the sustainability of the NHS and whether the government is doing enough to make sure that the NHS will still be alive and standing for the future generations.

Whilst the NHS is incomparable to any natural or man-made CPR, the logic of sustaining the commons is still applicable. Alderwick (2015) explained that the public draws from a pool of resources, such as health services, human capital, and estates, being provided by the NHS. The providers of NHS services, on the other hand, are only provided a limited set of these resources that is being paid for from an allocated national budget. Over time, these resources will run out and we should be thinking about other ways of managing the NHS in order to sustain it. In 2014, NHS England released a strategic document called Five Year Forward View (FYFW) to address the sustainability issues by promoting new models of care, such as the integrated care systems (ICS), in order to reduce costs and encourage collaboration across different parts of the HSC system through shared pooled budgets between local councils and CCGs, joint governance structures, and joint planning responsibilities (NHS England, 2014;

Checkland et al., 2015). However, our research believes that we could offer an alternative perspective to addressing the problems on sustaining our NHS.

1.2.2 Is governance the answer to fragmented health systems?

Governance has played an increasingly important role in health care systems. Amongst many issues, debates have centred around health governance as a prescription for institutional reform (Ramesh et al., 2013; Vian and Bicknell, 2013), transformation of organisational performance (Lockett et al., 2012; Shen and Snowden, 2014), collaboration between providers and decision-makers (Abimbola et al., 2014; Marais and Petersen, 2015) and corruption within global health programmes (Brinkerhoff and Bossert, 2008; Avelino et al., 2013). The concept of governing health care resources is not new. It is arguably the most complex but critical building block of any health system (World Health Organization, 2007). Studies have acknowledged the role of governance as a key contributor to the improvement on performance and health outcomes (Brinkerhoff and Bossert, 2013), and the various mechanisms that facilitate the implementation and delivery of an effective health system (Mikkelsen-Lopez et al., 2011; Cleary et al., 2013; Pyone et al., 2017).

Ultimately, NHS England[1] is the governance in charge of looking after the health systems in England. It was established as part of the Health and Social Care Act (HSCA) 2012 where it functioned as an arm's length and executive non-departmental public body of the Department of HSC (NHS England, 2013). This centralist model of hierarchy, where there is a central decision-maker on behalf of the population, has been promoted since the NHS was initially established in 1948. Competition and market principles were then introduced in the 1990s, which led to the purchaser-provider split and fragmented

[1] NHS England must not be confused with the overall NHS system. NHS England refers to the governance body overseeing the health system in England; whilst the NHS is the publicly funded national health care system of the UK.

delivery of care. This continued until the early 2000s before partnership working and collaborative models were promoted in 2010s to adopt to the changing needs on managing the HSC system. Literature suggests that the multiple dramatic restructuring of the NHS governance over the last two decades were catastrophic and resulted into a more complex system (Timmins, 2008; Ham et al., 2015). Ostrom et al. (1961:831) described this setting as polycentric, which connotes “many centres of decision-making that are formally independent of each other where there are overlapping domains of responsibilities”. The impacts of these reforms bring us to the question whether there is an alternative solution to effectively managing and governing the health systems.

1.2.3 The role of institutions in health governance

Studies have suggested that the perspective on stewardship governance can be better analysed through the institutionalist approach, where governance focuses on the role of institutions and how they shape interactions within diverse players and organisations (Chhotray and Stoker, 2008a; Pyone et al., 2017). Health governance frameworks highlight the importance of governance in explaining how health systems function and achieve desired health outcomes; however, there is a limited capacity to conceptualise the patterns of interaction of the complex system of actors involved in it.

Governance is influenced by the rules that distribute roles and responsibilities among societal actors and shape the interaction among them (Rhodes, 1996). These rules are referred to as institutions and they shape the way actors in a governance interact. By applying an institutional approach to health governance, it takes into account the formal and informal institutions in determining the arrangements and rules set by governmental and non-governmental health organisations and how these impacts the delivery of health services and outcomes (Abimbola et al., 2017).

Efforts to understand the role of governance in health care system in an institutional approach, however, have been limited. An institutional approach to governance not only

examines the role of the actors in the system, but rather embraces the range of formal and informal institutions that can determine how to govern the health care system (Mikkelsen-Lopez et al., 2011; Abimbola et al., 2017). For example, Abimbola et al. (2014) examined the role of institutions in primary health care systems in Nigeria using a multi-level governance framework. Using the theory of common pool resources to understand how primary health care services in Nigeria can be preserved and sustained, the framework emphasised the institutional approach to not only focus on structures, but also on the rules on demand and supply of collective actions of government and non-government actors. Similarly, Mikkelsen-Lopez et al. (2011) prescribed a governance framework for a health system steward, where consensus was sought by both state and non-state actors through co-producing decisions and participation in policy design.

An institutional approach to assessing governance focuses on a rules-based approach, where it maps out how key decision-makers affecting behaviour and decision-making in the health systems, and also to understand the formal and informal arrangements that shape the interactions in the context (Lockett et al., 2012; Abimbola et al., 2017). For example, Fattore and Tediosi (2013) investigated the role of culture in promoting universal health coverage. It suggested that cultural and societal values cultivate the idea of 'group identity', which is helpful in the possibility of the success of the willingness to adopt universal health coverage. Gilson (2003), Bloom (2011), and Baez Camargo and Jacobs (2013) highlighted the significance of informal institutions (i.e. trust, respect, social capital, etc.) in various settings (i.e. rural areas, low-income communities, etc.) where formal rules were not effectively applied. Both Gilson (2003) and Bloom (2011) posited that in low-income rural communities, establishing trust between patient and provider is highly crucial. This relationship mattered more to vulnerable patients or those who are less educated because of their associated level of needs and risks. On the other hand, Starke (2010) did not dismiss the role formal institutions in health governance, where highly centralised policy communities, like the

New Zealand health care systems, were prone to structural reforms. Partisan ideologies existed predominantly, and this potentially influenced the legislations and decisions of the governments who were in charge of stewardship of the health system.

1.2.4 Devolution: a panacea?

The UK government has had a contentious history of devolution, characterised by a variety of experimental policies as an attempt to rescale territorial governance and redistribute powers across different levels of regional and local governments presented (Pearce et al., 2005; Pike et al., 2017; Shaw and Tewdwr-jones, 2017). The implications of the devolution to Scotland, Northern Ireland, and Wales were vital to the future of the English local governance. First, it triggered a search for an alternative to recalibrating the relationship between centre and subnational governments. Second, the modernisation and regional policies of the New Labour government ignited a focus on urban regeneration through community-level decision-making in England. Lastly, it created pressure to address spatial disparities and increase accountability to Westminster by decluttering the current regional structures (Sullivan et al., 2004; Pearce and Ayres, 2012; Fenwick, 2015).

In a ground-breaking move, GM has landed a landmark devolution deal with the government. In addition to a directly elected mayor and delegation of powers on planning, land, transport, and fire services, the government and NHS England agreed to devolve over £6 billion in health and care spending to ensure joint planning responsibilities of these services can deliver better care for the population of the conurbation. This introduced new arrangements in the health governance structure through the Greater Manchester Health and Social Care (GMHSC) Partnership, which aimed to provide strategic direction to the overall development of the GM health and care economy and to cement the responsibilities, accountabilities and decision-making roles of the key and stakeholders. With the Partnership making up of relevant public, private, and community-based organisations, this has raised fundamental questions on who will

take charge, how far could health devolution go, what are the risks and how will it be managed, and what are the national implications of this initiative (The King's Fund, 2011; Quilter-Pinner, 2016).

1.2.4.1 The Devolution deals

As part of the Spending Review in 2015, George Osborne, former chancellor of the exchequer at that time, invited cities and non-metropolitan areas across England wanting to agree a devolution deal to submit proposals (Local Government Association, 2012). With the Northern Powerhouse movement fuelling the momentum for English devolution post-Scottish referendum in 2014, the Cities and Local Government Devolution bill was announced on 2015 to legitimise these efforts. It provided a legislative framework for the creation of a directly-elected mayor of a combined authority to exercise additional functions including transportation and police, with the aim of working across a wider geographical reach and create economic growth. It also detailed how local government structures are to be altered in order to grant some public authority functions to a combined or local authority (For in-depth details, see Communities and Local Government (2015, 2017) and Sandford (2017)). With over 30 submissions put forward, 10 areas (i.e. Cambridgeshire; Cornwall; Greater Manchester; Liverpool city region; London; North of Tyne; Sheffield city region; Tees Valley; West of England; West Midlands Combined Authority) have been successful. Following the ratification of the *Cities and Local Government Devolution Act 2016*, several other city-regions received a devolution deal (see Table 1 for an updated list).

Table 1: Devolution deals to date

	DEVOLUTION DEAL AGREED		
GREATER MANCHESTER	2014	November	Health July 2015
SHEFFIELD CITY REGION	2014	December	
WEST YORKSHIRE	2015	March	
CORNWALL	2015	July	
NORTH EAST	2015	October	Rejected

TEES VALLEY	2015	October	
WEST MIDLANDS	2015	November	
LIVERPOOL CITY REGION	2015	November	
LONDON	2015	December	Health
WEST OF ENGLAND	2016	March	
GREATER LINCOLNSHIRE	2016	March	Rejected
CAMBRIDGESHIRE AND PETERBOROUGH	2016	June	
NORFOLK AND SUFFOLK	2016	June	Rejected
NORTH OF TYNE	2017	November	
SURREY	2017	June	Health

1.2.4.2 Greater Manchester health devolution

The GM Devolution Agreement (or 'Devo Manc') set out further devolution of powers on planning, land, transport, and fire services, and the changing governance of the Greater Manchester Combined Authority (GMCA) to introduce new arrangements for a directly-elected mayor in 2017 (Communities and Local Government, 2017), making it the first of its kind outside London. This was monumental for GM, especially after decades of close political cooperation and joint working between the 10 LAs through various governance arrangements (Walshe et al., 2018). Whilst the negotiation stages were conflicted with the absence of public consultation (Jenkins, 2015; Prosser et al., 2017; Ayres and Bird, 2018) and the lack of enthusiasm for a directly-elected mayor (Deas, 2014; Gains, 2015), GM swiftly secured the Devo Manc agreement.

This became a catalyst for a supplemental devolution deal, focusing on developing a business plan for the integration of health and social care provision across GM (GMCA, 2016b). In February 2015, the government and NHS England also agreed to devolve over £6 billion in health and care spending to ensure that joint planning responsibilities of these services can deliver better care for the population of the conurbation (GMCA, 2016a). A Memorandum of Agreement (MoU) was signed between representatives from the Association of Greater Manchester Authorities (AGMA), NHS England, and the GM

Clinical Commissioning Groups (GM CCGs) to secure the devolution of all health and social care funding to Greater Manchester. Under this initial agreement, primary care providers (such as general practitioners or GPs) were not formally included, although letters of support were present from the GM NHS Trusts, Foundation Trusts (FTs), and North West Ambulance Service.

To provide strategic direction and govern to the overall development of the health and care economy of the city-region, the GMHSC Partnership was established to cement the responsibilities, accountabilities and decision-making roles of all key stakeholders (i.e. 10 local authorities, 12 CCGs, 15 NHS trusts and foundation trusts, and NHS England). This ground-breaking move was done at speed and without much public debate between the Treasury, NHS England, and key local government and NHS leaders (Jenkins, 2015; Walshe et al., 2016). It was considered as “a late and dramatic extension of the already ambitious devolution deal” by some (Walshe et al., 2016:2), given that GM is one of the only two city-regions in the country to bid for significant powers to control its own health and social care system at that time; Surrey and London being the other.

Although such arrangements usually require statutory or legislative changes to define the extent and scope of devolved powers, nothing changed in terms of existing accountabilities and structures within the NHS system. Some described the devolution as an illusion, due to the absence of legislative force to enact the full transfer of responsibilities to GM (Quilter-Pinner, 2016; Walshe et al., 2016). In fact, it was more of a delegation of NHS England responsibilities that fell in the hands of the Partnership, which controversially mirrored NHS England’s Sustainability and Transformation Partnerships (STP) (University of Manchester, 2016).

With the goal of improving the overall health outcomes of the 2.8 million population and to reduce health inequalities within GM and between GM and the rest of the country,

GMHSC is now in charge of steering the GM health economy towards this path. It is currently in its final phase of implementation and delivery of ‘Taking Charge’, which is the strategic plan dictating the reform themes that key GM partners will collectively focus on. With 4 years now since Devolution has started, the governance surrounding the GMHSC continued to evolve over time, where a lot of institutional architecture is involved to reconfigure the system to engage various stakeholders in working collectively.

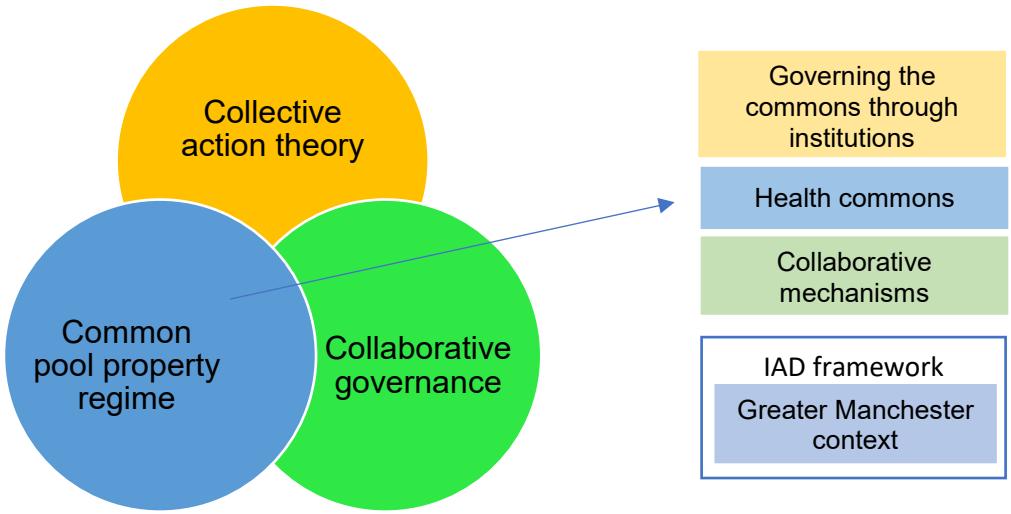
1.3 Rationale of the study

Given the context of the need to address the sustainability of the NHS, complemented by the ongoing political discourse to promote regionalist Devolution policies in English local governance, this research wants to propose an alternative perspective in managing and sustaining the health commons. Our policy review showed that the UK has used a plethora of centralist, market, and collaborative as an attempt to modernise regional policies, apply territorial fixes, and restructure the fragmented relationships between the centre and subnational governments. With the latest Devolution policy fuelling the full-scale localism agenda of the Coalition government, we want to examine whether the unique case of Greater Manchester can be used as a pioneer model to future decentralisation policies of NHS functions across England. Greater Manchester already possesses the key ingredients to constituting a strong policy; however, we wanted to examine their success (or lack thereof) and look at it from a different perspective. By applying the study on the health commons, we want to explore whether Greater Manchester is able to resemble the conditions analogous to Ostrom's design principles and create institutional arrangements to govern their health commons.

Moreover, one of the key objectives of this thesis is to extend the theoretical framework on the commons, theory of collective action, and collaborative governance, and apply it in the health policy context. The concept of the health commons has remained unexplored and has only been limited to the US health care context. Although

the UK and US health care systems differ in many aspects, they both share the problematic narrative on addressing their dwindling finite resources and financial sustainability. By applying an institutional approach to examining the health commons in the UK setting, we make a theoretical contribution to this research gap (Figure 1).

Figure 1: Addressing the research gap



1.4 Theoretical framework

This research argues that health care professionals, community service organisations, private organisations, and public officials can effectively act as stewards of their local health care resources and manage them by devising, enforcing, and monitoring their own institutional arrangements to address collective action dilemmas, i.e. sustainability issues. In order to address this, we use the theory of common pool resources, theory of collective action, and collaborative governance to guide the framework of the thesis. Our key assumptions are the following: first, organisations benefiting from a shared resource can form a collaboration to collectively govern their commons; second, a group of leaders can act as stewards of their own commons and make collective decisions on behalf of their population; and finally, stewardship of the health commons can craft, enforce, and monitor formal and informal institutional

arrangements to facilitate the decision-making process, shape the behaviour and incentives of the participants, and to constrain the access to the resource.

1.5 Research questions

The aim of this research is to offer an alternative perspective in managing the health commons by crafting and monitoring institutional arrangements to address collective action problems. This research explores the role of the institutions and how it emerged as a response to collective action dilemmas, how the formal and informal institutional arrangements influence the interaction of the actors within this collaboration, and how the actors make, change, monitor, or enforce these rules.

1.5.1 Research objectives

- To extend the theory of collective action and common property regimes and apply them in the health policy context
- To examine the contextual factors that enhance and/or hinder decision-making, and motivate collaboration and interaction between multiple actors across a fragmented, polycentric system
- To evaluate the collaborative and institutional mechanisms in place to resolve collective action dilemma

1.5.2 Research questions

1. Under what circumstances can collaborative governance mechanisms create a system of stewardship in governing the health commons?
    a. What are the external factors that influence decision-making bodies to collaborate and act as a collective unit?
2. What are the formal and informal institutions that emerged as a response to collective action dilemmas?

a. What are the rules-in-form (formal) and rules-in-use (informal) that were formulated?
b. How are they crafted, monitored, and enforced?

3. How are institutional arrangements influencing the different levels of collaborative processes in the governance of the health commons?
    a. How is the interaction of formal and informal institutions affecting the different levels of relationships between the participants?
    b. How are the rules-in-use (informal) utilised to facilitate the relationships within the collaborative governance?
    c. What are the collaborative mechanisms used by the decision-makers to enforce collective action?

1.6 Research design and methodology

In order to address the objectives of this research, we employ a qualitative approach. We particularly use case study methods to focus on the context of Greater Manchester's Health Devolution policy and unpack the collaborative governance mechanisms that emerged in order for them to govern their own local health economy. A combination of interviews and documents were examined to evaluate the collaborative and institutional mechanisms in place to resolve their collective action dilemma. The data was triangulated and analysed using the framework approach.

We identified the Institutional Analysis and Development (IAD) framework as the analytical tool to assist us in organising the complex situations that occurred to establish the institutional arrangements that emerged before, during, and as a result of the collective action in governing the health commons. We particularly take advantage of the explanatory power of this framework to investigate the institutional arrangements associated with collective action efforts. Moreover, we use the IAD's multiple levels of analysis to be able to compare how the rules obtained from one level affect the rules

configuration of the proceeding level. This advantage enabled us to extend the application of the IAD framework in the health commons setting.

1.7 Summary of the chapters

This thesis aims to theoretically and methodologically contribute not only on the study of the commons, but also to the conceptualisation health commons and the application of rules configuration as a response to collective action dilemmas. The thesis is organised as follows.

In Chapter 1, we examine the background of the study and establish the grounds as to why this research is important. We identify the research objectives and research questions, along with the theoretical framework that will guide us throughout this thesis.

In Chapters 2 and 3, we conduct a twofold review of the theoretical literature and the policy background of the health commons. Chapter 2 aims to examine the theoretical foundations pertinent to understanding what the common is and the role of institutions in governing the commons. We explore the literature to identify the theoretical assumptions that will guide the framework of the thesis. It covers the theory of collective action, the conceptualisation of the commons and the common pool resources, the responses to collective action, the role of institutions, the different mechanisms from an empirical review of the literature, and the working elements of the IAD framework. We continue to Chapter 3 with our conceptualisation of the health commons and its applicability to the context of the NHS and English local governance. We unpack the contextual background and the institutional evolution that led to the current polycentric state of the NHS and the oscillating reforms of centralist, regionalist, and localist approaches in the local English governance setting. Both chapters set up the necessary concepts and theories needed to guide our understanding on the institutional arrangements that led to the emergence of Devo Health and GMHSC Partnership.

In Chapter 4, we address the chosen research design and methodology of this study. Using a critical realist approach in qualitative research, we identify the rationale as to why case study methods is appropriate in examining GMHSC Partnership. We looked at the methodological approaches in the study of the commons and institutions and used these to justify our chosen resign design. Our tools for data collection and data analysis are detailed in this chapter, including the recruitment process and ethical procedures.

In Chapter 5, we analyse the external variables or existing pre-conditions that led to the Devo Health in GM. We focus in identifying the factors that were critical during the initial stages (negotiation and formalisation) of the Partnership. First, we identify the physical attributes of the health commons in question. Second, we examine the community attributes that reflect the shared norms between the participants. Lastly, we explore the initial set of rules that were established to prepare the operation of the Partnership. These three factors altogether constitute the antecedents that shape the impetus to collaborate and the starting conditions that are necessary to establish a collaborative governance. This chapter directly addresses the first research question.

In Chapter 6, we examine the action situation, which is the centrepiece of the IAD framework. It draws together the exogenous variables identified in the previous section and how the actors of the Partnership used these to organise their behaviour in making decisions and strategies, creating patterns of interaction, navigating through the system, and generating outcomes. In this chapter, we identify the various rules configuration that the Partnership created in order to facilitate their interaction within the decision-making arena. This chapter directly addresses the second research question.

In Chapter 7, we examine the outcomes and implications of the GMHSC Partnership as stewards of the commons as a result of the external factors, formal and informal institutional arrangements, interactions, incentives, and sharing of information that shaped their behaviour within the collective action arena. This also rounds up the

empirical findings from Chapters 6 and 7 using the multiple levels of analysis. This chapter directly addresses the third research question.

We end this thesis in Chapter 8 where we summarise the overall findings of the research and identify its contribution to addressing the research gap. We highlight the implications of the findings to future studies and also recognise the limitations of this study.

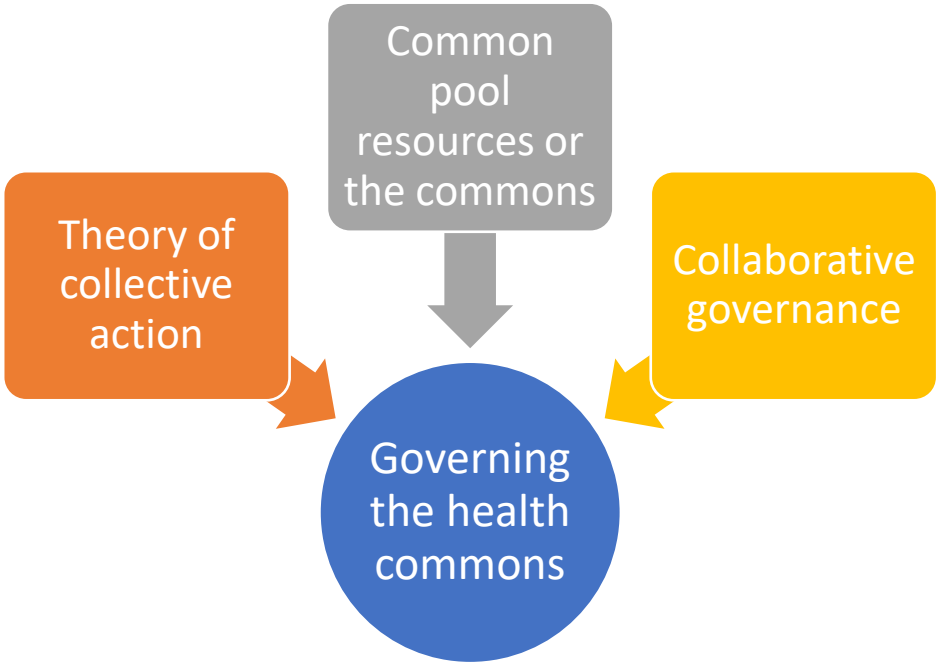
2 Literature Review

2.1 Introduction

This thesis is concerned about how organisations benefiting from a shared resource decide to collaborate by crafting formal and informal institutional arrangements to facilitate their decision-making process. The purpose of this chapter is to examine the theoretical foundations pertinent to understanding what the common is and the role of institutions in governing the commons, and to explore the literature and the theoretical assumptions that will guide the framework of the thesis. In order for us to situate the justification behind the health commons and how users can come together to protect it given some costs and benefits, we look at how these theories were applied in the study of the commons and how it was tested, evaluated, and replicated across a variety of contexts and fields of studies.

According to Ostrom (2011), development and use of theories make the necessary working assumptions relevant to answering particular questions, to diagnosing a specific phenomenon, to explaining processes, and to predicting outcomes. We particularly explore three key areas of literature in order to understand how institutions emerged as a response or mechanism to the collective action dilemmas. First, we examine theories that will help in building and supporting the mechanisms of our theoretical framework, particularly theories influencing individual behaviour: the theories of rational choice, bounded rationality, and collective action (Figure 2). Second, we look at the responses to resolving collective action dilemmas. We then map out the evidence from empirical literature regarding the different mechanisms used to address collective action dilemmas that are also found in collaborative governance settings. Lastly, we introduce the Institutional Analysis and Development (IAD) framework as the analytical tool that links all the conceptual variables identified from our literature search.

Figure 2: Theoretical framework



2.2 Underlying theories in understanding collective action dilemmas

This section examines the underlying theories on the study of the commons, particularly the foundations that will direct the assumptions of this study. Moreover, it aims to understand how and why individuals or organisations behave the way they do when faced with a collective action dilemma. Earlier scholarly views in economics used the expanded typology on the types of goods and their characteristics (e.g. theory in public goods economics) to determine the different types of individual incentives that motivate potential users from consuming them. Through organisational models of firms and human behaviours (e.g. rational choice models), various conditions were examined to identify how individuals react to accessing different types of goods and how it leads to market failure (or sustainability) if they continue to behave in a certain way. This

eventually became the basis of many debates and interpretations on how to efficiently manage and consume the commons.

2.2.1 The narrative of the commons

We begin our argument by identifying a shared sustainable resource system – let's say a water source, e.g. river. We shall refer to this as 'commons', to which members of a group share access to this resource (McGinnis, 2018:281). Let's say this water source is located geographically between the border of two small communities – town A and town B. In this context, shared access does not necessarily mean that each individual in the town claims to own any portion of the resource; but rather, a shared access for their own personal benefits or private use (Hardin, 1968). Both towns use the water source to supply their daily needs, such as watering the plants or cooking food, but neither of them monitors how much one takes nor who gets how much. Neither of them also takes into account what happens if the water source depletes or if they should look for an alternative source. Over a period of time, as more people appropriate from the resource, there is a higher risk of the water source becoming unavailable for future use as it continues to deplete.

There are a number of ways on how individuals may behave or react to this problem. Those benefiting from the resource now face a dilemma. People collect and use the water without thinking if there is enough left for their neighbour to use, or if there will be enough left for the two towns in a decade's time. Rational theorists would argue that individuals behave out of their self-interest and do not realise the collective implications of their actions in the future. This economic approach to understanding human behaviour posits that individuals act to maximise their long-term best interest and utility based on the best available information (see Becker, 1976). Their initial reaction is to get the maximum amount of gains without having to cooperate in overcoming the impeding dilemma. This behaviour eventually leads to the overuse and the degradation of the

resource, resulting into what policy scholars refer to as the “tragedy of the commons” (Hardin, 1968). Based on this scenario, there are a couple of theoretical arguments we need to examine. We explore scholarly explanations on how and why individuals behave this way, and what they should to resolve this type of dilemma.

2.2.2 Public goods economics

We look at earlier views on the nature of goods and consider the consequences that may arise on its overuse. Borrowing from neoclassical economic theories, Samuelson (1954) introduced two categories of goods. Private goods are excludable (i.e. individual can be prevented from consumption unless it's been paid for) and rivalrous (i.e. individual consuming this good keeps another individual's from consuming it), such as bread and shoes. Public goods, on the other hand, are non-excludable (i.e. excluding other people from consuming the good is difficult to attain) and non-rivalrous (i.e. a person using this good does not prevent others from using it), such as national defence. In his essay *The Pure Theory of Public Expenditure*, Samuelson (1954) argued that given optimal conditions of production, there is a Pareto efficient bundle[2] of private and public goods to which not one person can be made better off without making someone else worse off.

The characteristics of these goods (i.e. excludability and rivalry) enabled the creation of market arrangements to meet the demands of production. Delivery of private goods was organised through market transactions, whilst public goods were delivered through government intervention via imposed rules (Ostrom and Ostrom, 1977). Moreover, coordination was required to govern economic relationships and impose a command structure, through competition within the markets and accountability within the public sector.

[2] See Stiglitz, 1987

Adam Smith and his early works (1759, 1776) argued that one of the functions of the government is to be in charge of the provision and maintenance of public goods, such as public roads, health care, and education. He discouraged the profit-maximising firms in the market and wanted to promote a free market system where all classes of society benefit from their own self-interests. He also believed in the “invisible hand” where markets are free to buy and sell amongst themselves without the government having to intervene on the market prices (see Smith, 1776). The problem with public goods, however, is its excludability criteria, which makes it more difficult to exclude others from enjoying it. Individuals are then tempted to “free ride” on the efforts of those who contribute to the provision of the good, causing market provision and welfare gains to decline (Anomaly, 2015).

Policy scholars have attempted to empirically demystify the free-rider problem and how governments addressed them in various scenarios. Studies in public transportation, for example, found that deliberate fare evaders are rampant especially in transports systems where ticket controls are eliminated for cost efficiency (Barabino et al., 2015; Delbosc and Currie, 2016). The system created incentives for individuals to escape paying for fares because there was no monitoring system in place. This resulted in strategic motivations (Anomaly, 2015; Grandjean et al., 2018), where individuals engage in different behaviours based on finitely repeated interaction. Grandjean et al. (2018) showed in a cooperative game that individuals reduce their contributions to the provision of a good when they interact with free riders; whilst strategic players contribute larger amounts during the initial periods to sustain mutually beneficial future for the cooperation, but gradually reduces it as the cooperative game ends.

Whilst some advocate for the free-rider problem to be addressed with government intervention (see *Welfare Economics*, Keynes, 1936) such as taxation of goods (Groves and Ledyard, 1977), some believe that not all free-rider problems warrant government

action (Coase, 1960; Pasour Jr., 1981). Alternative solutions included private ownership of the economy (Arrow and Debreu, 1954), altruism and institutions (Ostrom et al., 1994), and even an introduction to membership and property rights arrangements (Coase, 1960; Buchanan, 1965). For instance, Coase (1960) advocated that property rights arrangements can be introduced to address externalities and free-rider problems without having the state to intervene in the market transactions. Under certain conditions, beneficiaries can pool their resources together given that they bargain with zero transaction costs. Similarly, Buchanan (1965) also introduced “club goods” as a third type of good, where cooperative membership arrangements are set-up to enjoy goods that are non-rivalrous and exclude non-members those who do not contribute towards the maintenance of that good. By introducing an exclusion mechanism, this addressed the free-rider problem by turning public goods into club goods through membership arrangements. A common example is subscription to cable TV. The market can charge a price to deliver cable TV for access and use in order allow those who paid for it enjoy it as a collective. These theoretical accounts in public goods economics provide a normative justification on how to mitigate externalities resulting from free-rider problems.

2.2.3 Collective action dilemma

As individuals learned how to cope with the problems associated with managing goods, theorists challenged Samuelson’s two-fold classification of goods and proposed an expanded typology. As a contribution to the discourse, Ostrom and Ostrom (1977) proposed a fourth type of good, which is one of the tenets of this research. Common pool resource (CPR) is a sufficiently large natural or man-made resource (i.e. fisheries, forests, underwater basins, and irrigation systems) from which it is difficult to exclude or limit potential users from appropriation and its joint benefits. There is only a finite quantity of resources available for its users, which means that consuming a portion of these resources makes it less available for others – a subtractability property it shares with private goods; and alternatively, it is difficult and costly to exclude or limit the use of the

CPR to its users, making it non-excludable like a public good. These characteristics were used to classify a new way of managing resources, particularly drawing from the assumptions on public goods economics in addressing free-rider problems (Table 2) (Ostrom, 1999).

Table 2: Four basic types of goods

		Subtractability of use	
		Low	High
Difficulty of excluding potential beneficiaries	Low	Club goods	Private goods
	High	Public goods	Common pool resources

Source: (Ostrom and Ostrom, 1977)

Hardin (1968) argued that if all users of the CPR restrain themselves from using the resource, then the resource can be sustained. However, there is a level of difficulty in excluding users from accessing and usage of the commons – a characteristic that is shared with public goods – which eventually poses a potential free-rider problem. As examined by Grandjean et al. (2018), the efforts of those who contribute to improve the long-term sustainability of the resource is reduced as soon as the risk of a free-rider is identified. When the commons has no restrictions to appropriation (i.e. open access), individuals face incentives to appropriate more without wishing to contribute towards collective outcomes (Ostrom, 2005), which eventually result into congestion, overuse, or destruction of the resource itself. This was illustrated by Hardin's (1968) influential article on the “tragedy of the commons”, which was deeply rooted in the assumption that unrestrained norm-free individuals have no intentions of cooperating to overcome the

dilemma that they face and still exploit the commons for their self-interests and own benefits in the knowledge that everyone else would do the same. This situation is described as a **collective action dilemma** (or social dilemma, in some literature), where in the absence of effective management or mitigating institutions, interdependent individuals are faced with incentives to choose actions that will yield maximum individual benefits but generate inefficient aggregate outcomes collectively (Ostrom, 1990; Swann and Kim, 2018).

Let's go back to the initial narrative presented at the beginning of this chapter. The water source is being accessed and shared by two small communities, and if it is not effectively sustained and/or managed, there is a risk of depletion or overuse. If we are to follow Hardin's (1968) assumptions, the two communities will act out of their short-term self-interests and keep appropriating from the resource for their own benefits, eventually leading to the degradation of the commons. This kind of behaviour generates inefficient collective outcomes in the future because rational individuals refuse to act to achieve common group interests.

2.2.4 Collective action theory

Collective action theory is one of the theoretical foundations in explaining why humans behave the way they do when they are faced with a dilemma to cooperate as a collective unit. Olson's (1965) classic *The Logic of Collective Action* was one of the most celebrated and criticised scholarly explanation in the field of social sciences in understanding how people produce and consume goods as a collective. He explained that rational individuals will always act on their self-interests and will be incentivised to free ride on the efforts of others without contributing to the costs[3].

[3] see Chapter 1, Olson 1965

2.2.4.1 Rational, self-interested individuals

Theoretical research on the commons draws from the assumptions that individuals are short-term maximisers motivated by their self-interests rather than their concern for others or for society as a whole (Dietz et al., 2002; Lam, 2014). Social scientists have used the foundations of rational choice theory to predict how individuals who are facing collective action dilemmas avoid the worst outcomes and approximate optimality for their own interests. This is derived from the concept of an 'economic man', where a self-interested individual makes choices based on the available information (Birkland, 2011; Cairney, 2012). A rational individual engages in a process of optimising his or her goals by choosing amongst all available alternatives to exhaustively solve a problem, and eventually yields to the best outcome or to the solution with the highest payoff (Leoveanu, 2013). However, these assumptions are unrealistic.

Critics were not convinced that the assumption of self-interest posited by a majority of rational choice theorists is inadequate in explaining collective action behaviour. The rational actor theory was viewed as a "theory of advice" (Ostrom, 1991:238) where it does not explicitly identify how an individual processes information or achieves objectives especially under circumstances of uncertainty and ambiguity. It is therefore inadequate in predicting unique prescriptions or behaviour in different situations (Ostrom, 1998).

Theorists like Lindblom (1959) and Simon (1972) presented a broader view on human behaviour through the theory of bounded rationality, which assumes that individuals are adaptive creatures who do not aim to maximise their short-term utility, but rather, satisfice to seek a course of action that is satisfactory or good enough under constrained circumstances. Individuals pursue goals but do so under constraints of limited cognitive and information-processing capability, and incomplete information.

Humans learned norms, heuristics, and full analytical strategies from one another to achieve satisficing outcomes (see 'muddling through', Lindblom, 1959).

Organisational studies also presented that in certain circumstances, individuals can take into account the interests of the group (see Sober and Wilson, 1998). When faced with collective action dilemmas, altruistic mechanisms and social norms can be used to avert the tragedy of the commons motivated by the warm glow of knowing they did the right thing (Elster, 1989:46). Whilst it is beyond the scope of this study to examine the vast amount of collective action literature, scholars have performed an extensive review on the evolution of the theory of collective action, particularly examining how Olson's view have moved beyond its initial assumptions on rational, self-seeking individuals and free-riding problem (see Oliver, 1993; Udehn, 1993; Reuben, 2003; Medina, 2013).

2.3 Responses to collective action dilemmas

In this section, we look at how research has evolved to offer innovative solutions in addressing collective action dilemmas and avoiding the pitfalls of the tragedy of the commons. Prior to Hardin's article, studies about the commons or CPR were rare (see van Laerhoven and Ostrom, 2007). Early formal analyses of Gordon (1954) and Schaefer (1957) on the economic factors in the CPR management of fisheries, for instance, became one of the key influential work in how to manage the commons. Their model applied microeconomics in policy design and posited that those appropriating fish from the resource only takes into account their own costs and not the increasing costs that individual efforts impose on others. Both scholars also assumed that at low levels of harvest, the yield of return increases rapidly as effort increases but once the maximum economic yield is reached, there is diminishing marginal returns (Dietz et al., 2002). Gordon (1954) and Schaefer's (1957) work became one of the important set pieces in explaining why social dilemmas and externalities occur in an open access commons.

If no rules exist to limit access to an open access commons, resource scholars suggested two potential solutions to address the management of the CPR – sole ownership via government or state control (Scott, 1955; Ophuls, 1977), or private management (Demsetz, 1967; Simmons et al., 1996). Scott (1955) suggested that in an environment where individuals compete to access a resource that is available to anyone, it is more efficient in the long run if a sole owner (ideally a government) manages the resource on behalf of everyone; however Simmons et al. (1996) believed that the political environment does not necessarily suffer the consequences of the decisions that they make on behalf of those who benefit from it. Instead, Demsetz (1967) and Simmons et al. (1996) advised that dividing the commons into private plots and enforcing rules and regulations is more effective because the private owners can bear the full costs of their actions and internalises the externalities. These were further reinforced by Hardin (1968) where he recommended “mutual coercion, mutually agreed upon” as an alternative mechanism to regulation. This was problematic because not only does it suggested that agreement can only be reached through the state, but also it implied that communities cannot develop informal and non-governmental institutions as coping mechanism (Dietz et al., 2002).

The study on the commons has garnered interest amongst distinguished scholars in many disciplines, especially in economics, social ecology, political science and policy analysis, and environmental studies (Dietz et al., 2002:6; van Laerhoven and Ostrom, 2007:5). A substantial amount of literature between the late 70s and mid 80s focused on challenging Hardin's (1968) article, creating a multidisciplinary approach on how to manage the common pool resources (Berkes et al., 1989) and why collective action issues occur (Olson, 1965; Ostrom and Ostrom, 1977).

Because of the emerging diversity in the study of the commons, critiques appraised Hardin's (1968) interpretation of the commons and its conceptual limitations and

questioned the generalisability and empirical validity of his model. In an examination the limitations of Hardin's model, Dietz et al. (2002) illustrated that Hardin's mistakenly referred to the commons as an open access resource with no rules existing to limit the users. Scholars (e.g. Ostrom, 1990; McKean and Ostrom, 1995; Baland and Platteau, 1996; McGinnis, 2013) clarified that common property rights existed, where communities benefiting from the common pool resources can agree to transform the resource systems into a 'common property regime' and create shared rights and responsibilities towards consuming and/or managing it.

Whilst CPR refers to the physical quality of the resource rather than the social institutions that individuals attached to them, common property regimes refer to the property rights arrangement in which users share duties towards a resource (McKean and Ostrom, 1995). McKean and Ostrom (1995) suggested that converting CPR to common property regimes offer a way of privatising the rights of individuals who benefit from a resource without having to divide it into parcels as suggested previously by Demsetz (1967) and Simmons et al. (1996). This, in effect, instituted collective rules to enforce property rights and functions as "…imaginary fences and informal courts" (McKean and Ostrom, 1995:9) contributing to administrative efficiency and improved productivity.

Over the most recent decades, the study and analysis of CPR have evolved from the theoretical understanding of institutions and collective action (Tang, 1992), historical studies of empirical analysis (McCloskey, 1972), to the institutional arrangements found in sustainable resource management (Ostrom, 1990). Different empirical accounts also explored a deeper understanding on what motivates individuals to behave the way they do when faced with social dilemmas, which were tested in a variety of settings (Ostrom, 1999; Ostrom et al., 2002). Such studies have contributed to the ongoing discourse of illustrating that in self-organising common pool resource settings, institutional

arrangements can result in efficient use, equitable allocation, and sustainable conservation (McKean and Ostrom, 1995; Agrawal, 2001).

2.3.1 A revised theory in collective action

In this research, we particularly draw interest from Ostrom's (1998) alternative individualistic conception to collective action. She posited that a behavioural theory of bounded rational behaviour is needed to address the shortcomings of Olson's (1965) theory. Individuals are capable of designing new tools – including institutions – to change the structure of their environment, and adopt short-term or long-term strategies based on the opportunities they face (Ostrom, 1998; McCay, 2002).

Whilst the conventional response suggested state ownership or privatisation to resolve collective action dilemmas, Ostrom and her colleagues have dedicated tremendous amount of work (see *Governing the Commons*, Ostrom, 1990) to illustrate a third alternative. In some self-governing resource-dependent communities, interdependent individuals have worked together to create properly designed institutional arrangements that limit their behaviour in order to govern the CPR. This have led to a reasonable degree of success over long periods of time as small-scale communities can create self-organised networks made up of actors, who are interested to craft institutions. They crafted, monitored, enforced, and revised these to order their relationships and regulate their decision-making. Such institutions include shared understandings amongst those involved that refer to enforced prescriptions about which actions are required, prohibited, or permitted, which information must or must not be provided, and what payoffs will be assigned to individuals dependent on their actions (Imperial, 1999; Ostrom, 2011).

Although CPR theory assumes that self-organised systems are more effective than government regulation and intervention, it is not necessarily a panacea to resource management. The role of the state, in fact, can sometimes be a key set piece to the

success of the CPR management. Mansbridge (2014) argued that governing CPRs are dependent on overarching structures of administration that can provide coercion and settle negotiations, especially in polycentric situations. Similarly, Agrawal (2002) explained that in some cases, even if communities have the inherent right to craft their own rules, the government is still the ultimate guarantor of property rights arrangements. Drawing from a critical examination of property and control of state forestry in the Indian Himalaya, Rangan (1997) also claimed that state involvement is needed to guarantee and enforce the rights of the communities, mediate disputes, and intervene at times of market failure.

In some instances, the resulting governance (i.e. decentralised, centralised, polycentric) is not a priori policy choice, but rather a response to institutional failure. For example, state intervention occurred to manage non-timber forest products in Canada (Tedder, 2008), where users of CPRs are disorganised and the provincial government struggles to identify appropriate policy responses. The role of the state ranges from a facilitative to cooperative to prescriptive approach to coordination, where a government identifies the source of institutional failure. On the other hand, privatisation of land use has been prescribed as a tool to increase protection and sustainable use in a dry region in Argentina where low-income peasants depend on multiple CPRs to survive (Altrichter and Basurto, 2008). The changing property rights from open access to private access demonstrates a more controlled use of stationary and low mobility resources, such as trees; but highly mobile wildlife continues to be under an open access regime due to lack of mechanisms to control the access of the resource beyond the private property.

2.3.1.1 Design principles to managing the commons

Using extensive fieldwork and comparative case studies generated by other scholars, Ostrom (1990) was able to collect from a sample of 14 cases where she drew the design principles for enduring CPR that are common to all successful cases and

absent in those that failed. Drawing from experimental-based models like prisoner's dilemma and game theory, she was able to successfully draw successful cases that uniquely exhibited collective action behaviour and crafted properly designed institutional arrangements to govern their commons, which led to a reasonable degree of success over long periods of time. These cases (i.e. mountain grazing and forest resources in Switzerland and Japan; irrigation systems in Spain and the Philippine islands) illustrated that in some small-scale communities, they can create self-organised networks made up of actors who are interested to craft institutions that they use to order their relationships and use in decision-making.

Fundamentally, the design principles are a configuration of the rules constituting how to sustain the commons through the formation of incentives that influence the behaviour of those benefiting from the resource. These included institutional arrangements related to who gets to withdraw which resources from the system, who is authorised to participate in decision-making, who is everyone accountable to, what are the sanctions and who monitors compliance to the rules, who monitors resource use, how are outcomes and costs distributed, and how conflict is resolved (Ostrom, 1990:90–102). More importantly, these design principles are useful in understanding how participants structure the appropriation of the resource, including the benefits and costs associated with it.

Table 3: Design principles illustrated by long-enduring CPR institutions

1	Clearly defined boundaries
2	Congruence between appropriation and provision rules and local conditions
3	Participation of resource appropriators in decision-making
4	Effective monitoring by monitors who are part of or accountable to the appropriators
5	Graduated sanctions for resource appropriators who violate community rules
6	Conflict resolution mechanism that are relatively cheap and easily accessible
7	Minimal recognition of the rights to organise for communities of resource appropriators
8	Organisation in the form of multiple layers of nested enterprises

Adapted from: (Ostrom, 1990; Cox et al., 2010)

Following this interest, scholars have evaluated and tested Ostrom's design principles in various contexts in order to provide empirical evidence and critique. The design principles reinforced each other and limited the damage on those who would be tempted to exploit the common resource for their own personal benefit. Ostrom does not claim, however, that all conditions needed to be satisfied in order to attain success in sustainability. In fact, she campaigned for the need for further theoretical and empirical work to apply the design principles in order to assert that the conditions are necessary for achieving institutional robustness (Gari et al., 2017). Cox, Arnold and Tomás (2010) re-examined Ostrom's design principles to characterise whether any theoretical issues have arisen since these principles were introduced and applied in managing CPRs. Their study included 91 empirical studies on the application of the principles and found that whilst the principles are well supported, it does not mean that they are complete. The authors, instead, proposed and redesigned some of the principles (1, 2 and 4) to account for user and resource boundaries.

Other scholars tested the principles in contexts such as polycentric systems (Carlisle and Gruby, 2017), community settings (Imperial and Yandle, 2005), and collaborative governance (Yang, 2017) to name a few. McGinnis and Ostrom (1992) justified that the principles were merely focused on the conditions to account for the success of these institutions, rather than the underlying mechanisms that direct the relationships between them. The main argument is that the participants created rule-setting conditions on appropriate and acceptable appropriation of the shared resources whilst taking an active role to craft, enforce, monitor, and revise such rules.

2.3.2 The role of institutions

Institutions as a solution to collective action problem is one of the key arguments of this research. Kosfeld et al. (2009) identified that the design of appropriate institutions is vital to preventing the market from failing as a result of the pursuit of individual interests

and conflict with the maximisation of the social welfare, particularly in the economics of public goods and common pool resources. Scholars like Baland and Platteau (1996) and Ostrom (1999) proved that creating an effective institutions in sanctioning led to a successful management of the common pool regimes.

In this study, we refer to these institutions as the “rules of the game” (North, 1990) that facilitate, guide, and constrain the behaviour of individuals and organisations. They are human-constructed constraints or opportunities within which individual choices take place and which shape the behaviour of the individuals and the consequences of their choices (McGinnis and Walker, 2010; McGinnis, 2011a; Storz and Schafer, 2011; Heikkila and Andersson, 2018). They promote socially beneficial outcomes by helping actors resolve the collective action dilemma and common pool resource problems and encourage individual behavioural and policy changes through the structure imposed to organise their behaviour and patterns of interaction.

Institutions vary in formality and authority depending on the appropriate circumstances (Moore and Koontz, 2003; Imperial and Koontz, 2007). **Formal institutions** or “rules-in-form” are binding rules, which encompasses laws and regulations of government, or binding legal documents and statutes; whilst **informal institutions** or “rules-in-use” are soft rules, which could be any unwritten shared understandings or social agreements like values, tradition, customs, norms, and working habits (Ostrom, 1990; Imperial, 1999; Rodríguez-pose, 2013; Cole, 2014). These informal institutions are the working rules used to structure and justify the patterns of interaction within and across organisations (Ostrom, 2005). These are also the rules that are followed and respected by the people or what is practiced by a collective group, which usually differs from the written statutes (Heikkila and Andersson, 2018).

Collective action theory posits that when actors come together to collaborate, they develop a set of working rules in order to determine who will be eligible to make

decisions, which actions will be allowed, and how costs will be distributed (Ostrom, 2005; Ansell and Gash, 2008). Institutions are particularly useful in addressing collective action dilemmas. In such cases (Ostrom, 1990), actors from self-organising communities establish amongst themselves some sort of regime, where resources and skills are pooled together. Access to the collaborative process itself is fundamental and stakeholders must be able to design protocols or ground rules to assist this interaction. Upon examination of multiple settings of common pool regimes and how self-organising communities developed their own set of rules to organise their relationships and determine the appropriation of the commons, Ostrom (2005) summarised this through the design principles. These served as a guide to policy scholars on the various types of institutional arrangements that emerge from a collective action towards managing a common pool resource.

2.3.2.1 Impact of institutions in sustaining the commons

As illustrated earlier, critiques suggested that CPR scholars (Ostrom, 1990; McGinnis and Ostrom, 1992; Ostrom et al., 1994; McKean and Ostrom, 1995) have focused in identifying which institutional arrangements are found in communities that are able to sustain over periods of time. Perhaps the greatest contribution of Ostrom's work is the conceptualisation of institutions in common property regime settings, which has not only extended the theoretical body of research interested on the impact of institutions to individuals, organisations, and society (such as Hardin, 1968; Parks *et al.*, 1981; DiMaggio and Powell, 1983; North, 1990; Baland and Platteau, 1996 to name a few), but also sparked an interest to investigate the role of institutions in regulating behaviour of individuals who are engaged in collective action and are sharing rights to a CPR.

CPR literature has been refined by scholars over the years and has evolved into efforts to finding causal relationships between formal and informal institutions in relation to the success or failure of robust common property regimes based on the previously

identified design principles of Ostrom. It has been applied into various situations where effective management of resources and efficient institutions have led to different socially optimal outcomes. For instance, scholars have explored how institutions influence the emergence of collaborative governance on a variety of common pool regime settings, such as large-scale ecosystems (Heikkila and Gerlak, 2005, 2018; Gerlak and Heikkila, 2006), watershed management (Moore and Koontz, 2003; Imperial and Koontz, 2007; Hardy and Koontz, 2009) and regional/local/metropolitan governance (Feiock, 2008; Ayres, 2017; Roberts and Abbott, 2017; Swann and Kim, 2018).

For managing natural resources that involves a large-scale regional collaboration characterised by heterogenous stakeholders and fragmented management responsibilities, Heikkila and Gerlak (2005) and Gerlak and Heikkila (2006) highlighted that establishing institutions played a vital role in organising decision-making structures in the constitutional, collective choice, and operational levels. This involved the establishment of a convening body that governs all participants, whilst day-to-day implementation or operational decisions were made in the lower levels. On a more recent study, Heikkila and Gerlak (2018) recognised the need for diversity of institutions in addressing collective membership, particularly in identifying which individuals are eligible to join the collaboration.

Consequently, smaller-scale collaborative management on natural resources focus on the types of institutional arrangements (i.e. group memberships) and the institutions necessary to create a sustainable collaborative governance. Moore and Koontz (2003) and Hardy and Koontz (2009) emphasised membership composition (i.e. agency-based, citizen-based, and mixed) in determining what kind of collaborating strategies will facilitate the participating groups. For instance, citizen-based groups are more likely to rely on adversarial means of negotiation, such as lobbying and petition, whilst agency-based and mixed groups rely more on technical advice. Hardy and Koontz (2009) also

argued that agency-based groups are more likely to abide by more formal rules established through statutory laws. These findings are all useful in identifying the types of formal and informal institutions that collaborating stakeholders use in sustaining the longevity of the collaborative governance (Imperial and Koontz, 2007).

Informal institutions play an equal role in regional, local, or metropolitan collaborative arrangements on delivering public services or implementing public policies. This is often characterised by fragmented lines of authority and misaligned collective interests, where institutions are crafted to impose coordination and shape incentives faced by the stakeholders (Feiock, 2008). In some cases, evidence postulated that where formal institutions are lacking, informal institutions fill those gaps. Informal institutions can "help explain conditions under which formal institutions can be difficult to be enforced" (Storz and Schafer, 2011:45) especially in circumstances where formal institutions are oftentimes absent. Whilst binding rules play an important role in legitimising the collaboration, more recent studies focus on the emerging role of informal rules, in particular, in sustaining interdependent relationships amongst stakeholders.

These involve uncodified interactions within and across actors that is not structured by pre-given sets of formal rules (Tatenhove et al., 2006). For instance, Yi et al. (2018) demonstrated that informal agreements provided the greatest autonomy as actors engage in frequent interactions through informal forums and venues. Such activities are as important as formal institutions in order to gain control in local government networks. Agranoff and McGuire (2003a) explained that this is a common approach to information seeking in order to reach agreement and to search for joint solutions. As a result, informal institutions reduce the transaction costs to collect information (tenet of New Institutional Economics, see Chhotray and Stoker, 2008a). Since a lot of the work occur “behind the scenes” or “back stage” (Peters, 2006:27), such as meetings, networking, or through informal contacts, the time and effort spent on negotiating and monitoring to ensure all

parties keep the agreement are reduced. This has valuable implications when implementing policies because of the high transaction costs associated with collective initiatives (Vanni, 2014; Pyone et al., 2017).

This, however, does not discredit the role of formal institutions in the emergence of self-governing communities and how it interacts with informal institutions when the desired outcome is not achieved (Storz and Schafer, 2011; Cole, 2017). Formal institutions are very useful in imposing autonomy and structure to the collective group. For example, in a study on collaborative watershed partnerships with differing membership profiles, Hardy and Koontz (2009) found that codified rules imposed by government-led collaboration (i.e. agency-based) make enforcement and sanctioning easier because they are backed by formal regulations.

2.3.3 Factors to effective management of the commons

Whilst institutions are important and are the focal point of Ostrom's contribution to the management of the commons, we also need to acknowledge other influencing factors that contribute to the effective management of CPRs. Formal game theoretical models, experiments, and theoretical speculations contributed to the evolutionary process of examining the structural variables that predict the likelihood of collective action (Ostrom et al., 1994; Agrawal, 2001, 2002; Kopelman et al., 2002; McCay, 2002; Agrawal, 2003; Ostrom, 2009). Research suggested that studies on commons are focused primarily on institutions and forgot other factors (Agrawal, 2001; Imperial and Koontz, 2007; Vanni, 2014; Yi et al., 2018), such as group size or external environment, as aspects of the commons that could affect durability of the long-term management of the system. Agrawal (2002) pointed out that the reason why scholars have focused so little on external factors, such as markets, population pressure, and technology, is because these have received attention from other streams of scholarship.

Agrawal (2001) examined statistical, comparative approaches to the commons and identified in detail the critical enabling conditions for sustainability on the commons, related to its resource system's physical characteristics, group characteristics, institutional arrangements, and external environment. This additional list of operational factors, ranging between 30 and 40 variables (e.g. group size, resource size, or shared norms; interdependence among group members, and fairness in allocation rules; ease of enforcement and supportive external sanctioning institutions), are correlated and potentially affect outcomes depending on their interaction. In a later study, Agrawal (2002) explained that these factors could perhaps explain emergence of commons institutions but not sustainable management.

Overall, behaviour in collective action dilemmas are affected by many structural variables, including size of the group, heterogeneity of the participants, dependence on the benefits received, the organisational levels, monitoring techniques, and the information available to participants (Ostrom et al., 1994; Baland and Platteau, 1996; Agrawal, 2001) to name a few. These act as causal links to the institutions created to constrain or regulate the use of common pool resources.

2.4 Collaborative governance

In this section, we want to address our research objective of extending the theory of common pool resources and collective action into a collaborative governance setting. In order to build our argument, we borrow our assumptions from Elinor Ostrom's (1990) theoretical conceptualisation of common property resources and Mancur Olson's (1971) theory of collective action, and apply them to the collaborative governance setting.

2.4.1 Role of governance in managing the commons

Governance is an act of governing using rules and forms to steer the economy and society, and reaching collective goals through an interaction of a multiplicity of actors

influencing each other (Stoker, 1998; Pierre and Peters, 2000). As the role of the state changed from the traditional steering role and top-down hierarchical approach (hierarchies) to a more displaced power and control to the private sector and civil groups (markets), fragmentation of public services delivery and complex interdependencies arose as a result. This created different levels of opportunities for collaborative governance to occur, in order to resolve conflicts and advance shared visions as a moral imperative in addressing “wicked problems” (Gray, 1989; Huxham et al., 2000; Swann and Kim, 2018). A new governance emerged (Rhodes, 1996), where formal and informal institutions of self-organising networks and actors were involved engaging in game-like interactions rooted in trust and regulated by the rules of the game agreed upon by the participants.

An emerging theme from CPR studies is the increasing role of governance where the capacity to get things done does not rest on the authoritative command of the government nor privatisation of property rights. Under a common property regime, participants can form an informal basis of coordination without an encompassing structure of command (Stoker, 1998). Governance in the commons is therefore described as autonomous self-governing networks, where actors and institutions interact, and pool their skills and resources to form a long-term coalition (Rhodes, 1996; Stoker, 1998). For example, Rudd (2004) highlighted that in small-scale communities managing ecosystem-based fisheries, the development of formal governance regimes and its interaction with informal institutions is vital in constraining short-term opportunism and maintaining sustainability of the resources.

In polycentric settings where multiple actors have overlapping roles and have competing statutory responsibilities to protect different constituencies, collaborative mechanisms have been developed by state and non-state actors to work together and overcome conflict (Ostrom et al., 1961). Imperial (2005) demonstrated that in six

watershed common property regimes, a series of separate collaborative activities are adopted to narrow the range of potential policy solutions. It led to better public participation and policy dialogue, resulting into a better informed, more creative, and enduring solutions. However collaboration amongst diverse institutional designs can also be a challenge, in terms of financial expense, complexity of problems, and uncertainty (Gerlak and Heikkila, 2006).

2.4.2 Conceptualisation of collaborative governance

Collaborative governance is an important tenet in this research. It has emerged as a new form of governance in the public administration and management literature, encompassing the engagement and networking arrangements between public, private, and third-sector agencies. Studies illustrated that collaborative governance is a useful approach in a range of sectoral problem and policy areas, such as the development of metropolitan regions (Feiock, 2009; Roberts and Abbott, 2017), management of urban infrastructure projects (Agranoff and McGuire, 2003c; Page and Melroy, 2008), resource management (Koontz, 2006; Imperial and Koontz, 2007), and public services management (Carnwell and Buchanan, 2008; Jung et al., 2009) just to name a few. It focused particularly on the impact of partnership working and building consensus between multi-sectoral actors in terms of reaching agreements, addressing collective problems, and planning and implementing of policies.

Definitions are crucial to theory building and it is important that we provide a consolidated version from the literature in order to encompass the salient points of the concept. Collaborative governance encompasses an amalgamation of various scope and scale of perspectives on cross-boundary engagement between public, private, and third-sector organisations. It emerged as an alternative to hierarchical and managerial forms of governance as a response to the failures of top-down implementation of policies and the high costs associated with it (Ansell and Gash, 2008; Ansell et al., 2017). This

research uses the following criteria for collaborative governance based on the variations provided by the literature (Gray, 1989; Wood and Gray, 1991; Himmelman, 1996; Thomson and Perry, 2006; Ansell and Gash, 2008; Emerson et al., 2012).

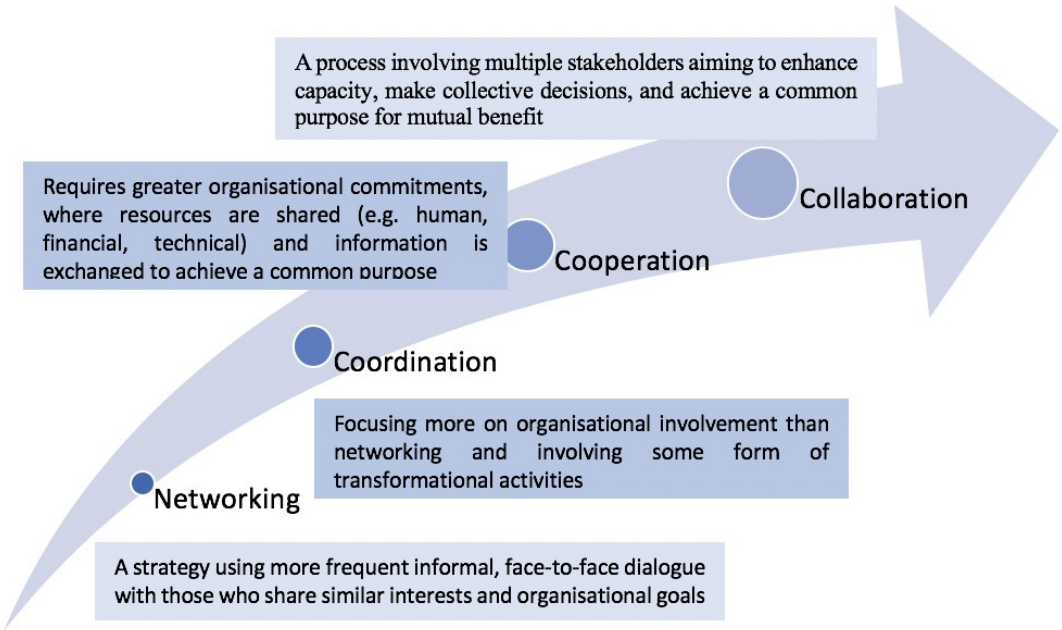
A collaborative governance has:

- a governing arrangement, where formal and informal institutions serve as an overarching dimension that regulates the decision-making behaviours of the group and the individuals
- stakeholders made up of public, private, and third-sector participants who are ultimately involved in all stages of the decision-making process
- a formal forum where stakeholders gather and meet on a regular basis, maintaining interdependent relationships and engaging in dialogues to achieve direction and control
- a collective, multilateral, and deliberate decision-making process
- a consensus-oriented decision rule
- a common purpose or shared intention to solve issues together
- an autonomous and voluntary participation, guided by accountability and legitimacy principles in decision-making

However, collaborative governance has been interpreted in multiple accounts across different studies, drawing further confusion to readers as different variations such as “partnership”, “joint working”, “cooperation”, and “cooperation” are used interchangeably in the literature (Himmelman, 1996; O’Flynn, 2009). This research recognises that concepts like networking, cooperation, and coordination are strategies to the collaborative governance process and are not to be used interchangeably when referring to collaboration (Figure 3). As scholars have suggested (Gray, 1989; Wood and Gray, 1991; Himmelman, 1996), we view collaboration as an iterative, emergent and cyclical

process rather than linear stages, where a continuum of strategies (i.e. networking, cooperating, etc.) are used to enhance stakeholder capacity, make collective decisions, and achieve a common purpose for mutual benefit.

Figure 3: Continuum of collaboration



2.4.3 Elements of collaborative governance congruent to collective action theory

2.4.3.1 Governance

Perhaps one of the most defining characteristics of collaborative governance that sets it apart from “partnerships” or “networks” is the added value brought by the governing arrangement that enables the participants to function as a collaborative institution. Governance, in the institutional context, determines ‘who can do what to whom, and on whose authority’ (McGinnis, 2011a). It is concerned with constituting rule–ruler–ruled relationships for collective action to cope with problems affecting the collective interest of communities of individuals (Lam, 2014).

Donahue (2004) stated that a collaborative relationship can be institutionalised through formal contracts to some degree in order to coordinate and monitor activities, whilst also recognising the value of informal institutions in operating (i.e. informal agreements or tacit understandings). Ansell and Gash (2008) also reiterated that a formal and structured arrangement was necessary to distinguish collaborative governance from other forms of public-private partnerships. This encompassed the critical component of governance, which served as an overarching element describing the institutions or rules of the game that guide collective decision-making between a multiplicity of actors, rather than a single individual or organisation making a decision.

2.4.3.2 Stakeholders

In its simplest sense, collaboration involves any joint activity by two or more organisations who intend to create public value by working together rather than separately (Imperial and Koontz, 2007; Von Wald and Boyes, 2010). Donahue (2004) stated that a minimum level of diversity to participate in a collaborative are at least one public and one private player. Ansell and Gash (2008) used the term stakeholders to refer to the participation of public and non-public agencies as individuals or as organised groups, with public stakeholders taking the leadership role in the collaborative governance. For example, in resource management collaboration, public agencies (e.g. the state; bureaucracies; courts; governmental bodies) have the authority in terms of the institutional and political setting for other participants. In a framework for analysing government roles in collaborative environmental management, Koontz (2006) indicated that the state play a key role in setting the agenda and providing resources, whilst also shaping group structure and decision processes. In a monograph on collaborative governance of public services in Australia, Shergold (2008) specified that public agencies impose the structure of collaborations particularly on deciding representation and its capacity to marshal resources and access to information, which mildly reflects the implicit hierarchical relationships between actors. Ansell and Gash (2008) did not

disregard, however, the role that non-public agencies play in terms of policy outcomes, more importantly in implementation.

Ultimately, all stakeholders should be involved in all stages of the decision-making process. Donahue (2004) and O'Brien (2012) stated that if other parties are simply agents engaged to implement a dominant player's agenda, this relationship is not a valid form of collaborative governance. Emerson et al. (2012) offered a more flexible definition for stakeholders by emphasising cross-boundary, multi-partner agencies (i.e. the state, the private sector, and the civil society), where joined-up arrangements such as public-private, private-social, or co-management regimes occur. This expanded a broader boundary in terms of who gets to participate in the collaborative, bringing the possibility of hybrid arrangements to fit the needs of the collaborating participants. For example, in metropolitan governance where cross-cutting issues like climate change and equity and accessibility to public services call for a more diverse collaborative arrangements that cut across traditional dichotomies of hierarchical governance (Roberts and Abbott, 2017). Similarly in environmental management, advisory groups play an important role in creating shared leadership amongst all members of the collaborative group (Koontz, 2003).

2.4.3.3 Forum

In collaborative organisations, formality may vary from relatively informal (i.e. informal agreements through corresponding trust and norms) or very formal structures institutionalised in binding legal documents (Imperial and Koontz, 2007). O'Brien (2012) stressed the importance of a formal forum where the stakeholders gather and meet on a regular basis. Ansell and Gash (2008) put great emphasis on the role of public agencies in initiating this forum, either to fulfil their own purposes or to comply with a mandate. The forum is particularly useful for knowledge sharing, sustained dialogue and mutual learning, which enables forging interdependent relationships between the stakeholders

involved in the collaboration. Subsequently, the forum is created to make collective decisions and is used to achieve direction, control, and coordination of the participating stakeholders (Imperial and Koontz, 2007; Ansell et al., 2017).

2.4.3.4 Collective decision-making

Collaboration involves collective decision-making, where public and non-state stakeholders communicate and influence each other through a multilateral and deliberative process (Ansell and Gash, 2008). Gray (1989) highlighted that there is also joint ownership of decisions and the participants are directly responsible for reaching agreement on a solution. This is also a key feature of governance (Wood and Gray, 1991; Chhotray and Stoker, 2008b) where decisions are taken by a collection of autonomous individuals through mutual influence and control, and shared rules, norms, or organisational structures.

In some cases, collective decision-making can also be an outcome of collaborative governance. Using a collective action perspective, Ostrom (1990) suggested that when parties come together to collaborate, they create set of formal or informal rules in addressing collective action problems. Using a structured set of collective choices, the stakeholders are able to develop and germinate new policy possibilities by feeding into formulation, implementation and evaluation (Wanna, 2008). The participants should be willing to monitor themselves and impose sanctions for noncompliance in order to succeed in collective decision-making. On the other hand, Shergold (2008) emphasised the role of public agencies in enhancing collaboration by championing the collective decisions through disproportionate power, on behalf of the rest of the collaborative venture.

2.4.3.5 Consensus oriented

Whilst consensus is a common decision rule, it is not necessarily always achieved or required (Koontz, 2006; Emerson et al., 2012). In collaborative forums, the goal is

typically to achieve some degree of consensus amongst stakeholders. Ansell and Gash (2008) used the term consensus oriented to acknowledge that although consensus not result into a successful collaboration, stakeholders can build consensus to address collective problems through a deliberative, multilateral, and formal forum. We must be reminded that collaboration is an iterative process where the search for solutions does not only happen just by reaching mutual agreement on answers, but also by jointly framing the questions and identifying the problems (Shergold, 2008). Stakeholders can design different rules and adopt different types of group decisions, and rely on consensus to compensate for imperfections resulting from the differences in decision rules especially (Koontz, 2006; Imperial and Koontz, 2007). As the decisions become more complex, alternative binding procedures (e.g. voting) are employed as a back-up in case achieving consensus becomes more difficult (Imperial and Koontz, 2007; O'Brien, 2012). For example, consensus is built during the initial stages where common ground is being established in order to define or frame a single shared challenge or a broader range of concerns (Donahue, 2004; O'Brien, 2012).

2.4.3.6 Common purpose

A key defining element of collaborative governance is the working together of stakeholders as a collective for mutual benefit and a common purpose. Ansell and Gash's (2008) definition purposively defines the focus of collaboration on public policies or issues. It could either be a shared intention to solve issues for the wider community, to resolve a conflict, or to develop and advance a shared vision which otherwise cannot be carried out by merely acting alone (Agranoff and McGuire, 2003c; Koontz, 2006; Emerson et al., 2012; O'Brien, 2012). Huxham (1996) referred to this as the moral imperative, where collaboration is the only way to address complex social problems, such as poverty, crime, etc., that cannot be tackled by any single organisation alone. Stakeholders develop a shared understanding and motivation of what they can

collectively achieve and improve together, and the willingness to enhance each other's capacity for joint action and mutual benefit (Himmelman, 1996).

2.4.3.7 Participation

Collaboration involves stakeholders who participate voluntarily and are autonomous (Wood and Gray, 1991; Huxham, 1996; Thomson and Perry, 2006). Although it may be mandated by court orders or legislatures, participation in collaborative governance is largely voluntary especially when they see the benefit in doing so (Huxham, 1996). Incentives are, therefore, vital when participating in a collaboration. When stakeholders believe that they can achieve their goals unilaterally or through alternative means, the incentives to participate in the collaboration is low (Ansell and Gash, 2008). In a collective action theory perspective, autonomous actors behave in accordance with their rational weighing of costs and benefits of strategies (Thomson and Perry, 2006; Swann and Kim, 2018). When the marginal costs exceed the marginal benefits, the participants will stop contributing to the collaboration before group optimum is met.

On the other hand, Wood and Gray (1991) emphasised the importance for stakeholders to retain their independent decision-making powers whilst abiding by the rules in the collaborative governance. Because of the recognition of autonomy of the stakeholders, they often come to the table with competing interests. Thomson and Perry (2006) and Shergold (2008) described this as dual identity, where stakeholders have to maintain their own distinct organisational identity and authority separate from or simultaneously with their collaborative role. This tension was also portrayed by Huxham (1996) as an autonomy-accountability dilemma, where collaborating organisations have conflicting intentions to participate out of self-interest versus collaborative interest.

2.5 Linking the structural variables using the IAD Framework

Guided by formal and informal institutions, the revised theory of collective action, and the concept of collaborative governance, this study employs an analytical framework to help link the various structural variables identified in the literature review.

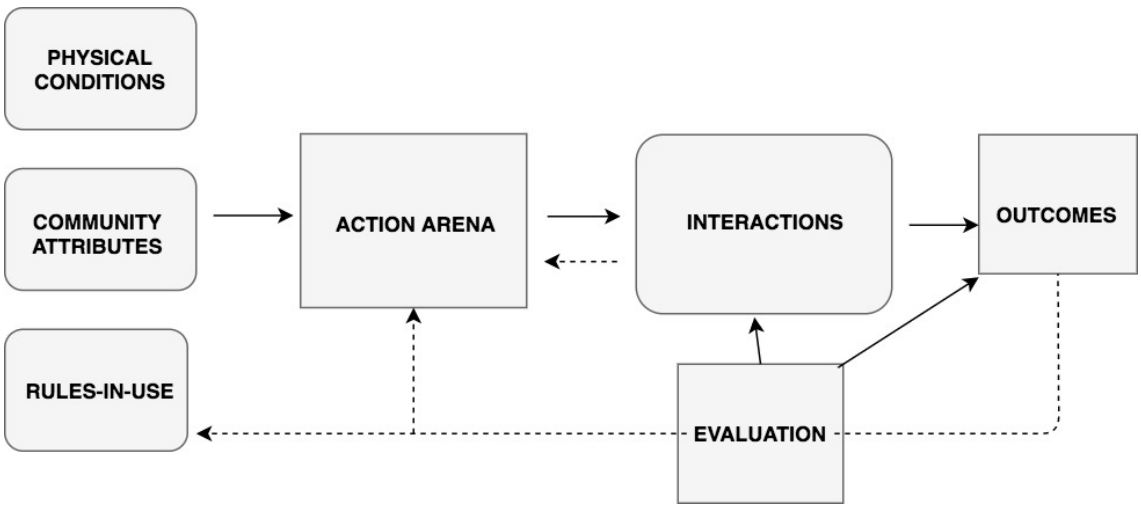
As we have continued to reiterate in this chapter, previous studies in managing the commons have emphasised the emerging role of institutions in common property regimes. Institutions provide a coordinating function where rules are established to regulate the entry and use of the resource systems, the incentives that shape the behaviour of those who benefit from it, the interactions resulting from this, and the types of outcomes obtained. Without these rules guiding the appropriation of resources, users compete with one another until their actions may destroy the CPR (McGinnis and Ostrom, 1992). Therefore, formal and informal arrangements may be devised to address collective action dilemmas. To examine the institutional arrangements that emerge in the introduction of stewards of the commons, this study selects the Institutional Analysis and Development (IAD) framework.

In 2005, Ostrom published another critically acclaimed book *Understanding Institutional Diversity* on the management of the common pool, which included a comprehensive framework on theoretical issues and empirical studies on successfully resolving common pool tragedies through locally devised institutions. These institutions are shared understandings amongst those involved that refer to enforced prescriptions about which actions are required, prohibited, or permitted, what information must or must not be provided, and what payoffs will be assigned to individuals dependent on their actions (Imperial, 1999; Ostrom, 2005, 2011).

Central to her new contribution to the study of the commons is the conceptualisation of the IAD framework and how it is a useful multi-tier conceptual map in analysing how multiple actors interact to solve collective action problems shaped by structures, rules,

positions and external attributes. The IAD framework is a systematic method that collects institutional contexts and policy analysis functions to understand how institutions shape outcomes, and how they operate and change over a period of time (McGinnis, 2011a). It claims an explanatory power to unpack the details of the institutional operations, which will be useful in understanding how a set of rules, norms, and beliefs are embedded within common property regimes and influence the way they address problems and enforce such existing institutions.

Figure 4: The IAD framework



Adapted from: (Ostrom, 2005)

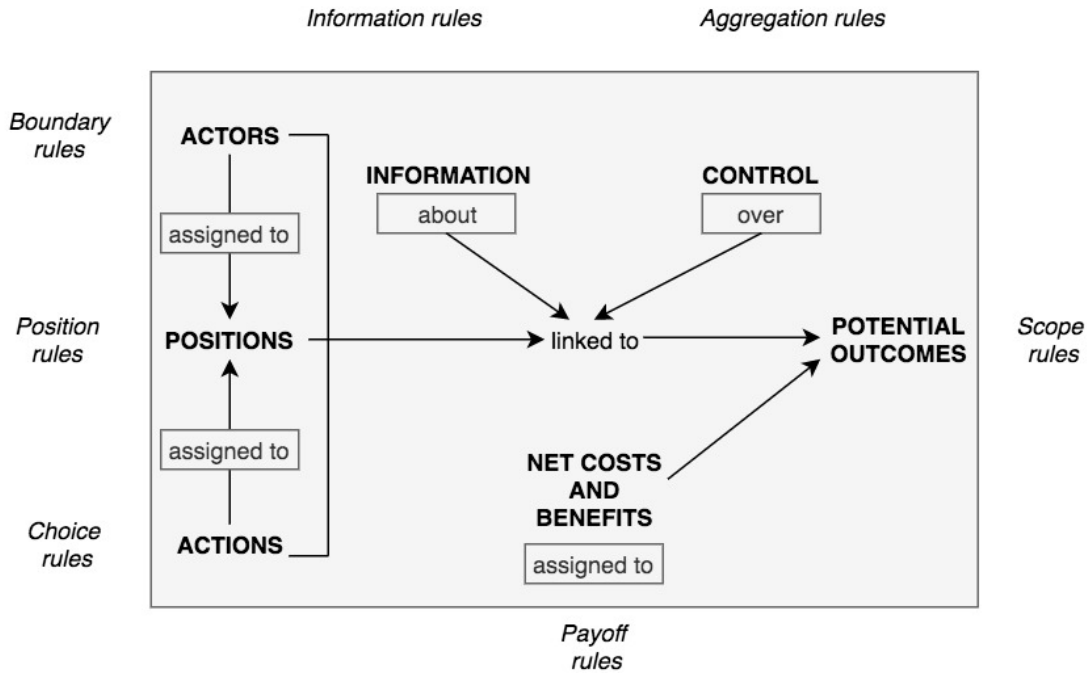
Figure 4 illustrates the elements of the IAD framework for multi-stakeholder sustainable stewardship for governing the health commons. The process-oriented framework has been designed to analyse the nature of institutional arrangements shaping the actors' behaviour, as well as the rules of the game. In Ostrom's later work, she included not only physical properties of the resource were identified in her design principles, but also the rules created to regulate the entry and use of the resources, the types of interactions emerging, and the outcomes obtained (Forsyth and Johnson, 2014).

The unit of analysis in the IAD framework is the action situation where policy choices are made (McGinnis, 2011a). It involves multiple individuals who engage in a set of actions that together lead to outcomes, and observe information, select actions, engage in patterns of interaction, and realise outcomes from their interaction (McGinnis, 2011a; Heikkila and Andersson, 2018). It is enclosed in an action arena, which includes those individuals or organisations that make decisions based upon information about how actions are linked to possible outcomes and the different costs and benefits attached to actions and outcomes (Imperial, 1999). To analyse an action situation, the following are identified:

> "1. the set of participants 2. the positions to be filled by participants 3. potential outcomes 4. the set of allowable actions and the function that maps actions into realised outcomes 5. the control that an individual has in regard to this function 6. the information available to participants about actions and outcomes and their linkages 7. costs and benefits – which serve as incentives and deterrents – assigned to actions and outcomes" (Ostrom, 2005:32)

Central to the analysis of institutions in the IAD framework focuses particularly on the rules-in-use. It addresses questions like (Ostrom, 1990): How many participants were involved? What was the group structure? Who initiated action? Who paid the costs of entrepreneurial activities? What kind of information did participants have about their situation? What were the risks and exposures of various participants? What broader institutions did participants use in establishing new rules?

Figure 5: Elements within action situation



Adapted from: (Ostrom, 2005)

To address these, Ostrom (2005) developed a typology for rules-in-use, which must be compatible with the underlying biophysical setting and community attributes. Each of these rules are interrelated with a specific function in the action situation (Figure 5). The rules typology included: *position* (determines types and roles of decision-makers), *boundary* (determines the entry, succession, and exit of actors), *choice* (defines the set of actions assigned to each actor), *aggregation* (determines collective agreement rules), *information* (determines information access), *payoff* (identifies the rewards and sanctions associated with outcomes of actions) and *scope* (determines the outcome variables) rules (Ostrom, 2005; Heikkila and Andersson, 2018).

Once these are the initial action arena has been evaluated, the variables affecting this are examined. There are three exogenous variables that influence the pattern of interactions among individuals and organisations in an action arena, namely attributes of the community, nature of the biophysical conditions, and rules-in-use (Ostrom, 2005).

These inputs are the contextual factors that set out the context within which an action situation is situated (McGinnis, 2011a). Once contextual factors are linked to action arenas, then it generates interactions and produce outcomes.

The IAD framework has been applied in numerous contexts in examining the commons including large-scale ecosystems (Heikkila and Gerlak, 2005, 2018; Gerlak and Heikkila, 2006), watershed partnerships (Moore and Koontz, 2003; Imperial and Koontz, 2007; Hardy and Koontz, 2009), fisheries (Rudd, 2004; Imperial and Yandle, 2005), forestry management (Koontz, 2003), and polycentric settings (Whaley and Weatherhead, 2014); however, it has yet been explored in the health commons context.

Another analytical framework was also examined to potentially address the objectives of this research. The Institutional Collective Action (ICA) framework by Feiock (2013) has emerged as useful analytical lens for explaining why different mechanisms are selected in collaborative metropolitan settings. Directly borrowing from IAD's rule types and configurations of rules, ICA framework focuses on principal-agent problems and free-riding behaviour found on collaborative governance arrangements, where “an authority’s incentives do not align with collectively desired outcomes” (Swann and Kim, 2018:274). However, it steers away from institutions; instead, it focuses on a more general approach on examining integrative mechanisms based on varying levels of transaction costs, authority, complexity of issue, and uncertainty to information (Feiock, 2013:404).

ICA framework has emerged as a useful analytical framework in empirical studies on the collaborative governance literature. In a systematic literature review, Swann and Kim (2018) identified 68 empirical studies that utilised ICA as a means of understanding how fragmented authorities strengthen collaboration through embeddedness and networks, contracts and agreements, and delegated and imposed authority. Similarly, Yi et al. (2018) similarly applied the ICA framework using quantitative analysis to examine why

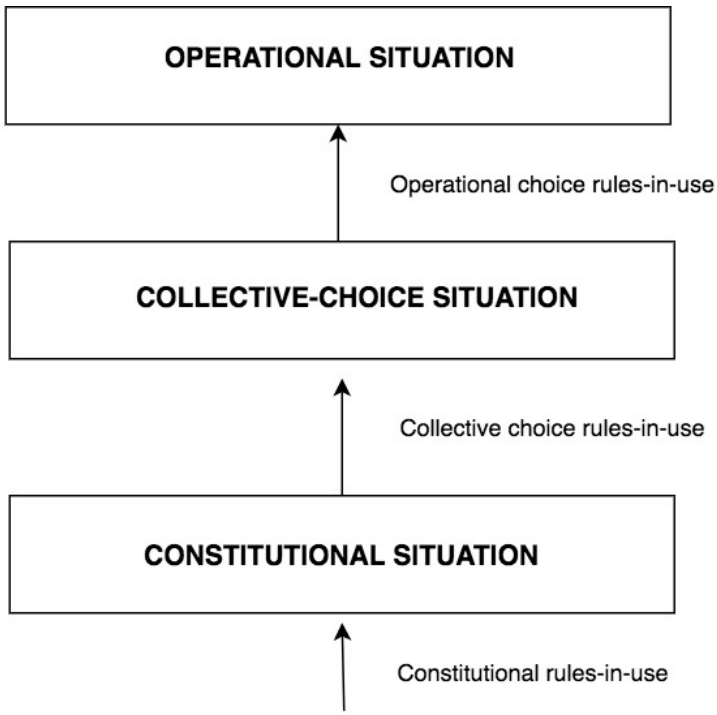
local authorities choose various mechanisms of cooperation given the variation in autonomy and authority on each jurisdiction.

Whilst ICA has its advantages in examining a wider range of collaborative mechanisms in fragmented settings, there are multiple reasons why it is not compatible for our research objectives and why IAD framework is more appropriate. First, ICA is focused on identifying the reasons to fragmentation and explaining the selection of the mechanisms to foster collaboration and its consequences. Swann and Kim (2018) identified that the ICA framework offers practical prescriptions on reducing risk and uncertainty in collaborative arrangements in regional and metropolitan settings, which is not really the focus of this research. Second, although the ICA framework can be useful in explaining the mechanisms used to resolve collective action dilemmas, IAD framework is focused on comparing the different types of rules of the game and their resulting outcomes, given the contextual setting, costs and benefits, and interaction within an action situation. Third, examining institutional arrangements require an organised conceptual framework where structural variables can be managed and easily understood, such as actors, characteristics of the resources, the amount of information available to actors, and the factors that constrain or facilitate their interactions (Imperial and Yandle, 2005:502). Although ICA framework borrowed from IAD's configuration of rules, it does not have a conceptual structure like IAD as illustrated in Figure 4. Fourth, IAD framework has the built-in feature of identifying the different institutional designs, given its congruence to the exogenous factors (e.g. physical setting, community attributes). Researchers can use IAD's rule typology to identify how institutional arrangements resulted in various policy outcomes (Heikkila and Gerlak, 2018).

Lastly, IAD has the explanatory power to be examined using multiple levels of analysis. This is to illustrate how all rules are nested in another set of rules (Ostrom, 2005:58), where one level of actions and outcomes obtained from the previous level

affect the proceeding level (Figure 6). For example, *constitutional* rules refer to who, when, and how can participants engage. These then affect the *collective-choice* activities, where choices about which institutions or strategies should be used in resolving collective decisions. These collective-choice rules then influence how day-to-day transactions and decisions are made by the participants in *operational* situations.

Figure 6: Multiple levels of analysis



Source: (Cole, 2014)

Overall, the IAD framework presents merits as an analytical tool for this study. Applications of the IAD framework in health governance has been limited (see Abimbola et al., 2014, 2017), particularly focusing on the multiple level analysis. This study takes advantage of the IAD framework by applying it in a unique context of the health system as a common property regime setting. It is a promising tool for investigating the institutional arrangements associated with collective action efforts.

2.6 Modified IAD model in collaborative governance

Ostrom (2011) posited that the development and use of models are vital in making precise assumptions about variables, in order to make precise predictions on the results of combining these parameters. Now that we have a clear definition on what collaborative governance entails, we will now examine the elements and mechanisms of the collaborative process as illustrated by various models presented in the literature and present a modified model of collaborative governance and collective action. We embed the structural variables previously identified on our examination of the collective action literature, particularly focusing on the role of institutions as facilitating mechanisms to address social dilemmas.

2.6.1 External conditions

There are many possible reasons as to why organisations come together to collaborate within a multi-layered context of political, legal, socioeconomic, environmental, and other influences (Emerson et al., 2012). Scholars have identified elements that distinguish or influence the emergence of a collaborative governance, including responding to complex issues (Gray, 1989; Agranoff and McGuire, 2003a) and collective action dilemma (Imperial and Koontz, 2007; Page and Melroy, 2008), advancing self-interests (Wood and Gray, 1991; Huxham, 1996), promoting cost-effectiveness, efficiency, or economic development (Himmelman, 1996; Agranoff and McGuire, 2003a), declining productivity growth (Gray, 1989), and overlapping and fragmented roles (Diaz-Kope et al., 2015; Roberts and Abbott, 2017). Such elements act not as starting conditions but as external factors that influence the key drivers to collaboration.

Gray (1989) and Wood and Gray (1991) highlighted that collaboration is a logical and necessary response to turbulent conditions, such as rapid economic and technological change resulting to globalisation and increasing political pressures for organisations to

adopt competitive strategies. In a study on collaborating metropolises, Roberts and Abbott (2017) argued that globalisation impacted the increasing links between countries, requiring governments to engage and share economic activity. This resulted in high levels of interdependence amongst governments and organisations, who now share power and have overlapping roles and responsibilities.

For government policy changes such as decentralisation, collaboration has become a mechanism to resolve the failures of downstream implementation and to the high cost and politicisation of regulation (Ansell and Gash, 2008; Wanna, 2008). For instance, the marketisation of public services resulted in fragmented institutional structures delivering those services. This resulted in “wicked problems”, as in those involving substantial goal conflicts, important technical disputes, and multiple actors from several levels of government (Sabatier, 2007; Bingham, 2011), which are exacerbated by systems of fragmented authority or overlapping jurisdictions. To address these, integrative organisational arrangements have emerged where such organisations cooperate to deliver services effectively, instead of competition (Rhodes, 2000; Saltman et al., 2007).

In organisational studies, collaboration is recommended to address collective action dilemmas, particularly those that create diseconomies of scale, positive and negative externalities, and common property resource problems (Feiock, 2009). Ostrom (1998) posited that collective action problems occur when individuals in interdependent situations face choices in which all individuals will be better off cooperating but fail to do so because of conflicting self-interests leaving everyone worse off than feasible alternatives. For example, in environmental management where the appropriation of resources is shared amongst grassroot communities, they face collective action problems such as restoration activities, permitting processes, etc. (Heikkila and Gerlak, 2005; Imperial and Koontz, 2007). Swann and Kim (2018) offered practical prescriptions

for governing fragmented governments, where the use of collaborative arrangements is vital to reducing risk and uncertainty when facing such dilemmas.

Overall, the external environment factors influence the impetus for organisations to collaborate. Collaboration has proven to be a useful tool in addressing a multitude of interorganisational problems – whether they aim to resolve conflict or a complex issue, or to create joint action in order to reduce costs, risks, or fragmentation of services.

2.6.1.1 Physical attributes

Physical conditions influence the action situation and constrain the institutional arrangements being formed. They provide significant implications for policy design and collective action, which are all critical aspects of the policy-making process (Polski and Ostrom, 1999).

Number of participants. Olson (1965) pointed out that unless the group has very specific characteristics to overcome the free rider problem, the provision of the collective good will fail. For instance, free riding is less likely to happen if groups are smaller because individuals are more incentivised to put in effort and contribute to the good being provided due to the potential gains. Larger groups, on the other hand, struggle to cooperate because individuals the individual benefit is too low and organisation costs are too high (Udehn, 1993; Reuben, 2003). This was, however, based in a public goods economics perspective where rational choice theory assumes that no one will cooperate in one-shot or finitely repeated interactions. Similarly, Agrawal's (2001) meta-analyses of structural variables in collective action discovered that small size and well-defined boundaries are likely to be better managed under common property arrangements. Although Ostrom (2010) pointed out that size being a factor on the likelihood of cooperation depends on other variables as well, such as group characteristics.

Heterogeneity of participants. Attributes of a community are likely to affect the behaviour of individuals interacting with one another. In self-organising resource regimes, homogenous and stable communities are likely to sustain the resource. Empirical studies in collective action illustrate that heterogeneity increases the transaction costs of reaching an agreement (Yi et al., 2018); whilst a diverse group makes it more challenging to develop norms of trust and reciprocity amongst the group (Heikkila and Andersson, 2018).

Shared resources. When organisations initially come together to collaborate, one of the few things they have to decide on is agreeing which resources (e.g. power, time, human resources, knowledge, capital, etc.) are to be shared amongst the members. This provides the potential for organisations to secure collaborative advantage (*see*: Wood and Gray, 1991; Huxham, 1996). In a study on management of common pool resources, Koontz (2006) identifies three broad categories for resources – human, technical, and financial. Human resources involve the manpower (i.e. volunteers, staff, leaders, etc.), who each possess skills, knowledge, and experience, that may be needed to advance collaboration. Technical resources refer to the local context and knowledge about the external environment, which can inform collaborative efforts. Finally, financial resources are the funding, donations, or contributions that the group receives to allow the collaborative arrangement to conduct and perform business activities. In a collaborative metropolitan governance for example, integration of planning resources is one of the first few steps to creating a sustainable regional development model (Roberts and Abbott, 2017). Much of this occurs by agreeing access to information, sharing resources and expertise, and integrating policy, regulation and administration functions.

Whilst sharing of resources is vital, not all organisations have the capacity to participate on an equal footing with other stakeholders; hence, it creates a power and resource imbalance amongst the participants. Himmelman (1996) noted that power in

relation to collaboration does not assert dominance, but rather as capacity to produce intended results. Ansell and Gash (2008) asserted that weaker organisations will be prone to manipulation by stronger actors, which may lead to distrust or less willingness to commit to collaboration. For example, small voluntary organisations may feel more vulnerable when collaborating with larger statutory agencies that bring major resources to the collaboration (Huxham et al., 2000). Diaz-Kope et al. (2015) suggested that citizen-based collaboratives often lack the human, technical, and financial resources. Thus, they form partnerships with public agencies, where the latter provides technical assistance, funding and provision in exchange of the citizens' direct knowledge about local context and issues (Koontz, 2006).

The extent of involvement may depend on the amount of resources an organisation can contribute to the collaborative arrangement. In some cases (Wanna, 2008), some stakeholders do not have the time or energy to engage in the collaboration, nor do they have the skills and expertise to participate in discussions. In order to address such power relationships, countermeasures such as leadership and representation (Huxham, 1996; Huxham et al., 2000) must be in place to avoid an unsuccessful collaboration process. This is a common practice in citizen-based collaborations, particularly those involving grassroot communities and government agencies (Koontz, 2006).

2.6.1.2 Community attributes

The attributes of a community refer to the degree of common understanding between the potential participants who share values, beliefs, and preferences about policy strategies and outcomes (Polski and Ostrom, 1999).

Incentives to participate. Collaboration is likely to emerge when actors have incentives to participate. This is often shaped by the scope and nature of the problem being resolved (Emerson et al., 2012), the power differences amongst the participants (Gray, 1989), or whether participation is mandated or voluntary (Diaz-Kope et al., 2015).

In studies on common pool resource, for example, Ostrom (1999) posited that incentives can be generated for self-organising communities facing dilemmas on resource appropriation. However, these incentives will only be effective if they have a reasonable expectation to continuously enjoy benefits from it. For instance, Ansell and Gash (2008) proposed that incentives increase if the stakeholders perceive that their participation can directly lead to concrete, tangible effective policy outcomes.

Power imbalances are also determinants to the types of incentives to participate. Gray (1989) argued that power differences influence the willingness of some participants to the table. For mixed-agency structures, public agencies often exert dominance over citizen actors because of their advantage on resources (Diaz-Kope et al., 2015). However, as power asymmetry increases, participants will be more likely to shop around for alternative venues or to at least keep their options open. Stakeholders become discouraged with the collaborative process when they find other places to pursue their agendas (Ansell and Gash, 2008).

Incentives to participate can also depend on the legitimacy of the collaboration. For agency-based collaborations, stakeholders participate because it is mandated by legislature, which in turn creates a sense of legitimacy. This compels stakeholders to collaborate and work towards collective interests, creating positive incentives for participation. Voluntary participation for citizen-based agencies, on the other hand, is motivated by pluralistic incentives to exert influence over policy outcomes (Gray, 1989; Logsdon, 1991; Diaz-Kope et al., 2015).

Various incentives presented to participants are also subject to the autonomy-accountability dilemma (Huxham, 1996), where stakeholders have competing interests between achieving individual organisational missions and maintaining accountability to collaborative partners. When participants are presented with multiple incentives to collaborate, they oftentimes find themselves in a situation where they struggle to

maintain their own self-interests (i.e. their accountability to their own organisations or constituents) versus compromising with their collaborative interests, thus making it harder to make concessions with other stakeholders. This was the one of the core arguments of the collective action theory, where Olson (1971) expounded that rational individuals will act on their own self-interests and will not act to achieve group interests when participating in collective group decision-making. Roberts and Abbott (2017) stated that when accountability lines are not clear, especially for the private sector and community groups, self-interests may be easily involved in the policy process. On the other hand, Swann and Kim (2018) argue that citizen participation create positive incentives to build legitimacy and accountability in a collaborative governance because delegated entities are indirectly accountable to citizens.

History of cooperation. Literature suggests that history of antagonism or cooperation between stakeholders can either hinder or facilitate collaboration (Gray, 1989; Thomson and Perry, 2006; Ansell and Gash, 2008). This oftentimes dictates the direction of the collaboration in terms of the amount of resources (e.g. information) and/or common ground needed to be established. Much of the evidence on the literature suggest that having a previous history in cooperation generate strong trust and interdependence amongst stakeholders, thus resulting in collaboration (Heikkila and Gerlak, 2005; Imperial, 2005; Roberts and Abbott, 2017). In metropolitan governance literature, cases with a long history of cooperation result in more successful collaborative efforts. Lee et al. (2012) proved that on an analysis in regional collaboration, communities' cooperative perception appears to be a strong reinforcing mechanism to forge network relationships amongst their potential partners, thus increasing the likelihood to collaborate. Consequently, in situations where there are little history of cooperation, this can be resolved by establishing interdependence or by taking positive steps to rebuild the low levels of trust amongst stakeholders. Swann and Kim (2018) noted that in collaborative environmental management, governments with little to no history of collaboration

oftentimes need more capacity to share information and coordinate; thus, focusing on smaller projects in the first instance before making larger commitments may be the best alternative. This type of incrementalism is oftentimes advantageous for collaborative governance with limited history in voluntary collaboration.

On the other side of the coin, having a history of conflict is likely to have low levels of trust, which in turn produces unwillingness to commit, manipulative strategies, and dishonest communications (Ansell and Gash, 2008; O'Brien, 2012). This oftentimes become a barrier to collaboration, leading to unsuccessful attempts in overcoming collaborative process and to resolve collective issues. For example, in comparing large-scale ecosystem collaboratives, Gerlak and Heikkila (2006) noted that a history of polarised relationships amongst stakeholders made it more difficult to implement projects.

We do not discount, however, the possibility of high levels of conflict to lead to a successful collaboration. In fact, when stakeholders are highly interdependent, they are more likely to create a powerful incentive to collaborate when there is some level of conflict present (Gray, 1989; Ansell and Gash, 2008; O'Brien, 2012). When stakeholders deal with disparity of power and/or resources and it's becoming more costly to organise, this type of conflict causes an impetus to encourage collaboration. Similarly, when there is history of competition amongst the stakeholders, which is particularly more evident on studies in polycentric metropolitan governance, Lee et al. (2012) suggest that there is a stronger motivation to collaborate to learn best practice, reduce costs, and gain valuable information.

Interdependence. Perhaps one of the tenets of collaboration is the interdependence of stakeholders, which encompasses the coming together in order to accomplish something which they are unable to do so on their own. Collective action begins with the recognition of the actors' interdependency with each other to resolve an issue that affects

the actions of others. Thus, when stakeholders have a give-and-take relationship and depend on each other, it generates stronger collaborative solutions (Gray, 1989; Emerson et al., 2012; Lee et al., 2012).

Literature suggests that interdependence is the root of several collaborative strategies (Ansell and Gash, 2008). Logsdon (1991) asserted that willingness to collaborate depends on an organisation's perceived interdependence with other groups in addressing a social problem effectively. The author designed a logical path for evolution of organisational commitment to collaboration using a conceptual matrix based on level of risk and interdependence. When an organisation accepts solving a social issue to achieve its interests (high stakes) and also realises that joint efforts are vital to resolving such issue (high interdependence), it is more likely that the organisation will engage in collaborative efforts. When an organisation reaches this point, it is highly likely that they have already identified the resources to be shared, recognised legitimacy, and established shared motivation and mutual commitment to collaborate (Emerson et al., 2012). Thomson and Perry (2006) particularly identified forging mutual beneficial relationships is deeply rooted in interdependence, where organisations either have the shared motivation (homogeneity) or differing interests (complementarities) to forego their own interests at the expense of others. As long as participants can satisfy each other's differing interests without losing incentives to themselves, then collaboration can continue.

Emerson et al. (2012) provided a more elaborate explanation on how *shared motivation* encompasses all the interpersonal elements (social capital), such as trust, mutual understanding, and commitment, and how these are conditional to creating higher levels of interdependence. As participants engage in multiple interactions, they establish trust and respect with each other’s interests, thus creating bonds of commitment that eventually contributes to sustaining shared motivation to pursue

collaboration. *Principled engagement* is also another element rooted in interdependence (Thomson and Perry, 2006; Emerson et al., 2012). This involves getting the right people at the table during the negotiation stages to either forge out their differences or to identify commonalities based on each other's needs.

Overall, higher levels of interdependence provide a fertile ground for the key drivers of collaboration to foster. It is an intermediate outcome to a shared vision in achieving collective goals together, coupled with principled engagement, mutual trust and understanding, and deeper levels of commitment.

2.6.2 Action situation

The action situation is the centrepiece of the IAD framework where it highlights how institutions and structural attributes of the contexts affect the behaviour of the actors participating in it (Ostrom, 2005). In collaborative governance theory, the mechanisms of the "black box" or the collaborative process is analogous to the IAD's action situation. Wood and Gray (1991) described this as the linkage from inputs to outputs, and Thomson and Perry (2006) and Emerson et al. (2012) referred to it as the dynamics necessary to ensure a successful process. Whilst the patterns of the "black box" differ per context, the general sequence is usually dependent on the key drivers. It is important that we identify these elements to determine the various actions that participants take when engaged in a collaborative relationship with each other. We want to evaluate the different strategies they adopt resulting from the collaborative process, particularly focusing on their change-oriented, emerging relationships.

Common definition of problem. During the problem-setting stage of the collaborative process, stakeholders identify the problem or issue that they are more or less likely to resolve. Gray (1989) believed that it is important for all parties to narrowly define the problem to the satisfaction of everyone, otherwise, there will be little incentive to collaborate. They have to find a common ground and weave out their differences in order

to construct the problems they need to deal with. This is usually resolved through incremental negotiation and deliberation (Ansell and Gash, 2008; Emerson et al., 2012). During this discovery stage, participants reveal their individual and group interests and concerns until they develop a shared understanding of what they can achieve collectively. In some cases (Imperial, 2005; Imperial and Koontz, 2007), stakeholders act as “entrepreneurs” where they sell their ideas and display high creativity in order to form a niche that distinguishes the collaborative arrangement from its member organisations. The success of this stage depends on the level of interdependence between the participants.

Other scholars distinguish the role of agenda framing (Gray, 2004; O’Brien, 2012) as a specific way of stakeholders addressing conflict or problem at hand. In a study on environmental collaborations, Gray (2004) illustrated how stakeholders frame conflicts has an influence on the process and outcomes. She elaborated that participants may have different interpretations of the problem, thus construing their identity and consequently, behave defensively. By framing the agenda, the actors redefine the problem and tackle what action should be taken.

Role of actors. Governance involves establishing administrative structures that moves governance to action (Thomson and Perry, 2006). This involves identifying which participants are eligible to participate, establishing clear lines of responsibilities amongst the participants, and creating monitoring or accountability mechanisms. Ansell and Gash (2008) described that a broadly inclusive participation of stakeholders must be actively sought in order to ensure a successful collaboration. By identifying the critical and rightful participants who are affected by the issue, and ensuring that all collaborating organisations are equally represented, the legitimacy of and commitment to the process are preserved (Gray, 1989; Imperial and Koontz, 2007).

When crafting rules as to which actors will be involved and what positions should they occupy, it is also important to take into account that not all participants will be able to partake in the decision-making at the same extent or at the same time. Deciding such levels of participation indicate how responsibilities and benefits are to be distributed (Gray, 1989). Literature also suggests that leadership roles are important to identify. For example, Gray (1989) and Wood and Gray (1991) identified the presence of a convener in establishing, legitimising, and guiding the collaborative alliance. Whilst it's not a necessary precondition, the convener has the ability to identify and bring all legitimate stakeholders to the table. Logsdon (1991) demonstrated this in their studies on traffic congestion where the collaboration was convened by a previously assembled network of industry representatives who were negatively affected by the traffic problems.

Collaboration is inherently political, which involves a lot of negotiation, bargaining, and extensive discussions; thus, roles vary according to the existing context. Himmelman (1996) provided an elaborate typology on the other roles that stakeholders can take, such as catalyst, conduit, advocate, organiser, funder, technical assistance provider, capacity builder, partner, and facilitator – each of which stimulate the collaborative process. In collaborative public management literature, Moore and Koontz (2003) illustrated how institutional arrangements affect the roles that stakeholders play in the collaboration. In agency-based collaboration, for instance, provide technical advice to policy makers to improve strategic planning in local decision-making. The role of strong leaders is instrumental in influencing policy making as compared with citizen-based collaborative groups, who oftentimes resort to traditional adversarial methods such as lobbying or petitioning in order to make an impact. The former is oftentimes conducted through less subtle and informal channels, as also explored by Ayres (2017) and Bailey and Wood (2017) where leaders use "hands-off" or "arms-length" influence to shape the practices and preferences of other actors. Imperial (2005) described this

role as being a coordinator or facilitator, where informal processes become useful to resolve disputes, organise meetings, or conducting negotiations.

Some emphasise the role of catalysts, where leaders facilitate rather than directing (O'Brien, 2012) and stimulate the discussion with a vision and longer-term strategy in mind (Himmelman, 1996). In collaborative environmental management, citizen-based agencies oftentimes have individuals who play the roles of fixer, broker, or champions (Imperial, 2005). These roles tend to be strong supporters of the collaboration to either encourage more participants to get involved or to help find opportunities for joint action amongst the stakeholders.

We argue that leadership is important in steering the direction of the collaborative governance. Stakeholders agree upon a set of rules in terms of who gets to participate in the collaboration and what participative or leadership roles, power, or responsibilities they undertake, which helps sustain the collaborative governance as it continues to evolve.

Information. In experimental studies where interactions were tested multiple times, information about past actions and dialogue exchange between participants can influence the likelihood of collective action (Agrawal, 2001; Kopelman et al., 2002; Poteete et al., 2010). As the group is becoming more heterogenous or diverse, the level of optimal information being shared across the group also increases (Oliver, 1993). This could include information about their willingness to cooperate, their history of cooperation, the number of people they have known, etc. (Reuben, 2003), which could all be factored in when understanding if a heterogenous group is likely to make similar or dissimilar actions and make a dominant strategy to address the collective action dilemma. Kopelman et al. (2002) found that increased levels of communication through group discussion also yielded to positive cooperative effects and improved group identity

or solidarity. Both communication levels and information sharing constitute reputation, which can be built as the levels of interaction increase over time.

2.6.3 Interaction

Given a set of allowable actions, information, and the constraints provided by the exogenous variables (i.e. physical and material characteristics of the health commons, community attributes, and the rules-in-use), participants who occupy different positions then use different collaborative mechanisms in order to interact and produce their desired outcomes.

Dialogue. After identifying who gets to participate, what positions they can take, and what their responsibilities are, we now discuss how these stakeholders must interact with one another in the decision-making arena. We focus particularly on dialogue as a strategy and consensus decision-making as an intermediate outcome to the communication process.

Interdependence of the collaborating actors is built on face-to-face dialogue (Ansell and Gash, 2008). They continue to interact and exchange information with one another as the collaborative process matures from the direction-setting to the implementation stage. For instance, at the beginning of the collaboration process, actors use a more informal dialogue as a means of networking to establish shared interests (Himmelman, 1996; Wanna, 2008). Imperial (2005) and Imperial and Koontz (2007) added that establishing networks is a useful way of adding structural stability as the collaboration is being developed. In a study on collaborative management of multi-actor watershed programs, the authors findings suggest that organisations with strong network ties can communicate and share information and ideas quicker, thus creating more opportunities to build interdependence and social capital. As the collaboration process develops, the stakeholders engage in more formal forms of dialogues, such as meetings or public forums. Having a forum can be a place for stakeholders to create opportunities to

influence policies (Huxham, 1996), institutionalise decisions (Yang, 2017), exchange ideas (Roberts and Abbott, 2017), and coordinate their actions (Gerlak and Heikkila, 2006).

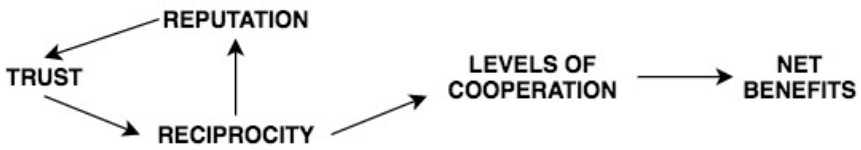
When stakeholders have the opportunities to participate in forums and engage interactions with one another, it builds interdependence amongst them and contributes to reaching an agreement on decisions by consensus. Gray (1989) discussed that personal forms of interactions result into subsequent debates over issues and exploring multiple options. This deliberation process ensures that stakeholders take advantage of the forums available to them where they can make reasoned communication with one another, such as having “hard conversations, constructive self-assertion, asking and answering challenging questions, and expressing honest disagreements” (Emerson et al., 2012:12).

Face-to-face dialogue, however, is not always advantageous or essential. It could create conflicting decisions that may result in difficulties in reaching a consensus. Scholars suggest that informal forms of communication are also becoming a more frequently used strategy in the collaborative process. For example, Moore and Koontz (2003) identified that agency-based collaborative groups are more likely to use informal means of communication (i.e. unsolicited technical advice) to influence policy making. Peer pressure and daily staff interactions are also useful means to reconciling competing values without having to resort to formal forums (Imperial, 2005). Informal mechanisms have been widely explored in the multi-level governance literature (High et al., 2005; Tatenhove et al., 2006; Ayres and Bird, 2018), which illustrate the strong interest to explore informal institutions as a complement to formal modes of governance. Tatenhove et al. (2006) for example referred to informal dialogues as a lubricant to the formal processes, where actors have more freedom to experiment and engage without having to abide to or change the rules. Similarly, Ayres (2017) also exemplified that informal

discussions, such as reaching out to another stakeholder after a meeting, had a positive impact on the decision-making process.

Shared norms. As participants continue to interact, they adopt rules and norms that govern their collaborative activities. Whilst formal rules were used to structure the relationships, informal institutions like shared norms were also found useful in facilitating the collaborative processes (Rodríguez-pose, 2013; Heikkila and Gerlak, 2018). Norms consist of shared understandings about which actions are obligatory, permitted, or forbidden (Crawford and Ostrom, 1995), and influence human behaviour on how to behave in various social situations. For instance, individuals can decide to adopt a different set of rules and change their behaviour to conform to norms.

Figure 7: The core relationships of collaboration



Adapted from: (Ostrom, 1998)

Trust, reciprocity, and reputation. Aside from social norms, trust, reciprocity, and reputation are also as equally important in facilitating an effective collaboration. Scholars have used individual strategic decisions models like prisoner's dilemma to debate the likelihood of collective action occurring between individuals using the payoff matrices (e.g. cooperation vs. defection) (Tedeschi et al., 1969; Oliver, 1993; Reuben, 2003). Ostrom (1998) examined a series of infinitely repeated situations and found that as participants engage in repeated interactions with one another, individuals who acquired reputation led to developing levels of trusts and higher levels of cooperation (Figure 7).

Collective action theory posits that institutions, including rules, norms, and strategies, structure the behaviour of the participants in a collaborative and collective agreement

(Ostrom, 2005, 2011). As social capital increases the likelihood of forming stronger network ties, therefore leading to more cooperation (Swann and Kim, 2018). This could involve frequent, informal social networking plays to promote the collaborative governance or to engage others in a dialogue about similar goals and interests.

Trust is the extent to which members of this community feel confident that other members will not take maximum advantage of any situation, and that others will live up to their agreements regardless of their immediate interests (McGinnis, 2011a). If one trusts someone with a reputation of being trustworthy, then they are more likely to engage in productive social exchanges and cooperation. As the chain strengthens, more members encourage others to cooperate with those they have cooperated in previous encounters. This is referred to as reciprocity (Ostrom, 1998, 2010). This is a common practice where individuals tend to react positively to actions of others with positive responses, and negative actions of others with negative responses. Collaborative governance literature (Thomson and Perry, 2006), for example, illustrated that participants are more likely to willingly interact and behave accordingly if the other partners also demonstrate the same level of eagerness.

2.6.4 Evaluation and outcomes

After identifying the institutional arrangements in the action situation, participants interact and generate outcomes. We use Ostrom's design principles to evaluate under which conditions can institutional arrangements resolve collective action.

Well-defined user and resource boundaries. Having clear boundaries, makes it easier for the users of the commons to make arrangements on collaborative efforts. Since the earlier studies on the commons involved the management of natural or man-made resources such as fisheries, watershed, irrigations, and forestry, a well-defined boundary is crucial. It identifies the inclusion and exclusion criteria through a geographical boundary on who gets to appropriate from the resource and which area are

they allowed to use (McKean and Ostrom, 1995; Agrawal, 2002). This is, however, problematic in areas where social or ad hoc boundaries are in place, or in polycentric settings where spill-over boundaries exist. Boundaries also sometimes emerge from a long natural process of historical competitive or cooperative interactions (McGinnis, 2013a).

Congruence with local conditions. In many setting of the commons, various rules emerge depending on the local conditions or the physical attributes of the resource involved (Ostrom, 1997). For instance, rules in appropriating water from a shared river will be different from the rules in grazing on a shared piece of land. Agrawal (2002) and Cox et al. (2010) also suggested that the rules should also be congruent with the characteristics of the users. This could include shared norms (e.g. culture, ideology, customs, etc.), past leadership experiences, level of interdependence, and group size.

Collective choice agreements. This is the principle supporting the institutional arrangements that users make collectively, where they have first-hand and low-cost access to modify the operational rules and strategies of the resource (Ostrom, 1997). If the users do not have the bargaining power to change the rules, then they have more incentives to benefit from the system as identified earlier by the theory of collective action. This set-up is particularly common in small groups (McGinnis and Brink, 2012), where users of the resource also have the right to participate in making decisions.

Monitoring mechanisms. Once initial agreements have been established, there is not guarantee that users of the resource will abide by the rules. Therefore, monitoring mechanisms are particularly important in order to generate incentives and motivation for the users to conform to the rules that they all collectively agreed in. Ostrom's (1990) field studies suggested that without these rules, systems are unable to survive for a very long time. For instance, studies on monitoring fisheries suggested that formal rules and regulations with various degree and type of penalties are good mechanisms to decrease

the likelihood of fishermen cheating (Rudd, 2004; Gerlak and Heikkila, 2006). This could involve a convening body and various committees to monitor and regulate the compliance of all users. The types of monitoring schemes also depend on the costs associated with it. In some smaller communities or multilateral partnerships with larger, nested networks, monitoring may be costly and difficult to implement (Swann and Kim, 2018). For instance, in a study on 28 villages protecting their forestry, Agrawal and Goyal (2001) found that because of the size of the group benefiting from the resource, they had to externally hire a guard who monitored and maintained cooperative behaviour amongst the users. Baland and Platteau (1996) also specified that central monitoring can be extremely costly especially if there is only a single agency collecting all the information. They emphasised, however, the importance of imploring specialised monitoring driven by morals and norms to demotivate and incentivise users from breaking the rules.

Graduated sanctions. Whether the monitoring rules are governed by an internal and/or external group, there should also be appropriate sanctions in place to punish those users who violate the collectively-agree rules. The type of sanctions also act as deterrent for participants from overusing the user and comply with their institutional arrangements. Ostrom (1990) highlighted the value of a system of sanctions applied in a graduated manner, rather than a single centralised punishment applicable to all kinds of violations. Not only does this allows the monitoring agents to resolve issues in a low-cost manner, but also, it gives them the opportunity to implement lower sanctions and resolve any issues or disagreements before it escalated to a higher level of punishment. In this way, violators can reflect on their actions at an earlier stage and prevent the rule-breaking behaviour in a more pragmatic manner. Of course, if they do decide to violate the rules again, more severe punishments should be imposed.

Conflict resolution. Ostrom (1990) valued conflict resolution mechanisms that are easily available and costs cheaply to implement. This could be informal institutions such

as face-to-face communication, open dialogues, and/or other traditional modes of dispute resolution. In groups where community ties and shared norms or values are deeply embedded, interpersonal disagreements are usually resolved more effectively (Rangan, 1997). In larger groups, having a formal collaborative governance structure became a useful avenue to address any disputes (Jung et al., 2009).

2.7 Summary

The aim of this chapter is to explore the literature on the role of the institutions and how it emerged as a response to collective action dilemmas, how formal and informal institutional arrangements were used to govern the commons, and what are the mechanisms that are common to addressing collective action problems that are found in collaborative settings.

Based on the literature review, our research therefore argues that institutional arrangements can be devised to address collective action dilemmas. We argued that organisations benefiting from a shared resource can form a collaboration to collectively govern their commons, where group of leaders can act as stewards of their own commons and make collective decisions on behalf of their population. Stewardship of the commons involves crafting, enforcing, and monitoring formal and informal institutional arrangements to facilitate the decision-making process, shape the behaviour and incentives of the participants, and to constrain the access to the resources.

These assumptions are based on the following theoretical framework:

Collective action dilemmas: The theory of collective action is one of the theoretical foundations in explaining why humans behave the way they do when they are faced with a dilemma to cooperate as a collective unit. This theory assumed that individuals are short-term maximisers motivated by their self-interests rather than their concern for others or for society as a whole. Whilst state ownership or privatisation has proven to

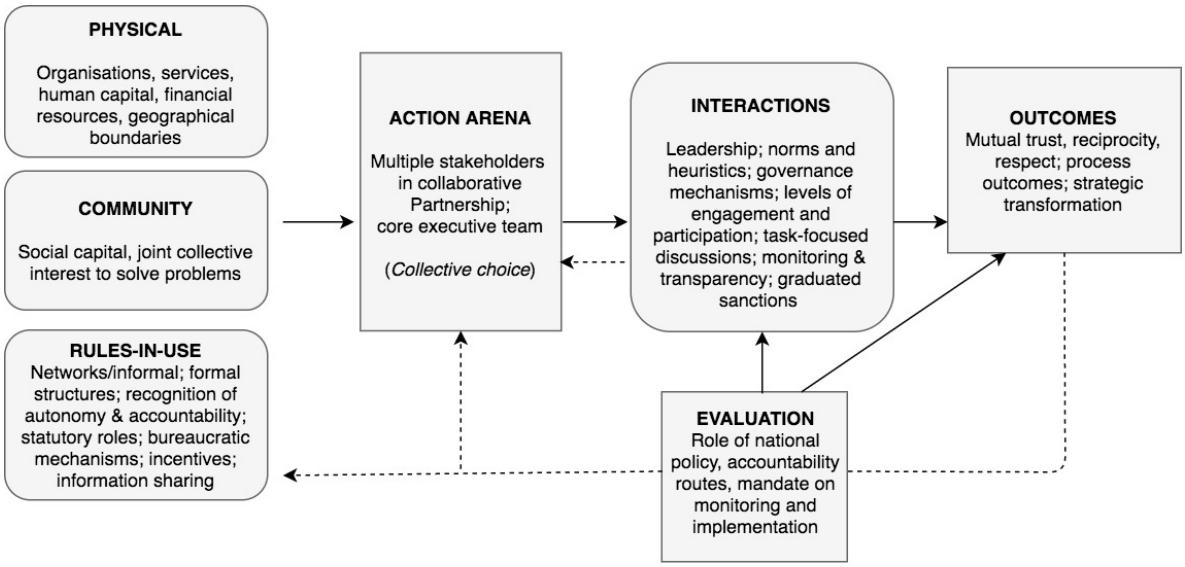
resolve collective action dilemma, the study on the commons suggested that creating common property rights to share responsibilities towards consuming and/or managing the resource can be a cheaper and more effective alternative.

Institutions: Ostrom (1998) offered an alternative individualistic conception to resolving collective action and posited that individuals are capable of designing new tools – including institutions – to change the structure of their environment, and adopt short-term or long-term strategies based on the opportunities they face (Ostrom, 1998; McCay, 2002). Institutions are “rules of the game” (North, 1990) that facilitate, guide, and constrain the behaviour of individuals and organisations. Collective action theory posited that when actors come together to collaborate, they develop a set of working rules in order to determine who will be eligible to make decisions, which actions will be allowed, and how costs will be distributed (Ostrom, 2005; Ansell and Gash, 2008).

Collaborative governance: Collaborative governance is a new form of governance in the public administration and management literature, encompassing the engagement and networking arrangements between public, private, and third-sector agencies (Gray, 1989). There are various elements of collaborative governance that are congruent with collective action theory, namely: governance, stakeholders, forum, collective decision-making, consensus oriented, and shared vision or common purpose. We link all these variables together to form a modified model of the IAD framework.

We embed the structural variables previously identified on our examination of the collective action literature, particularly focusing on the role of institutions as facilitating mechanisms to address social dilemmas. We linked them and present a modified collaborative model embedded in an IAD framework (Figure 8)

Figure 8: Modified collaborative model embedded in IAD framework



3 Policy Background

3.1 Introduction

In the previous chapter, we established a theoretical framework supporting the assumptions of this research. We applied the theory of collective action using an institutional analysis approach in collaborative governance to identify that self-organising communities can thrive and sustain the commons by crafting, enforcing, and monitoring their own institutions (also referred to as “rules of the game”). However, one of the contributions of this thesis is extending this theoretical framework and applying it in the health policy context. In this chapter, we devise the concept of the ‘health commons’ to encompass the health and social care resources pooled as a shared property regime, wherein a population within a particular geographical boundary can contribute and share access to (McGinnis, 2013a). Under the conditions analogous stated in the theories of collective action, common property regimes, and collaborative governance, we hypothesise that a group of individuals can emerge to take a stewardship role in governing the health commons on behalf of the population and create their own set of rules to facilitate the relationships of the individuals benefitting from that resource within a set of geographical boundaries.

In order to contextualise the health commons, we also need to examine the policy background in the UK and look at the different approaches and mechanisms that the UK government have devised to govern the NHS. We want to understand the motivation behind the events leading to the Devolution of Health in some English city-regions and its implications on the competitive and collaborative relationship patterns across the different NHS organisations. More importantly, we want to examine the plethora of tested organisational restructuring and collaborative arrangements that have emerged over the decade in order to justify the use of collaborative governance as a means of governing the health commons.

This chapter therefore aims to explore the institutional evolution leading to the current decentralisation policies being implemented by the government and the current polycentric state of the NHS. We have identified in the previous chapter that multi-sectoral organisations create collaborating arrangements in order to address a financial, moral, or instrumental imperative, by working together to resolve the collective action problem. By exploring the various characteristics of the key stakeholders involved in NHS England, we provide a rationale to the potential behaviours as to why certain organisations act the way they are as soon as they are immersed in a collaborative situation. This provides a contextual background to the study as we begin to examine the mechanisms utilised by the GMHSC Partnership in addressing their own social dilemmas. We look at the events leading to the Health Devolution in GM and how we can compare the case of the Partnership as stewards of the health commons.

3.2 Health commons

The aim of this section is to introduce what the health commons is – its emergence in the field of common pool research, its assumptions, and how it has been applied in the field of health governance. We highlight the importance of this emerging perspective in viewing health as a common property regime and how regional and local governances can act as stewards of the health commons by initiating and facilitating institutional arrangements in order to take charge of their own health resources.

Although governing the health commons has always been present in the literature (see medical commons, Hiatt, 1975); studies were very limited to conceptualisation and not much on empirical examination. For instance, Saltman and Ferroussier-Davis (2000) explored the theory of stewardship and challenged its readers on its potential applicability on health policy; but failed to empirically investigate it on a particular health care setting. Later on, Saltman and Bergman (2005) conducted a historical analysis of

the Swedish health care system and offered insights on how it can be renovated as a health commons. It was, however, also shorthanded in offering any empirical advice.

University of Indiana Bloomington scholar and Ostrom's colleague Michael McGinnis pioneered empirical investigations on the health commons, along with other researchers in the ReThink Health initiative funded by the Fannie Rippel Foundation in Cambridge, Massachusetts. They offered an alternative perspective in managing the health commons by crafting and monitoring institutional arrangements akin to that of Ostrom's (1990) ground-breaking discoveries on small communities benefitting from a common pool resource. McGinnis and his team developed a series of action-based research, workshops, and reports (both published and unpublished) to document the study (McGinnis, 2011b, 2013a; McGinnis and Brink, 2012; Linton et al., 2014) that explores how the regional health community of Grand Junction, Colorado managed to generate positive health outcomes to their population through self-crafted institutional arrangements. In particularly, they examined how collaborative stewardship between health care professionals, community service organisations, private insurers, and public officials effectively acted as stewards of their local health care resources. Under the conditions analogous to Ostrom (1990) and Cox, Arnold and Tomás's (2010) design principles to managing sustainable common pool resources, McGinnis (2018) was able to compare how we can recognise health resources as shared property between those who benefit from it, and how those said individuals (or organisations) can function as self-organising communities by crafting their own rules to monitor who, what, and how to appropriate from the commons.

3.2.1 The "health commons" and its working assumptions

McGinnis (2013) identified that the rising threat to long-term sustainability and fragmented governance of health care systems can be addressed by treating health care as a common property regime, where multiple users of this resource can collaborate and

act as stewards. Health commons encompass “all of the physical, financial, human, and social capital resources relevant to the delivery of health care and/or the promotion of population health in a geographic region” (McGinnis, 2013a:3).

In the previous chapter, we illustrated how Ostrom (1990) demonstrated that local communities who are dependent on continued access to natural resources can, in some circumstances, work together to craft, monitor, enforce, and revise rules, thereby managing to keep such resources sustainable for long periods of time. McGinnis (2013) makes an interesting analogy that health care can be treated as commons, where ‘an institutional arrangement through which specific group of individuals share the responsibility for jointly consuming and/or managing shared resources.’ (p. 3). Health governance, therefore, may be regarded as the “health commons” in a way that an arrangement is made between a group of users share rights and duties, where they make collective decisions together to ensure the sustainability of the system (McGinnis, 2013a).

Drawing from Ostrom's (1990) design principles for sustainable governance of CPR, McGinnis (2013) believes that under specific conditions, users of health care can act as stewards to conserve the appropriation and provision of the ‘regional health commons’. Health system actors (i.e. government leaders, health care providers, private organisations, voluntary groups, etc.) act as stewards by generating resources, delivering services, and/or exerting influence over decisions through collaboration and coalition building (World Health Organization, 2007; Abimbola et al., 2014). They, together, form a stewardship team with the collective responsibility of overseeing the health commons, making decisions on behalf of its population to ensure that the resource will be sustained for later use.

Upon examination on the functions of health governance, Travis et al. (2002) identified three broad tasks of an effective stewardship of the health systems, namely

“providing vision and direction for the health system, collecting and using intelligence, and exerting influence through regulation and other means” (p. 1). McGinnis (2013) pointed out although the act of stewardship in any health communities vary in different sizes i.e. from small communities (Linton et al., 2014) to large regional health governances (McGinnis and Brink, 2012), not all people involved make decisions that affect the system as a whole and make decisions to ensure the sustainability or availability of these resources. Moreover, physical and financial health resources may be more or less already allocated by another group, but with only a limited authority (Travis et al., 2002); therefore, stewardship encompasses a larger population and the task of planning and prioritising which programmes to carry forward.

It is important to address the issue of excludability and subtractability of health care, and whether it is a public, private or common pool good. McGinnis (2011b) argues that the overall system of health and delivery of health care services is best understood as a ‘common property’ that encompasses multiple types of resources, goods, and services.

Table 4 below shows the variety of property rights associated with health care resources. One can argue for example that publicly-funded national health systems, such as the NHS, are non-excludable and rivalrous (Palumbo, 2017); however, there are certain services in the NHS where one needs to pay (e.g. ophthalmology and prescription services) which violates the assumption of non-excludability. Rather than viewing the health care resources as a CPR, what McGinnis (2011b) suggested is this critical point of departure of analysis to view the health care system as a ‘common property’ where a common set of rules are agreed as to who can access it, which services can be accessed, and how, where, and when can it be accessed (i.e. the commons). This means that participating providers of care (i.e. health care professionals, commissioners, etc.) engage in activities and make decisions according to collective rules, bound by formal and informal institutional arrangements.

Table 4: Comparison of the conceptualisation of CPR and Health commons

	Common pool resources	Health commons
Common property regime	Joint ownership of the fish in the lake	Joint access to the commons via stewardship of health resources
Common pool resource	Population of fish in a lake	Overall stock of health resources in the region
Resource unit	A fish once it has been caught	Access to health services
Appropriation	Extraction of fish from the lake	Access to health services
Actors		Stewardship team acting on behalf of population as a whole
	Appropriators: Fishermen who harvest from the lake	Providers: Health care professionals; Users: patients
Provision	Replenish resource or maintain infrastructure	Allocative efficiency in producing and maintaining health resources
Rules	Rules restricting appropriating behaviour of the actors	Rules that shape how decisions are made by the stewards and how to access the resources
Provision rules	Contributions to replenishment or maintenance of the resource	Limitations on how parties can spend savings from programs or what initiatives they should undertake (e.g. NICE guidelines)
Rule-making activities	Self-organising communities create rules	Stewardship team sets priorities for programmes
Higher-level public authorities	State intervening to local users	Regulations from the state
Tragedy of the commons	Degradation or destruction of the resource	Rising health care costs reducing overall economic productivity
Sustainability	Ensure future access to resource	Financial viability, improved health outcomes, lower costs, productivity and equity

Although the key findings from Ostrom's field studies on the design principles were applied mostly in the fisheries, forestry, and irrigation studies (see Cox et al., 2010), it continued to evolve and be applied in numerous contexts, varying from polycentric systems (Carlisle and Gruby, 2017), community settings (Imperial and Yandle, 2005), and collaborative governance (Yang, 2017). It has been, however, deeply unexplored in the health policy context, which is why the work of McGinnis and his colleagues were crucial into the contribution of the health commons to the discourse in the sustainability of common property regimes. Through a series of action-based research, McGinnis and his team focused their attention to the health community of Grand Junction, Colorado, with the primary intention of identifying the conditions to which the health commons can be sustained via collaboration and coordinated stewardship (McGinnis and Brink, 2012; McGinnis, 2013a, 2018).

Grand Junction is a small municipality in Colorado, with a relatively low population and is geographically isolated from larger urban areas. For several decades, they have relied on an informal leadership team that took charge as stewards of their local health care resources. Their effective system was able to deliver an unusually high quality of care compared to neighbouring towns of similar size (Levin, 2010). These community leaders were led by a family of physicians, who built a financially based commons that provides reimbursements to physicians for health care services regardless of the funding source of the patients (i.e. private or commercial insurance, and/or Medicare or Medicaid). As a result, patients had equal access to private care and became less likely to access expensive emergency services.

The key findings from their research on the health commons included:

- Grand Junction leaders reached outside their boundary to call upon other organisations to join their reimbursement programmes.

- The leadership team makes up more than 85% of their local physicians, which meant their commons is managed by their very own health care providers.
- The level of autonomy by the leadership team, was however, questioned because of their commitments to operate on behalf of Grand Junction and maintain their allegiance with their practices.
- A health care collaborative was created to act as the collective consortium for various health care organisations within their community. They met monthly to discuss issues about their practices.
- Monitoring principles were developed, such as peer evaluation process, to ensure that all participating physicians present their financial reports and the quality of their performance.
- The leadership team exercise informal means, such as “taking someone out for coffee” (p. 5), as a form of sanction. This is masked as a gentle form of mentoring to encourage physicians to modify their behaviour. This also applies with conflict resolutions, where open communication has been a long-standing practice.

These findings indicated that a community like Grand Junction, Colorado was able to successfully craft, enforce, and monitor their own institutional arrangements to take charge of their own health care resources and generate positive outcomes. Akin to Ostrom’s design principles, the local community leaders came together to act as stewards and act as an interdependent and collective unit. On a much updated report, McGinnis (2018) explained that the history of cooperation by the family physicians, who gained substantial control of the local health care services in their town, contributed to the long-term sustainability of their resources. They used informal institutions to moderate the behaviour of the providers, who also acted as decision-makers for the commons. Moreover, their crucial finding is the interaction between the leaders, where

they took advantage of their strong social ties beyond their geographical boundary and used this interdependence to build mutual trust and respect.

The findings from the study of the health community in Grand Junction, Colorado, supported by the collaborative governance model and design principles outlined in the previous chapter, will be the foundation of this research in examining the institutional arrangements for sustaining the health commons. However, we need to acknowledge the limitations of McGinnis' conceptualisation of the health commons and his findings from Grand Junction, Colorado, and why its applicability to the UK context might be entirely different.

The US health care system is complex and largely operated by the private sector, supplemented by some ownership by the federal, state, county, and city governments. McGinnis' research and later reports were limited to this context, particularly on a small community like Grand Junction where it is driven by a top-down collaboration on health care stewardship.

Whilst there were attempts to apply it in other areas in the US, they were unsuccessful in replicating the full scale of McGinnis' study. Linton et al. (2014), for instance, examined Bloomington, Indiana's health community and designed an action research to create a web-based health information commons for local health professionals and local governments to utilise. The methodological approach is quite different because the research team was trying to initiate a collective action rather than examining a setting that already has an inherent collaborative unit. Due to the difficulties posed by the uncertainty of current government health policies being implemented at the time (e.g. 2010 Affordable Care Act to name a few), this deterred local government agencies establish shared goals and make collective decisions. McGinnis (2013b) raised that local governance of health care needed traction in the US; however, it is almost impossible for regionalisation of health care, primarily because of the partisan politics

paralysing the debates for a reform at the state and national levels. Although there was already an existing community of collaborative relationships who meet informally via networking, these community organisations failed to create a strong foundation of collective action. Linton et al. (2014) acknowledged the challenges of this project and encouraged scholars to apply the theoretical contribution of the health commons to other contexts.

Since then, there has been a limited but growing interest in expanding the study of the health commons to health care systems outside the US. For example, Wong et al. (2014) and Palumbo (2017) examined systems with universal health care coverage. Wong et al.'s (2014) extension of the health commons particularly mimicked the common pool resource regime settings by using small tight-knit indigenous groups in Malaysia. They examined the success of their health commons through the effective management of their shared natural resources and strong knowledge base on how to preserve their health systems for the future generations. Similarly, Palumbo (2017) offered a thought-provoking theoretical narrative on the conceptualisation of the health commons into the publicly-funded health care systems in most European countries. Whilst there were no empirical evidence presented to support their framework, the author managed to extend the scientific inquiry on the health commons outside the US context and offer a framework that may allow future examination of sustainability issues in national health systems.

Drawing from the limitations of the existing research on the health commons, this study aims to contribute to the existing discourse and fill the literature gap in two ways. First, we want to extend the theoretical inquiry on common pool resources and apply it in the health commons settings outside the US context. McGinnis' studies focused on US health care setting, which is characterised by a predominant ownership of private firms with a shared control between the state and federal agencies, and commercial

organisations. This is widely incomparable to the UK setting. Although the two health care systems differ in many aspects, they both share the problematic narrative on addressing their dwindling finite resources and financial sustainability.

Second, we want to establish an alternative perspective to addressing the problems on sustaining our NHS. Although there has been a wide amount of research available addressing how and why we should sustain the health resources in the UK through a plethora of state-led policies, place-based approaches, and/or partnership working (Alderwick, 2015; Ham and Alderwick, 2015; Ham, 2018a), empirical evidence using a collective action and institutional approach to regional stewardship of managing a particular segment of the NHS remained unexplored.

3.3 The NHS and the devolution of the English local governance

In the previous section, we emphasised the conceptualisation of the health commons. This section presents a thematic overview of the policy background of the NHS and the English local governance. In order to understand the motivation or rationale behind the Devolution policy, it is useful to highlight the issues and context that stimulated it. We look at the existing health and social care system and the various governance modes that emerged throughout the decades, and the birth of the Devolution policies in the English local governance context. We also explore the health reforms that evolved over time, particularly the “concerted attempt” (Greener and Powell, 2008:617) to marketise the welfare state, which influenced the constant reshaping of the structures of the NHS. By examining the different approaches and mechanisms that the UK government devised, we get to understand the motivation behind the Devolution of English cities and its implications on relationship patterns across the subnational layers.

The GM Health Devolution has been the product of decades of oscillating pendulum between centralist, regionalist, and localist approaches by the UK government and the NHS. In order to organise our understanding on the evolution of governing structures in

the NHS and the local governments, we divide the historical narratives on the governance reforms and the centre-local relationships into three subsections: the centralist approach, the internal market, and the pragmatist era. First, we examine the centre-local or hierarchical relations and the establishment of the NHS during the welfare state era. Second, we look at the accounts of regionalisation and how the government responded through markets and corporatist approach to public services management. Lastly, we illustrate the post Devolution policies to highlight the "centralisation of decentralisation" approach of the Coalition government in addressing the localist agenda.

3.3.1 Centralist approach

The United Kingdom (UK) has traditionally been a unitary majoritarian state, which favoured a top-down hierarchical, quasi-elite mode of governing. This was described by Stoker (1998) as the "Westminster Model", where there is a single, homogenous central government that is responsible to a sovereign Parliament and has a strong cabinet, accountability, and majority party control of the executive. There was a strong presence of the central authority in terms of rowing the direction and retaining control over the local governments, most particularly evident in England. This was illustrated in the literature significantly focused on 'central-local relations', describing the contentious relationship between the Parliament and the subnational governments as unequal and diminishing (Leach and Percy-Smith, 2001; Pearce and Ayres, 2012; Ayres and Pearce, 2013; Fenwick, 2015; Blunkett et al., 2016).

The NHS was established in 1948 during the post-war settlement to cement the public provision of health care services as a state responsibility. It advocated for free (at the point of use) comprehensive health care services, including primary care (general practice, optometry, pharmacy, and dentistry), secondary or acute (hospital), and community (health visiting) services to the whole of the UK population (Gorsky, 2008).

Hospital services previously administered by local authorities were removed from their control, and the NHS became the responsibility of nationally elected officials who exercised top-down control on planning and management (Exworthy et al., 1999; Saltman et al., 2007). This model of hierarchy, where there is a central decision-maker on behalf of the population, was promoted at that time as a way of controlling the distribution of resources, increasing central accountability, and promoting efficiency in the delivery of health care services (Allen, 2013).

Some accounts focus instead on the interaction between the state and the doctors, rather than the state and local relations (Klein, 2010). At its creation, the NHS delegated the day-to-day running or operationalisation of the NHS to medical professionals because of the unorganised and underdeveloped administrative structures at that time (Greener and Powell, 2008; Ham, 2009). At the provision level, GPs and hospitals still control much of the practice; therefore, the state effectively still purchased health services from them. This showed that although the NHS is centrally run by the state and accountable through the Parliament, provision of health services was delegated to GPs and consultants at the local level. This led to the state being paralysed in influencing the day-to-day running of the services, but are still being held accountable for the efficient delivery of the services (Greener and Powell, 2008).

The prominent central-local relations of the British political system was characterised by bureaucratic hierarchies, where there is a high degree of centralisation of decision-making and resource allocation and limited autonomy for the local governments (Rhodes, 1996). This was described by Bulpitt (1983) as ‘dual polity’, where there is a distinct separation of powers between ‘high politics’ and ‘low politics’. The former was a responsibility of the central government concerning matters such as macroeconomic policy, the economy, and national defence; whilst the latter involved the local government, administrative matters, and the delivery of public services in key local

areas. The elites in London were more concerned with matters that are deemed more important, whilst the local governments were dealing with parochial affairs and were left out of the limelight as they were largely self-governing (John, 2009; Shaw and Tewdwr-jones, 2017).

This illustrated that UK constitutional arrangements are constantly evolving and reforming where deals were brokered between rival elites (Blunkett et al., 2016), exposing the weakness of the centre and its inability to govern the periphery properly. Literature on modern reforms on England's local governance have applied Bulpitt's (1983) framework to show the modes of governance used in managing territorial and political dilemmas for subnational governments. For instance, Ayres et al. (2018) demonstrated that the changing nature of centre-periphery relationships still exists in England, where the mode of statecraft is still dominated by central autonomy. Shaw and Tewdwr-jones (2017) also used Bulpitt's (1983) framework to illustrate the current disorganised nature of England's devolution reforms, where patchwork of local governance solutions was heavily influenced by the centre and rewards go to those who "dance to the tune of the government" (p. 222).

3.3.2 Marketisation, competition, and the internal market

The period between 1946 and 1997 illustrated that spatial and economic planning were characterised with a 'central government localism' approach (Wood, 1994; Harrison, 2012) by promoting centrally-controlled policies in a local scale of implementation. We see a shift from regionalist policies by the interventionalist Labour party to the disintegration of territorial structures by the Conservative government, both disarming the autonomy of local governments and highlighting the centralist nature of the government to command and control.

The successive Conservative government under the term of Margaret Thatcher in 1979 embraced the New Public Management (NPM) ideology of driving the management

of the public sector similar to that of the private sector, whilst prompting the marketisation of public services. This introduced a new style of governance that relied less on bureaucracy and formal structures, and more on third-party organisations to stimulate competition, choice, and incentives (Ham, 2009; Le Grand, 2011). Local autonomy weakened as central government controls over the public sector increased. The Conservatives viewed local governments as an obstacle to modernise the economy, hence, leading to the abolition of the previously established institutional structures under the *Local Government Act of 1972*, further constraining the role and capacity of the local state (Pike and Tomaney, 2009). This was achieved primarily through tighter financial control on public spending, and planning bodies that were tasked to represent the local views were removed.

When market mechanisms were introduced in the late 1980s and early 1990s, provision of public services were removed from local authorities and were heavily influenced by competition and contractualisation to the private and voluntary sector. This brought further fragmentation of services and spatial inequality arising from privatisation and establishment of arms-length agencies to enable provision of services (Taylor, 1997; Leach and Percy-Smith, 2001) on the behalf of local authorities. More importantly, this resulted into the hollowing-out of the state which led not to a loss of central power, but rather influence and control were secured through the formation of self-organising networks (Rhodes, 1996; Taylor, 1997).

The provision of public services was geared towards a more bureaucratic, customer-oriented, and private sector style of management. Contractual arrangements were used to facilitate transactions between three key roles (Leach and Percy-Smith, 2001:159): the policy makers responsible for determining overall strategy; the client side responsible for setting and monitoring standards; and the service provider responsible for delivering services. This was adopted by various agencies of the government as joint authorities

were established for fire, police, and transport services, whilst work contracts were introduced (*Local Government Act 1988:* Parts 1 and 2) to induce competition for utilities and public services.

This led to one of the most significant changes in the direction of the policy and governance of the NHS in the late 1980s. As part of the government's commitment to increase accountability, greater allocative efficiency, and reduction in the power of specific professional groups, the NHS created a market-oriented and competitive approach to state provision through the **internal market**. The internal market was divided between the providers (those who provided services like hospitals, local authorities, and community services) and the purchasers (those who purchased services from them like the health authorities (HAs) and GP fundholders). By separating the NHS organisations into purchaser and provider roles, it induces competition in the provision of services and promote responsiveness to the needs of the population by increasing patient choice (Le Grand, 1997; Brereton and Vasoodaven, 2010). The main argument was that it enhances the 'technical efficiency' (Allen, 2013:3) with the least amount of costs, i.e. ensuring the greatest output for the least resources used.

When the New Labour sat in office on 1997, they heralded a modernisation reform that promises development of community leadership within the local government and working in partnership to meet local needs and to promote good governance (Sullivan et al., 2004). More importantly, they committed to "clean up politics...and decentralise political power throughout the United Kingdom" promising to "give Britain the leadership in Europe which Britain and Europe need" (Labour Party, 1996). Statutory powers were granted from the central government to Scotland, Wales, and Northern Ireland in 1998 in order to meet this pledge. This involved new institutional arrangements in terms of the multi-level governments in the UK, devolving policy-making, delivery and monitoring, and decision-making responsibilities to a Parliament in Scotland and Assemblies in Wales

and Northern Ireland respectively (Pearce et al., 2005; Pearce and Ayres, 2012). Moreover, the devolution to Scotland, Wales, and Northern Ireland also led to the division of the NHS health care system into four: NHS England, NHS Scotland, NHS Wales, and HSC Northern Ireland. A separate account reports the impact of the devolution to the four countries of the UK (see Bevan, 2014).

This reflected the transition from top-down processes to a less facilitating role of the state. It advocates for costs efficiency, service effectiveness, managerial improvement, and restructuring of the delivery of public services. Localisation has fuelled governments to reform public services delivery by bringing decision-making down to the subnational governments through devolution and delegation. This is to provide autonomy on key aspects of public service delivery and to improve public service performance.

3.3.1 Promoting cooperation

The New Labour promoted increased patient choice and a more collaborative approach. The NHS abandoned most of the features of the internal market experiment and abolished competition on the commissioning bodies or purchasers. Instead, 'cooperation' was promoted as a way of promoting uniform national standards of care (Niemietz, 2016). There are several accounts itemising the implications of the internal market to the succeeding reforms (Le Grand, 1991; Cutler and Waine, 1997; Hughes et al., 1997; Mays et al., 2001; Propper et al., 2008; Brereton and Vasoodaven, 2010).

First, the creation of the internal market was a result of the increasing power of medical professionals in controlling the way the NHS was being run with minimum accountability. As a way of taking over control and legitimacy, the state reduced the responsibilities held by medical professionals and introduced tighter regulations through regulatory compliance rules to monitor their practice (Greener, 2008). This period saw the establishment of several regulatory institutions, such as what is now the National Institute for Health and Care Excellence (NICE), which provides recommendations on

cost-effectiveness of treatments, the National Service Frameworks (NSF), which provides clinical guidelines in identifying and disseminating medical best practice, and what is now the Care Quality Commission (CQC), which is an inspector of health care facilities (Niemietz, 2016).

Second, in order to facilitate effective hospital performance management in accordance with the new regulatory guidelines, the role of general managers was introduced. They stood outside the hierarchies of professionals to create a chain of command and to promote accountability and performance management (Leach and Percy-Smith, 2001). This was influenced by the NPM movement characterised by 'managerial revolution' (Pierre and Peters, 2000), where elected officials are left with a more peripheral role and managers are in charge of administration, evaluation, and performance management of public services. This marks a fundamental shift from 'administering' towards 'managing' (Saltman et al., 2007) with regulatory and management functions devolved and the contracting out of public services to the private or internal market (Le Grand, 1991; Hope and Bornwell, 2000).

3.3.3 Governance restructuring

The NHS has undergone multiple dramatic structural changes throughout the last two decades, as a result of the ever-increasing demand on health care services and tighter budget allocations (see NHS White Papers, 1997, 2002, 2010). In this section, we want to break down the governance structures before and after one of the most revolutionary reforms in the history of the NHS (Checkland et al., 2015), the Health and Social Care Act (HSCA) 2012.

3.3.3.1 Before HSCA 2012

As outlined earlier, prior to HSCA 2012, the NHS was deeply rooted in the internal market principles and purchaser-provider split created in the 1990s. NHS trusts (providers) were established to mirror the NPM movement during the Thatcher era and

to function as a corporate-like institution headed by a Board of Directors consisting of Executive and Non-Executive Directors (Blackler, 2006). They are semi-autonomous hospitals provide acute, community, and mental health services. Then there were HAs (purchasers), which were local administrative units carrying out NHS functions such as strategic planning and purchasing of services within a specific geographical area.

As a means to abandon the internal market and introduce integrated care, the NHS White Paper *The New NHS, modern. dependable.* It outlined the need for an organisational restructure based on "what has worked but discard what has failed" (p. 3) with patient needs at the forefront of the NHS priority. In 2000, to fulfil the modernisation reform of the New Labour and the promises of the 1997 NHS White Paper, Primary Care Trusts (PCTs) were created to replace HAs. They were led by managers, as opposed with clinicians, who were only limited to advisory roles, and ultimately carried out commissioning functions for primary, community and secondary health services (Checkland et al., 2015). PCTs were overseen by Strategic Health Authorities (SHAs), alongside the hospitals that have yet been converted into Trusts. Primary care providers (i.e. GPs and community nurses), on the other hand, remained in the scene through the establishment of Primary Care Groups (PCGs). They aimed to bring services closer to the patients, holding a devolved responsibility for budget and planning their resources based on their local needs (National Health Service, 1997).

Evaluation on the effectiveness and implications of these new structures illustrated that the quasi-market culture in the 2000s still persisted and bred a further organisational divide between the providers and purchasers of health care services, with little to no impact on the improvement of the quality on performance and delivery of services (Blackler, 2006; Le Grand, 2007; Propper et al., 2008; Timmins, 2008; Bevan, 2014; Niemietz, 2016). Whilst there were promises on costs efficiency, service effectiveness, managerial improvement, and restructuring of the delivery of public services through

decentralisation, critics argued that the same problems were never addressed. Propper et al. (2008), for instance, presented empirical evidence that the creation of the internal market resulted in a small negative effect on the quality of health outcomes. Since competition is dependent on the geographical area, their results showed that hospitals in competitive areas led to higher cumulative emergency admissions and death rates. Niemietz (2016) posited that because of the tighter regulations and increasing competition, hospitals were pressured to perform at higher standards in order to retain funding. This instead led to principal-agent problems (Greener and Powell, 2008; Allen, 2013), wherein providers were like 'knaves' acting on their own convenience instead of like 'knights' who should be acting on behalf of the patients, and patients were being treated like 'pawns' rather than 'queens' (Le Grand, 1997, 2003). Despite the high transaction costs posed by the internal market, some (Le Grand, 2007; Bevan, 2014) still believed it had the greatest potential to deliver high quality of health care services.

3.3.3.2 After HSCA 2012

With the Cameron Coalition government coming in on 2010, majority of the set pieces that were initiated by the previous Labour government were annihilated. The Conservatives had long opposed regionalisation, whilst the Liberal Democrats favoured the strengthening of local authorities in participating in planning and development (Pearce and Ayres, 2012; Pemberton and Shaw, 2012; Shaw and Tewdwr-jones, 2017). Accompanied by a long period of austerity, some were not as enthusiastic with public service reforms that did not really bring any substantive changes from the previous governments (Niemietz, 2016).

The HSCA 2012 (also known as the Lansley reforms) aimed to improve the overall quality and choice of care for patients through local partnerships and integrated care systems as a response to the changing health needs and challenges of managing care for people with long-term conditions (see *NHS White Paper*, 2010). The top-down

reorganisation has abolished several structures in the system, including the PCTs and SHAs, and has transferred commissioning of services to new structures called the CCGs that were (meant to be) led by GPs The rationale behind this is to transition the system from a manager-led to clinician-led commissioning culture, putting health care experts who know patients' needs best at the core of the decision-making in the NHS (Department of Health, 2012).

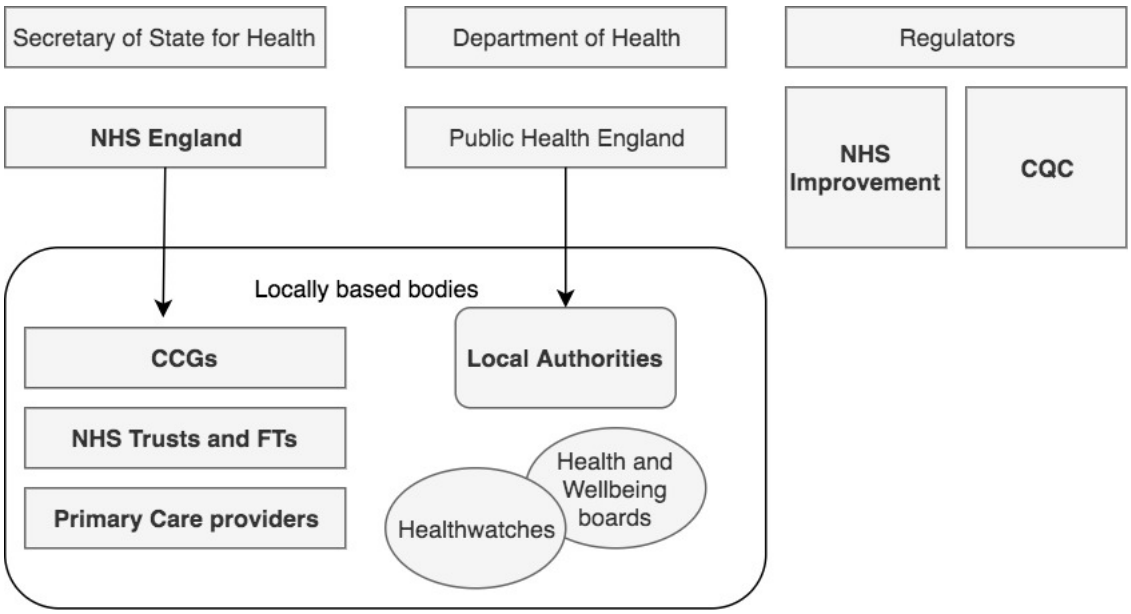
In addition, the NHS England was established as an arm's length body of the Secretary of State for Health and to replace the autonomous NHS Commissioning Board[4]. They received statutory responsibilities for commissioning primary care to arguably cover a wider geographical footprint (see *NHS White Paper*, 2010). Since the aim of HSCA 2012 is to promote a patient-centred approach through a more joined up working between local authorities and local NHS organisations, statutory entities like the Health and Wellbeing Boards (HWBs) and Healthwatches were embedded in the local health systems (Local Government Association, 2012). To ensure streamlines of local and national accountability across all parts of the system, regulatory bodies (e.g. what is now NHS Improvement {NHSI}, CQC, NICE, etc.) were also put in place (Figure 9).

To further complicate the governance structures, NHS England has published on 2014 a Five Year Forward View (NHS England, 2014) to set a national vision for collaboration. The promoted the delivery of new care models and increased integration by sharing responsibilities on leading the system with local leaders, communities, and clinicians. New programmes of work (e.g. Better Care Fund, Vanguards, and Accountable Care Organisations (ACO) to name a few) were promoted to emphasise the need for the integration between health and care systems, through shared pooled

[4] Its predecessors were all part of the Department of Health prior to receiving statutory independent status

budgets between local councils and CCGs, joint governance structures, and joint planning responsibilities (Checkland et al., 2015).

Figure 9: The new and current NHS



This marked the beginning of another era for the NHS where collaboration, integration, and partnership working being promoted. The government seemed to have a vision of moving away from the culture created by choice and competition towards a more patient-centred and integrated approach. This was orchestrated through several iterations on the existing NHS governance structure, abolishment of old existing structures and replacement with newer bodies but with similar functions, and promotion of repackaged policies.

The HSCA 2012 has impacted the current system, perhaps far more than the initial establishment of the internal markets back in the 1990s (Allen, 2013; Checkland et al., 2013, 2015, 2016; Timmins, 2018). The biggest reorganisation in the history of NHS reforms has been dubbed as “the world’s biggest quango” (Timmins, 2018) primarily because of the shortcomings between the vision and the outcomes it produced a few years down the line. The establishment of NHS England was a shot in the dark to attempt

to “liberate the NHS” (National Health Service, 2010). It wanted to free itself from political interference and to depoliticise the decision-making from the Whitehall, which is the antithesis to the top-down hierarchical form of governance that existed when the NHS was first established. However, Hammond et al. (2019) suggested that the relationship between the state and NHS England still remained through the layers of upwards and downwards formal accountability arrangements. This was illustrated by Timmins (2018) when he highlighted that the relationship between the Secretary of State for Health and the NHS Chief Executive was interdependent; the former dictates the budget and the latter runs the organisation based on those constraints.

3.3.4 Post devolution: Localism, partnerships, and city deals

The Cameron Coalition government signalled the beginning of a localism agenda, rejecting the full scale of Labour’s regional approaches and promoting the vital role of local authorities in responding to people's needs and delivering services closer to the communities (Communities and Local Government, 2011). The *Localism Act 2011* suggested that decision-making was to be brought closer to citizens by increasing freedom and flexibilities for local governments in order to enable them in achieving their desired outcomes. This was done through City Deals, local enterprise zones, and various other measures, steering away from traditional one size fits all subnational arrangements which were previously seen in past reforms. With the government's commitment to offer bespoke City Deals on a case-by-case basis based on the “spatial levels at which decisions are made”, this meant that a combination of powers were to be allocated at various areas further reinforcing the element of asymmetrical devolution (Shaw and Tewdwr-jones, 2017:217).

The City Deals marked a revolutionary attempt to devolve responsibilities amongst core city-regions in order to boost economic growth outside London. There was a renewed interest in the concept of ‘city-regions’, emphasising these areas as self-

contained metropolitan territories, with linked commuting flows extending from the city to surrounding rural areas (Coombes, 2014).

To galvanise the metropolitan governance of city-regions, the Coalition government granted statutory status and created what was called Combined Authorities (*Local Democracy, Economic Development and Construction Act 2009*). This became the legal framework through which the elements of the previously agreed City Deals and LEPs were coordinated and implemented. It also inspired the "Northern Powerhouse" movement of George Osborne, which sought to bring together northern English cities (i.e. the "super metro-region" of Liverpool–Manchester–Leeds–Sheffield) and function as a single economy at scale to counterbalance London, and to address the spatial disparities between the North and South (Colomb and Tomaney, 2016; Lee, 2017).

Although it was a significant agenda at that time, the concept itself was vague; it is not a defined institution or plan, but rather an idea which shaped government policy and ignited political discussions over rebalancing the economy and reducing the North and South divide. Martin (2015) and Lee (2017) argued that the Northern Powerhouse can be viewed as a long-term strategy, focusing on various policy actions around a single goal. However, given that significant resources to fund this vision were limited, it became more of a form of branding or re-packaging of already pre-existing policies to be more coherent and focused. It did, on the other hand, foster a collaborative working to bolster city-regional ambitions with elected mayors, creating a momentum for the "Devolution Deals" (*Cities and Local Government Devolution Act 2016*) to pave way for spatial rebalancing on economic development.

Amidst the Scottish referendum in 2014, then Prime Minister David Cameron raised the "English question" and proposed restricting the rights of Scottish, Welsh and Northern Irish MPs in the Parliament on voting matters relevant to England (i.e. "English vote for English laws") (Armstrong and Ebell, 2015; Colomb and Tomaney, 2016). It

highlighted the rise of English nationalism and how the central government departed from regionalist agendas proposed by previous governments. Localism became the new brand of the Coalition government, emphasising the role of local authorities in delivering the needs of the communities but masquerading the pressures on austerity and using it as a leverage to persuade city-regions to take the deals. By devising repackaged or rebranded policies (e.g. LEPs, City Deals, Combined Authorities, and now Devolution Deals to name a few), they were able to exert their influence through arms-length agencies. This further brought the polycentric nature of the subnational governments in England, as network arrangements and fragmentation continued to flourish in multi-sectoral relationships.

3.4 Implications

The literature primarily focused on the formal institutional arrangements that resulted in the establishment of the current governance structures. This section now focuses on the implications of formal policies and how the various pockets of the system reacted and behaved.

The Coalition efforts served as a catalyst for the emergence of networks of public, private, voluntary, and community agencies to come together in planning and delivering services to localities. This was illustrated by the following: First, local and regional actors were able to adapt to the oscillating institutional changes by forging strong informal arrangements that foster public-private collaboration and partnership working despite the absence of a statutory framework. For example, when metropolitan councils were abolished in 1986, Greater Manchester created a coalition of its ten unitary local authorities to form Association of Greater Manchester Authorities (AGMA). This was a clear indication of Greater Manchester's organic efforts to continue low-profile joint initiatives and pursue a variety of public- and private-sector partnerships to develop metropolitan growth across the city-region (Deas, 2014). It fostered high levels of trust

and cooperation between local actors, allowing them to function as self-organising networks.

Second, the strengthening partnership networks meant a departure from the traditional centralist approaches of top-down imposition of planning and strategic vision. Instead, local autonomy was empowered by redistributing some powers and funding back to the communities for them to take charge of their own resources and use them the way they deemed. The government essentially allowed local authorities to have more freedom to work together in new ways to meet local peoples, given that drive down costs and foster growth to support the local economy (Communities and Local Government, 2011). For example, the retention of locally-raised business rates by each local authority represented a significant move towards fiscal devolution (Sandford, 2017a).

However, others argued that there was still an element of local delivery of central objectives. Bailey and Wood (2017) described the establishment of LEPs and elected mayors as reconfigured networks for the benefit of the central government to exert arms-length influence and constrain the actions of local authorities. Similarly, Pike et al.'s (2015) study on the emergence of LEPs also illustrated that LEPs kept direct connections with the central government, ensuring that their localist behaviours were in tune with central government agendas whilst functioning alongside local authority leadership structures. Deas (2014) branded this as “contractual localism” whilst Shaw and Tewdwr-jones (2017) similarly cited it as “centrally orchestrated localism”, highlighting how the devolved local responsibilities were determined by the centre in exchange of meeting contractually agreed performance and efficiency checks based on underpinning national policy guidelines. Clearly, the enhanced freedom and flexibility came with an increased cost, disguised by repackaged policies as bottom-up solutions to better enable and facilitate economic development to lower level institutions.

These accounts do not discount the tensions and the challenges arising from the localist policies imposed upon by the central government. First, under the period of austerity, Shaw and Tewdwr-jones (2017) showed that key drivers such as budgetary pressures and uncertain economic conditions influenced the decisions of the current government to resort to devolution. They served as temporary political and territorial fixes with an overriding objective of assisting in the reduction of public sector deficits. Pearce and Ayres (2012) explain that the devolution deals were being pursued alongside a government target to eliminate the public sector budget deficit, which meant that local authorities relying on central government grants face substantial cuts. This pressured local councils to absorb public service cuts in exchange of the promise of additional powers and future funds from the Devolution deals (Shaw and Tewdwr-jones, 2017). This was described by Bailey and Wood (2017) as network framing, where fiscal conditions were used by the central government to exert influence over local authorities. This also represented the arms-length influence of the state in terms of the proportion of local government spending, “taking one hand and giving with the other with strings attached" (Bailey and Wood, 2017:978).

Second, another pervasive challenge is the problematic centre-local relations and the contradicting implications of the decentralisation policies. The Devolution agenda was meant to be a significant step away from the power-hoarding top-down government and a shift towards empowering local councils, communities, etc. It was designed for local authorities to create bottom-up initiatives and put themselves forward to the Devolution deals, with the state providing policy guidance on how to apply. However, evidence suggested that the guidelines (i.e. to create a business case and an implementation plan) were purposefully vague in order to allow the government for some "wiggle room...to seek the outcome they wanted" (Ayres et al., 2018:859). Pike et al. (2015) also exhibited that this was also present when the LEPs were first introduced,

characterising the experience of “guided localism” as a “British vice” of masking centralisation as decentralisation.

Third, there will always be an element of competition arising from the retention of market principles inherited from the Thatcher government. When the first wave of City Deals was introduced, local authorities had to enter competitive bids in order to gain advantage over the negotiations with the central government. Incentivisation has become a common theme to encourage competition between neighbouring areas, where poorer areas lose out on more affluent areas over funding allocation (Ayres and Pearce, 2013; Deas, 2014; Bailey and Wood, 2017). This was not true across all cases however, as some areas fostered voluntary and collaborative arrangements amongst local leaders in order to carry out local initiatives. For example, despite the absence of formalised governance structures, Greater Manchester's organic and voluntarist efforts enabled them to make collective decisions making them the viable pilot for the Devolution models (Deas, 2014).

Lastly, there were some indications of democratic deficit or the lack of public engagement and consultation by the central state. Ayres et al., (2018) described that “local elite assimilation” dominated the appointment of LEPs, where key decisions were oftentimes made by a small number of key officials. When the subsequent Devolution deals were introduced, the council leaders took upon themselves to make a decision without consulting the public or engaging the citizens. This contributed to weak citizen mobilisation and lack of legitimation of the Devolution process. It implied the entrance of post-political forms of governance, where political elites dominate the decision-making, with a restricted basis on discussion and debate amongst a predefined consensus (Deas, 2014).

The English governance context was also unfortunately mirrored by the implementation of NHS policies. First, it is without contention that the quasi-market

reforms in the 2000s resulted in further fragmentation on the delivery of services as higher transaction costs emerged from the entrance of market-like structures to induce competition amongst multiple purchasers of health care services, such as private companies and non-profit or charitable institutions. Niemietz (2016) highlighted that the New Labour abolished the internal market created by the Conservatives, only to repackage it half a decade later into a newer version that not only disrupted the system, but also inherited the weaknesses that the internal market already made. Second, there are still elements of centralised and hierarchical control in the NHS after the Lansley reforms. NHSE remained to promote top-down policies, alongside with performance metrics and layers of upwards and downwards formal accountability arrangements (Timmins, 2018; Hammond et al., 2019). Third, the creation of markets bred a culture of choice and competition amongst organisations, which generated silo mentalities, principal-agent problems, and purchaser-provider split (Greener and Powell, 2008). This made it more difficult for current policies to implement collaborative or integrated models of care. Lastly, literature suggested that there is a movement away from local paternalism with national accountability to national paternalism. Greener and Powell (2008) suggested that the new reforms emphasise the role of local delivery of services with NHS England playing a meta-governor role of dictating centrally arranged strategic policies.

The evidence presented in this section illustrated a disorganised, cluttered, and fragmented path towards the English decentralisation. This was characterised by the pendulum swing between regionalist and localist agendas promoted by different governments, which illustrated the lack of long-term vision and united voice in terms of what the future of England local and regional governance should look like. Whilst the Labour governments focused on regionalisation and the creation of regional governments within the state, the Conservatives more often than not switch back to localist approaches as a way of disarming the localities in order to preserve the unitary state of the UK. With the entrance of the Coalition government, we see various

institutional arrangements to promote policies that strengthen the autonomy of local authorities in order to address spatial disparities and rebalance the economy.

3.5 The Manchester model

In the previous section, we evaluated the path that paved way to the current fragmented state of English regional governance. We saw the different attempts of the central government to decentralise power but still exert influence on the regional and local nodes. In this section, we focus our attention to Greater Manchester and how it pioneered the English city devolution packages.

3.5.1 The devolution argument of the Manchester model

It came to no surprise that GM was the frontrunner and the best viable candidate to the devolution deals when it was first introduced. GM's metropolitan status was initially established in 1974 when the governing arrangements of Greater Manchester County Council (GMCC) was created through the *Local Government Act 1972*. When the metropolitan councils were abolished in 1986 following the *Local Government Act 1985*, the 10 remaining unitary authorities formed the Association of Greater Manchester Authorities (AGMA) to maintain voluntary collaboration and joint working.

Several evidence-based reports recognised the development of the "Manchester Model" (McKillop et al., 2009; Holden and Harding, 2015) as the exemplary prototype when the Devolution deals were first raised by former Chancellor of Exchequer, George Osborne, in his Northern Powerhouse speech. Because of its history of organic cooperation and formal institutionalisation of governance structures, it is without a doubt that GM would be the ideal frontrunner for the remarkable deals.

> *"But something remarkable has happened here in Manchester… the once hollowed-out city centres are thriving again, with growing universities, iconic museums and cultural events, and huge improvements to the quality of life." (Osborne, 2014)*

Scholars and think tanks closely monitored GM's successive approaches over the last two decades (Deas and Ward, 2002; Deas, 2014; Haughton et al., 2016). Many have acknowledged the organic efforts and institutional capacities inherent within the conurbation (The Economist, 2013; Deas, 2014; Holden and Harding, 2015; Haughton et al., 2016), whilst others were more critical about the role of the quango-like coalitions and policy elites in influencing the administrative and strategic direction of the governance (Blunkett et al., 2016; Haughton et al., 2016; Kenealy, 2016; Prosser et al., 2017). Others have focused on the existing Devo Health aspect, particularly on the existing overlapping health and social care structures and how this polycentric nature of governance have affected the spatial rescaling (Checkland et al., 2015; Lorne et al., 2018) and relationships (Sandford, 2017b) within the local NHS organisations. Whichever angle you look at it, however, it is undeniable that GM had all the necessary tools it needed to anchor its way on top of the political arena, putting itself ahead of everyone else in seeking devolved powers through bottom-up solutions alongside community-based models of delivery of public services across its conurbation.

Scholarly articles and evidence-based reports more often than not passively mention the long-existing historical cooperation existing within its 10 local authorities and acknowledging this as one of the foundations to GM's successful bid to the devolution deal (Holden and Harding, 2015; Lorne et al., 2018; Walshe et al., 2018). Deas (2014) provided a more detailed qualitative account on the institutional evolution of GM structures, highlighting the role of subnational spatial regeneration and the transition from hard to soft institutional spaces. Similarly, Haughton et al. (2016) conducted a qualitative study on how scalar fixes inspired the development of the Manchester model and how this nurtured the current city-region initiatives. Their evidence suggested how GM adopted agglomeration economics to create an evidence-based political appeal to support urban growth and manage spatial inequalities across the city-region.

Studies have also drawn interest to examine the evolution of city-regional institutional arrangements and used GM as a primary example as to how a new post-political form of governance is emerging. For instance, Deas (2014) viewed GM as a voluntarist model having made exemplary progress in shaping economic policies and governance. Through a qualitative study with semi-structured interviews undertaken post-establishment of Local Enterprise Partnerships (LEPs) and the GMCA, the author acknowledged the efforts of GM in utilising hard and soft institutions into promoting cooperation amongst its constituent local authorities. GM's preference to non-bureaucratic administration reflected business- and quango-like structures, where policy elites dominate the decision-making arena leaving little to no effort for citizen participation. The author claimed that such institutional structures represented an erosion of local democracy and the beginning of a post-political form of governance characterised by colonisation of decision-making by policy elites.

Similarly, Colomb and Tomaney (2016) drew lessons on the recent strategic planning and territorial development of city-regions and how it addressed the fragmented administrative and institutional boundaries that was inherited from centralised patterns of governance. It reflected on GM's ability to withstand these unprecedented challenges and recognised the role that policy elites have played to set-up Manchester as the potential northern rival to London. In a series of qualitative research projects examining the centre-periphery relationships in the English devolution context, Ayres et al. (2018) explained that there has been a degree of local elite assimilation throughout the negotiation process of the devolution deals. This view as also confirmed by Kenealy (2016) and Prosser et al. (2017), citing that the Devo Manc deals were poorly promoted for citizen engagement, and was highly technical and targeted to policy experts or elected representatives rather than the public. We have seen how the political landscape in GM have evolved from informal to formal cooperative structures. This evidence of stable and focused model of local leadership has put GM in a pedestal, developing a

reputation for “being easy to deal with and efficient, with a network of hard and soft institutions” (Deas, 2014).

3.6 Summary

In this chapter, we devised the concept of the health commons to encompass the health and social care resources pooled as a shared property regime, wherein a population within a particular geographical boundary can contribute and share access to (McGinnis, 2013). We contextualised this to the current health policies and local English governance reforms. Overall, we unpacked the contextual background and the institutional evolution that led to the current polycentric state of the NHS and the oscillating reforms of centralist, regionalist, and localist approaches in the local English governance setting. We also identified why Greater Manchester was a pioneering model to the latest decentralisation policies and the reasons behind its success. This policy background will guide our understanding on the institutional arrangements that led to the emergence of Devo Health and GMHSC Partnership.

4 Methodology

4.1 Introduction

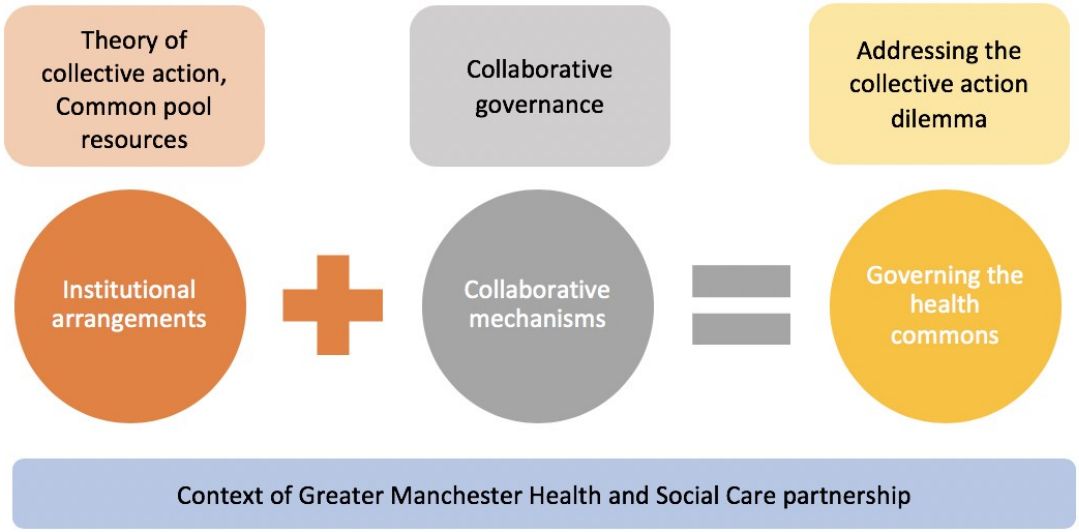
The aim of this chapter is to address the chosen research design and methodology of this study. In the previous chapters, we presented a theoretical inquiry on the study of the commons and how institutions have emerged to address the collective action problems of small communities depending on a common pool resource. We then contextualised that in a collaborative health governance setting and posited that we could apply the same design principles on sustaining the commons to local health systems as long as there is a group willing to act as stewards.

Therefore, this study wants to address the following questions:

1. Under what circumstances can collaborative governance mechanisms create a system of stewardship in governing the health commons?
2. What are the formal and informal institutions that emerged as a response to collective action dilemmas?
3. How are institutional arrangements influencing the different levels of collaborative processes in the governance of the health commons?

As outlined in the theoretical chapter, the research is built on the following theoretical framework (Figure 10). We argue that health systems leaders of a regional or local-based health system can come together and act as stewards of their health commons. Together, they can devise institutional arrangements and collaborative mechanisms in order to take collective action and address the sustainability issue of the health commons.

Figure 10: Modified theoretical framework



In order for us to successfully explore this phenomenon, this research employs a critical realist approach using qualitative research. We particularly use case study methods to focus on the context of Greater Manchester's Health Devolution policy and unpack the collaborative governance that emerged to take charge of their own local health economy. A combination of interviews and documents were examined to evaluate the collaborative and institutional mechanisms in place to resolve their collective action dilemma. In this chapter, we provide a justification on this research design, why these methods were chosen, which data collection and data analysis tools were used, and which philosophical position supports the methods of this research. The chapter concludes with a review on the ethical procedures conducted to mitigate the methodological risks of the study.

4.2 Methodological approaches in the study of the commons and institutions

Social scientists have historically relied on quantitative methods and formal theoretical models to address policy problems (*see* Moses and Knutsen, 2007). As an

attempt to make social science more scientific, statistical methods, experiments, and formal theoretical models dominated the fields of psychology, economics, and political science particularly during post-World War II era. Moreover, proponents of quantitative methods embraced the scientific power of positivism to logically deduce insights about processes and test existing theories to generate formal models (Poteete et al., 2010; Johnson et al., 2016). Whilst the role of quantitative and theory-driven research has always been important, this was met by criticisms by the advocates of qualitative methods.

Qualitative approaches in the social sciences emerged as critics argued that studying relationships require more than just measurement, but rather, a deeper examination of human agency influenced by meaning and interpretation is needed (Denzin and Lincoln, 2005; Mohajan, 2018). Formal theoretical models failed to capture aspects of social conditions and unearth real situations where formal and informal institutions or cultural understandings occur. Therefore, institutional theorists used small-N case studies methods to provide thick descriptions on social context and causal relationships (Poteete et al., 2010; Suddaby and Lefsrud, 2012). However, with the shift from old to new institutionalism, scholars began to utilise large-N samples using empirical methods and multi-variate techniques to identify causal mechanisms that produced institutional effects on organisations (Von Beyme, 2009; Suddaby and Lefsrud, 2012). The social sciences continued to evolve with its methodological approaches, whilst still recognising the dominant role of theory and deductive approach to empirical inquiry. For instance, textbooks still recommend theory-building as the prescription to conducting political science research projects (Moses and Knutsen, 2007; Johnson et al., 2016).

Studies on the commons and collective action have utilised a diverse set of methodological approaches in order to prove that sustainability can be attained if self-organising communities establish their own institutional arrangements, as opposed with

state-led or private-owned approaches. Using comparative case studies and experimental field work generated by other scholars, Ostrom (1990) was able to establish a rich empirical base and collect from a sample of 14 cases. Successful cases uniquely exhibited collective action behaviour where they crafted and developed their own diverse institutional arrangements to managing the shared natural resources and was able to sustain them for a period of time. Her contribution on managing the commons inspired the use of experimental-based models as a means to bridge the gap between theory and observational findings (McGinnis and Walker, 2010), which encouraged a three-way interaction between theory, experiments, and field work.

This signalled the movement of the political and social sciences from the traditional positivist approach rooted in formal models and empirical analysis, to a more deliberative and diverse approach in addressing complex policy problems. In a piece called *Beyond Positivism*, Ostrom (2014) acknowledged the role of formal theory and models in identifying the critical elements in a policy problem and how it's important in asserting the relationships between variables. However, she also identified the limits of the value-laden theory and quantitative empirical measures to describe relationships, and the need for scholars to depart from positivist generalisations and move towards diverse methodological approaches that are more participatory and experimental (Ahn and Wilson, 2010; Forsyth and Johnson, 2014). Critics, however, still questioned the validity of Ostrom's neo-institutionalism and rationalist stance in terms of her methodological approaches in generating empirical evidence. de Sardan (2013) argued that her efforts to steer away from simplistic formal models led to little knowledge on the explanatory factors or variables found in her case studies. This was also supported by Agrawal (2014), who pointed out the need for any advances on the commons and institutions to use more sophisticated analytical methods that will allow more rigorous testing on the causal mechanisms and relationships.

Despite this, the impact of Ostrom's work on configuration on rules of the game influenced the future application of the commons across interdisciplinary studies in different contexts. Poteete et al. (2010) wrote a volume of on interdisciplinary methods in the study of the commons, ranging from case study methods, field-based research, meta-analysis, action research, experiments in the laboratory and field, and agent-based modelling. Although case studies were one of the most commonly used methods (Gerlak and Heikkila, 2006; Koontz, 2006; Rahman et al., 2012), others such as mixed methods (Lowndes and Pratchett, 2005), meta-analysis (Milinski et al., 2002; Yi et al., 2018), agent-based modelling (Agrawal and Goyal, 2001), field experiments (Cardenas et al., 2013), and qualitative comparative analysis (Heikkila, 2004) also proved to be emerging in the literature. This illustrated that researchers wishing to advance the study on the commons acknowledged that no single method can fully address the collective action problem and that a pragmatic movement for diverse methodological traditions is needed.

4.3 Research design

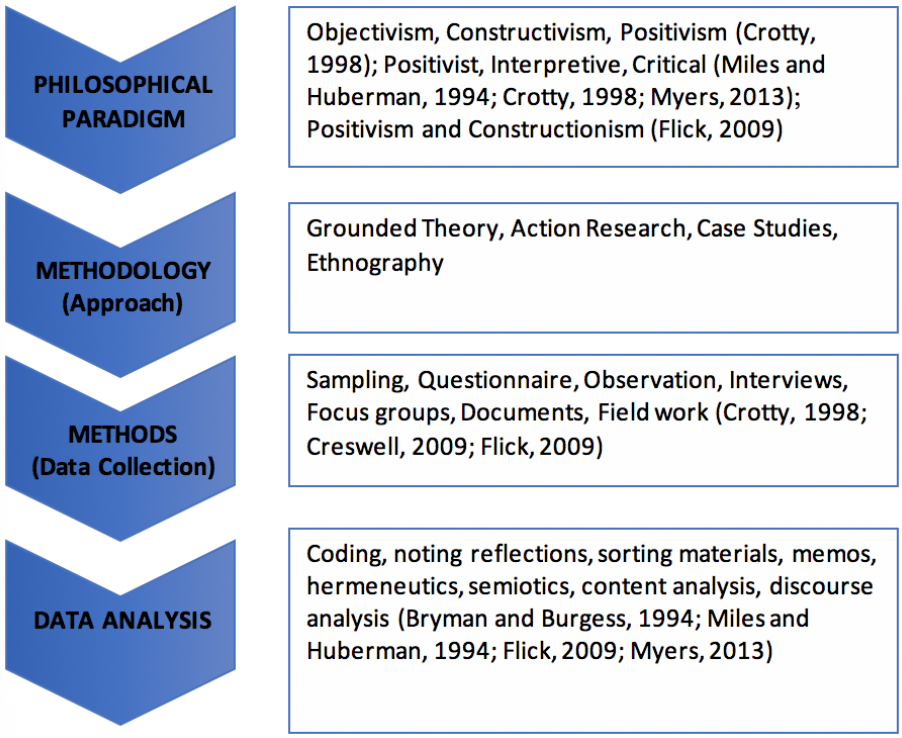
In the previous section, we illustrated how the positivist stance and quantitative methods dominated the studies in social sciences and transitioned into a more deliberate and pluralistic methodological approach in building empirical knowledge. As illustrated by scholars who explored the role of institutions in governing the different contexts of the commons, both quantitative and qualitative approaches are valuable and that the field does not affix to a single approach in advancing knowledge. This study, however, finds the value in the qualitative research approach – particularly in the use of case study methods – and its ability to contextualise causal mechanisms and to explore a social phenomenon (Yin, 1994; Denzin and Lincoln, 2005). In the later sections, we will provide more detail on the justification of the chosen research approach.

In this section, we lay out the research design. Research design is the plan or proposal to conduct research, with a primary purpose of providing clear guidelines and procedures on what you intend to do (Creswell, 2009; Myers, 2013). Myers (2013) identified that a good model for qualitative research design should have a set of philosophical assumptions, a research method, data collection techniques, data analysis approach, and a written record of the findings.

4.3.1 Philosophical assumptions

Every research project is based on some philosophical paradigms that provide context for the grounds of the research problem (Crotty, 1998; Myers, 2013) (Figure 11). Paradigms are defined as worldviews or belief systems (Plano Clark and Creswell, 2008) or it could be an epistemological stance, shared beliefs, or a model of examples (Tashakkori and Teddlie, 2010) that guide the researchers. There are two main elements of philosophical assumptions that provide good foundations in social sciences research – ontology and epistemology.

Figure 11: Elements that inform the research process



Adapted from: (Crotty, 1998; Myers, 2013)

Ontology mainly refers to the nature of reality and the study of being (Creswell, 2007), the issue of what exists or 'what is' the nature of existence (Neuman, 2011), and 'what the world is made of' (Crotty, 1998). In the field of political science research, Moses and Knutsen (2007) identified two main ontological stances: naturalism and constructivism. **Naturalism** seeks to discover and explain patterns that exist in nature driven by the need for scientific legitimacy. **Constructivism**, on the other hand, is rooted on the possibility of multiple and equally valid realities. Constructivists believe that we do not just experience the world directly, but rather, we channel our perceptions of the world.

Tashakkori and Teddlie (2010) reminded researchers to treat paradigms with caution because there is the temptation to follow a single package of assumptions, when in fact a range of methodological presumptions do not necessarily have to go together. Instead, Moses and Knutsen (2007) recommended the use of ontological and epistemological positions to assist the researcher in picking the appropriate philosophical assumptions needed to address the research problem in question. Whilst this research does not necessarily identify in any of these two typologies, we do acknowledge their importance. We direct our attention instead to epistemology and how the relationship between theory and research will help us address our research problem.

Epistemology describes the nature of knowledge and 'what it means to know' (Crotty, 1998). It primarily focuses on the relationship between the researcher and the subject (Creswell, 2009) and refers to the assumptions on how to best study the world and the method of determining is true (Bhattacherjee, 2012; Johnson et al., 2016). Myers (2013) identified two main underlying epistemological positions in social sciences research, namely positivist and interpretivist approaches. **Positivism** originated from the natural sciences, where it relies heavily on logic and reason i.e. naturalistic or scientific methods (Flick, 2009). For positivists, reality is independent of the observer, where reality can only

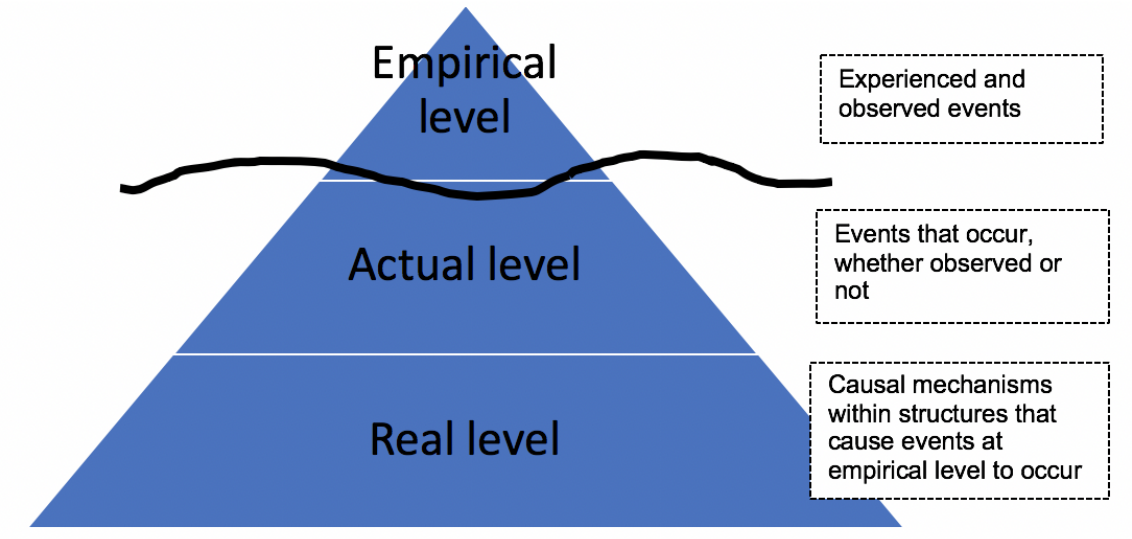
be experienced through direct observation. With regards to the relationship between theory and research, positivism believes scientific method (i.e. empiricism) is the only way to observe and measure the phenomena we experienced (Trochim, 2006). This is usually done through **deductive** reasoning, where the researcher tests concepts and patterns known from competing theories and applies it to know which context it will work best (Bhattacherjee, 2012).

Interpretivism, on the other hand, is a post-positivist approach rejecting the central tents of positivism. For interpretivists, reality is a constructed nature of reality and the only way individuals or participants can understand certain phenomena is through interactions (Flick, 2009; Myers, 2013). Social constructs, such as human behaviour, emotion, attitudes, experiences, etc., are detailed by the rich description of the lived experience of human beings. The researcher, therefore, draws empirical evidence from such data and builds theory based on the observed patterns that emerged (Bhattacherjee, 2012). This is referred to as an **inductive** form of reasoning.

Given the two epistemological approaches, this research relies on Ostrom's (1990) advancement of the study of the commons which sits on the post-positivist realm but not entirely rejecting the value of theory-testing and empirical methods. We acknowledge the weaknesses of both positivism and interpretivism and we posited that neither recognises that observation is fallible, and that theory is revisable. We then turn to other forms of post-positivist stances that draw from both methodological strains of positivism and constructivism. We also need to associate with a philosophical paradigm that will enable us to draw causal mechanisms and patterns of relationships as it is the central tenet of our research problem. Based on this, this research employs a **critical realist** stance, where it accepts that theory can only be impartial representations of reality (i.e. weakness of positivism) and that we may have to rely on some underlying events and/or contexts that we cannot observe (i.e. weakness of constructivism).

Emerging through the works of Bhaskar (1975) and expounded by critical realists like Sayer (1992) and Collier (1994), **critical realism** is a post-positivist paradigm and serves as an alternative approach to the two dominant philosophical paradigms. It places a heavy emphasis on the use of causal mechanisms to describe the world, with the performative function of using power, agency, structure, and relations to the contextualisation of the research problem being examined (Easton, 2010; Smith and Elger, 2012; Fletcher, 2017; Vincent and O'Mahoney, 2018).

Figure 12: Three levels of reality according to a critical realist (iceberg metaphor)



Source: (Fletcher, 2017; Vincent and O'Mahoney, 2018)

Critical realism is appropriate in this research for two main reasons. First, our research problem requires us to identify causal mechanisms that led to the establishment of institutional arrangements in a particular context. Critical realism treats reality as theory-laden and not theory-determined. This means that whilst critical realists recognise theories as useful in framing the context and guiding the research context or problem, there are also theories that help us get closer to the underlying structures of "real" world, i.e. causal mechanisms (Figure 12) (Easton, 2010; Shannon-Baker, 2016; Fletcher, 2017). In this research, therefore, we recognise that there is a rich theoretical basis as

to why collective action problems occur; however, we want to know under which circumstances did it work and what factors influenced or caused it to emerge. This also means that we are testing if the elements in our theoretical framework work in our chosen context (i.e. theory testing/deductive), but also generating new insights on the unobserved structures that caused the observed phenomena to occur (i.e. theory building/inductive). This is also known as the process of **abduction**, where there is a back and forth movement between deduction and induction (Shannon-Baker, 2016).

According to Pawson (2006), critical realism adopts a generative understanding of causation in policy, where it breaks the habit of basing evaluation on 'What works?' but rather on 'What works, for whom, in what circumstances and why?'. Instead of seeking to describe a policy, critical realists account for engaging with the contextual factors influencing outcomes of activities to provide useful evidence. This was illustrated by Pawson and Tilley's (1997) model on realistic evaluation: Mechanism + Context = Outcome (Figure 13), where the scientific inquiry does not only focus on the outcomes produced by the policy intervention in question, but also the significant conditions in which the interventions took place.

Figure 13: Critical realist view of causation

Source: (Sayer, 1992; Pawson and Tilley, 1997)

Second, our research needs a suitable methodological approach that will support the search for causal mechanisms in the given context. Since critical realism is more of a meta-theoretical stance and a general philosophical framework, it does not have any associated set of methods; instead, it reconciles the weaknesses of quantitative and

qualitative approaches and recognises the utilisation of both methods (Shannon-Baker, 2016; Fletcher, 2017). Easton (2010) explained that identifying mechanisms requires the 'why' and the 'how' that qualitative research employs, and also recognising the formal theoretical or linear statistical models that quantitative research provides in order to guide the relationships of the mechanisms. Given the extent of my research questions, qualitative research is the chosen and more suitable methodology because we want to explore a phenomenon that has not been observed in this context before (i.e. the health commons in the context of Greater Manchester). Qualitative research has the power to create an exploratory reflection on individual accounts of attitudes, motivations, and behaviour in order for us to understand the context as to which actions and decisions have taken place (Miles and Huberman, 1994; Hakim, 2000).

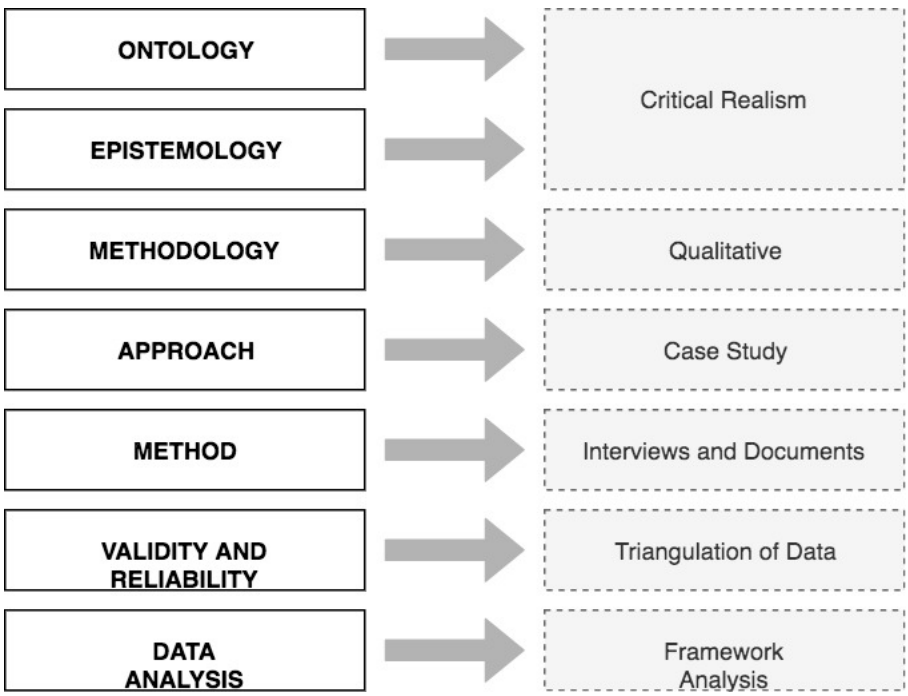
Some of the advantages of qualitative approach in a critical realist approach are:

- the distinctiveness of qualitative research tend to not rely solely on statistical or empiricist methods only (Bryman and Burgess, 1994; Bryman and Bell, 2011);
- instead, it assists the researcher to take an existing model on mechanisms and adopt its analogies to other known subjects, which will then be used to explain a set of observable patterns (Roberts, 2014)
- researchers actively engage with people in real organisations (Miles and Huberman, 1994) to gather more information that is not necessarily observed at an empirical level, which therefore, extends new insights on how causal mechanisms operate and under what conditions they are achieved

Table 5: Summary of philosophical paradigms

	Positivism	Constructivism	Critical Realism
Ontology (Nature of reality)	There is a single reality	There are multiple constructed realities	There is a reality independent of our thinking and all observation is fallible and revisable
Epistemology (Relationship of the knower to the known)	Knower and the known are independent	Knower and the known are inseparable	Knower applies causal languages to describe the known
Relationship between theory and research	Deductive theory testing	Inductive theory building	Abductive
Generalisations	Law-like generalisations derived are independent of the researcher	Generalisations are derived from researcher's experience and methods	Generalisations are based on theoretical observations rather than empirical level

Figure 14: Research design



4.4 Research methodology

The aim of a critical realist research design is to identify and explain how and why causal mechanisms affect or result into a particular phenomenon using relationships identified by the theoretical framework. In order to provide an in-depth exploration and abduct causal mechanisms from empirical manifestations (Vincent and O'Mahoney, 2018), qualitative research methods using a case study design is employed. Sayer (1992) suggested that this form of intensive method in critical realism addresses where the context is known and what produces change. In this section, we examine the remaining elements of the research design (Figure 14) that focuses on the data collection techniques and the tools to data analysis that were used to frame and address the objectives of this research.

4.4.1 Case studies

Geva-May (2005) stated that in the social sciences, case study is a prominent mode of research method. Since policy research is about defining and solving existing problems embedded in complex systems by drawing on social science theories (Geva-May, 2005), using case studies is a useful method in providing a fully contextualised definition of the problem.

Whilst some suggested that statistical analysis and nomothetic approaches should be the prescribed methods in examining institutions and collective action (Von Beyme, 2009; Suddaby and Lefsrud, 2012), case study research has proven it has the explanatory power to frame a good deal of processes as opposed strictly to just empirical outcomes. As identified in the early section of this chapter, case studies were widely used in the study of the commons. Varying from small to large-N studies, case studies in the commons provided not only a good empirical base on organisations illustrating successful (and failed) collective action, but also challenged existing theories through various context-specific relationships (Poteete et al., 2010).

From a critical realist's perspective, case study is able to define the 'how' and 'why' in outcomes (Easton, 2010). Compared with the generalised variables produced from sole quantitative analysis, case studies seek to trace explanatory and operational links across a multitude of factors and relationships (Yin, 1994). Moreover, case studies can be tested through experiments, multivariate analysis, meta-analysis, and agent-based models, which illustrates its analytical strength in terms of theory development (Poteete et al., 2010). This shows its flexibility to adapt between quantitative and qualitative data collection and analysis techniques, where it relies on multiple sources of evidence and uses theoretical propositions to guide the iterative process of the research.

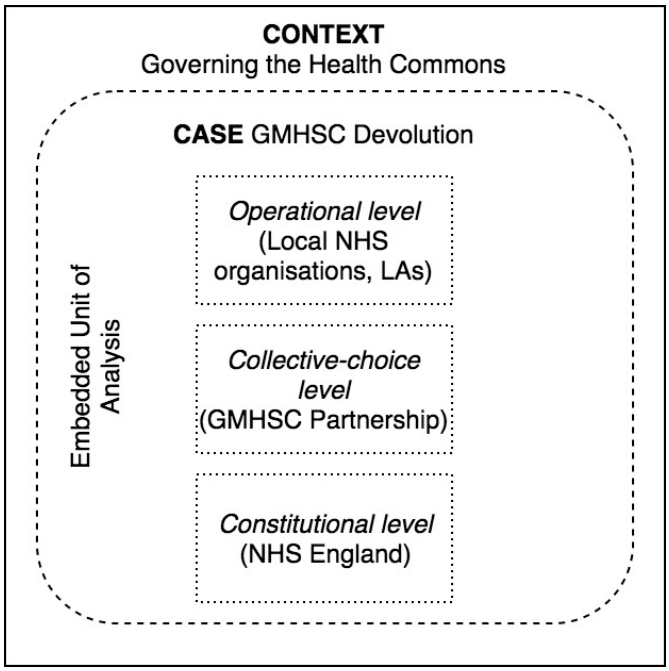
The role of theory is essential in research design because it identifies the purpose of the case study. Since case studies are based on multiple data sources, building constructs could lead to replication of emerging theory. (Eisenhardt and Graebner, 2007) describe that theory building from case studies bridges qualitative evidence to mainstream deductive research (i.e. abductive approach), which explains its increasing popularity in research. Inductive and deductive logic mirror each other, where inductive theory building produces new theory from data, and deductive theory testing uses data to test theory. This approach is embedded in rich data, making case studies likely to produce accurate and testable theories (Eisenhardt, 1989).

4.4.2 Case research design

Case study methods are, therefore, an appropriate qualitative methodology for this research because it proposes to gain an in-depth understanding of a concerned phenomenon in a real-life setting (Yin, 1994). A critical realist case approach is well suited if the phenomena is clearly bounded but complex (Easton, 2010), which is illustrated by the collaborative governance structure of the Partnership. The Partnership is made up of multiple organisations working across different health sectors in Greater Manchester (GM). This study is set within the 10 local authorities of GM, where we limit

our case to the group of organisations that are situated within this geographical boundary and are formally committed to the Health Devolution policy. Our units of analysis, however, are spread out across three levels of decision-making based on Ostrom's (2005) multiple levels of analysis as outlined in the previous chapter. We will expand the application of this analytical framework in a later section below. Based on Yin's (1994) designs for case studies, our research is classified as an embedded single-case design with multiple units of analysis (Figure 15).

Figure 15: Embedded single-case design of this research



4.4.3 Limitations of case studies

We need to address the weaknesses of our chosen case study design – these are *selection bias* and *generalisability* (Poteete et al., 2010). Since this research is focused in a single case only, this meant that selection bias may not truly represent variation on the relationships between the causal mechanisms and outcomes (Yin, 1994). This also means that there is limited possibility for generalisation of results. Since our chosen methods do not involve any empirical or statistical analysis, full replication of the case study research may be more difficult.

There are multiple reasons why GM is the only case chosen for this study. In the previous chapters, we introduced Greater Manchester health and social care devolution as the particular phenomenon that we wanted to study. In particular, we wanted to focus on the role of the Greater Manchester Health and Social Care (GMHSC) Partnership as stewards of the overall health economy of the 2.8 million population of the GM conurbation and how they devised institutional arrangements to make collective decisions regarding the sustainability issues of their health commons.

First, although the Devolution across English local governance has been implemented across multiple city-regions, our focus is narrowed down on the health policy aspect. This makes Greater Manchester an extreme case to this research topic because it is the most advanced amongst all other devolved regions and it is the pioneer on receiving devolved health functions from the National Health Service (NHS). Second, Yin (1994) identified that a single-case design can represent the critical test of a significant theory. Since the concept of the health commons has been unexplored in the UK setting as outlined in the previous chapters, the GMHSC Partnership presents a unique opportunity not only to advance theoretical research, but also to become a model and draw lessons from for future health devolution policies in England. Third, GM was selected out of logistical convenience to the researcher. GM was the only city-region to receive delegated health functions at the time the research projected began, therefore, it was sensible to focus only a single location. Lastly, GM was the only case selected for this research because of the perceived methodological barriers on recruiting participants. There were ethical difficulties to recruiting participants who are NHS employees, which posed methodological time constraints to this research. This will be detailed in a later section of this chapter.

In order for us to address the limitations of our single case study, we apply Yin's (1994) four tests to assess the quality of a case study research. These are: construct

validity – establishing the operational measures of the concepts being studied; internal validity – distinguishing patterns and making inferences; external validity – knowing whether a study's findings are generalizable beyond the immediate case study; and reliability – ensuring that the results of the cases can be repeated. Using these criteria, strengths and weaknesses of case studies are derived.

Construct validity. One of the strengths of case study is the depth and richness of information gathered from the research. Case studies are descriptions of instances of phenomenon that are typically based on a variety of data sources, which may be available beyond conventional historical study (Yin, 1994; Creswell, 2007). The use of evidence in case studies address broader historical and behavioural issues, enabling convergence of lines of inquiry and development of the process of triangulation. This increases the quality and richness of the research.

Internal validity. A distinct characteristic of case study research is that it has a unit of analysis, either an individual or a collective organisation, in a bounded system. There are clear boundaries, which identify the problem or phenomenon to be examined, capturing the deeper examinations of a single unit and retain a holistic flavour (Geva-May, 2005; Myers, 2013). This makes case studies exemplary. Case studies focus on the 'how' and 'why' of the examined problem, probing to meaningful characteristics of real-life events and describing one example of a more general category (Yin, 1994; Geva-May, 2005; Myers, 2013). Description of the cases is used to draw conclusions about the phenomena being studied. However, this limits the ability of case study to establish causality. The emergence of randomised field trials or 'true experiments' (Yin, 1994:15) establishes causal relationships, or the efficiency of a 'treatment' in producing an 'effect', which case studies cannot directly address.

External validity. A well-written case study is representative, wherein it represents a real story that most researchers can identify with 'face validity' (Myers, 2013). Since most

case studies examine contemporary events, they are tightly connected with theoretical generalisations and not just represent samples of larger studies (Yin, 1994). However, this leads to little basis for scientific generalisation because the goal of case studies is to expand theories (analytic) rather than enumerate frequencies (statistical) (Yin, 1994; Geva-May, 2005).

Reliability. The most important characteristic of a good case study is ensuring that the results of the cases can be repeated. If other researches could replicate the results of the case study, then it allows minimisation of errors and biases in the study (Yin, 1994). A well-documented study, through a case study protocol and database, increases the reliability of the research. Each case stands on its own that serves as replication, contrasts, and extensions to emerging theory (Eisenhardt and Graebner, 2007). Given that, theory development and building constructs could lead to replication of the case study. Exploring or testing theories within context allows the researchers to get close to action. Also, building theories create empirically valid results and constructs from case-based evidence (Eisenhardt, 1989; Eisenhardt and Graebner, 2007; Myers, 2013). The greatest concern on case studies is the lack of rigor (Yin, 1994). Due to the multiple sources of evidence that researchers can use, some tend to not follow systematic procedures, or allow equivocal biases to influence the direction of the findings of the case study. Therefore, it is important to carefully plan the research design to prevent lack of rigour to be present.

Table 6: Strengths and weaknesses of case study approach

Type of test	Strengths	Weaknesses
Construct validity	Rich and in-depth information	Time consuming
		Access to data
Internal validity		Failure to address causality

	Single unit of analysis in a bounded system	
	Exemplary	
External validity	Representativeness	Little basis for scientific generalisation
		Poor research design
		No control over situations
Reliability	Replication	Lack of rigor
	Theory building and development	

4.4.4 The case: Greater Manchester Health and Social Care devolution

This research uses an embedded single case design to examine the contextual mechanisms that influenced the GM Health and Social Care Partnership in governing the health and social care services in the conurbation. It is an appropriate methodology for this research because it proposes to gain an 'in-depth' understanding of a concerned phenomenon in a 'real-life' setting (Yin, 1994). More importantly, from a critical realist point of view, case studies are effective in framing causal mechanisms and "understanding how the dominoes fall in long causal chains" (Thomas and Koontz, 2011:106).

Greater Manchester (GM) is a metropolitan region and combined authority in the North West of England, with an estimated population of over 2.8 million and comprises

of local authorities, namely Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside and Glossop, Trafford, and Wigan (Figure 16). The combined authority collectively has an overall gross value added (GVA) of £66.4 billion, making it the largest city-region economy outside London (Office for National Statistics, 2018a, 2018b).

Between 2014 and 2015, GM has landed a landmark devolution deal with the government, which included not only devolved powers in planning, land, transport, and fire services, but also some delegated health functions from the NHS. A Memorandum of Agreement (MOU) was signed in February 2015 between representatives from the Association of Greater Manchester Authorities (AGMA), NHS England, and the GM Clinical Commissioning Groups (GM CCGs) to secure the devolution of all health and social care funding to Greater Manchester.

Figure 16: Greater Manchester's administrative boundaries

In this study, the sample of interest were the organisations that make up the Greater Manchester Health and Social Care Partnership. They are a collective unit, which was tasked to provide strategic direction to the overall development of the health and care economy of the city-region. It is made up of the following organisations: 10 local

authorities, 12 CCGs, 15 NHS trusts and foundation trusts, and NHS England, which make up as the units of analysis in this research. Greater Manchester has been selected as the sole case in this study because it is the most advanced case amongst the devolved English city-regions. GM has a strong track record of collaboration, integration, and various governance structures in place to collectively manage health and care services locally.

4.5 Data collection methods

The role of the researcher in qualitative research (Creswell, 2009) is involved in setting the boundaries for the study and collecting information to answer emerging research questions. Purposefully selected sampling and ethical issues must be considered prior to data collection, which involves careful selection of individuals and sites to inform your research problem. Qualitative research methods may have different data collection techniques. For example, grounded theory uses observations, interviews, historical records, and surveys (Urquhart and Fernández, 2013). Ethnography mostly uses fieldwork and observational protocols, interviews, and documents (Creswell, 2007). Case study relies on extensive documents and records of interviews and fieldwork (Yin, 1994), whilst action research uses fieldwork observations and interviews (Myers, 2013).

Critical realist case studies can choose from an array of qualitative methods of data collection techniques, where triangulation of data is necessary to bolster validity and reliability (Easton, 2010; Thomas and Koontz, 2011). Case study research uses triangulation of methods, drawing from a combination of multiple sources of evidence to create converging lines of inquiry (Yin, 1994; Poteete et al., 2010). Using multiple sources of evidence allows a more in-depth and contextual evidence base and increases the breadth of a case study's scope. Myers (2013) named three main categories for data collection, namely interviews, fieldwork, and documents, respectively.

- *Interviews* allow the researcher to gather rich data from the participants, especially when the participants cannot be directly observed. It could be in a form of a structure, unstructured, semi-structured, or focus groups (Flick, 2009; Myers, 2013). However, interviews may be problematic if the participants provide biased responses and filter the information due to lack of trust with the researcher (Creswell, 2007).
- *Fieldwork or participant observation* involves gathering data by interacting and/or observing people in their natural setting. Fieldwork could be in the form of a non-participant or participant observation (Flick, 2009), where the role of the researcher varies on whether he/she decides to watch from the outside or interact from the inside. This technique enables the researcher to have first-hand experience with the participants, however, it may also be seen as intrusive and lack of enculturation, leading to problems in gaining rapport with the sample (Creswell, 2009; Myers, 2013).
- *Documents* enable researchers to access information of participant observations and interviews, through public (e.g. meetings, newspapers, reports, etc.) or private (e.g. journals, diaries, letters, etc.) records. Such documents are written materials may be a historical proof of someone's thoughts or actions (Myers, 2013). While documents may be convenient and time saving (Creswell, 2009), access may be a problem. Materials may be incomplete and not provide authentic and representative information (Myers, 2013).

Table 7: Strengths and weaknesses of data collection techniques

Data Collection Category	Types	Strengths	Weaknesses
Interviews	Structured, Unstructured, & Open Interviews	Rich data from participants that cannot be directly observed	Filtered information and biased responses due to lack of trust

	Focus groups	Historical information	May be seen as intrusive
		Researcher control over direction of the questions	Not all participants may provide logical and consistent answers
Observations	Participant and non-participant	Researcher has first-hand experience	Gaining access to the research site
		In-depth data due to researcher's immersion to the culture	Enculturation or the process of learning the culture's acquired values
		Unusual aspects may come up during the observation	Certain participants may have a hard time building rapport with the researcher
Documents	Public documents (e.g. meetings, newspapers, reports, etc.)	Researcher can access at a convenient time and at a cheap cost	Unavailability for public/private access
	Private documents (e.g. journals, diaries, letters, etc.)	Represent information of participant observations and interviews	Materials may be incomplete and not provide authentic and representative information

Adapted from: (Myers, 2013)

4.5.1 Documents

The first phase of the data collection is to gather relevant documents to establish the various formal institutions utilised in the formation of the collaborative governance. This included a variety of public documents, such as general meeting reports and agenda items between NHS England and Greater Manchester leaders (December 2015 to April 2016) and the Partnership board (April 2016 to July 2019), strategic documents and frameworks, and Chief Officer's Reports (December 2015 to July 2019). Moreover, legislative documents itemising the statutes leading to the Devolution policies were also examined to include the formal institutions that influenced the formation of the GMHSC Partnership. Formal rules come in the form of legal documents and statutes, which

encompass laws, policies, and regulations of government (Rodríguez-pose, 2013) and they are valuable in setting up the initial ground rules of the collaborative governance.

4.5.2 Interviews

The second phase of the data collection is to conduct semi-structured interviews on selected stakeholders of the GMHSC Partnership, particularly those who were involved in the governance, evaluation, and implementation of the overall Health Devolution policy.

Interviews are important in gaining access to individual experience, particularly in revealing causes of action (Smith and Elger, 2012). Rules-in-use are oftentimes not written down; it is conceptualised and understood by the participants where it has evolved over long periods of time (Ostrom, 2007; Poteete et al., 2010), therefore, understanding the institutional shaping of governance formation requires that the research goes beyond large-scale surveys based upon national samples (Lowndes and Pratchett, 2005). As Ostrom (2007:39) explains: 'obtaining information about rules-in-use requires spending time at a site and learning how to ask non-threatening, context-specific questions about rule configurations'. To unearth the 'real' rules that shape participation – informal as well as formal – it is necessary to ask people 'how things are done around here' and 'why is X done, but not Y' (Poteete et al., 2010; McGinnis, 2011a).

Since we are unable to conduct field studies and engage in an ethnographic mode of collecting data, this research relied heavily on the information provided by the semi-structured interviews in order to identify the emerging institutions from the GMHSC Partnership and draw relationships from its underlying mechanisms. Supported by the theory of collective action, we wanted the interviews to reveal the types of rules that they crafted and enforced, along with the unravelling of the exogenous factors and collaborative mechanisms that they used to successfully foster collective action.

An appropriate framework guiding the interaction between the researcher and the respondent is crucial to a theory-led critical realist approach. According to Pawson and Tilley (1997), interviews should be theory-driven, where the interviewer's interactions with the interviewee are drawn from conceptual framework. This critical realist approach recognises that the interviewer and the interviewee have different levels of expertise characterised by wider contexts and outcomes of action, reasoning, choices and motivation, and conceptualisations from the theory (Smith and Elger, 2012). The interactive process then generates responses which contributes to the formulation a and evaluation of structural and causal mechanisms from the "real" and unobserved level. To apply Pawson and Tilley's (1997) critical realist approach to interviewing, we derived the interview questions from the abduction of empirical evidence from the literature search guided by the collective action theory (Table 8). Although the questions were directly informed by theory and our conceptualisation of formal and informal institutions, we framed the questions to be flexible in order to enable the respondent to draw from their own subjective experiences and provide a more personal narrative account.

Table 8: Sample interview questions arising from the abduction process

Rules	Definition	Corresponding element in IAD framework	Sample question/s
Boundary	specify how participants enter or leave their positions	Set of participants	Who is eligible to hold a certain position? Which positions are assigned to certain actors? How are these positions filled?
Position	a set of positions that actors may hold, each of which has a unique combination of resources, opportunities, preferences and responsibilities	Positions to be filled by participants	Who are the actors involved? What are their responsibilities? What resources are available for them?

Choice	specify which set of actions is assigned to which position; prescribed actions that actors in positions must, must not, or may take in various circumstances	Set of allowable actions	What are actors allowed to do?
Aggregation	specify the transformation function from actions to intermediate or final outcomes	Control that individual has in regard to this function	How do we agree on decisions? How do we translate actions into outcomes?
Information	specify the information available to each position	Information available to participants	What are the types of information available? How do they communicate this across? What channels do they use?
Payoff	specify how benefits and costs are required, permitted, or forbidden to players; assigns rewards or sanctions to particular actions	Costs and benefits	What are the incentives that drives motivation?
Scope	specify a set of outcomes	Potential outcomes	What are the types of outcomes that usually result from this decision?

Adapted from: (Ostrom, 2005; Heikkila and Andersson, 2018)

4.5.3 Pilot study

In order to detect potential problems in the initial research design and instrumentation, a pilot study is important to be conducted in a qualitative research design. Piloting the interviews can help identify any flaws on the interview protocols, which then allows the researcher to make the necessary modifications to the instrumentation and the final research design (Bryman and Bell, 2011; Majid et al., 2017).

Using a small subset of the target population as the pilot sample (Bhattacherjee, 2012), pilot interviews were conducted with four policy experts from the Greater Manchester Combined Authority (GMCA) on July 2018. Since the piloted sample do not have any expertise or working knowledge about the current Health Devolution policy, the questions were instead directed to their experiences on collaborative governance and the underlying mechanisms that help them generate successful policy outcomes. For example, the participants were asked to draw from their recent experiences on collective decision-making and identify how they overcome the challenges in working in a multi-sectoral organisation. The outcomes from the pilot study were later on adopted to the final interview instrument (see Table 9).

Table 9: Refined interview questions

1. Describe your role in this organisation.
2. How did this role come about?
    a. Secondment; Fixed-term contract; Other
3. What was your role before Devolution?
4. Can you please talk to me about a project that you recently participated in? Walk me through the process on how it was formulated, how decisions were made, etc.
    a. Who were the people involved?
    b. What were the key decisions made?
    c. How did this emerge? What was the problem you were trying to solve?
    d. What was the outcome of this project/programme? If ongoing, what stage is it currently on?

    ** At this point, when interviewees mention the role of the governance structure, there are follow-up questions regarding it.
5. What were the challenges/difficulties of collaborating with different actors from multiple organisations? Why do you think so?
    a. Did these problems exist before Devolution? Why do you think so?
    b. How do you think these problems are best resolved?
6. What do you think were the key differences that Devolution in health has brought into the agenda in GM? Why do you think so?
7. How do you see the GMHSCP in the future? What is your outlook of the future of the Partnership? Why?

4.5.4 Recruitment process

Selection of participants is an important aspect of research. Pawson and Tilley (1997) emphasised the importance of selecting key informants that have expert knowledge on the topic. Purposive sampling method based on the selected characteristics of a

population was employed “to choose strategically key informants based on the researcher’s perception that the selected cases will yield a depth of information or a unique perspective relative to the phenomenon of interest” (Tashakkori and Teddlie, 2010:357). We focused on a particular subgroup, in which all the sample members were similar, such as occupation or level in an organisation's hierarchy. Using this technique, parameters or boundaries were initially established to delimit the characteristics of the key informants will be observed.

Our inclusion criteria included the following:

- Must be staff of the Greater Manchester Combined Authority. This include any of the 10 Local Authorities of Greater Manchester
    - Bolton Council, Bury Council, Manchester City Council, Oldham Council, Rochdale Council, Salford Council, Stockport Council, Tameside Council, Trafford Council, and Wigan Council) or,
- Must be staff of the NHS Clinical Commissioning Groups (CCGs) or NHS Foundation Trusts (FTs) within Greater Manchester.
- Must also be holding a position in either the NHS or in the council that has a role in decision-making. Position may vary from councillor, director, policy associate, project lead, commissioner, etc.
- Must be working in Greater Manchester directly affecting the various work programmes within the devolution health agenda, including decision-making duties, developing policy, implementing policy, commissioning or evaluating programmes, etc.

To recruit participants, a gatekeeper from the GMHSC Partnership has been identified, as per NHS ethical protocol. This person served as the main contact person throughout the recruitment process. An invitation to recruit for participants was sent out

to the members of the Partnership according to the inclusion criteria. Participants who agreed to take part of the study recommend others who they may know who also meet the criteria. Therefore, snowball sampling method was utilised as a means of a convenient method of asking participants to recruit more individuals to join the study (Tashakkori and Teddlie, 2010). This draws on participants' own expertise in developing the sample as well as expanding the sample beyond contacts known to the researcher. To avoid informational redundancy, recruitment of participants ceased once data saturation is achieved. This means that the researcher recruits participants until nothing new is apparent, and there is enough information to replicate the study (Saunders et al., 2018).

A total of 38 participants were recruited for the study (Table 10), which included members of the GM HSCP project management and executive team; CCG directors; Public Health directors; senior leaders from local authorities; General Practitioners (GPs) and clinicians from provider and foundation trusts; and members from voluntary sector and other partner organisations who were involved in multiple streams of decision-making within the Partnership. They acted as key informants for the study, providing narratives about the emergence of the Partnership, how the organisations interact with one another, how collective decisions were made within the governance, and how the health devolution and the Partnership had impacted the delivery of health and social care services in GM.

Interviews were conducted between July and December 2018 (Table 11). Participants were given the choice to pick a venue that is comfortable for them, such as their office or a nearby coffee shop. Participants were not presented a copy of the interview schedule; however, they were briefed what the study was about and were given opportunities to ask questions or further clarifications. This also allowed the participants

to comfortably converse in an open dialogue and engage in a free-flowing interaction with the researcher without feeling constrained to address all questions.

4.6 Data analysis techniques

Once data from the documents and interviews have been gathered and collected, data triangulation is used to corroborate the findings and strengthen the validity of the case research design (Yin, 1994).

Table 10: List of participants recruited for the study

Identifier	Role	Organisational group
C01	Senior CCG Lead	CCG
C02	CCG Integration Lead	
C03	CCG board member	
C04	CCG board member	
F01	Foundation Trust Senior project director	NHS Foundation Trust
F02	Foundation Trust Senior officer	
F03	PFB Senior officer	
G01	Partnership project management lead	GMHSC Partnership
G02	Partnership finance lead	
G03	Partnership project management lead	
G04	Partnership project management lead	
G05	Partnership project management director	
G06	Partnership project management director	
G07	Partnership project management lead	
G08	Partnership senior director	
G09	Partnership project management lead	
G10	Partnership project management lead	
G11	Partnership project management lead	
G12	Partnership project management lead	
G13	Partnership senior director	
G14	Partnership project management lead	
G15	Partnership senior director	
G16	Partnership project management lead	
G17	Partnership senior director	
L01	Councillor (Health and Wellbeing board)	Local authority
L02	Local Authority Senior Leader	
L03	Councillor (Public Health)	

L04	Councillor (Public Health)	
L05	Local Authority Senior leader	
L06	Healthwatch senior lead	
P01	Consultant, partner	Partner organisation
P02	Senior project lead, partner	
P03	GP senior officer	
P04	GP senior officer	
P05	VCSE Director	
P06	Senior project lead, partner	
P07	Senior CCG board member	
P08	Senior CCG board member	

Table 11: Timeline of data collection

February 2018: Application for the university Ethics procedure

March 2018: Preparation for the NHS Health Research Authority (HRA) Ethics procedure

Development of the research instrument, including consent forms, participation information sheet, interview questions template, letter of invitation to participant, and research protocol

April 2018: Submission of HRA Protocol

June 2018: Approval received from the HRA
Contacted gatekeeper to begin recruitment of participants

July 2018: Pilot study, N=4

July to December 2018: Conducted semi-structured interviews, N=38

December to January 2019: Transcription of interviews

February 2019: Coding of interviews via SPSS

4.6.1 Framework analysis

This study uses a framework approach developed by Ritchie and Spencer (2002) for use in applied health policy research. The method begins with a theory, followed by conceptual codes induced from the relevant theoretical framework. This is then used to formulate questions and deduced for the qualitative interviews, which are then re-coded

back into the framework and re-defined before and during data analysis (Hsieh and Shannon, 2005). This analysis technique is suitable to the critical realist approach, which promotes an abductive process between theory and data.

The framework approach involves a systematic process of sifting, charting, and sorting material according to key issues and themes and uses a 'spreadsheet' approach to facilitate recognition of patterns and contradictory information (Gale et al., 2013). Following Ritchie and Spencer's (2002) five-step process to framework analysis (e.g. familiarisation, identifying themes, indexing, charting, and mapping and interpretation), we emphasise the importance of the analytical process in highly interconnected stages. There is no right or wrong way to approaching a framework analysis. Ritchie and Spencer (2002) stated that although the process is usually presented in a particular order, there is no implication that it is a mechanical process; rather, it involves constant zooming in and out of the various stages of the elements of the framework to determine the relationships, mechanisms, and institutions emerging from the data.

4.6.2 The IAD Framework

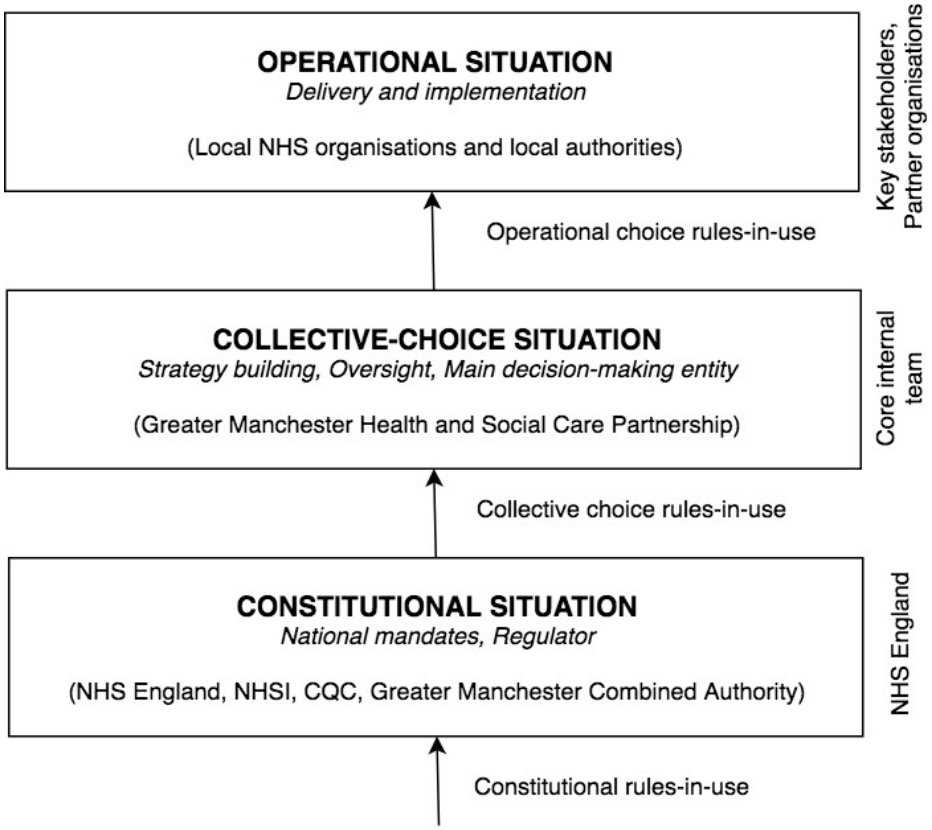
As identified in the previous chapters, this research uses the Institutional Analysis and Development (IAD) framework to capture all the elements (e.g. external variables, action situation, interactions, outcomes, and evaluative criteria) in managing the health commons. It claims an explanatory power to unpack the details of the institutional operations, which will be useful in understanding how a set of rules, norms, and beliefs are embedded within common property regimes and influence the way they address problems and enforce such existing institutions.

More importantly, in order for us to situate the institutional rules that emerged and how participants interact in each phase, we recognise that institutional choices can occur in three levels. Ostrom’s multiple levels of analysis illustrate how all rules are nested in another set of rules (Ostrom, 2005:58), where one level of actions and outcomes

obtained from the previous level affect the proceeding level. For example, *constitutional* rules refer to who, when, and how can participants engage. These then affect the *collective-choice* activities, where choices about which institutions or strategies should be used in resolving collective decisions. These collective-choice rules then influence how day-to-day transactions and decisions are made by the participants in *operational* situations.

These three levels helped us identify the embedded units of analysis in our single-case research design (Figure 17). We were able to examine and compare how various rules and interactions emerged from the GMHSC Partnership and the organisations involved in it, and how the decision-making processes at different levels of Partnership activities occurred. In the *operational* situation, we focus on how the key stakeholders and partner organisations interacted with one another to deliver and implement the GM Strategic Plan. In the *collective-choice* situation, we look at how the Partnership acted as the steward to GM's health economy and how it fulfilled its oversight role in strategy building, delivery, and monitoring and assurance. We also want to explore how various participants come together in the collective-choice action arena to make decisions collaboratively and collectively. Lastly, the *constitutional* situation refers to the role of NHS England as a key player to the GMHSC Devolution agreement and how it controlled the collective-choice activities by implying national mandates and regulatory roles.

Figure 17: Modified multiple levels of analysis



4.6.3 Analysis

The process of framework analysis began by reading national level policy documents outlining the legislative process of the Devolution in Greater Manchester. This helped me familiarise the overall political context of local governance in England and how the Devolution policy arose as a solution. Moreover, agenda documents from public meetings between the NHS and leaders of the GMCA were examined to identify how Health Devolution emerged. As interviews were being conducted, I continued to immerse myself with public documents being published on GMHSC's website and other evaluative reports being conducted by University of Manchester. After the transcription of the interviews from various individuals involved in the GMHSC Partnership were conducted, the data was analysed and coded into NVIVO in accordance with the various elements in the IAD Framework.

Using data from both documents and semi-structured interviews, I followed Polski and Ostrom's (1999) guidance to using the IAD framework where I took advantage of the IAD framework's analytical power to break down the themes from the policy documents and interviews into manageable sets of practical activities.

We carry out a two-part analysis to examine the (1) institutions that emerged during the establishment of the Partnership, and (2) the collaborative interactions between the actors involved and process outcomes resulting from this. First, I identified the exogenous variables that influence the action situation and constrain the types of institutional arrangements being informed. These are the physical attributes, community attributes, and rules-in-use. We particularly focused on identifying the factors that were critical during the initial stages (negotiation and formalisation) of the Partnership. The three factors altogether constitute the antecedents that shape the impetus to collaborate and the starting conditions necessary to take collective action.

Second, we proceeded to the examination of the action situation where we zoom in on the collective-choice arena (i.e. the Partnership) highlighting how institutions and structural attributes of the contexts affect the behaviour of the actors participating in it. We assume that the action situation occurs after the period of the establishment of the Partnership to its implementation stages, where we observe how individual behaviours and rule configurations changed over time. We go through each element of the action situation and examine how each element corresponds with a set of formal and informal institutions emerging as an outcome of the interactions from the action situation.

We summarised and concluded the analysis of the data by looking at the emerging patterns of interaction and outcomes according to Ostrom's multiple level of analysis as a result of the different institutions set up within the constitutional, collective-choice, and operational levels. The results from the data analysis will be presented in the proceeding chapters.

4.7 Ethical procedures

Ethical considerations are important in research, especially when dealing with human subjects and protecting the privacy of their data (Bryman and Bell, 2011). To comply with the ethical procedures, this study obtained an ethical approval from both the University (sponsor) and the Health Research Authority (HRA) (NHS sponsor). HRA Approval was introduced as the process for applying for ethical approvals for any project-based research involving NHS in England and Wales, such as patients or staff (Health Research Authority, 2016). Because this study involved recruiting participants who are NHS employees, an electronic application was formally lodged in the Integrated Research Application System (IRAS) website.

The ethics application process took almost 5 months in total, including preparation and ongoing feedback and consultation with the University ethics team. The application included the submission of a research protocol outlining the study procedures (recruitment process and inclusion/exclusion/withdrawal criteria), reporting procedures for adverse events, data handling and archiving procedures, monitoring and audit of data, regulatory procedures (data protection and confidentiality), and dissemination of the results. Consent forms, participation information sheets, interview questions template, and letter of invitation to participant were also included in the IRAS application.

4.7.1 Data handling and record keeping

Data for the interview was recorded in an audio recorder with real-time file encryption and password protection. Moreover, notes were also taken during the interview. Audio recordings were encrypted and stored in an encrypted and password protected university computer, and on a secure network, safe from unauthorised access and processing, accidental loss, damage or destruction. Transcribing of audio recordings were conducted solely by the principal investigator (i.e. the student). Once the recordings have been

transcribed, the documents were stored in password protected word documents and saved to a secure university network.

All transcripts were anonymised, and an identification log was securely stored separately from the anonymised data. The anonymised data was coded, and the codebook was stored in a separate location from the anonymised data. The audio recordings will be stored until the completion of this project and an additional 3 years to verify the validity of the research in the unlikely event that it is challenged. After this period the recordings will be deleted according to the university's archiving and destruction procedures. All printed and electronic data were encrypted and stored in a secure safe from unauthorised access and processing, accidental loss, damage or destruction. Paper consent forms, audio recordings, identification log, and codebook were also kept separately, under lock, and were stored in a secure, separate location from the anonymised data.

4.7.2 Reflection on the ethics process

Due to the tedious process of the HRA, there were a few factors that posed as a methodological barrier to this research (see McDonach et al., 2009). First, we acknowledge the value and importance of the NHS ethical approval. However, it is possible that not all social science postgraduate researchers may be aware that such system exists should they take interest in conducting research involving the NHS. I do thank the University Ethics team for extending their hand to help me submit a strong and robust proposal, which led to the approval of my application with minor amendments. Second, it is worth noting that the processing time lasted at least 8 weeks from the original submission (April 2018) to the final approval (June 2018), including the time to revise for minor amendments. This also does not take into account the time since I started preparing the documents for the application. The research design, at that time, was still not fully developed and I needed to finalise everything within a short period of

time whilst taking into account the flexibility of the proposal just in case any changes in my research occurs. I was made fully aware of that any deviations from the approved protocol may result into another application. These limitations discouraged me from attempting to expand my case research design and reaching out to other policymakers involved in Health Devolution outside GM.

Despite the difficulties, there were good outcomes from my application. Having the HRA approval allowed me to reach my participants without any hesitations. The participants were more comfortable joining my research knowing that I have received ethical approval to interview them. This also meant that all research instruments used for the interview were pre-approved by the HRA. More importantly, I learned a valuable technical skill that I could apply in future research projects that will involve recruitment NHS participants.

4.8 Summary

This chapter lays out the research design and methodological tools that guide the analysis of this research. We employ a qualitative research because of its We employed a qualitative research approach using case study methods to gain an in-depth understanding on the GMHSC Partnership and the institutional mechanisms that they used to govern the health commons. Although we have a single, we have embedded the IAD's multiple levels of analysis to address the limitations of our chosen case study design. A combination of interviews and documents were examined to evaluate the collaborative and institutional mechanisms in place to resolve their collective action dilemma. Using the IAD framework, we triangulated and analysed the data and carried out a two-part analysis. Ethical procedures were also outlined to illustrate the HRA application process and the value of this experience to the researcher. Results will be presented in the proceeding chapters.

5 Exogenous factors

5.1 Introduction

In the previous chapters, we have established the theoretical grounds to justifying how various institutional arrangements can be created in order to govern the health commons. We also introduced the city-region of GM and how we're using the GMHSC Partnership as our case to argue that local decision-makers can devise, enact, and monitor their own rules to act as stewards of their own health commons. The question on whether the commitments made in 2015 are being delivered effectively or not is beyond the scope of this study (see GMCA, 2018; Lorne et al., 2018; Walshe et al., 2018). Instead, this thesis analyses how a group of collaborating organisations developed their own mechanisms in order to take charge of their health commons, and how they crafted institutions to enforce and monitor amongst themselves on who, how, and what they can appropriate from their shared or pooled resource.

Following Ostrom's IAD framework as an analytical tool, we carry out a two-part analysis to examine the (1) institutions that emerged during the establishment of the Partnership, and (2) the collaborative interactions between the actors involved and process outcomes resulting from this. It specifically addresses the objectives of this research to unearth the external factors leading to the formation of the collaborative governance, the mechanisms used during the collaborative process, and the formal and informal institutional arrangements made in order to address the collective action problem. By using this theoretical perspective, we aim to evaluate on whether these arrangements can be sustainable to governing the health commons and whether it has potential to be replicated elsewhere; and whilst the principles may not be directly comparable to a natural common property regime setting, we are hopeful that we draw some lessons on how this can be examined by scholars in the future.

In this chapter, we particularly focus on the factors that were critical during the initial stages (negotiation and formalisation) of the Partnership. First, we identify the physical attributes of the goods and services being considered, which have significant influence on the formation of the governance regime. In health commons literature, we refer to these as the physical resources that are pooled together by the collaborating participants, i.e. human capital, geographical boundaries, financial resources, etc. Second, we examine the community attributes that reflected the common understanding or socially accepted norms in which the participants share with each other. These include social capital and their joint collective interest to solve problems, which in effect influence the behaviour of the actors. Lastly, we explore the initial set of rules that when the Partnership was established. Based on the physical and community factors, the participants determine, formulate, and enforce rules to order their relationships. These three factors altogether constitute the antecedents that shape the impetus to collaborate and the starting conditions that are necessary to establish a collaborative governance.

5.2 Physical attributes

Physical conditions influence the action situation and constrain the institutional arrangements being formed. They provide significant implications for policy design and collective action, which are all critical aspects of the policy-making process (Polski and Ostrom, 1999). In this research, we refer to health commons as the unique common property regime setting that encompasses a variety of human, physical, financial, and social capital relevant to the delivery of health and social care services. We explore in this section the physical attributes of the health commons that the Partnership is looking after, i.e. the health and care economy of Greater Manchester, of which is being shared between a segmented population. These include the physical structures and health care services, the financial resources being pooled, and the geographical boundaries covering the population. The social capital element will be covered in the community attributes.

5.2.1 The Greater Manchester Health and Social Care Partnership

The decision-makers of the city-region of Greater Manchester established a governing body who will be responsible for the regional stewardship or collective management of the health commons. Through the Devolution deals, a new Greater Manchester Health and Social Care (GMHSC) Partnership was introduced to bring together 37[5] statutory institutions, including 10 local authorities, 10 CCGs and 13 NHS trusts and foundation trusts, along with representatives from primary care, Healthwatch, community and voluntary sectors, Greater Manchester Police, Greater Manchester Fire and Rescue Service, and NHS England, to take charge of the health and social care economy of the city-region and to undertake the responsibilities outlined in the Health Devo MoU. The body is responsible for strategic planning and financial and monitoring oversight of the £6 billion budget for health and social care in GM. Decision-making was based on subsidiarity, i.e. making decisions at the most appropriate level, meaning that the NHS in Greater Manchester is not going to be controlled by either the councils nor the NHS centrally, but by working collaboratively and promoting inclusivity amongst its partners.

As stewards of the health and social care economy of the 2.8 million residents of Greater Manchester, the system covers the geographical boundaries of the Greater Manchester Combined Authority, including the NHS organisations within the 10 local authorities of Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside and Glossop, Trafford, and Wigan, and the 10 local councils.

In addition, the following are also part of the GMHSC system and are represented in the Partnership:

[5] 37 at the time of signing MoU on 2015, but Manchester CCGs/Trusts have merged. Current count is 33 organisations

- Primary Care providers
    - 500 General Practitioner Practices;
    - 450 General Dental Services;
    - 700 community pharmacies;
    - 300 community optometry services;
- At least 300,000 carers;
- 27 social housing providers;
- 14,500 voluntary and community organisations;
- Greater Manchester Police;
- Greater Manchester Fire & Rescue Services;
- NHS England; and
- 2.8 million residents of Greater Manchester

5.2.2 Autonomy and accountability arrangements

The devolution deals brought about new arrangements for NHS England to transfer certain responsibilities to local organisations that will drive the policy direction towards a more place-based commissioning and decision-making. With the overarching principle of "all decisions about Greater Manchester will be taken within Greater Manchester" (AGMA et al., 2015:5), Health Devo was presented as a catalyst for GM to make local decisions about how their resources are to be spent and how national policies will be implemented. This, however, raised a question on the level of autonomy awarded to GM – whether the newly established Partnership is receiving devolved powers similar to that of the statutory arrangements in NHS Scotland, Wales, and Northern Ireland (i.e. full devolution), or NHS England is merely delegating some responsibilities to GM to make regional decisions on strategic planning and delivery (i.e. delegation).

As it stands, devolution of health and social care in GM resembled the latter, largely because there was no statutory or legislative basis. Instead, it came in the form of what

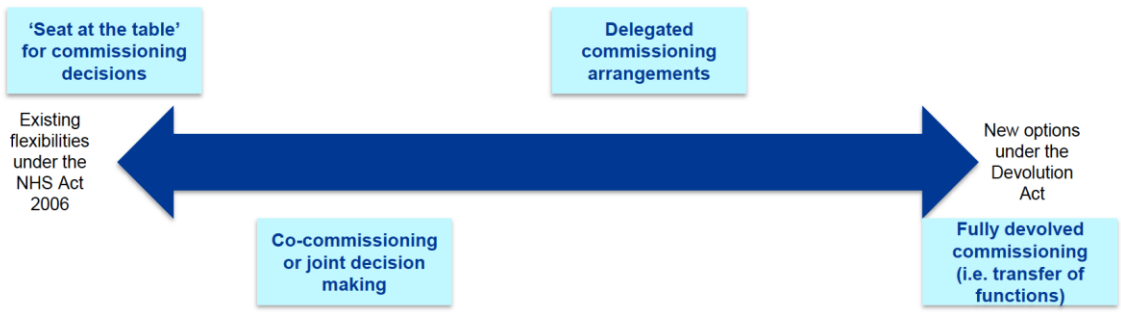
was called the 'Warner amendments' (The King's Fund, 2015) to the *National Health Service Act 2006* via the *Cities and Local Government Devolution Act 2016* Schedule 4 (CLGD Act 2016 hereafter) in relation to delegation and joint arrangements that support and improve the integration of health and social care services and place-based approaches (*see* NHS England, 2015a). It also expands the range of possibilities for local organisations to work together whilst making their own decisions, with the health-specific amendments focused in the extent of devolved NHS functions to combined authorities or local NHS organisations acting together through a joint committee.

First, the legislation does not in itself transfer NHS England's supervisory powers or functions over CCGs. This is in order to preserve the 'N' out of the NHS and to ensure that the national standards and assurance processes are not lost in the devolution process. Second, the amendment also ensures that the Secretary of State retains his/her statutory duties, including regulatory and supervisory functions fulfilled by the Care Quality Commission (CQC) and the like. This meant that there will still be a significant degree of national oversight and control, reinforcing the retention of existing organisational statutory responsibilities and lines of accountability. Third, NHS England may delegate specialised commissioning and other functions to a joint committee, including at least one combined authority and/or LA, and at least one CCG. This allows CCGs to share commissioning functions with combined authorities. This also clarifies a distinction between the powers of the directly-elected Mayor and those of the combined authority, making them responsible for different services (i.e. health is not under the remit of the directly-elected Mayor).

The extent of the devolved responsibilities was outlined in the Health Devolution Memorandum of Understanding (MoU) (AGMA et al., 2015) and the subsequent documents clarifying accountability and monitoring principles (NHS England, 2015a, 2015c). To further clarify the nature of devolution in respect to NHS England functions,

a document was released on September 2015 to set out the overarching models of devolution of NHS England functions in terms of the current legislative framework and how the devolution agenda linked with the current policy on STPs (NHS England, 2015c). This framework was set to encourage future devolution proposals to consider asking within the lines of delegation rather than full devolution of planning and commissioning functions (Figure 18). Drawing from the existing powers under NHS Act 2006, the lowest level in devolution spectrum is a 'seat at the table' for commissioning decisions. This meant that decisions about a function are taken by the function holder but with an input from another body, hence the expression 'seat at the table'. There is no legal or organisational change on parties involved, and lines of accountability and responsibility (e.g. budgetary and funding for overspends) remain with the original function holder.

Figure 18: Devolution spectrum of NHS functions



Source: (NHS England, 2015c)

The next level entails co-commissioning or joint decision-making, where two or more bodies with separate functions come together and make decisions together on each other's functions (see *NHS Act 2006* Section 75 Partnership arrangements between NHS bodies and local authorities). Following that is the level on delegated commissioning arrangements, which is the current arrangement received by GM. Exercise of the function is delegated to another body, including decision-making and budget. Lines of accountability and responsibility (e.g. budgetary and funding for overspends) still remain with the original function holder. Lastly, the bottom end of the

devolution spectrum involves fully devolved commissioning where the function is transferred to another legal body on a permanent basis, including responsibility, liability, decision-making, budgets, etc. The new body will be the new owner of the accountability and responsibility for the transferred functions, as in the case of the devolved NHS in Scotland, Wales, and Northern Ireland.

The success of the revolutionary Health Devo deal formed the basis of the principle-based decision criteria designed by NHS England for future health devolution proposals from areas who are considering asking for extra freedom on health functions. Based on an assessment criteria framework (see NHS England, 2015b), areas seeking devolved arrangements of NHS England functions are to be assessed through a formal process using the NHS England board-agreed principles and decision criteria. The framework evaluates the robustness of the proposal through the following areas:

- A vision clearly articulating the benefits of devolution;
- A 'health geography' supporting coterminosity and devolved decision-making;
- Quality and continuity of care linked to the safe transfer of responsibilities;
- Impact on other populations, including appropriate safeguards for users of local services from outside the relevant geography;
- Financial risk management and mitigation actions identified;
- Support of local health organisations and political leadership, demonstrating cooperation amongst all parties;
- Demonstrable leadership capability and track record of collaboration between NHS bodies and local government;
- Demonstrable track record of collaboration and engagement with patients and local communities;
- Clear mitigation plan and exit route in the case of failure;

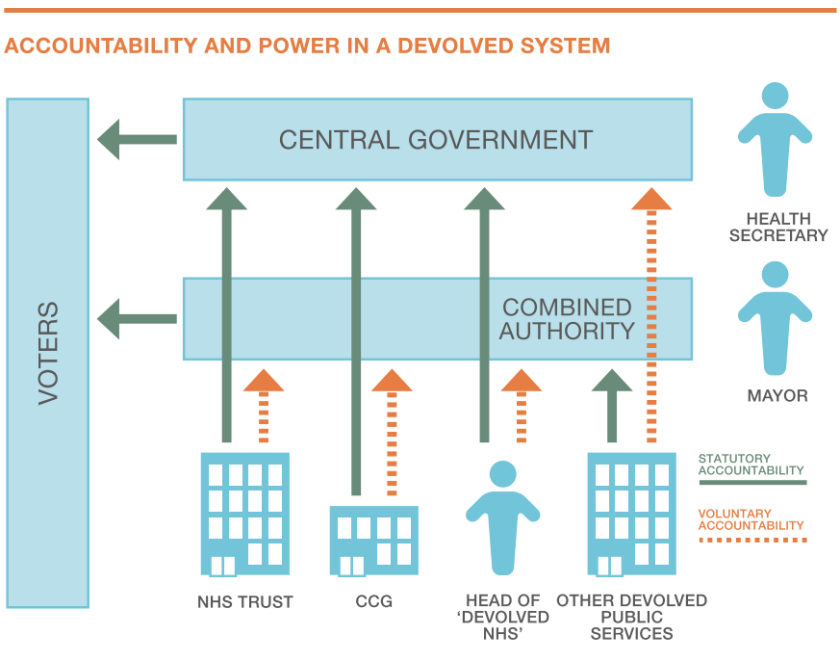
- Accountability and governance arrangements with an MoU in place as necessary; and
- Organisation impact assessment, as well as employment model and arrangements in place

It was expected that the formal process will take approximately 18 months from the expression of interest in a devolution deal, which was mirrored from the progress that GM has demonstrated. Subsequently, the framework was implemented to those who were invited to submit proposals for their own bespoke devolution deals on early September 2015.

Devo Health illustrated the redistribution or delegation of responsibilities to a semi-autonomous entity like the combined authority of GM through the GMHSC Partnership. This new layer in the health and social system is created to provide some form of regional oversight whilst retaining a degree of accountability back to the central government, mimicking the regional health authority models that were abolished by the Health and Social Care Act 2012. The degree of autonomy is therefore limited to the devolved (or rather, delegated) NHS functions, such as administrative responsibilities (such as planning and commissioning); financial responsibilities (such as handling the total budget and allocating the budget within the system); and political and strategic responsibilities (such as objective and outcomes setting). This covers system services such as, acute (including specialised services) and primary care (including GP contracts), community and mental health services, social care, public health, and health education, research and development (The King's Fund, 2015). This arrangement was agreed upon by NHS England and key leaders of the GMCA and GM NHS organisations after the initial Devo Manc agreement.

Because of this set-up, GM still remains part of the NHS and social care system subject very much to the NHS constitution and mandate. GMHSC's member organisations (i.e. CCGs and local authorities) will retain their statutory functions and existing accountabilities for funding flows (AGMA et al., 2015:4), and the CCGs and Foundation Trusts will still be accountable to Whitehall or NHS England, and the Local Authorities will still be accountable to the public voters (Figure 19). This also means that the NHS statutory organisations are still subject to national monitoring and regulatory agencies, such as CQC and NHSI. It is the Partnership's responsibility to also respond to national 'asks' or 'must-dos' and ensure that they are keeping up with national guidance and strategies.

Figure 19: Accountability lines



Source: (Quilter-Pinner, 2016)

5.2.3 Financial arrangements

During the 2015 Spending review, a £7.7 billion health and social care spending over the next five years is forecasted for Greater Manchester, with at least £6.2 billion allotted on health services like mental health, GP services, specialist services and prescribed

drugs, and £1.5 billion on local authority budgets for public health and social care services (GMCA and NHS in GM, 2015g). Given the existing pressures in the system and fragmentation of services, it is unprecedented that GM is facing a challenge of £2.1 billion financial deficit by 2020/2021. In order to secure that the vision of the Partnership and the Health Devolution will materialise, GM needed to make financial arrangements in order to not only operate as a single Partnership body, but also to ensure that all the right decisions are being made to ensure the financial sustainability of the GMHSC system. In order to address this, GM submitted a Strategic Financial Plan in August 2015 to NHS England as part of the Comprehensive Spending Review (CSR), outlining how the Partnership intends to meet the clinical and financial challenges during the five-year CSR period and what resources are required to significantly close the financial gap (GMCA and NHS in GM, 2015g:47).

Whilst Health Devo brought flexibility in terms of making decisions and bringing resources closer to the communities, it does not necessarily come with the power to fully control the budget. This meant that GM did not really receive any fiscal devolution powers (i.e. in the case of the fully devolved nations of Scotland, Wales, and Northern Ireland), but rather, delegated responsibilities on how to make decisions on spending its £6 billion annual budget (i.e. commissioning arrangements). Existing funding flows between NHS England and CCGs for commissioning health care services still remained, as well as commissioning social care services by local authorities.

To clarify, a Partnership project management director said, “we don't play a role in terms of the partnership team in saying where a proportion of that money should go to Bolton, a proportion should go to Manchester to Tameside” (G05). The annual GM health and social care spending was set through a national allocation formula during the 2015 Spending Review for a five-year period. Like the rest of the country, the money comes from the Parliament through the Department of Health, then to NHS England, and

essentially down to the CCGs of Greater Manchester. The only thing that has changed is that instead of NHS England North West regional office having the responsibility to support strategic direction and to monitor the quality, financial, and operational performance of the NHS organisations within its remit, this was delegated to the Partnership (G05, G06).

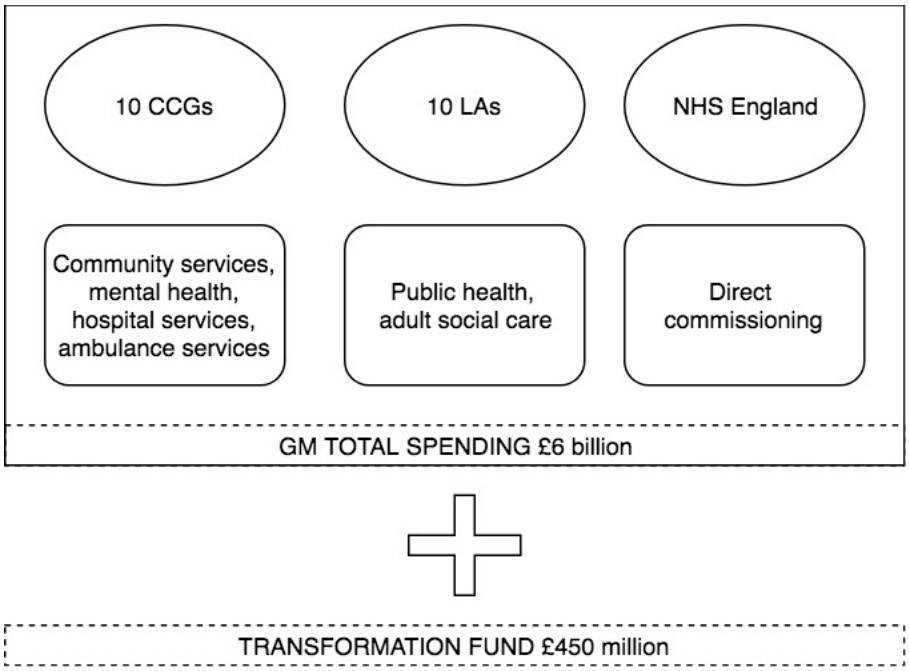
One of the Partnership senior directors described this arrangement as “actually most of that's a seat on the table… made up of effectively existing NHS budgets so that the bulk of them are the CCG allocations” (G13), where CCGs hold the budgetary functions but the Partnership makes collective decisions on how and where to spend it. However, the beauty of devolution is that Greater Manchester is managing the £6 billion pot in its entirety. It allows GM the flexibility to set priorities and have local discretion on how to meet national targets (C03). Whilst it is the remit of the Partnership to make sure the GM system is financially sustainable and to make sure that the partner organisations are delivering what is asked of them, the CCGs and providers are still subject to performance assessment and assurance processes by the NHS England regulators in order to ensure that they are meeting their targets (G06).

> *“The £6 billion is a way of capturing all of the money that's spent on the GM population on health and social care. And increasingly we have the ability to be more directing locally on how that's spent but all within the rules of the NHS Constitution so all of the national targets around referral to treatment, around A&E and four-hour waits, all of those things that are in the NHS Constitution we still have to meet. All of the priorities that are in the national plans, we still have to meet, but we have much more discretion over how we go about it.” (G13)*

The second and perhaps the more impactful element to the Devo Health funding arrangements is the £450 million Transformation Fund (TF) injected to the GM health and social care system from NHS England (GMCA and NHS in GM, 2016a) from

2016/2017 to 2020/2021. A one-off access to the TF was part of the resources required to reduce the £2 billion financial gap and also to boost transformative changes on the delivery of health and social care services within the city-region, as outlined in the high level Strategic Financial Plan. The amount was set by NHS England based on the evidence submitted by GM on what was deemed to be the minimum amount required to deliver clinical and financial sustainability over the five-year period.

Figure 20: Funding arrangements



As part of the Devolution deal that GM received, the three-year non-recurrent £450 million TF was ring-fenced and was considered to be the only pot of cash fully devolved to GM (G02). This was not only allocated for funding the implementation of transformational programmes, but also to double-run services and operational costs (i.e. salaries for Partnership posts). There was a positive response to this because it allowed the partners to have an exclusive access to a lump sum of money upfront in order to deliver better health outcomes in a financially sustainable way and to close the financial gap. This brought an impact to NHS organisations, particularly to their planning and procurement process. Bidding to the national pot can be quite tricky because things could

change during that period, making it more difficult to put in a plan that could cover a long-term period. Because of this, CCGs can only plan for a limited period of time (i.e. one year) instead of a three to four-year duration in order to avoid having to re-bid in case anything changes (C04). Figure 20 summarises the initial funding arrangements that were devolved from NHS England to Greater Manchester.

5.3 Community attributes

The attributes of a community refer to the degree of common understanding between the potential participants who share values, beliefs, and preferences about policy strategies and outcomes (Polski and Ostrom, 1999). In the health commons, this involves the inherent attributes of the participants that influence the level of participation and their willingness to collectively govern the commons. In the case of Greater Manchester, the decades of collaborative relationships and the desire to address problems collectively contributed to the galvanisation of the GMHSC Partnership.

5.3.1 Greater Manchester's track record of working together

Greater Manchester has had a long history of collaboration long before the devolution deals were introduced, as illustrated in the previous chapter. They've always had a strong reputation and a track record of working together, which is why it came to no one's surprise that GM was a viable candidate for the devolution deals. There was a sense of pride that GM, more than anywhere else, have succeeded in working together despite the absence of any statutory mandates from the central government. This voice, in particular, was more present with local authorities where key leaders were proactive in recognising the needs of the GM economy by taking upon themselves to pursue and maintain voluntary relationships. A coalition between the 10 localities in the city-region have been forged through the AGMA after the abolition of the Greater Manchester City Councils (GMCC) in 1986. The two decade-long of coordination and organic efforts were

rewarded when an opportunity to establish a more formal city-regional governance emerged in 2011 through the GMCA, the first of its kind in the UK.

These, in addition with trust-building and joint working resulting from the structures of relationships, became GM's recipe to success – all they had to do was wait for the right moment. When the Northern Powerhouse agenda came up, GM grabbed the opportunity to lobby with key political leaders (i.e. George Osborne, etc.) to push the devolution agenda forward and to convince them why GM was in a strong position to receive the deal (G13, L05). A local authority senior leader who played a key role during the negotiation process expressed, "the government could feel we had ourselves arrangements that make things happen, you know so they had confidence that if they were to give us some devolution, we were probably less likely to make a mess of it than other parts of the country." (L05) In effect, the existing structures (i.e. AGMA, GMCA, etc.) became key drivers to landing the Devolution deal because GM was successfully able to display that they have a strong governance presence to make decisions more effectively as a collective group. It has placed GM in a unique pedestal to putting forward a more convincing and attractive bid for Devolution.

5.3.2 Tensions in the local health and social care system

The GM's local NHS organisations, however, have followed a different path. The reforms were described as a "… pendulum swing from centralisation then back to a very local emphasis in services" (C01) by a senior CCG lead, resulting in an extra layer of structures added to the existing local governance arrangements and more fragmentation in the already complex health system (C01, C02, C03, F02). The constant reconfiguration of the system has bred a different culture amongst NHS organisations; some have found themselves competing with one another in order to survive (P03, P05, F03) whilst others used the chaotic, fragmented system as an opportunity for joint working and informally meet as a collective unit (L03, C02).

Evidence from the interviews suggest that the HSCA 2012 reforms in particular, have affected the relationships between primary care providers (i.e. GPs, optometrists, dentists, etc.), CCGs, and provider Trusts. The CCGs for example, were intended to be clinically led, where GPs and other clinicians have the opportunity to influence commissioning decisions for their local population. However, a senior CCG lead felt the intentions to make GPs more involved in commissioning of services from arrangements that have been in place for PCTs have backfired (C01). In theory, the commissioner is supposed to say and know what the needs of the population area, then come up with solutions to address those needs then commission them from a provider organisation. In reality though, the commissioners that have moved into clinical commissioning are GPs who do not have any knowledge expertise in, for example, radiotherapy, chemotherapy or surgery. “They have expertise in general practice. And so, a criticism of commissioning has been that it's weak and ineffective. And that it doesn't have the expertise to deal with the things that it's trying to tackle.” (C01)

These particular weaknesses have affected how services are being commissioned locally, resulting in poorer health outcomes in the area and variations across the GM system. The Lansley reforms also resulted in a huge gap between primary care providers and CCGs, where there was a separately distinct voice between the two. CCGs only commission GP services but no other primary care services (i.e. optometry, pharmacy, and dental services are commissioned by NHS England), hence, the services are not consistent across the system. Because the way CCGs were set-up to work separately and independently, it was likely that they produce different solutions and end up with one part of the system blaming and criticising one another rather than working together to deliver better collective outcomes for the people of GM (C01).

In addition, some believed that conflict of individual, professional and organisational interests come to play. Clinicians are tasked to give their advice and expertise regarding

their local areas under the remit of their commissioning duties, but then they also have their day jobs which might affect their perspective in bringing in services (P03, C01). Because clinicians are representing their own organisations, there is a possibility for their decisions to be influenced by their attachments from their own discipline or the area they represent.

> *"Everybody starts behaving differently, because you are commissioning yourself. You are signing off on making decisions about your own personal income...They're bringing their organisation but also bringing their role in that organisation and what that means to them. Are you sitting there as a CCG employee? Are you sitting there as a GP? Are you sitting there as a small business owner? What exactly are you?" (P04)*

Because of the "lack of what feels like parity of esteem in provider land between what the NHS call providers, which is secondary care, and what we think as providers in our world" (G15), the GPs felt like they needed a single voice for their roles to be represented. Some believe that the concept of what a provider is misunderstood in the first place because of the way NHS England uses the terminology (G15). It misrepresented GPs or the primary care and community providers and referred to hospital providers instead. Therefore, GPs believed that up until Devolution was introduced, the discussions have always been favoured to and dominated by commissioners (P03, P04). Whilst the intention to embed GPs in the commissioning culture, it has not really been effective in getting funds out into the communities. "GPs who've become commissioners are either outweighed by more powerful voices or ignored, or they'd become a commissioner and changes their point of view of the GP." (G15) a Partnership senior director described. GPs see themselves as less inferior and in direct competition with Trusts in terms of providing services because there is a tendency for CCGs to prioritise the hospital trusts because they are "big powerful entities with very powerful chief executives and so they can have a strong influence on the

commission” (G15). This view highlights the provider-purchaser split that was caused by the creation of the NHS internal market in the 1980s and was heightened furthermore by the Lansley reforms.

> *“Patients should feel like they've been referred into one NHS, but in practice we haven't got one NHS. We've got lots of individual organisations that when you've added them together, it's the NHS, but they don't necessarily work in that way.” (C01)*

The existing structures created on 2012, such as Health and Wellbeing boards (HWB), also brought difficulties in terms of coordinating decisions and being on the same page with CCGs, Trusts, Primary care providers, and the voluntary sector. Local authorities particularly voiced out the presence of power struggle when it comes to making joint decisions regarding community health services in the Health and Wellbeing boards. Fuelled by the budget cuts that LAs had to endure during periods of austerity, LAs are also pressured to deliver community-level services and develop joint working with GPs, CCGs and Trusts at the same time. Although the structure was created to bring together key local health and care leaders in a table and make joint decisions, LAs believe that “it's hard trying to be equal partners with the CCGs” (L02) especially when a vast majority of the money lies in their (CCGs) hands. GPs and LAs believe that since CCGs hold the money, “all of a sudden, the CCGs make all the decisions which actually wasn't what it was supposed to be” (P04). Because of the CCGs’ statutory obligation to hold the money or referred to as a “piggy bank” by a participant (G06), there was a tug of war in terms of who has more power to make the decisions and which decisions to prioritise.

An LA Senior leader, for instance, illustrated a scenario where “a vast majority of the money was in the hands of the CCG who if they didn't want this… you could get halfway through, they could plan and not got enough money, and they could say well it's

a great plan, but we can't do all that preventative stuff because we've got to do in the hospital." (L02) Thus, the differences in interests and priorities make it more difficult to compromise a decision, especially because of the way the existing structures have been set-up. Local authorities felt like there were little efforts to integrate an already fragmented health and social care system especially on the side of the CCGs.

> *"Make everybody on health and wellbeing board equal partners. We're not telling clinicians how to be clinicians. But if we agree a plan and we're going to spend that, what we should have the power as a board to… sign it off; but a lot of people think we've got the power to stop things or to change things." (L02)*

This is not the case, however, in some areas where the political tension is not as strained as other localities. For instance, an LA councillor described its Health and Wellbeing board as an alliance rather than a place where separate organisations meet (L01). The CCGs and the LAs forged a relationship through an integrated commissioning board, where the HWB plays a strategic arm overlooking the decisions being made for their local population. Others think they are trying hard to overcome the barriers and to do everything by trust and goodwill (L02), although the way the system is set-up does not really allow them to do coordinate their voices and reduce the level of uncertainty on their decisions. The concept is that everybody generally comes to an agreement. In reality though, HWB is there as a last stop for political sign-off and there is no room for discussions as soon as it reaches the table (i.e. all arguments must have already been done beforehand); otherwise, there's no point (C04).

> *"Everybody's got to agree to it beforehand because otherwise there's no point. You don't want an argument at health and well-being board. It's too late by then. And one thing I should say throughout all of this is these arrangements are very difficult to make. It's cumbersome legally, they're cumbersome practically. So, the only right way that it's been made to work is by political leadership on both sides. And when I say political, it's small p as well as the big P. So that means*

the councillors wanted this to work. The leadership within the council, the chief executive and so on wanted it to make it work. They think that it's the right way to go." (C04)

The Provider trusts also offered a similar perspective. The way Foundation Trusts were set-up was never really geared towards collaboration because they were meant to compete with one another in order to be sustainable and "stay in the business" (F03). As opposed with primary care providers, the hospitals have an organisation-based cultural profile, where they are driven by a board to make the right decisions on their financial sustainability. It goes without saying that a hospital trust's activity and business are driven by GPs because that's where the referrals are, but the link between the GPs and Trusts is noticeably cracked as described earlier (G15, F02).

Moreover, there is a level of difficulty in terms of coming together as a collective GM unit and make joint decisions for the greater good per se, because chances are if decisions will negatively impact one's Trust or changes of service will have a disadvantage on another, then they are more likely to make a choice that will benefit their own organisation thus making it less likely for a collective unit to reach a joint unbiased decision. Whilst there is an intention for Trusts to overcome their vested interests, at the end of the day, they are internally accountable to their organisations and their board of directors. "{We} are sovereign organisations. We have a board of directors and I am accountable to my board of directors for delivery. And it's very hard to blur those boundaries in organisations. So how do you actually work together but be accountable to your own board of directors?" (F02) In addition, NHS Trusts are also accountable to NHSI as their regulator. NHS trusts and foundation trusts need to adhere to NHS standards, driven mostly by centrally mandated policies, and this added pressure contribute to the way they behave and interact with other stakeholders in the GM health and social care system.

"The way Provider trusts were set-up in the system isn't, never really geared towards collaboration. They're established as autonomous organisations. They have a responsibility to their governors and membership and local population. So, if anything, like the system as a whole, providers are constituted there to compete. They're set-up to compete more than to collaborate, and I think that's the tension you still have in the system." (F03)

5.3.3 Joint collective interest to solve problems

Perhaps what makes GM an interesting candidate to become stewards of its health commons is its sheer determination to jointly solve problems as a single, collective unit. There is evidence from the interviews suggesting that joint working has always been intrinsic in the GM NHS organisational culture despite the breeding competitive culture of the NHS imposed upon the organisations. The local NHS groups have the inherent desire and appetite to create opportunities and make things happen, ahead of their organisational differences, competing interests, and political tensions.

For instance, representatives from 10 PCTs historically met as an Association of GM PCTs to carry out joint commissioning functions across the city-region since 2005 (Walshe et al., 2018). Following the introduction of the 2012 Lansley reforms, the 12 CCGs of GM came together to form the Association of GM CCGs as a continuation of the work previously done by the collective GM PCTs (National Health Executive, 2013; NHS in GM, 2013). Because of the previously established relationship between the PCTs, the emergent directors and chief officers of the CCGs were already familiar with each other through organic partnership working. The new Association of GM CCGs transitioned to carry out commissioning functions supported by a robust GM-wide governance arrangement called the Association of Governing Groups (AGG)[6].

[6] AGG was abolished after Devolution to transition to integrated commissioning through the Joint Commissioning Board

Since then, GM has always had a single voice when dealing with commissioning arrangements across the region. The CCGs of GM recognised the variation in system where there are services being duplicated 10 or 12 times in each local population (C01), hence, it only made sense for them to have a single conversation and coordinate with each other to tackle collective problems. Whilst the AGG was meeting on an informal basis (i.e. Association of GM CCGs is not a formal organisation but more of a partnership agreement), it helped in building coordination amongst the CCGs where they all collectively agree and recognise that something needs to be done centrally in GM.

> *"I guess from the perspective of the 10 CCG chief executives coming together and saying there's lots of common challenges facing us in GM. We need to come together as a collective. It was more a case of them being an informal session." (G05)*

The GM provider Trusts also have a similar arrangement where the chairs, chief executives, the directors of operations, the chief finance officers, etc. meet collectively through informal meetings, which have emerged post 2012 Lansley reforms. However, it was more of "a gentleman's agreement " (F02), where there was some degree of accountability but there were no formal arrangements on working together. The discussions with CCGs were also not strong enough for them to arrive at a collective decision or solving problems, to a point where if an organisation has challenged a decision, the CCGs succumb to defeat (F02). Despite the barriers, they do however recognise the need for joint decisions through a more formal and enforcing forum.

GM primary care providers (GPs in particular), on the other hand, are members of a body called Association of GM Local Medical Committees (LMC), which is a loose association supporting general practice. As opposed with GP-led CCGs, the representative group LMC aims to coordinate GPs across GM and to provide a single professional voice across the city-region. They coordinate with a variety of other

organisations, such as the community and voluntary sector and the GP Federation, to deliver services that meet the needs of the GM population (Association of GM LMCs, 2019).

Primary care is a big group, which include general practice, pharmacy, dental, and optometry, and it is such a complex and difficult group to collectively govern especially when GM LMCs operate under informal agreements and terms of reference. They have a collective objective of breaking the hospital-primary care divide and foster a collaborative relationship with neighbourhoods and communities in order to raise awareness about primary care services. Whilst GPs could be competitive to receive contracts for certain services that might be given to hospitals instead, GPs are more collaborative by nature because they are small businesses trying to help one other (G15). This was illustrated by the GP Federation, which is a network-based commercial arm of GPs working at scale (British Medical Association, 2018a). In GM,

> *"I'm not sure there were enormous barriers at the time we were securing the deal. I think there was appetite and support. I think it's a different thing on the back of the deal that then gets in to so now that we've got devolution. How do we work it in. What's the nature role of the partnership team in relation to the partnership. So I think one of the trickier areas is confusing some of those, so people see the partnership as the team here and not the organisations. So I think there's a bit of I don't know what to call it really, it's kind of system OD if you like or some of the sort of psychological development of partners in the system to see themselves as leaders of the partnership and not people who work with a partnership of Greater Manchester and leaders in an individual local place. Now that actually that's quite if we think of a maturity model for collaboration, that's really at the high end of that. So it's a kind of civil society model you know where people establish a community through the vehicle a partnership and understand what their stake and their contribution and their responsibility to each other is." (G17)*

If we look back at the assessment criteria framework that NHS England has designed to measure the robustness of the devolution proposal, it is without a question that GM ticks all the boxes. However, it also illustrates the contrast between the evolution of GM's political landscape and its NHS structures. On one hand, you have GM with a strong track record of collaboration, and on the other hand, you have the existing NHS structures and its culture of competition restraining the potential of organisations to fully partake in a collaboration. In the following chapter, we shall look at how the formation of the GMHSC Partnership addressed these barriers through various institutional mechanisms.

5.4 Initial set of rules

In the IAD framework, rules shape behaviour and influence how individuals make decisions. They can be enforced prescriptions about which actions are allowed to do, or sometimes, they can be a shared understanding resulting from the habitual behaviours of participants (Ostrom, 2011). In this section, we look at the rules-in-form or the formal institutions (i.e. contracts, legal documents, statutes, etc.) that were established to prepare for the operation of the Health Devolution. Rules-in-form are formalised or written down rules, and mainly presents a general legal framework on how decisions and actions should be taken by individuals in particular settings (Ostrom, 2011).

Perhaps it is important to clarify that the information that will be presented is based on the contents of the documents at the time of the formation of the Partnership, as we are only focusing on the initial institutional arrangements that were made prior to the formal operation of Devo Health on April 2016. We acknowledge that the governance and other institutional arrangements initially set out in the Memorandum of Understanding (MoU) or during the preliminary agreements in 2015 have already evolved, and these will be analysed in the next chapter as mechanisms to adopting to the collaboration process.

5.4.1 Memorandum of Understanding

When the MoU for Devo Health in GM was signed on February 2015, it was clear that the city-region will take control of the £6 billion per annum budget for health and social care. This MoU represented the formal agreement that outlines the framework for achieving the devolution of health and social care responsibilities to the participating organisations in GM. MoUs are oftentimes used in the NHS to record joint working agreements that are not legally binding (NHS Improvement, 2018). Whilst it is not a legal document, MoUs institutionalise the common intent and agreement between the parties in question and identify the roles and responsibilities of those involved. The Devo Health MoU was signed for by local authority representatives of the AGMA, NHS England, and the GM CCGs. Under this initial agreement, providers (general practitioners or GPs) were not formally included, although letters of support were present from the GM NHS Trusts, FTs, and North West Ambulance Service.

The Devo Health MoU (AGMA et al., 2015) set out key important things about the ambition for full devolution of funding and decision-making for health and social care within GM from shadow form on April 2015 leading to its full operation on April 2016 (i.e. the build-up year). First, it set out the commitments made in the initial Devo Manc agreement to develop a business plan (GM Strategic Sustainability Plan) for the integration of health and social care services in GM. This plan, later known as 'Taking Charge', underpinned the strategic framework on how to achieve the collective ambition of the city-region to improve the health outcomes of their population within the next 5 years (GMCA and NHS in GM, 2015g). Second, the MoU illustrated a roadmap identifying key milestones on how and when the participating organisations were to achieve their aims during the build-up year. This included the rationale and objectives of the devolution, what it aimed to deliver and how it will be achieved, and the principles on how they will implement any changes within the said time frame. Lastly, the document identified the overarching governance structures and the funding responsibilities that will

be devolved to GM. Perhaps this is the most important element that clarifies the nature of the devolution arrangements and how it affects the autonomy and accountability principles of the participating organisations.

The MoU recognised the importance of addressing the health and wellbeing of all residents of GM, whilst achieving not only clinical but also financial sustainability. It also acknowledged the needs to deliver an improved provision of services through a collaborative partnership across the integrated system. This included world class research institutions, such as universities and science knowledge industries, and NHS England as contributors to developing health innovation.

A few months later, several other stakeholders supplemental MoUs to cement further partnership workings. Officers were assigned to lead on the development of MoUs as the governance group was being developed. These included groups who did not initially sign the MoU but needed to be engaged with, such as primary care providers (GPs, etc.), patient groups, and the voluntary/third sector. For instance, Public Health England et al. (2015) signed an MoU to solidify the shared commitment to the improvements of the health of the GM population. It particularly focused on prevention, early detection, and early intervention, through a unified public health leadership system. Another MoU was signed to tackle how research and innovation can contribute to generating solutions to improve the health economy of GM (Health Innovation Manchester, 2015), and another to endorse partnership working between Sport England and GM to develop behavioural change approach to sport and physical activity (Pleasant, 2016). These agreements were all in conjunction with the initial commitments outlined on the Health and Social Care MoU signed in February 2015.

5.4.2 The Health and Social Care Devolution Programme

The shadow period of April 2015 to April 2016 was escorted by a transition management team comprising of representatives from the main stakeholder groups (e.g.

GMCA, NHS England, CCGs, NHS Trust Providers, etc.), who were either on secondment, attachment, or working in addition to their existing roles (GMCA and NHS in GM, 2015e). Over the next 12 months, they worked closely with NHS England under the umbrella of the GM Devolution Programme Board (also sometimes referenced to as the project management office [PMO]) and were responsible for overseeing the transition to the full operation and final form of GMHSC devolution on April 2016.

The Programme Board was an additional governance put in place to support key workstreams. This was a task and finish group led by key representatives from GMCA, CCGs, Trusts, NHS England, and Department of Health. They were responsible for providing direction and oversight on the development of the key workstreams underpinning the high-priority deliverables outlined in the MoU (GMCA and NHS in GM, 2015d, 2015c). These 5 areas were: strategic planning; establishing governance arrangements; devolving responsibilities and resources; partnerships, engagement, and communications; and implementation priorities. Each programme area was led by a member of the transition group and had different tasks on hand.

5.4.3 The GMHSC strategic plan and sustainability framework

The focus of the programme during the early stages was to produce a GM health and social care strategic plan by mid-December. A lot of the work behind it involved the development of locality plans with the 10 local authorities and the transformation initiatives, collaborative working across and within the provider sector, and work already taking place or emerging across GM. The draft was taken through the governance structures of the 37 organisations for stakeholder engagement.

In December 2015, the GMHSC strategic plan was signed off and was published under the branding, ‘Taking Charge of our Health and Social Care in Greater Manchester’ (or simply Taking Charge) with a collective vision of achieving the “fastest and greatest improvement in the health and wellbeing of the 2.8 million people living

across GM" (GMCA and NHS in GM, 2015g:8). The document outlined in detail how the city-region is going to deliver this vision and key outcomes through a set of strategic objectives:

- Transforming the HSC system to help more people stay well and take better care of those who are ill;
- Aligning our HSC system to education, skills, work and housing;
- Creating a financially balanced and sustainable system;
- Making sure services are clinically safe throughout

Taking Charge also recognised the key importance of transforming population health, with the need to address the existing poor health outcomes variation in GM and to glue together the fragmented pieces of the system. This meant that the plan focused on a place-based approach by pulling services together and integrating them around communities rather than on the different organisations that deliver the services. Moreover, Taking Charge also emphasised the importance of overcoming the financial sustainability challenge of closing down the £2.1 billion deficit on 2020/2021 by integrating commissioning services at a GM or cluster level[7].

5.4.3.1 Locality plans

To achieve this, each of the 10 localities – Bolton, Bury, Rochdale (including Heywood and Middleton), Manchester, Oldham, Salford, Stockport, Tameside (including Glossop), Trafford, and Wigan – have mapped their own 5-year locality plan, which outlines which is focused in place-based approaches to innovatively pull services together and integrate them in their respective communities. The outcomes and key

[7] Neighbourhood (more than 500,000); locality; cluster (more than one locality); or GM-level

deliverables of these locality plans shaped by the overall GM Strategic Plan and were signed off by their Health and Wellbeing Board (GMCA and NHS in GM, 2016h). The locality plans included steps on the comprehensive integration of HSC that form a platform for both integrated commissioning and provision. This meant that CCG and LA commissioning functions were to align single service models, with a single commissioning plan, pooled budgets, and integrated governance, decision-making and commissioning skills.

5.4.3.2 Local Care Organisations

The integration of health and social care services is one of the priorities of the NHS and is a fundamental piece to the growth and reform strategy of GM. The Partnership responded to this through the establishment of Local Care Organisations (LCOs), which is an umbrella term used in a GM-level referring to single service integrated models that bring together community health and social care services for each locality, including community, social care, acute, mental health services, third sector providers, and other local providers such as schools (GMCA and NHS in GM, 2015g). This involved integration of services, jointly exercising health functions, and pooled funds between CCGs and LAs to allow more control and freedom within the partnership agreements. These arrangements were already occurring nationally prior to devolution[8], and the LCOs were variations of the national-led new care models on integrated care (see Accountable Care Organisations and Integrated Care Partnerships (Ham, 2018)).

5.4.3.3 Transformation themes

One of the key strategic policies of the Partnership was to promote transformational changes that cover all aspects of care and support in GM (GMCA and NHS in GM,

[8] see *Integration Transformation Fund or Better Care Fund*, (NHS England and Local Government Association, 2015)

2015g). These themes were: population health; community-based care and support; acute and specialist care; back clinical support and office services; and enabling better care. To drive the transformation changes required, a one-off £45 million Transformation Fund (TF) was injected from NHS England to the GMHSC system (GMCA and NHS in GM, 2016a). This is to incentivise and encourage localities to put forward a strong locality plan that aligns with Taking Charge. Aside from the transformational themes, the GM Strategic Plan also identified 5 crosscutting programmes focused on mental health, dementia, learning disability, cancer and children's services.

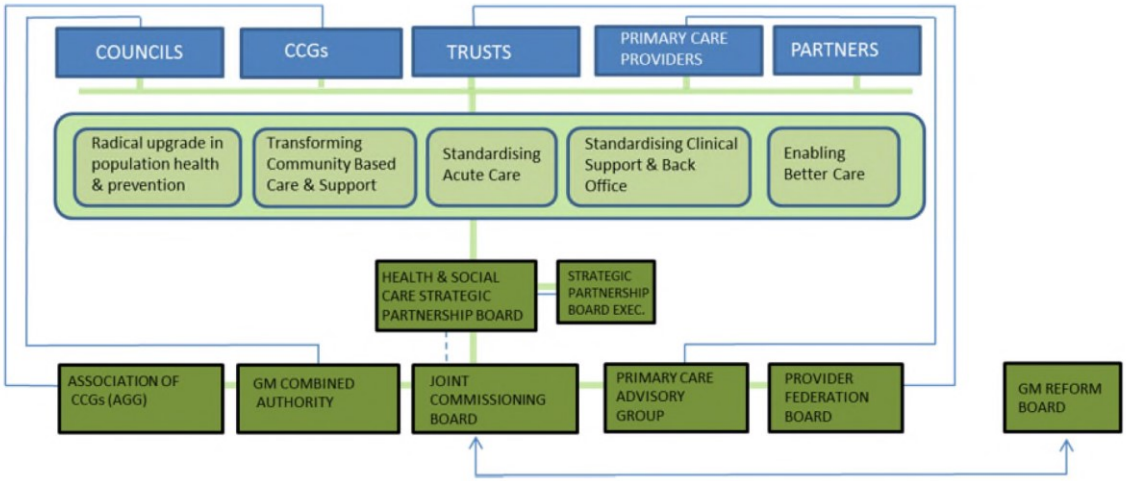
5.4.4 Initial governance arrangements

With the purpose of enabling the system and creating new models of inclusive decision-making (AGMA et al., 2015:4), governance arrangements were put in place to facilitate the GM Strategic Plan. This leadership governance was necessary to drive and oversee the changes, to engage the system with the individual programmes, and to act as a single Partnership team dedicated in supporting organisations locally and across GM.

During a standing conference on September 2015, it was agreed that the governance principles will be produced through an iterative process. A governance group drafted a governance and accountability framework that was essential to support a devolved health and social care economy in GM. Keeping in mind the lines of accountability and statutory functions of the member organisations, the governance pathway was outlined (Figure 21) in several iterations to emphasise the arrangements needed to ensure inclusivity amongst localities, CCGs, providers, trusts, and national bodies. The team focused on four distinct packages: the establishment of a Partnership board and executive board, the Joint Commissioning Board (JCB), legal and accountability framework, and development of further MoUs. Governance structures were also being developed to incorporate the existing collective collaborating organisations in the

decision-making streams as advisory groups (i.e. Association of GM CCGs, Association of GM LMCs etc.).

Figure 21: Governance April 2016 to December 2017



Source: (GMCA and NHS in GM, 2016f)

During the transition period, the Governance group designed a set of proposals outlining a decision-making framework and scheme of delegation for the SPB and the SPB executive board. A series of focus group sessions were conducted over a three-week period with all relevant stakeholder groupings to stimulate discussions and encompass inclusivity. It included 11 people through telephone discussion, 4 people through email feedback, the wider leadership GMHSC team, and the AGM CCGs (GMCA and NHS in GM, 2015b). The governance structure proposals (Figure 21) were finalised through a 'straw man' document and were engaged with people from LAs, CCGs, Provider trusts, and NHS England, then taken back to GMHSC using an agreed approval process. By the end of October 2015, the shadow governance arrangements were live. It comprised of what was then called the Strategic Partnership Board (SPB) and the

Strategic Partnership Board Executive (SPBE)[9] and was transitioned to its full operation on April 2016. This was later on revised on January 2018, as initially agreed that the governance structure will be adjusted as necessary to reflect the different stages of implementation.

5.4.5 The GMHSC Strategic Partnership Board

The Strategic Partnership Board (SPB) was responsible for setting and monitoring the overall strategic vision and direction for GM health and social care economy. To ensure holistic approach and inclusivity on its membership, representatives from the GM health and social care system were incorporated, including but not limited to the GMCA, 10 AGMA authorities, 12 CCGs, 15 provider trusts, GM LMC, GM Centre for Voluntary Organisations (CVOs), and NHS England. Representatives from the NHSI, CQC, Public Health England (PHE), Health Education England (HEE), GM Fire and Rescue Service, and GM Police and Crime Commissioner were also invited to attend as non-voting members of the Board.

The SPB convened monthly from October to December 2015. It is not a legal body and its decisions are not binding; however, it provides recommendations for its members to formally adopt them following their own organisational governance procedures, which may include delegation to a group of its members where possible (GMCA and NHS in GM, 2015a, 2015b). The key responsibilities of SPB were:

- To set the framework within which the Strategic Partnership Executive will operate

[9] The governance framework was modified on January 2018, which will be outlined in the next chapter. This initial governance arrangements were essential to highlight the steps taken by the Partnership to crafting institutional rules

- To agree the strategic priorities in accordance with the NHS Five Year Forward View to be delivered across the localities
- To approve content of GM Strategic Plan and 10 locality plans
- To agree the criteria and determining the access to the Transformation Funding and ask allocators (NHS England and GMCA) and recipients (LAs and CCGs) to adopt them
- To ensure ongoing organisational commitment across the GM health economy to both the devolution agenda and a devolved health system
- To be responsible to the people of GM and to each other for the financial and clinical sustainability of GM health economy, through the agreement and delivery of the GM Strategic Plan
- To provide mutual assurance function over the outcomes linked to the commissioning decisions taken by members to deliver the GM Strategic Plan
- To agree on an assurance framework developed jointly with regulators where required, to ensure that there is formal assurance from each individual party in delivering on their commitments to the GM Strategic Plan
- To provide leadership across the GM devolved health system and be accountable to ensuring that key priorities from the GM strategic plan are achieved
- To receive regular update reports from the Executive board on the ongoing process and delivery of the GM strategic plan, and regular reports of GM's performance against agreed assurance metrics

5.4.6 The GMHSC Strategic Partnership Board Executive

The Strategic Partnership Board Executive (SPBE) was essentially in charge of the operational and transactional issues relating to delivering the GM vision outlined in the

MoU and GM Strategic Plan (GMCA and NHS in GM, 2015a, 2015b). During the transition period, the SPBE is expected to deliver on:

- Completion of the GM Strategic Plan, ready to operationalise by March 2016
- Development of an Implementation plan from April 2016
- Overseeing financial and governance performance across GM
- Enabling the implementation and locality plans, and ensuring they support the direction of the GMHSC
- Assuring the operational delivery of health and social care, in line with the devolved functions from NHS England (e.g. CCG assurance)
- Leading GM commissioning where agreed and endorsed by Partnership Board and Joint Commissioning Board
- Sponsoring, driving, and facilitating GM Transformational projects
- Understanding overall performance and delivery of services across the whole system
- Establishing effective working arrangements with regulators
- Leading on the development and delivery of public and political engagement

The SPBE comprised of a Chief Officer and 5 Executive Lead roles at Director Level. The Chief Officer is responsible for 6 key areas, namely strategic development and leadership; direct management of all functions, programmes of work and teams operating at a pan-GM level; support and develop concept of subsidiarity within the GM HSC system whilst developing collaborative working across organisational boundaries; assurance of CCGs in line with the requirements of the SPB and NHS England, and in relation to any jointly held funds with LAs; direct commissioning of functions including specialised services and non-medical primary care services for GM; and collaborating with the regulators and national bodies to influence and shape their interactions with any

part of the GMHSC. The Chief Officer is directly accountable to NHS England, ensuring that the key stakeholders deliver the NHS Constitution.

The 5 executive lead roles are as follow:

- Chief Operating Officer. Deputy to the Chef Officer and operate on a day-to-day basis to anticipate and manage specific workstreams and emerging agenda on behalf of the Chief Officer. This role also oversees the day-to-day performance management agenda across the GM system.
- Executive Lead for Strategy and System Development. Responsible for the implementation of the GM Strategic Plan and delivery of locality plans, whilst also securing standardisation in delivery and access of health and social care. This role is the lead contact for CCGs, Provider trusts, local councils, and regulators in relation to the strategy working across GM.
- Executive Lead for Commissioning and Population Health. Responsible for taking a long-term perspective in terms of the overall health and well-being of the GM population, including the transformation models of care, GM growth reform, and other wider determinants of health and care. It facilitates cross-sector working and identifies new ways to engage relationships between the stakeholders and the GM population.
- Executive Lead for Finance and Investment. Responsible for ensuring financial sustainability and day-to-day operational finance responsibilities. This role looks after the Transformation Fund and develops investment decision-making process required to ensure that the fund is allocated for best effect and impact.
- Executive Lead for Quality. Responsible for NHS England functions (i.e. quality surveillance and re-validation of doctors and nurses) and for assuring the quality of care delivery within GM. This role is occupied by a clinician, which links a wider network of clinical leadership across GM.

Apart from the Chief Officer and Executive Leads, SPBE also comprised of 4 representatives each from CCGs, LAs, and Providers and 1 representative from NHS England, fulfilled through the position of the Chief Officer of the GMHSC Partnership. In addition to the SPB and SPBE, a supporting and enabling structure is needed to secure administrative services like operational IT support, general administrative support, operational HR support, and legal support (GMCA and NHS in GM, 2016f).

5.5 Summary

This chapter examined the external variables or existing pre-conditions that led to the Devo Health in GM, where we particularly focused in identifying the factors that were critical during the initial stages (negotiation and formalisation) of the Partnership. Using the three exogenous variables identified by the IAD framework, we were able to identify the factors that shaped the impetus and the starting conditions that are necessary to establish the GMHSC Partnership.

First, we examined the physical attributes. In this context, we refer to the physical resources that were pooled together by the collaborating participants. Our evidence suggests that first, Health Devo in GM emerged with no statutory basis. Instead, NHS England and a group of key influential leaders negotiated a devolution deal that outlines range of devolved NHS functions to be delegated to the GMHSC Partnership via the Chief Executive. This was formalised through an agreement called Memorandum of Understanding (MoU). This MoU highlighted the financial and accountability arrangements that could potentially foster or hinder the interactions of the participants in the action situation.

Second, we looked at the community attributes that reflect the shared norms between the participants. Our evidence illustrated that the Partnership has had decades of

flourishing collaborative relationships, demonstrating that having a strong history of collaboration can lead to collective action. However, there were also cracks and tensions in the existing HSC system, which reflected the impact of the previous NHS reforms. The relationships amongst the organisations were characterised by strained relationships, competitive nature, and partisan behaviour towards their own organisations. This could also potentially foster or hinder the interactions of the participants in the action situation. Finally, we examined the initial working rules that the Partnership established in order to facilitate and organise the relationships of its participating members. Initial governance arrangements were created by a shadow transition management team.

6 Action Situation

6.1 Introduction

In the previous chapter, we examined the three factors that shaped the impetus to collaborate of the Partnership and how constitutional rules-in-use influenced the emergence of the GMHSC Partnership. In this section, we focus on the action situation, particularly on the collective-choice arena (i.e. the Partnership) influenced by the constitutional rules on determining who is eligible to participate (i.e. the initial institutional arrangements used to establish the Partnership) and the rules to be used in crafting the set of collective-choice rules.

The action situation is the centrepiece of the IAD framework where it highlights how institutions and structural attributes of the contexts affect the behaviour of the actors participating in it. In this chapter, we attempt to situate the “black box” of the collaborative process by bringing together the exogenous variables identified in the previous section and how the actors use these to delimit their behaviour in making decisions and strategies, creating patterns of interaction, navigating through the system, and generating outcomes.

Ultimately, this research wants to understand how the actors behave in the action situation, influenced by physical properties, community attributes, and rules-in-use identified earlier. Actors hold different positions and pursue various tasks and enter the action arena with diverse preferences regarding their perceived costs and benefits associated with their actions, and which mechanisms, information, skills, and resources they will use to relate with one another. The actions they take then result into different modes of interaction which in turn produce outcomes. For instance, a potential outcome of a collaborative governance is to agree via consensus with the rest of the team and come up with a collective decision. The participants have the option to use a default

action of engaging in a dialogue and cooperate, whilst the alternative is to challenge the decision and refuse to coordinate actions.

We assume that the action situation occurs after the period of the establishment of the Partnership to its implementation stages, where we observe how individual behaviours and rule configurations changed over time. In this chapter, we explore the seven elements which make up the internal structure of the action situation: (1) participants; (2) positions; (3) potential outcomes; (4) set of allowable actions; (5) control in function; (6) information available to participants; and (7) perceived costs and benefits. Each of these elements corresponds with a set of rules, which emerges as an outcome of the interactions from the action situation. This will be later on discussed at the succeeding chapter.

6.2 Participants

Participants refer to the decision-making entities or actors in an action situation. This research divides the participants or actors into three: (1) the key stakeholders, (2) the partner organisations, and (3) the core staff of the GMHSC Partnership team. It is important for the three to be distinguished because they play different positions within the action situation.

6.2.1 Actors in the Partnership

As mentioned in the previous chapters, the devolution deals resulted in the establishment of a new GMHSC Partnership in order to bring together 33[10] statutory institutions, including 10 LAs, 10 CCGs and 13 NHS trusts and FTs, along with representatives from primary care, Healthwatch, community and voluntary sectors,

[10] 37 at the time of signing MoU on 2015, but Manchester CCGs/Trusts have merged so total count is updated to reflect these organisational changes

Greater Manchester Police, Greater Manchester Fire and Rescue Service, and NHS England.

There are four key stakeholders in the Partnership who signed up to participate in the Health Devolution deal in Greater Manchester. These are the CCGs, the Trusts and FTs, the Primary Care providers, and the LAs. All four groups are represented in the Partnership governance board. The CCGs and LAs, in particular, are amongst the agreeing parties who signed the initial MoU in February 2015. Meanwhile, the GM NHS Trusts and FTs provided a letter of support to the devolution agreement, whilst the Primary Care providers were not initially consulted (G15). The latter, including the GP Federations, was approached later on to be represented in the Partnership governance board and the Primary Care Advisory Group.

In detail, the four groups are comprised of the following (GMCA and NHS in GM, 2016h):

- 10 local councils;
    - Bolton Metropolitan Borough Council
    - Bury Metropolitan Borough Council
    - Manchester City Council
    - Oldham Metropolitan Borough Council
    - Rochdale Metropolitan Borough Council
    - Salford City Council
    - Stockport Metropolitan Borough Council
    - Tameside Metropolitan Borough Council
    - Trafford Metropolitan Borough Council
    - Wigan Metropolitan Borough Council
- 10 Clinical Commissioning Groups (CCGs);
    - Bolton Clinical Commissioning Group

    - Bury Clinical Commissioning Group
    - Heywood, Middleton and Rochdale Clinical Commissioning Group
    - Manchester Health & Care Commissioning[11]
    - Oldham Clinical Commissioning Group
    - Salford Clinical Commissioning Group
    - Stockport Clinical Commissioning Group
    - Tameside and Glossop Clinical Commissioning Group
    - Trafford Clinical Commissioning Group
    - Wigan Clinical Commissioning Group
- 12 acute, community and Mental Health (MH) Trusts & 1 ambulance Trust;
    - Bolton Hospital NHS Foundation Trust
    - Bridgewater Community Healthcare NHS Trust
    - Manchester University NHS Foundation Trust[12]
    - Pennine Acute Hospitals NHS Trust
    - Pennine Care NHS Foundation Trust
    - Salford Royal NHS Foundation Trust
    - Stockport NHS Foundation Trust
    - Tameside and Glossop Integrated Care NHS Foundation Trust
    - The Christie NHS Foundation Trust
    - Wrightington, Wigan and Leigh NHS Foundation Trust
    - North West Boroughs Healthcare NHS Foundation Trust
    - Greater Manchester Mental Health NHS Foundation Trust[13]
    - North West Ambulance Service NHS Foundation Trust
- Primary Care providers

[11] Formerly Central Manchester CCG, South Manchester CCG, and North Manchester CCG
[12] Formerly Central Manchester NHS FT and University Hospitals of South Manchester NHS FT
[13] Formerly Greater Manchester West Mental Health FT and Manchester Mental Health FT

- 500 General Practitioner Practices;
- 450 General Dental Services;
- 700 community pharmacies;
- 300 community optometry services;

In addition to the key stakeholders, the GMHSC also signed MoUs with partner organisations in order to deliver the key programme enablers identified in the GM strategic plan “Taking Charge”. These included PHE and Sport England, Health Innovation Manchester, GM Work Estates, GM Healthwatches, GM pharmacy industry, and the Voluntary, Community and Social Enterprise (VCSE) sector. By signing an MoU, a framework of support and engagement is ensured between Partnership and its partner organisations, ensuring that they have aligned and shared their ambitions towards achieving the target outcomes in GM's devolution agenda.

Moreover, the delegation of NHS functions to GM via the devolution agreements meant that NHS England remained to be a key partner and very much part of the Partnership, particularly through the Chief Officer and several Executive Directors posts. The MoU states the clear purpose of NHS England’s presence in the Partnership and that is to “actively lead and facilitate the links to other national bodies to help all key bodies (e.g. Department of Health, CQC, NHSI, and HEE) align to achieve the outcomes described in this MoU” (AGMA et al., 2015:10).

6.2.2 Employment arrangements of the core Partnership team

Apart from the delivery of the programmes outlined in the GM Strategic Plan, the Partnership also received delegated statutory responsibilities from NHS England – for instance, the delivery of A&E targets, the role and function of CCGs, and making sure the system is financially viable to name a few (G06). This meant that the Partnership

team needed to employ staff members to deliver some of these responsibilities, including operational, monitoring, and implementation and delivery of the GM Strategic Plan.

Because of the nature of the structural arrangements of GMHSC (i.e. the Partnership itself is not a statutory organisation), it does not employ staff, nor does it have any formal streams to hold money (G14). The staff recruited within the core GMHSC Partnership team were either on secondment, fixed contract, or appointed on a permanent basis (*see* Table 12).

Table 12: Employment roles

Identifier	Role	Employment
G01	Partnership project management lead	Permanent
G02	Partnership finance lead	Fixed-term
G03	Partnership project management lead	Secondment
G04	Partnership project management lead	Secondment
G05	Partnership project management director	Fixed-term
G06	Partnership project management director	Secondment
G07	Partnership project management lead	Secondment
G08	Partnership senior director	Permanent
G09	Partnership project management lead	Secondment
G10	Partnership project management lead	Permanent
G11	Partnership project management lead	Secondment
G12	Partnership project management lead	Fixed-term
G13	Partnership senior director	Permanent
G14	Partnership project management lead	Fixed-term
G15	Partnership senior director	Fixed-term
G16	Partnership project management lead	Permanent
G17	Partnership senior director	Permanent

According to NHS staff policy, secondment, in its simplest terms, is a temporary transfer from their substantive (permanent) post to another post either in the same or another organisation. The contractual terms, such as salary, working hours, location, etc., vary depending on the secondment period, but it is anticipated that it occurs over a defined period of time normally not exceeding 2 years in total. The employee is expected

to return to their old post at the end of the secondment period. In the case of GMHSC, the Partnership is the host organisation where the employee works during secondment and the seconding organisation is the employee's main employer, where all his/her contracts and pay checks still come through. Placements can either be from an external NHS (i.e. from one NHS organisation to another) or non-NHS organisation (i.e. from a LA department, etc.). Unless the secondment is a post with a higher grade or more contracted hours, the seconded employee will have the same basic salary and receive other employment conditions of their original contract (i.e. sick leave, etc.). For more information, *see* NHS Confederation (2016).

Secondment is not to be confused with fixed-term contracts, wherein the duration of the role is specified between 12 to 36 months and there is limited funding for the post available. The contract finishes at the end of the specified period, and either when the specified task has been completed or when the funding for the post comes to an end. It can be renewed for a short-term period extension, otherwise, the contract finishes. The fixed-term employees are hosted by either NHS Manchester Clinical Commissioning Group, Manchester City Council, or the GMCA, and funded by the Partnership through the Transformation Fund. Most of the fixed-term staff were for task-and-finish roles, project management and implementation, or specialised functions. The lines of responsibilities and accountability remain with the Partnership, and the host organisations are merely there to channel the wages because the Partnership is not a legal entity.

> *"We then got quite a few people on fixed term contracts and what's happened there mainly is that we've got Transformation Fund the £450 million as you know. We've used a proportion of that money to basically pay for some posts in the partnership team to kind of lead Greater Manchester level work. But obviously that funding is only for a limited time, so those roles could only be offered on a fixed term basis. So, when someone has got one of those roles, say for 2 or 3 years until 2020, the only option really is they need some sort of statutory body*

to formally employed them. So, the Manchester CCG is being used to do that." (G05)

Finally, a Partnership employee can also be appointed on a permanent basis. The executive team in particular are permanent posts with the exception of the associate leads (G13). For example, an Executive Director is employed and hosted by NHS England, where they carry dual roles as Partnership executives for operational purposes and as NHS local directors for NHS England functions (i.e. financial sustainability, monitoring and assurance, quality, etc.). In addition, several staff from NHS Greater Manchester (former NHS local area office under North West regional cluster), including Greater Manchester and Eastern Cheshire Strategic Clinical Networks (SCN), were transferred to the Partnership as substantive posts as part of the organisational change. These employees are all hosted separately by local NHS organisations.

To sum it up, the posts created for the Partnership were non-traditional, where all the staff members came together from different employers in different roles. However, they also follow a traditional route of organisational structure where there are reporting and accountability lines, and some level of hierarchy in the governance (G03).

6.3 Positions

The participants each take a position in the action situation where each has diverse options for a combination of resources, opportunities, preferences, and skills. In this section, we examine the roles that the different key groups in the Partnership have acquired in order to position themselves in the decision-making arena. Overall, participants can occupy the following positions: (1) Provider of service (mostly occupied by the 4 key groups); (2) Internal and external regulators (NHS England, and Partnership's assurance groups and senior management team i.e. Executives); (3) Taskforce groups (Partnership programme delivery group); (4) Decision-making bodies

(Health and Care Board and Executive board); and (5) Advisory groups. These positions were collectively agreed by all participants during the initial stages of the formation of the Partnership and was revised later on to reflect the system-wide changes in the GM Health and Care economy and delivery phase of the GM Strategic Plan.

6.2.3 Updated governance structure

In order to ensure that the GMHSC stakeholders, partners, and core team have opportunities to be equally represented in the Partnership, a governance structure was initially established as outlined in the previous chapter. However, the Partnership recognises that they needed to adapt and address new and changing needs as a natural consequence of being the first locality in England having a devolved arrangement for HSC (GMCA and NHS in GM, 2018:3). As a result, a revised governance structure was presented in January 2018 to reflect the progress that the Partnership has made in terms of transitioning from the initial strategy-setting phase to supporting the delivery and implementation of the GM vision set out in Taking Charge. More importantly, the Mayor of GM took office in May 2017 and the Partnership needed to recognise his ambition for public service reforms by coordinating with each other to realise the outcomes of the health and social care strategic plan.

The initial governance established by the shadow group has significantly progressed between April 2016 to December 2017. Recognising that more support is needed to develop and establish initial links in delivering Taking Charge, a series of boards were formed (outlined in the previous chapter) to secure programme oversight, financial sustainability, and monitoring and assurance checks are in place. These arrangements still form the core of the GMHSC governance.

The governance has continuously changed several times over the course of 2 years (2016-2018), where one participant described this iterative process as “evolutionary” and “a living governance structure” (G08). It was obvious that the arrangements set up in

2015/2016 were geared towards setting-up the different decision-making routes to create, coordinate, and socialise the overall GM strategy to the wider community. As the Partnership enters the delivery phase of the programmes, they had to employ more staff and re-shuffle the governance structure to have clearer lines of responsibilities and accountabilities at all levels, to secure clarity on how decisions are made, to reduce the amount of bureaucracy and duplication, and to ensure all key stakeholders have equal opportunities to provide input into the governance groups (GMCA and NHS in GM, 2018).

> *"That's not because we ever got it wrong. It's because you take one step and then you get the confidence to take another step and so on and so, it's an iterative process...And I think that's a bit of strength actually, it's not been a weakness... It's saying you know what, every time we learn, we can refine, and finesse and we can move on to the next bit. So, I think there's an efficiency in there which is helpful."* (G08)

For instance, a Primary Care Engagement Network was set-up in November 2015 to reflect the inclusion of the Primary Care representative voice in the governance framework. As mentioned in the previous chapter, the Primary Care groups were not initially consulted during the signing of the MoU, highlighting the imbalance on the parity of esteem between hospital providers (i.e. Trusts and FTs) and primary care providers (G15). In order to address this, a Primary Care Advisory Group (PCAG) was formed to draw membership from the four aspects of primary care (i.e. GP, dentistry, optometry, and pharmacy) and ensure that they represent a collective voice in the wider GMHSC governance discussions and programmes of activity (see GMCA and NHS in GM, 2015). An LCO Network was also set-up in December 2016 to support the localities in working across the transformation programmes, aligned with the overall GM public service reform (*see* GMCA and NHS in GM, 2016a).

Despite the several additions, a newer and more updated governance was needed to reflect the challenges and barriers to engaging in the wider GMHSC system. Wider system changes were also a factor, including the merger of Manchester CCGs and Trusts, and the establishment of a new GM Mental Health. The development of integrated commissioning across localities and the impact of the GM Mayor and GMCA portfolio holders also have implications for the existing governance arrangements. Lastly, there is a need for the Partnership to strengthen its relationship to localities, by making them more accountable to the Transformation Fund and by creating links with Health and Wellbeing Boards to support joint commissioning decisions (GMCA and NHS in GM, 2018:9).

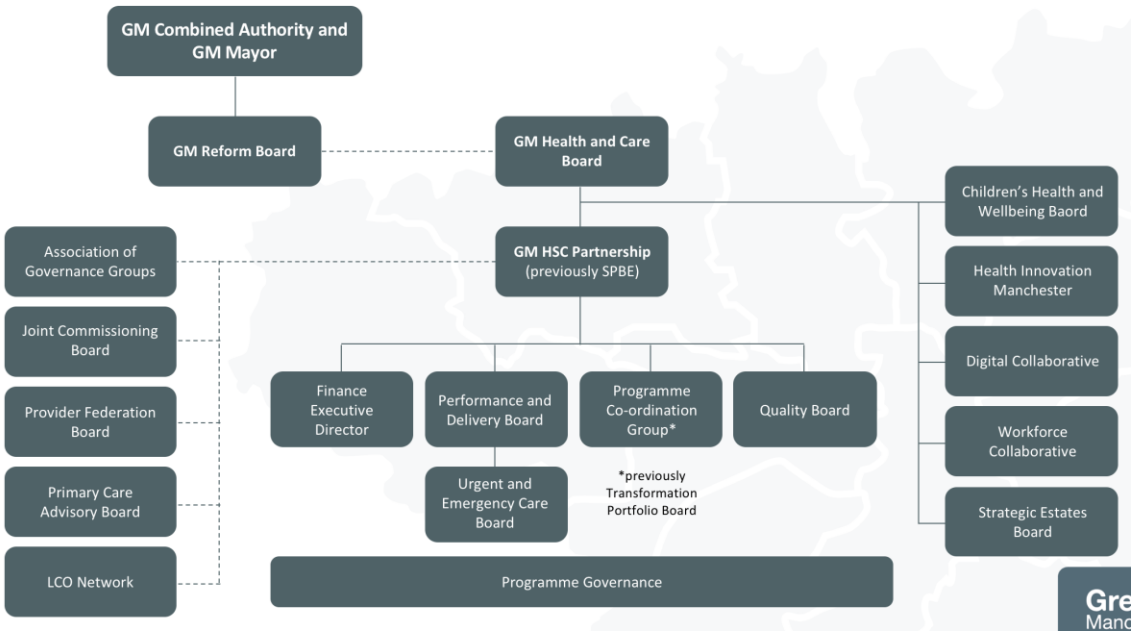
Perhaps what is also not visible in the governance structure but is worth mentioning is the individual governance of each locality. All of these structures feed into the Partnership through their representatives attending the HCB and Executive meetings. By revising the streams for the stakeholders to participate in the decision-making process, it aims to reduce the amount of duplication in the system and to provide a clearer role for the core GMHSC Partnership team as a facilitator of the governance.

A few of the newer additions to the revised governance were:

- The Strategic Partnership Board (SPB) becomes GM Health and Care Board (GM HCB)
- The Strategic Partnership Board Executive (SPBE) becomes GM HSC Partnership Executive to reflect more functions in the operationalisation of Taking Charge
- The establishment of the Joint Commissioning Board (JCB) serviced by the GM Commissioning Hub
- The enhancement of the Provider Federation Board (PFB)
- A simplified version of the Executive sub-governance

- The Workforce and Digital Collaboratives, the integrated Estates team, and Health Innovation Manchester are to become core enablers of the governance

Figure 22: Governance January 2018 to present



Source: (GMCA and NHS in GM, 2018)

This updated structure (Figure 22) reflects a more integrated and collaborative way of working together with a dispersed style of leadership (GMCA and NHS in GM, 2018). It is also still based on several key principles from the MoU and its previous iteration, which were retained as fundamental building blocks for the new structure. This evidence illustrates that the Partnership's level of collaboration and interdependency, and the maturity of relationships and their willingness to achieve their collective ambition have evolved from the time it was established.

6.2.4 Providers of service

The providers of service are mainly occupied by the LAs, CCGs, Trusts and FTs providers, and the Primary Care groups. As key stakeholders of the Partnership, they

are responsible to delivering the GM Strategic Plan to their own respective localities and retain their respective accountability lines. Each group is represented in the decision-making arena via different routes where they get to participate in the various roles in the cross-cutting programmes across the Partnership. For example, the city of Stockport has the following: Stockport local council (accountable to the voting public and Public Health England), Stockport NHS Foundation Trust (accountable to its board members and NHS Improvement), Stockport CCG (accountable to NHS England), and GP, dental, optometry and pharmacy practices (accountable to patients and Care Quality Commission).

6.2.5 Advisory groups

The advisory groups are made up of the sectoral networks that has informally developed and met as a GM collective over a period of time prior to the devolution deals. They are composed of the key stakeholders (i.e. CCGs, LAs, Trusts and FTs, and Primary Care groups) under collective formal arrangements, which are incorporated in the GMHSC Partnership governance for representation and decision-making gateways.

The advisory groups are:

- GM Association of CCGs. A formal arrangement between the 12 GM CCGs Senior leaders
- Provider Federation Board. A formal arrangement between the 15 NHS Trusts and FTs Senior leaders
- Primary Care Advisory Board. A board representing the PCAG composed of representatives from GPs, dentistry, ophthalmology, and pharmacy
- LCO Network. A GM-level group representing the standalone LCO organisations of the 10 localities

- Joint Commissioning Board. The forum for collective commissioning undertaken on a GM footprint, made up of representatives from the 10 localities (CCGs and LAs)

Each advisory group has a board set-up, who is then in charge of strategic oversight of their respective sectors and in some instances, leadership and reporting duties on the delivery of some work programmes. They have representation in the Health and Care Board and Partnership Executive respectively. They do not have definitive legal responsibilities or voting rights; however, they do possess an advisory capacity to provide non-binding strategic advice to the HCB and Partnership Executive.

6.2.6 The regulators

The devolution agreement between NHS England and GM meant that the performance of GMHSC Partnership is subjected to monitoring and regulation. The respective key stakeholders retain their lines of accountability to their individual organisations and regulators (external), whilst the performance delivery of any Partnership programmes and assurance and accountability to the Transformation Fund are subject to monitoring by the Quality board and Partnership Executive (internal).

6.2.6.1 External regulators

Because of the devolution arrangements, the Partnership is still subject to NHS Constitution and mandate. This meant that the Partnership has no statutory functions to regulate its member organisations. Instead, these are still discharged through NHS Improvement and Care Quality Commission.

- NHS England via Chief Officer. Some of NHS England's functions are delegated through the Chief Officer. The Chief Officer is responsible for the assurance of the 10 GM CCGs in line with the requirements of the SPB and NHS England.

Moreover, the Chief Officer is directly accountable to NHS England, ensuring that the key stakeholders deliver the NHS Constitution.

- Care Quality Commission (CQC). CQC is an independent organisation that monitors, inspects, and rates the quality of health and social care services delivered and the organisations who deliver it. These include community health services, GP services, dental services, mental health, care home services, and social care provided at home (Care Quality Commission, 2018) within the city-region of GM.
- NHS Improvement (NHSI). NHSI is statutory responsible for monitoring the quality, safety, and financial sustainability of the NHS trusts and foundation trusts, and independent providers of NHS-funded patient care. It is their remit to assess and make recommendations about recovery plans for GM NHS Trusts and FTs, if needed (GMCA and NHS in GM, 2016b).

6.2.6.2 Internal regulators

The GMHSC governance also incorporated an assurance and delivery framework to monitor and assess progress of the range of the responsibilities taken on by the Partnership and to connect core decision-making components with the wider infrastructure on delivery of the transformation programmes (GMCA and NHS in GM, 2016h). These positions are usually occupied by the core staff of the Partnership team but can also be taken on by representatives from the key stakeholders.

Ensuring assurance and monitoring

- Quality Surveillance Group (QSG). One of the statutory functions delegated to the Partnership is driving quality improvement across GM. In order to fulfil this, a QSG was set up as a requirement of the National Quality Board and to represent GM footprint. The role of QSG is to engage in the surveillance of quality at a local

level, including patient safety, contract breaches, and failure to meet CQC standards. This position is chaired by the Executive Lead for Quality of the Partnership, with membership including Chief Operating Officers of CCGs, and representatives from CQC, NHSI, HEE, PHE, and Healthwatch (*see* GMCA and NHS in GM, 2016a, p. 7).

- Performance and Delivery Board. This group is in charge of maintaining the constitutional and mandated requirements of the Partnership to NHS England and initiating taskforces to support improvement and recovery when appropriate. It is the single point for reviewing performance across the GMHSC system. It particularly deals with evaluating performance and delivery at a system-level, ensuring that all constitutional mandate standards are reviewed with the outcomes. Membership includes nominated representatives from within each sector where they act in an advisory capacity (*see* GMCA and NHS in GM, 2016a, p. 11).

Ensuring financial sustainability and resource allocation

- Transformation Fund Oversight Group (TFOG). TFOG was initially established to review the applications and make recommendations on the allocation of the Transformation Fund. It was a taskforce group formed from a pool of representatives from the 4 key stakeholder groups (CCGs, LAs, Trusts and FTs, Primary Care groups), led by the Executive leads, the Head of Transformation Fund, and the TF Lead. Their primary task was to lead the assessment process of the proposals for the access to TF (see GMCA and NHS in GM, 2017). The group can only make recommendations, and final allocation of the funding is down to the Partnership Executive and Finance Executive Group (FEG). TFOG's

operation ceased in early 2018 and monitoring and evaluation on the delivery of the TF terms and conditions were transferred to FEG.

- Finance Executive Group (FEG). FEG is a forum responsible for system-wide financial advisory and assurance function. It deals with the identification and assessment of any strategic financial issues, risks, and opportunities, including the budget and funding of the core Partnership team. Its membership is led by the Executive lead for Finance and Investment, with representatives from the financial officers or treasurers of the CCGs, Trusts and FTs, and LAs (*see* GMCA and NHS in GM, 2016c).

6.2.7 Taskforce groups

There are a multitude of transformation programmes that needed additional staff support from the Partnership. Such task and finish groups were set up to provide oversight and strategic delivery of the projects, whilst working hand-in-hand with the 10 localities and NHS organisations. These positions are occupied by both internal Partnership staff and representatives from the key stakeholders.

Ensuring oversight on delivery

- Transformation Portfolio board. The Transformation Portfolio board was initially in charge of the oversight, implementation, and delivery of the GM Strategic Plan. It brought together the locality leadership within the GM transformation programmes, ensuring that the risks and issues were proactively assessed and managed (*see* GMCA and NHS in GM, 2016c), particularly the management of the 10 locality plans, 5 GM transformation themes, and the 5 cross-cutting programmes. Its membership included the Senior Responsible Officer (SRO) for Themes 1 to 5 (internal staff) and SRO from each of the 10 localities (key stakeholder representatives) (*see* GMCA and NHS in GM, 2016b).

- Programme Management Office (PMO). In addition to the SPB and SPBE, the GMHSC governance structure created a PMO, to support the Transformation Portfolio board and to serve as the delivery arm of the Partnership. It is a small core team functioning as a strategic delivery vehicle overseeing the delivery of the transformation projects and cross-cutting programmes. It also works closely with localities and other statutory and delegated functional groups and stakeholder groups in GM, establishing opportunities for integrated working (see GMCA and NHS in GM, 2016c, p. 15).
- Transformation Theme programme board. Beneath the PMO sits a sub-governance structure for each Transformation Theme. Each Transformation programme board is in charge of their own projects related to the thematic strategies identified in Taking Charge, and their key responsibilities are to support its delivery and to provide effective leadership critical to the success of the Theme. The programme boards are usually comprised of an SRO, senior project leaders for each constituent project, NHS Provider trusts or FTs representative/s, CCG representative/s, LA representative/s, and Director/s of strategy, Director/s of operations, and representatives from appropriate reference groups (*see* GMCA and NHS in GM, 2016f, 2017b).
- Programme Coordination board. The Transformation Portfolio board was later on revised to as the Programme Coordination board in order to recognise and align the changing roles that the Partnership had in terms of strategic to delivery role. It works hand-in-hand with the Performance and Delivery board, in terms of taking the recommendations from the performance review and ensuring that the require transformational change is delivered by the localities (GMCA and NHS in GM, 2018).

6.2.8 Decision-making bodies

The decision-making bodies are they key forums where representatives across the system congregate to make collective discussions and decisions together. These positions are mainly occupied by senior leaders of the Partnership team and the core stakeholder groups.

6.2.8.1 The GM Health and Care Board

The new GM HCB is more or less similar to its predecessor (the SPB) in terms of its role in providing oversight for the strategic vision and direction for the health and social care in GM. As the Partnership moved from the strategic phase to the implementation of the programmes, and to start thinking about the future operating model post transformation phase, the HCB focuses on ensuring that the feedback from the key stakeholders and the residents of GM influence the actions from the Partnership. It also revised its membership in order to replicate and align itself with the ambition of the local Health and Wellbeing Boards (HWB), which were initially established during the 2012 Lansley reforms. These changes resulted into the HCB becoming a non-statutory body that brings together the partners in one table to create a more holistic approach (GMCA and NHS in GM, 2018). Currently, its membership includes:

- Chair and Chief Officer of each of the GM CCGs
- Chair and Chief Executives of GM Provider Trusts and Foundation Trusts
- Leader and Chief Executives of GM local authorities
- NHS England, delegated through the GMHSC Chief Officer
- NHS Improvement representative/s
- Public Health England representative/s
- Primary care representative/s through PCAG
- GMCA through GM Mayor and Chief Executive
- GM Fire and Rescue services representative/s

- GM Police representative/s
- Voluntary, community, and social enterprise (VCSE) sector representative/s
- GM Healthwatch representative/s

HCB sits atop the hierarchical chart and works in parallel with the GM Reform Board regarding coordination of agendas for the public service reform in GM. The Enablers (i.e. Health Innovation Manchester, Digital Collaborative, Estates, Workforce Collaborative and Children's HWB) all directly report to the HCB, whilst HCB is still accountable to GM. Representatives of HCB are also still accountable to their respective organisational and stakeholder grouping.

The HCB is the highest level and ultimate decision-making body in the governance structure. To further distinguish it from the Executive and to avoid duplication of functions, HCB offloads some of its responsibilities to the Executive including performance check, delivery of strategy, Transformation Fund allocation and assurance, and risk management (all of which were initially under the remit of the SPB). Its agendas now focus more on the impacts of the transformation programmes in the localities rather than the operationalisation and delivery of the strategy.

6.2.8.2 The GMHSC Partnership Executive

The Strategic Partnership Board Executive (SPBE) was renamed the Partnership Executive, carrying over previous duties in operational and transactional issues. It was mainly responsible for enabling the development of GM Strategic Plan Taking Charge and engaging localities to prepare them for the delivery of the programmes. In order to adopt to the transition to the implementation phase, the Executive team is now focusing on assurance and monitoring role, particularly in the performance of localities across the system and holding them into account for the delivery of the cross-cutting and GM-level transformation programmes. Moreover, the Partnership Executive also monitors the

Transformation Fund, making sure that the recipients of the funding are on-track in terms of delivering what they promised to do.

The newer version of the Partnership Executive recommended to revise the membership structures. Particularly, it wants to represent the GM HSC system but will not have all organisations as members as previously identified in the previous chapter. All localities must be represented across the 12 nominated members from the 4 key stakeholder groups. The revised membership rules now include:

- 3 representatives from GM CCGs, as identified and agreed by the Association of CCGs
- 3 representatives from GM Trusts and Foundation trusts, as identified and agreed by the Provider Federation Board
- 3 representatives from the GM LAs, as identified and agreed by the wider leadership team
- 3 representatives from Primary Care, as identified and agreed by the PCAG
- NHS England through the Chief Officer of the GMHSC Partnership
- 2 representatives from the third sector, as identified and agreed by the GM VCSE

The Partnership Exec reports to the HCB. In addition, the following governance groups report directly to the Executive team: Finance Executive Group, Performance and Delivery Board, Programme Coordination Group, and the Quality Board (as previously outlined). These groups are mainly responsible for the effective assurance and delivery across the range of the Partnership's responsibilities (also *see* GMCA and NHS in GM, 2016a).

6.4 Allowable actions

Actions refer to the set of allowable actions that each participant can select from at any particular stage in the decision-making process (Ostrom, 2005). These prescribed actions could be attributed to what the participants are allowed to do or not to do, and under what circumstances these actions might be allowed in the decision process (Cole, 2014; Heikkila and Gerlak, 2018).

Partnership activities are mainly divided into three phases: (1) Strategic building; (2) Delivery and implementation; and (3) Monitoring and assurance. In each phase, participants occupy positions and refer to different set of prescribed actions. In this section, we want to understand how each position chooses from a set of strategies and eventually frames themselves in the action arena based on a prescribed Partnership activity.

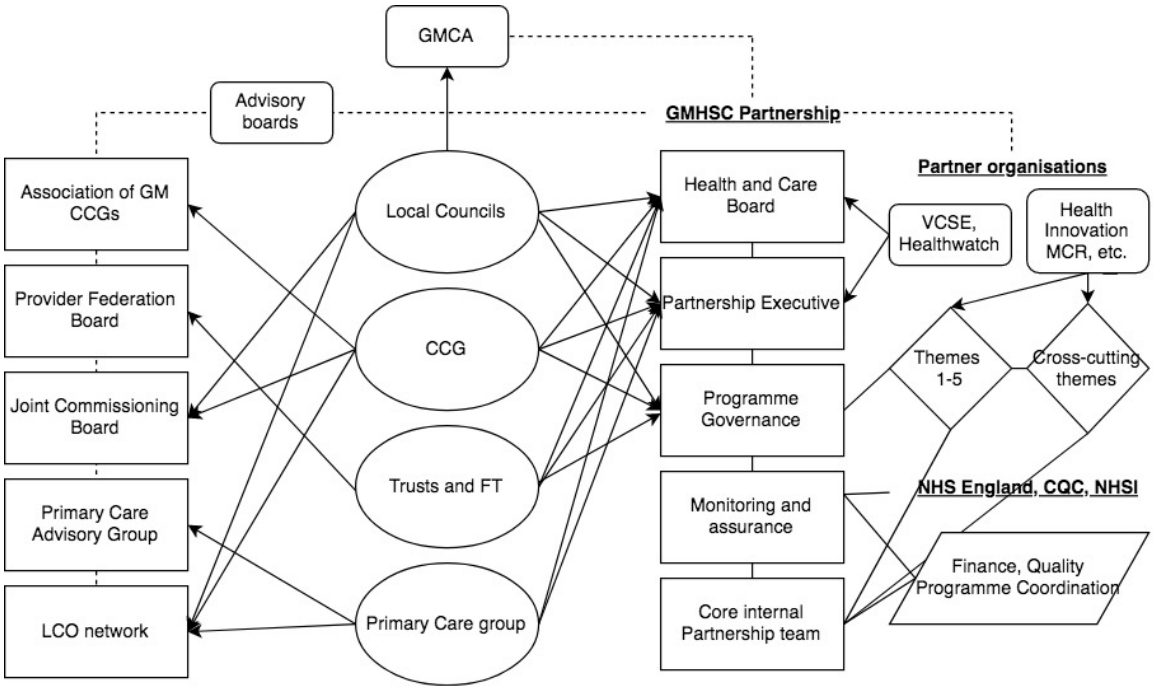
6.4.1 Representation

We start by going to the bottom tier of the governance – the key stakeholders. Whilst they are in the lower end of the hierarchy, they have important roles to play during decision-making. Each core key stakeholder group (i.e. LAs, CCGs, Trusts and FTs, and Primary Care groups) has to have representatives in various boards across the governance. This was initially agreed when the MoU was signed and when the shadow governance was being formed.

To illustrate (Figure 23), each of the 10 LAs Authorities of GM has a local council, an NHS Trust or FT, a CCG, a group of Primary Care Providers, Healthwatch, and a VCSE group. Each organisation has representatives in GM-level sectoral groups that were previously set-up some time predating devolution (e.g. GM Association of CCG) to informally coordinate with one another, or as a result of devolution (e.g. PCAG). They also have representatives sitting across various decision-making boards and programme

governance within the GMHSC Partnership, such as the programme governance boards, advisory groups, HCB, and Partnership Executive when appropriate. Representatives play an active role in various Partnership activities like the formulation of and approval strategy, engagement in meetings, networks, or steering groups, implementation and delivery of a programme, etc.

Figure 23: Representation



In any collaborative arrangement, representation is important in order to address power relations and extent of involvement. This was normally used as a countermeasure when stakeholders do not have the time or energy to engage in the collaboration, or as a means of contributing when they do have the skills and expertise to participate in discussions (Huxham et al., 2000; Wanna, 2008). In the case of the Partnership, this was a way for the stakeholders to provide human capital and contribute to the pool of shared resources as part of the agreement to collaborate. More importantly, it is a way of getting involved in the decisions and having opportunities to provide a voice for the sectoral groups that they represent.

Each organisation within a locality has committed and signed up to the GMHSC Partnership through the MoU, which means they have taken on a responsibility to deliver the collective vision that they agreed in. For instance, a Trust Senior officer (F03) said that “within the executive, you get representation from each of these sectoral groups. So, the Federation board, we have 3 reps on the executive. The commissioners have reps. The primary care have reps and local authorities (sic).”

> *“Each individual organisation is doing all of its usual business, but then some organisations have taken on a leadership role across the whole system. Either a leadership or a supporting role across the whole system. So, it could be that with respect to a range of services, their focus is completely inward, and they're just looking after their own population. But it could be, for one subject, they've got a responsibility to try and look after the whole system.” (C01)*

The default allowable action, therefore, of the key stakeholders it to represent their organisations within the Partnership governance. What happens in theory is that having representatives in the governance allows them to make significant decisions taken at the Partnership or GM level. It is essential that the key stakeholders are also not isolated in any of the core Partnership activities, such planning, delivery, and evaluation of the programmes (G01). At the end of the day, what the Partnership does and what it stands for particularly involves these stakeholders. A Partnership project management lead described, "the program we're delivering involves all of them" (G14) thus it is only right they have a say on the choices of programmes that suits them as a collective group. Representation, therefore, becomes the primary means of participation by the key stakeholders and without it, they are unable to partake in any decision-making process or have the opportunity to influence the collective vision of the Partnership.

6.4.2 Oversight on strategy and delivery

We now examine the core internal Partnership team and the set of actions they choose from within their roles. In this particular section, we focus our attention to the non-senior membership staff (i.e. non-Executive roles), who are typically situated in the programme governance or in the internal monitoring team. They are in charge of either leadership, delivery, and assurance roles, or administration and operational responsibilities.

Evidence from the interviews suggests that the internal Partnership staff mainly have the following sets of action when it comes to programme governance: (1) to facilitate or (2) to enable. Because the Partnership has no legal mandate to enforce any agreed decisions, interventions, or programmes to its members, they had to play a proactive role in encouraging the implementation of the various work pieces highlighted in the GM Strategic Plan.

Before we explore the given sets of action that they take, it is important to recall that the programme governance is established to provide oversight on strategy and delivery of the Transformation programmes outlined in Taking Charge. They are comprised of a combination of internal Partnership staff and representatives from key stakeholders and partner organisations. Their key function is to provide an overall direction and management of the projects assigned to their respective Transformation theme. During the interviews, I asked them to recall a project they recently participated in and reflect the role they played, how they participated in it, and what steps did they take to make decisions. This has allowed me to analyse their choices and establish a set of strategies that they make when they're facing an action.

6.4.2.1 Facilitator

One of the key functions of the programme boards is to manage the delivery of the projects assigned to their respective Transformation theme. Interviewees suggest that

facilitating is an important strategy in order to achieve this. Facilitating could refer to two things. First, it could be about facilitating the project itself. It ranges from duties such as planning, designing and developing the strategy, mobilisation of resources, finding solutions to issues, launching and executing, and providing support all throughout the duration of the project.

To illustrate, a prime example of a project in action is the delivery of 7-day access to general practice where the team developed “a suite of GM medical standards to look at how these shape the primary care at a scale, whilst also looking at the neighbourhood model and in terms of the new models of care and how to build that as a foundation of the LCOs.” (G01) A Partnership project management lead described their involvement in facilitating the design and development of a thematic strategy at a GM level, which can be adopted and implemented in each of the 10 localities (G01). A Senior project lead from a partner organisation also said that the extent of their participation involved facilitating health and social care improvement and making sure that the work is aligned with the Partnership's vision and that they work together collectively (P06). This level of facilitation is visible across the programme governance, particularly on the task and finish groups where they are focused in making sure that “the different threads are coordinated, and then specific teams will deliver on key aspects of work” (G08). Project management responsibilities, however, are stated in documents such as the Terms of Reference for each programme board, so it gives the impression that these are expected of staff members or partners to perform anyway.

Interviewees expressed that managing the delivery of a project is not the challenge in terms of facilitating, but rather, getting everyone to converse with one another. This is when we come to the second action of facilitating relationships. During the initial stages of strategy building, Partnership staff gathered various members of the HSC system to

get their representative opinions on how to approach issues, what they think the Partnership should address, and how can they contribute to this.

One of the mechanisms that is commonly used to facilitate conversations amongst different groups of actors is the steering groups. The steering groups were mostly made up of experts from different localities and organisations, who are interested in the particular Transformation project theme. Although its role is similar to programme boards (i.e. providing strategic direction), they are also different in a way that steering groups are informal and do not have nominal authority to make decisions in terms of what happens in the project, what gets prioritised, or what gets funded. Most steering groups were initiated during the formative stages of the project. They were established "because it had genuine influence, it shaped our thinking. It was a sounding board. In challenge, does it give us suggestions and ideas, but it wasn't a decision-making body. We were quite clear about that… you can't have two bodies that might have eight different decisions responsible for the same program." (G07).

Whilst steering groups were introduced as a way for the Partnership project teams to have a representative oversight on the direction of the project (G03, G11), it was also useful in engaging with the different pockets of the system. It was a way for Partnership staff to ensure that they have the right people inputting into the workstreams and it's not just internal members making decisions on behalf of the GM level. "It's an opportunity for them to feed in ideas into work as it emerges," (G11) which made the conversations more inclusive and representative. For example, a Partnership project management lead said that the steering group has set-up an externally facilitated workshop to bring together representatives from CCGs, Trusts and FTs, LAs, and primary care groups (G01). This involved conversations like, "What do you think? What would you do think are the possible? What could we do for ambition? What would you want? What are we prioritising?" (G01, G03) as a starting point for discussion. For some where steering

groups facilitated events that include active patients, it became a powerful avenue to draw lessons from their real-life experiences. A Senior project lead from a partner organisation said, “when I'm engaging with the system, I'm also engaging with service users, so they come along to events.” (P02)

6.4.2.2 Enabler

Another key theme that emerged from the interviews is that the Partnership is an enabler in the system, in terms of implementing and delivering the GM Strategic Plan. This resonated from the interviews partly because of the power that the Transformation Fund has created to allow partner organisations and key stakeholders to get that extra funding to develop transformative projects within their localities. For instance, a local authority councillor who was in charge of public health portfolio believed that the TF has enabled them to address local challenges, focus on their neighbourhoods, and have the opportunity to work differently (L03). Similarly, CCG leads believed the extra money gave them the opportunity deliver better outcomes and close the financial gap. It also enabled them to take responsibility and use the money far more sensibly tailored to address their own local problems (C01, C02).

The TF has indeed created an opportunity for local health organisations, particularly for local councils that were under financial pressures and did not have the kind of resource to drive key changes in the long run. But apart from all that, with or without the funding, the Partnership staff believed that it is their role to enable the system to achieve the outcomes outlined in ‘Taking Charge’ in as many was as possible. “Being able to do that and flex and enable the system to do that, I think that's part of my role (sic),” a Partnership project management lead stated (G03). A project management director also said, “as it says on the tin, it's a partnership. It is not about us doing to the system, it is about us facilitating for the system to enable them to get to where they need to be.” (G06)

Actions take place in the localities and it is very important for the Partnership to enable them to achieve the outcomes they promised to deliver. So, in reality, it is not only about enabling the system via extra funding, but also about having that capability to work through multiple lenses on how they can make people work together collectively at a GM level. It could be some form of “hand holding” (G11) where they take the local health organisations from point A to point B. A lot of the conversations involved motivating the localities to take the path which suits their circumstances and encouraging them to get where they needed to be as part of the collective agreement that they signed up for. As much as possible, the Partnership wanted to play a proactive role in empowering the localities and making sure that they get all the support that they needed in order to achieve not only their desired outcomes, but also the collective vision of GM.

> *“Here's as much as we can possibly do to assist you and you need to kind of get it over the line almost. I know it sounds a little bit patronising almost but it's that, it's more than just kind of enabling something to happen. We're trying to support them as much as possible to deliver like some changes in the system.” (G11)*

6.4.3 Monitoring and assurance

After the initial phases of strategy building and as soon as the implementation stage commences, the Partnership activities transition to monitoring and assurance. This particular action is prominent within the internal groups, who are in charge of ensuring that the localities and key partners deliver the project as streamlined by the programme governance. It is also important for their progress to be monitored and make sure that they adhere to national standards and the NHS constitution.

Because of the nature of the devolution arrangements, the Partnership has no statutory powers to enforce their partners to adopt to the programmes outlined in the GM Strategic Plan or to bind them in the decisions made by the HCB. Instead, they had to

use different formal and informal mechanisms to encourage the partners to take the strategic recommendations and implement the programmes in accordance to their own organisational circumstances. One formal mechanism they use comes in the form of the Delivery and Assurance Framework (see GMCA and NHS in GM, 2016a), which sets out amongst other things, the responsibility to manage and improve system performance through assessments, metrics, and the like. When appropriate, the Performance and Delivery board and the Programme Coordination board conduct the necessary checks to make sure that system wide and programme specific performance requirements are achieved.

Another mechanism for monitoring and assurance is the agreed Terms of Reference (ToR) that different collaborating committees created within the Partnership. This guides the agreeing parties to a structure according to the scope and limitations of the project identified, its goals and objectives, membership and voting rights, frequency of meeting, reporting lines, etc. As mentioned earlier in the previous section, Partnership staff refer to the ToR to identify their project management responsibilities. Specific roles within transformational programme boards are tasked with the realisation of the project's objectives, track key progress, and ensure achievement of predetermined programme milestones.

If and when the Partnership fails to deliver the NHS Constitution, mandate, and financial controls at an aggregate level, high-level escalation measures are to be put in place as outlined in the Assurance and Delivery framework (see GMCA and NHS in GM, 2016a, p. 14). Because monitoring functions were delegated to the Chief Officer of the Partnership, NHSE does not have direct power to intervene in this monitoring process (C04). These controls are:

- an improvement or recovery plan
- monitoring of the standard at prescribed frequency

- a requirement for GM to seek further prescribed support to secure recover
- NHSE exercising powers of intervention with an individual CCG

When a locality, on the other hand, fails to deliver a programme area and perform in accordance with the outcomes framework or performance metrics, proper intervention and rescue plans are also to be put in place. In extreme cases (i.e. CCG or place performance is below the threshold described in the Accountability Agreement or financial control), the Partnership may use its step-in rights on behalf of NHS England to take the necessary escalation measures to demand the organisation to present an Improvement plan on how performance can be improved and return to the required standard (GMCA and NHS in GM, 2016b:14). The step-in rights are based on NHS England working through the GMHSC Partnership where both parties agree how to work to address the issues that have been identified. Because of the nature of the devolution agreement, NHSE's powers previously exercised at the national level are now delegated to the Partnership via the Chief Officer, and he has the power to monitor NHS organisations without direct interference from NHS England (C04).

To illustrate how the Partnership puts this in action, we drew from the specific examples that the interviewees used to describe the reality of the monitoring and assurance process. After the devolution arrangements were put in place, CCGs became accountable to the Partnership via the delegated responsibilities of NHSE to the Chief Officer. However, others believe it is like “smoke and mirrors” (C04) because the Partnership Executive team still have links to NHS England and CCGs are still governed by the structural powers surrounding NHS bodies.

Interviewees described the complexity and intensity of having to keep up with the protocols in place and the parallel process of the Partnership’s monitoring of the running programmes and the assurance for CCG performance (C01, C03, C04). “There will be

performance reviews, accountability reviews, duct tapes in terms of where we're up to and whether we're doing enough. Have we been managing the risks appropriately or are we progressing things at enough pace? There's quite a real complex structure," according to a CCG board member (C03).

Whilst there are formal protocols to follow for recovery, Partnership staff employ other ways to assess the severity the situation before making recommendations to the upper tier boards for formal intervention. As much as possible, the Partnership wanted to encourage local health organisations or partners to perform at par with the agreed outcomes framework, whilst also offering opportunities to discuss any difficulties (G05). This could be in a form of "brokering" (G03, L05) where they act as mediators or negotiators between different groups to resolve issues prior to any escalation or intervention from the Partnership board. "The fact that these things aren't mandated from NHS England and NHSI, means that it's about negotiation within the system and discussion within the system, (sic)" (P02) a Senior project lead from partner organisation said.

The Partnership plays an important role in enabling those conversations happen and making sure that the right people are included in any form of deliberation or negotiation. Because of the way the governance was structured in terms of monitoring, assurance, and accountability, the Partnership has constructed enough barriers for key stakeholders or partner organisations to get through, such as deliberations and problem-solving mechanisms, the performance management boards, etc., before reaching the highest tier of the governance. If it does reach the Partnership Executive or even the HCB, it would have to be a fundamental change that needed to be addressed in a collective level (G08).

A Partnership project management director said, "depending on the situation, it may be that it will be more of a conversation about how can we help you. (sic)" (G05). There

are roles in the project management teams that are specifically geared towards performance measurement, and it is under their remit where they go in and have conversations with localities that are performing poorly and ask the difficult questions about why their performance in some areas not where it needed it to be. This allows them the opportunity to address and rectify the issues before a recovery plan is put into action.

There are day-to-day and/or monthly conversations on assurance as well, which involves a diverse range of discussions on performance against different provision in different localities all the time. This could be a conversation between commissioners on sub-contract management, or sometimes issues in a GM-level (G07, G08). Any issues are usually picked up on the mid-tier levels (i.e. Performance and Delivery board, Quality board, etc.) where they are examined in different orientations. LA councillors, for instance, have expressed that they comply with the extensive structures in place by attending assurance meetings and engaging in conversations (L02, L03, L05). It involves sending representatives to the performance management monitoring framework for formal reports.

From the perspective of the partner organisations or key stakeholders, they believed that they have effectively agreed to the terms and agreements that may have come with it when they signed up to work in partnership (C01, C04). This included agreeing to commit to the collectively agreed deliverables, especially if their locality or programme area has been awarded with some Transformation Funding. “What we've then done is we've actually said, we'll voluntarily do this,” (C04) a CCG board member explained. Because of GM’s history of working together, there has already been an established mutual respect between all parties, thus, agreeing to be part of the Devolution agreement meant that they have to honour this collaboration by default. There is a collective element where organisations are taking ownership of what they agreed to be part of (C01, L04).

In some cases where transformation money has been awarded to a particular programme or place in order to fund the project, it was more about the performance management staff putting pressure to the organisations to adhere to the agreed performance metrics. In effect, the Partnership has enabled these programmes to happen, so when they signed the contract or investment agreement, the involved parties should be able to deliver this vision and make the most out of the funding that was awarded to them (G02, G06). A Partnership project management director explained, “we’ve given you this money, we now want to see what you've done, and if you've not done it, why have you not done it and we might take it back.” (G06)

> *“There is reporting by exception, which is you know across all of the things that we've allocated money to, are they delivering what they need to deliver? Yes or no. Which ones are not delivering? And there may be decisions, because some of the process in GM and it's the same with the rest of the country, where the national team is giving them money. If you're not demonstrating that you're utilising the money effectively, it will stop.” (C01)*

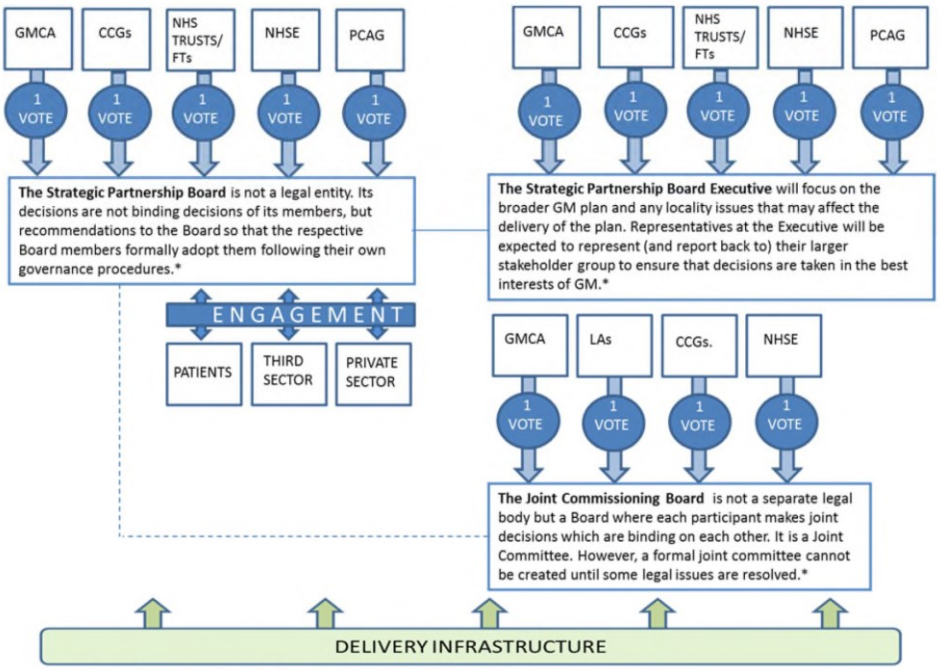
6.5 Control

Each participant has a level of control on how the sets of actions can be translated into intermediate or final outcomes (McGinnis, 2011a). In this research, control is determined by two main decision-making bodies: the HCB and the Partnership Executive. The interviews suggest that the two bodies transform actions into outcomes by consensus decision-making in (1) challenging discussions and pre-approval; and/or by (2) ratification and final endorsements. These mechanisms distinguish the level of power between the two. In this section, we examine how the HCB and the Partnership Executive utilise the sets of choices presented to them, come to an agreement, and transform these actions into outcomes.

6.5.1 Consensus decision-making

The Partnership has a dominant approach of decision-making via consensus-building arrangement. “We have to work by consensus. There is no other way forward,” (L05) an LA Senior Leader states. Without general agreement, the participating decision-makers with opposing views will end up discussing for a long period of time (G01, L05). This feature was considered as one of the strengths of the governance structure, particularly at the senior level (G07, G08, G13, C04, L05).

Figure 24: Voting rights



Source: (GMCA and NHS in GM, 2018)

In order to keep a collective and united voice, voting arrangements were put in place in order to reach a decision on a majority process (Figure 24). The HCB, for instance, has set-up an agreement on voting rights to determine how a final decision is to be convened by the board members. As previously agreed, the principal core stakeholders and original signatories of the Health Devo MoU (i.e. LAs, CCGs, NHS Trusts and FTs, and NHSE) are the voting members of the HCB with a vote of 75% in favour in order for

any proposal to be endorsed or carried forward. When the primary care vote through PCAG was added later on, the level of support needed was increased to 80% (GMCA and NHS in GM, 2018). The decisions made by the HCB are not binding, but rather recommendations made are to be formally adopted by the members following their own governance procedures. Similar arrangements apply to the Partnership Executive. The VCSE sector, however, does not have voting rights in the Partnership Executive, but rather, they are granted a seat on the table to shape the discussions and represent the collective views of their respective group.

6.5.2 Challenging discussions and pre-approval

To illustrate how the Partnership puts this in action, we examine the flow of decisions and the dynamics of power between the Partnership Executive board to the HCB. We asked interviewees to draw from their experiences on any Partnership activities they have been recently involved in (e.g. project proposal, strategic document, assurance framework, etc.) and to describe how it was translated into an outcome via the 2 decision-making entities.

Primarily, the Partnership Executive board is a closed-door forum where all the dialogue and discussions happen between the representatives from various sectoral groups. It is considered as the “engine room” (G08, G17) of the Partnership, where all the discussions occur prior to the final endorsement of any proposal, amendment, recommendation, or update in the HCB. It primarily focused on “identifying the challenges, asking for the work to be done… having debates between different kinds of stakeholder… and where all the most difficult conversations happen.” (G08)

When the Partnership was at its strategy building phase, the Partnership Executive was focused on ensuring that a strategic proposal was engaged across different parts of the GMHSC governance, particularly to the Advisory Groups (F03), and discussing about how to further refine the items in the document (G08). For instance, a Partnership project

management lead said they had taken the Primary Care strategy to the Advisory Groups for sign-off, and to ultimately, what was then the Strategic Partnership Board Executive (SPBE) and then finally to HCB (G01). This works similarly for other strategical documents that needed to be taken around the governance structure before it reaches the Partnership Executive. The Partnership Executive is the penultimate lap of the "socialisation" (G01, G07, G12, F03) loop of the strategic document, and by the time it comes to that point, "Partnership exec will then say well actually we got some concerns around this issue, so we might have to go around the cycle again." (G06).

Furthermore, the allocation of the Transformation Fund was also an important point of discussion within the Partnership Executive board. Discussions were particularly intensive on agreeing to a final decision on whether money should be awarded or not to various localities and programmes after extensive reviews by other sub-committees. For illustrative purposes, a Partnership finance lead described the scenario like, "They would say, let's keep with Stockport for simplicity, Stockport have applied for Transportation fund. This is what Stockport are promising to do, Stockport wants 20 million. TFOG recommend the approval subject to these material conditions. Do you Partnership Executive Board, support the decision to give Stockport 20 million?" (G02) In this case, the TFOG sub-committee has already performed the leg work and they are presenting a summarised version of the presentations to the Partnership Executive board.

A Partnership project management lead described a meeting with the Executive board as "provocative and challenging" (G12), where board members asked questions about the how the programme will go forward and why is it important. Similarly, an FT Senior project director compared the bidding process similar to "dragon's den" (F01), where the Executive directors were very intense when it comes to probing why they should give them the money and what outcomes are they promising to return for the investment.

*"We had to pitch for the money. And I can remember, at that point by then *Executive director*[14] was very involved, and said "Okay how many are you going to roll out to? By when?" And I kept saying "Well it depends it depends." And they kept pushing me." (F01)*

During the delivery, monitoring, and assurance phases, the Partnership Executive board acts as an even tougher critic. They have oversight on all operational and transactional issues; therefore, they have established a rigorous process on ensuring that all members of the Partnership are performing up to a standard that is expected of them. It is up to sub-governance teams to perform weekly to monthly checks on different levels of quality and assurance. Any areas of performance, whether it's problematic or not, goes into the Partnership Executive Board for further discussion or intervention and recovery plans if appropriate. As much as possible, any issues will be filtered through by the Executive unless an ultimate decision is needed to be escalated to the HCB. A Partnership senior director said, "We monitor it in different ways, and we wouldn't take it back to HCB unless there was a fundamental change in what we need to." (G08)

Executive directors also play a dual role in terms of monitoring and assurance, where they carry responsibilities as Partnership executives for operational purposes, and as NHS local directors for NHS England functions. For instance, the Executive Lead for Finance and Investment is in charge of managing and monitoring the overall financial position for both Trust and FT providers, and the commissioners as part of his NHSE role; whilst the same position is also in charge of overseeing the management and financial aspects of the Transformation Fund and the financial operationalisation of the Partnership itself. These dual functions allow Executive directors to carry a bigger role

[14] Name omitted for ethical purposes

in terms of monitoring its member organisations against not only to national standards but also against the commitment to the Devolution agreement (G13).

Overall, the Partnership Executive has a greater scope on decision-making. It has the responsibility to pre-approve everything before presenting it to the HCB, which explains why their process is more intense when it comes to probing for discussions and asking more difficult questions to the participants. The environment is more of like a “debating chamber” (G08, G13), unlike the HCB where it's more of the leaders of partner organisations or stakeholders sitting on the table. Because the Partnership Executive board members are constituencies (i.e. nominated by their organisations) of the key sectors, there is enough representation to make significant decisions taken at this level on behalf of the GMHSC system. They have a larger decision-making power in terms of addressing problems at a collective level and have discretion to control and prevent any escalation of any types of decisions or issues to the HCB.

6.5.3 Ratification and final endorsements

The HCB is the highest level and ultimate decision-making body in the governance structure. Interviewees described HCB as the last point of call in terms of giving its seal of approval and ratifying or endorsing a recommendation or decision. The HCB is a public meeting, thus, ideally, it is more of a “rubber-stamping” (G13, P01) presentation of pre-approved proposals and pre-determined reports that was already sifted and debated through the governance structures.

The HCB and Partnership Executive work hand-in-hand. When a decision reaches the top of the hierarchy (i.e. the HCB), the Partnership Executive must be able to say that they already had an extensive debate about the risks and implications, and whether it should be presented in the HCB agenda or not for ratification. There's nothing to stop, however, the HCB from having the discussion. But the point is that by the time it gets to

them, all the legwork should have been done and the decisions have already been made (C01, P01).

> *"We'd expect that to have been done in advance, so that's the final place where we've got everybody on board, we bring it there. We then say to them, 'Do you now endorse, support and buy into this?'" (G08)*

Since the HCB meetings are open to the public and televised via a webcast, some described it as "theatrical" (G08). The meetings are done in a council chambers and are attended by the senior leaders of every partner organisation. Because of this public facing nature, there really is a limited opportunity for discussion and comment. The agenda is published beforehand, where all attending members receive summarised versions of the agenda items and the Chair of the meeting asks, "Are we all backing this? Is this the way forward?" (G08)

In fact, when something lands on the HCB table, it meant that the agenda has already been through the governance structures and everyone attending the HCB meeting (i.e. the senior representatives) are already aware or familiar with it. The discussions involving the HCB are more of just a re-confirmation if everyone agrees with it, then they publicly declare their consensus agreement. "If it was significant enough… or it was relevant to the success or failure of the implementation 'Taking Charge' and it landed on that table, what you'd get is a sense of What does this mean for hospital providers? What does it mean for primary care providers? What does it mean for local government and politicians? What does it mean for clinical commissioning groups? What it does mean for the voluntary and community sector? And then we come up with a settled consensual view." (G17) a Partnership senior director explained.

The impact of an HCB decision is important to any Partnership activity. It gives a stamp of approval and a final endorsement to carry on with the next steps. Because of the Devolution arrangements, the HCB does not carry any legal binding powers to enforce any decisions to its partner organisations. It does, however, have the authority to make recommendations for its members to follow any formal decisions made within their own organisational governance structures. It is up to the localities to implement these decisions and the Partnership then plays a supporting role to it. A Partnership project management lead says, “we've set our ambition, we've got an agreement, but how they commission and deliver and fund it, it is up to them.” (G01) Senior leaders, to say the least, follow these decisions out of respect on the MoU they signed. There is a sense of collective ownership and buy-in amongst the key stakeholders, thus, they implement any decisions even without the legal enforcement (C01, L04).

Moreover, having something signed off by the HCB meant that all the effort by the Partnership programme staff members and participating representatives from the key stakeholders are finally put into test. A Partnership project management lead says, “it puts us in a very strong position to make a difference and be a bit bold. Because if you get signed off at that HCB, then that means it's serious and you've got to do it.” (G12) For example, when a programme strategy was approved, the HCB has written a letter to all GM chief executives to say, this has been approved. “We don't want this just to be a strategy that sits on the shelf and doesn't have any impact. And we've suggested a 100-day challenge for people to, for organisations and localities to commit to some action to help deliver the strategy over a 100-day period.” (G04) a Partnership project management lead explained.

Although the Partnership Executive has a wider scope when it comes to decision-making, the HCB has the final say on whether it is going to be endorsed to its members

or not. Therefore, it has greater weight on its decision-making powers in terms of making recommendations for enforcement to the entire GMHSC system.

6.6 Information

Each participant has a set of information available to them prior to making any action within the action situation. In the Partnership, information is disseminated across the structures through a variety of channels. A Communications Strategy was initially released in September 2016 to support the sharing of information across the sectors participating in the Partnership, supplemented by other forms of formal meetings and/or informal networking.

6.6.1 Communications Strategy

To formally support the engagement of the Partnership and increase its presence across the GMHSC system, a Communications Strategy was signed in September 2016. The document mapped out mechanisms on how to build significant awareness on the GMHSC devolution and communications between the participating organisations through the following (*see* GMCA and NHS in GM, 2016b):

- Stakeholder engagement. The document emphasised the importance of maintaining effective, reciprocal relationships with stakeholders by establishing monthly checkpoints and bulletins. Reporting to the HCB is also recommended to maintain formal ties with the Partnership.
- Content strategy and brand development. Content strategy aims to raise awareness on the strategic plans of GM and its tangible benefits to the localities. Reinforcement controls are in place to highlight the financial impact that Devolution can bring, with regular reports on Performance and Statutory duties.
- Media relations. Media training and briefing arrangements are to be provided especially to senior Executive leaders in order to maintain an online presence or

media profile. They are to proactively engage with different media coverages through a variety of materials, such as case studies, opinions, and comments. The Partnership is to monitor media coverage about Devolution and round them up in summary reports or monthly bulletins.

- Digital engagement. The Partnership wants to build an effective presence in online conversations about Devolution and in engaging with the public and other stakeholder groups. Websites and social media accounts are to be monitored.
- Campaigns. Agreed national campaigns are to be incorporated in a GM-level context, in coordination with the partner organisations such as Sport England, Public Health England, and Department of Health.
- Internal staff engagement. To build a cohesive GMHSC community amongst the internal staff members through staff bulletins, face-to-face briefing, Executive board briefings, access to training and leadership, and incorporating brand management (i.e. ID/lanyard and core templates for staff members).
- Partnership working and public engagement. A simple operating model for communications and engagement is agreed by the Partnership members to be embedded across GM. This include sign off and consultation requirements in order to build knowledge, skills, and capacity at a GM and place level.

It also laid out the four different levels of engagement and communicating operations of the Partnership, namely:

- National level. Engagement at the national level over the delivery of the NHS Five Year Forward View and the accountability with NHS England.
- GM level led by GM core Partnership team. Overall responsibility of the Chief Officer on the delivery of the GM Strategic Plan and ensuring the resources,

skills, and capacity are in place to deliver programmes within the Strategic Plan. Assurance and support at place-based level on behalf of NHS England.

- Place-based level. Delivery of locality plans and assurance to Partnership at GM level.
- Organisational level. Responsibility and accountability to its organisational leaders. Delivery of engagement and consultation activities in related to transformation programmes.

Overall, the Communications Strategy identified the ideal way of sharing information across the different groups within the Partnership. It provided a sound framework on how the Partnership formally plays an active role in ensuring that all participating stakeholders and partner organisations are engaged collectively within the system through various channels of information.

6.6.2 Meetings and reports

Meetings and reports are other ways of sharing information between the members of the Partnership. Majority of the interviewees attend meetings convened by the Partnership, where HCB, Executive, and programme board meetings as the most frequently cited.

The HCB meetings were initially conducted monthly between 2016 to 2018 (initial establishment and strategy building phase). During the delivery and implementation phase on 2018, meetings were revised to every two months but still retained its public-facing nature (i.e. televised via webcast). The venue was also rotated between the 10 LAs to ensure a locality dimension and to increase public accessibility across GM. Members of the HCB represent both their respective organisation and locality when attending the meetings (GMCA and NHS in GM, 2018). The meeting is chaired by GM Combined Authority portfolio holder for Health and Social Care, and co-chaired by the

Chief Officer. The Chief Officer's report is one of the staple items and is usually the first point on the agenda of HCB meetings. It summarises key items of interest both within the GMHSC Partnership and its partner organisations. It also provides updates on Partnership activities, key discussions and decisions of the Partnership Executive board, including reports highlighting performance, transformation, quality, finance and risk. The HCB usually notes and comments on the Chief Officer's report afterwards. Documents and recorded webcasts of the meetings are released to the public through the Partnership website for transparency and accountability.

The Executive, on the other hand, still meets every month with a forward plan of agenda items to be distributed in advanced to ensure clarity on which items are to be discussed and agreed. The following groups also submit regular reports to the Partnership Executive, wherein summarised versions are included in the agendas: Finance Executive Group; Performance and Delivery Board; Programme Coordination Group; and Quality Board (GMCA and NHS in GM, 2018). Since this meeting is closed to the public, documents are not released to the Partnership website. Decision logs are completed following every meeting in line with the GM Accountability agreement. These are reported back on a quarterly basis to the HCB. Short summary reports of Partnership Executive meetings could be included in the Chief Officer's report, to which the board members can comment on during the HCB meeting.

As part of the assurance process, CCGs hold quarterly meetings with the Executive directors of the GMHSC Partnership along with the leaders of the localities (C02). Each CCG Executive team must send representatives to this meeting to satisfy the statutory requirements. A CCG board member illustrated, "…as a group we provide, every quarter I think it is, a highlights report about how we're spending the money, what we're spending on or what the risks are associated to that project" (C04) Assurance meetings provide a forum for the Partnership and the localities to connect and communicate with each other

about their progress and how they are getting on with the implementation of their respective programmes across different sectors. Project management leads (G10, G14, G16) explained that locality performance and assurance meetings are held on a regular basis, where localities are asked to update on progress in this context against the agreed outcomes frameworks or national standards. Finally, the Partnership also releases an Annual Report and Business Plan report every year to update its stakeholders about the financial and sustainability performance of the GMHSC system, and progress on the implementation of the GM Strategic Plan. This was their way of updating their members and the public about the status of the Partnership in terms of financial and operational performance.

6.6.3 Informal networks

In the previous chapter, we have seen how the various sectoral groups coped with the tensions in the system by retaining informal arrangements to collectively remain as a GM-level unit. Because of the built-in networks that existed in GM long before Devolution was introduced, it was easier for them to communicate and work with one another when the Partnership emerged (G01, G09, C03, F02). There is a high level of interdependency amongst the members of the Partnership, which makes it easier to build and maintain relationships and create collaborative conversations.

> *"I think that is from a history of having meetings together and people regularly seeing each other, so even before we (the Partnership) existed, there were kind of meetings and people got to know each before that so if you had those personal relationships, it makes it a lot easier to move ahead with work (sic)." (G09)*

Whilst the Partnership laid out the building blocks for bridging communications between the partners across the system, interviewees used other mechanisms to share information and interact with one another without having to go through the formal

channels. For instance, a Partnership project management lead described socialising ideas and pieces of documents around the governance structure in order to familiarise them about the piece of work they are doing (G01). Another Partnership project management lead said it was an effective way of getting people onside and raise their understanding about what the Partnership is trying to do (G07). “Socialisation” is a common practice of sharing knowledge or progress across the system, or a way of getting everyone to buy into an idea and getting them on board (C01, P06) prior to its discussion in the formal forums of the decision-making entities (i.e. Executive board meeting or HCB meeting). This is also a cheaper and more cost-effective way of raising the profile of the GMHSC Partnership and the various internal teams working around a multitude of programmes across the 10 localities (G07).

The more people they involve during the socialisation period, the more feedback they receive (G04). It gives the Partnership more time to refine the idea and add more input from the various people they consulted with. A CCG Senior Lead, for instance, described, “We involved lots of people, patients and different organisations, different professional groups, as we were developing it. We had various versions, went to various groups. They gave feedback. We changed it. It was very, very well received.” (C01) This process created a more interactive relationship between various sectors because they get to discuss the more important things that are closer to their own local problems and tailor it to how they can address it as GM collective unit.

> *“So, you know we got broad agreement around the what, some people were saying yes these are the things that are important to us. This is what we ought to be doing. Some of this, some of this is being prescribed nationally, but you needed to get local ownership and buy in to it. So that people don't say, well "That doesn't work for us, you know we're different. Our population is different. Our priorities are different." So, we have to make sure that was buy-in and ownership.” (C01)*

Another mechanism used for information sharing is through influencing. This practice is commonly used by partner organisations and core stakeholder groups, who do not sit or hold any position within the Partnership team. A Foundation Trust Senior project director, for example, described how she found networks within the Partnership team and maintained in-contact with them to help her understand and be updated with what's happening next on a particular transformational programme (F01). Because she has no direct participation or no direct way of attending the meetings, she used this opportunity to establish a two-way relationship in order to influence various Partnership teams on the work piece she is involved in.

> *"I help feed her information of what's going on. But that gives me an ability to influence, but it also gives me the ability to hear what's going on. Rather than waiting for it to trickle down through other routes. So, in many ways having this establishment has made a whole lot more things to happen but actually, potentially it gives us opportunities to work differently… it's another layer in the cake, which some people would say is more difficult. But actually, it's a layer that has potential to influence more directly." (F01)*

Consequently, a Foundation Trust Senior officer also said that influencing their own organisation was useful in bridging relationships at different levels within the Partnership (F02), especially in areas within the system where there are existing tensions between the key stakeholders. Coming from a perspective of an FT where they are organically rooted to their board of directors for accountability, having the ability to influence and bring people aboard from their own organisation made it easier for them to have honest conversations when they meet formally in meetings within the Partnership. Having the ability to influence gives them a step advantage when it comes to getting people signed up for an idea and resolving existing tensions amongst themselves before, they step forward in a collective forum.

More so, influencing can also be a counter mechanism to persuade people, most especially decision-makers, about an idea you are selling (F01, P02). If you want them to change their existing opinions or if you want to lobby for ideas, having the ability to influence the right people within the Partnership could pay off.

> *"It just means you need to influence more. So, if you walk into a meeting and everybody's got a different agenda, you have to think, right how can I influence them and actually you know what, or are they right? That is more important than what I'm asking right now? And so how do I influence given this new landscape?" (F01)*

This leads us to another common way of sharing information, which is through principled engagement. When participants interacting in a decision-making arena have the opportunity to engage with one another, they are more likely to establish trust and respect with each other's interests (Emerson et al., 2012). This means getting the right people to negotiate and resolve their conflict with one another outside formal forums. For example, a Senior project lead from a partner organisation explained how identifying the right people to engage in prior to the "dropping a piece of paper" (P02) moment was crucial to the principled engagement process. This include asking the right questions such as, "Who do you speak to? Who are the movers and shakers? And who's going to be actually able to influence the decision makers?" (P02)

Getting the right people in the room can be a challenging task, especially with the complex governance structures in place (G07, G14, P03, P04, P05, L05). Since there are multiple projects running at the same time with cross-sectoral organisations working together, interviewees suggest that resolving differences or conflicts can be best addressed by informal conversations outside meetings (G01, G09, L05). For example, a Partnership project management lead sometimes attend what they refer to as a "kitchen cabinet" meeting (G12), where several other project managers meet together on a

monthly basis to play catch up on what they are up to. An LA Senior leader also illustrated that when something is getting out of hand and participants cannot come up with a consensus, they had to sort out the issues separately and privately (L05). This ultimately helped in dealing with difficult conversations and resolving conflicts that tend to build up during formal meetings.

> "Try and cope with those offline. It is worth trying to do it. So, if you wait until the meeting and have a bigger row… you then got to pull people back together. So, if you try and get them together beforehand, get them to identify what their issues are to see if we can work with you going forwards." (L05)

Another Partnership project management lead said that different organisations within a locality may struggle to converse with one another if they are in the same room, so it is up to the Partnership staff to "join the dots" (G07) and manage their relationships to resolve their issues. These important debates all needed to occur before gathering in any decision-making forum (L05). "What you can't really have is a major fall out amongst all of the people in a large public board meeting because they've never seen something before," a CCG Senior lead explained (C01). This statement reinforces the impact of reconciling issues prior to raising an item in any agenda, most especially in the HCB meeting (G08, G13).

It was important for the Partnership to keep having these difficult debates and conversations with the various pockets of the system, otherwise, they lose traction (F02, L03, P05). "You have to choose you battles. You work on when the time is appropriate to raise those issues," a LA councillor said (L03). Whether they engage, influence, or socialise the ideas, the organisations and the Partnership needed to find innovative ways on consolidating views or reconciling issues outside the formal decision-making forums. More importantly, the more they engage with each other in informal venues, the more chances they have on making the conversation relevant or significant enough to be

brought to the formal table (G17, L05). Because of the fragmented structures existing before Devolution was introduced, everyone needed to navigate their way through the new system in place.

> *"So, what tends to happen with that is that you'd have a whether an implementation plan or an implementation problem. If it was significant enough, that it spoke across the, it was relevant to the success or failure of the implementation taking charge, and it landed on that table." (G17)*

Overall, evidence suggests that navigating through the Partnership system is all about relationship management and informal networking. Whilst there are governance routes and engagement framework set-up to guide the relationships, the interviewees believed that the complexity of the governance structure made it more difficult to navigate through. They had to find different ways of working in order to share information across the table and make sure that the right people are engaged in the conversations.

6.7 Costs and benefits

For every action that a participant takes, there are attributed rewards or sanctions that either incentivise or disincentivise the production of the desired outcomes of the Partnership (Heikkila and Andersson, 2018). In the case of the GM Health Devo, we examine what motivates the stakeholder groups, partner organisations, and the core Partnership team from collaborating with each other and what are the trade-offs if they decide to do so. Our research suggests that the participants' incentive to collaborate are be shaped by: (1) the imposed binding rules of the devolution agreement; (2) their own organisational agendas that yield maximum benefits, and more importantly, (3) the Transformation Fund money available for their financial gains. These were all reflected in the previous sections above, but we attempt to lay it out in terms of identifying how

these shape the Partnership members' incentives to collaborate and participate in Partnership activities within the action situation.

6.7.1 Imposed rules by the Devolution agreement

It was a common theme from the interviews that participants agreed to engage in the Partnership itself because of the Devolution agreement that they all signed up for. The MoU, in particular, cemented the "gentleman's agreement" (F02) where everybody was pretty much working with each other via a "social contract" (P05). Whilst none of the agreements have any legal mandates, the organisations who signed up for Devolution were all working based on their existing social attributes (i.e. trust, reputation, reciprocity) and working relationships (i.e. built-in informal networks, tensions within the system), which they have known from their previous experiences. Whilst some believe they collectively have to participate in Partnership activities because they signed up for it, others believed they had to do it because it is the right thing to do. The interest for joint collective actions has always been there for some organisations.

6.7.2 Organisational agenda

If it doesn't benefit their own organisation, chances are they try to find other ways on how to influence the system. This partisan behaviour was one of the effects resulting from the purchaser-provider split that emerged during the 1990s. This posed some level of difficulty in terms of making joint decisions for the greater good because if the decisions are to negatively impact one's organisation, for instance, then the participants are more likely to make a choice that will benefit their own organisation. We demonstrated in the previous chapter that CCGs and Trusts struggle to overcome their vested interests due to the blurred lines of accountability (C01, F02).

> *"If you put in pressure on individual organisations that might make them behave in a way, that only looks after their own interests rather than the greater good of the whole... We still see behaviours that are about either protecting something,*

or you know, sort of vested interests and it's really difficult to try and get people to step out of their own organisation." (C01)

6.7.3 Financial gains

With the TF coming into GM, there has been a full devolution effect felt across local NHS organisations. Since this pot of money was protected and there was more certainty on how much money GM is going to collectively get over a three-year period, CCGs and Trusts were able to plan accordingly. Moreover, it allowed more freedom to spend the money based on the priorities outlined on the GM Strategic Plan. "We get to decide at Greater Manchester-level what it gets spent on. So instead of us bidding or for being part of these formula changes over a period of time, we have certainty about how much money we were going to get." (C04)

"We don't have to bid for money against other parts of the country and potentially not to get our fair share because our bid wasn't good enough. We do get our fair share. And the reality is over time some of the national pot that we're getting a fair share of, hasn't been spent on transformation. So, in the end we will have spent more money on transformation in GM than anywhere else because we've protected all of that £450 million for transformation, we'd not used it to proper minor organisations." (G13)

The TF was separate from the conventional funding allocations to CCGs and was focused on the delivery of the five transformation themes outlined in the GM Strategic Plan. Although TF allowed more flexibility on how GM wants to spend the money on, a separate funding application process within the Partnership was put in place for the localities and other programmes of work to adhere to, which will then be assessed by an independent team internal to the Partnership and approved several external boards (GMCA and NHS in GM, 2016a). This is to ensure that there are equal opportunities for

everyone to bid and that the distribution of the funding is spread out across various places. The TF, therefore, provided a financial incentive for stakeholders and partner organisations to participate in the collective action. It enabled them to conduct various work programmes of which the Partnership has strategically managed.

A monitoring and performance framework was also put in place to make sure that those receiving the money will produce the outcomes they promised to deliver. With this process put in place, it brought a sense of ownership for local leaders from LAs and NHS organisations to have responsibility to the money they're applying to or been given access to. A Senior CCG Lead said, "…rather than the Treasury every year having to put more and more money in to close the gap, it will say have the money now, and then you use it locally and you'll use it far more sensibly... and you will sort out some of the big problems in your system because you're taking responsibility for it." (C01)

6.8 Potential outcomes

In this research, we are not concerned about evaluating the impact or the tangible outputs of the Partnership, but rather on the immediate process outcomes arising from the collaborative relationships and (in)formal mechanisms in place to govern the health commons. Therefore, outcomes in this research, therefore, refer to the desired process outcomes of every action taken by every position in the Partnership (see Table 13).

Earlier in this chapter, we have identified major positions occupied by the various participants within the GMHSC Partnership, namely: the providers of service (occupied by the key stakeholders); the internal and external regulators (occupied by both the Partnership staff and NHS England); the taskforce groups occupied by the Partnership staff and partner organisations, and the decision-making bodies occupied by participant groups who are all equally represented. Each of these positions have a specified set of actions to which they choose from prior to participating in any Partnership activity. Using the set of information available to them and other external factors, such as the attributes

of the participants they interact with, they select an action and transform them into outcomes. Each outcome as a result of the combination of information, costs and benefits, and external factors, is therefore highlighted as follows.

Table 13: Link between Actions and Outcomes

Position	Accountability	Allowable action	Outcomes
Health and Care board	NHS England through Chief Officer	Ratifying proposals or recommendations via consensus	Final endorsement
Partnership Executive	HCB	Presentation of proposals; Engage in discussions; "Dragon's den"	Makes recommendations to HCB
Advisory groups	Respective organisations	Sign-off/Providing recommendations	Endorsement
Programme boards	Partnership Executive	Strategic oversight; assurance to key stakeholders	Risk assessment and assurance on delivery
External regulators	Secretary of State	Monitoring and assurance on key stakeholders	Risk assessment and assurance on quality and financial sustainability
Internal regulators	Partnership Executive	Monitoring and assurance on delivery of programmes	Risk assessment and assurance on quality and financial sustainability
Key stakeholders	Respective organisations	Providing representation across all governance boards	Engagement and delivery of programmes

6.9 Summary

The purpose of this chapter was to draw together the exogenous variables from Chapter 5 and examine how they informed the participants within the action situation utilised them to modify and regulate their behaviour. We particularly explored the seven elements which make up the internal structure of the action situation, namely: participants, positions, potential outcomes, set of allowable actions, control in function, information available to participants, and perceived costs and benefits. Each of these elements corresponds with a set of rules, which emerges as an outcome of the interactions from the action situation. This is the rules configuration stage of the process,

where they craft, monitor, and enforce formal and informal institutions to facilitate their relationships.

As illustrated above, our evidence suggests that the Partnership was able to successfully devise their own formal and informal institutional arrangements in order to shape the behaviour of their participants. They relied on soft structures, such as frameworks, strategic plans, governance structures, assurance and monitoring guidelines, and the MoU, to substitute to the absence of statutory legislation. This was used to create order and mobilise the relationships amongst its participants. More importantly, the Partnership resorted to informal institutions like shared norms, trust, and reciprocity, in order to overcome the limitations of the absence of formal institutions. They took advantage of the strong history of collaboration by the embedded networks and used this to facilitate debates and enable conversations that are difficult to conduct in a formal forum.

Table 14: Summary of findings according to the elements from the action situation

Action Situation	***GMHSC Partnership***	
	Formal	Informal
Actors	Key stakeholders; Partner organisations; Core staff of the Partnership team	
Positions	Provider of service; Internal and external regulators; Taskforce groups; Decision-making bodies; Advisory groups	
Actions	Representation; Oversight on strategy and delivery; Monitoring and assurance	Facilitating relationships; Enabling informal conversations; Brokering; Negotiating

Control	Voting arrangements; Consensus decision-making via HCB and Partnership Exec; Rubber stamping	Hard conversations; Conflict resolution via debates
Information	Monthly or weekly face-to-face assurance meetings; Reports	Networking; Influencing; Socialising; Principled engagement
Net Costs and Benefits	Financial gains; Monitoring and assurance	Conflict resolution; informal conversations

7 Interactions and Outcomes

7.1 Introduction

In the previous chapters, we outlined the formal and informal mechanisms that the Partnership and its member organisations have employed in order to establish the governance structure and how the participants should behave and make choices within the decision-making arena. Given a set of allowable actions, information, and the constraints provided by the exogenous variables (i.e. physical and material characteristics of the health commons, community attributes, and the rules-in-use), participants who occupy different positions then use different collaborative mechanisms in order to navigate their way through the action situation and produce their desired outcomes.

In this chapter, we aim to round up the empirical findings and address each of the research questions of this study.

1. Under what circumstances can collaborative governance mechanisms create a system of stewardship in governing the health commons?
2. What are the formal and informal institutions that emerged as a response to collective action dilemmas?
3. How are institutional arrangements influencing the different levels of collaborative processes in the governance of the health commons?

First, we examine the emerging patterns of interaction according to Ostrom's multiple levels of analysis, as a result of the different institutions set up within the constitutional, collective-choice, and operational levels. More importantly, we want to understand how the participants coordinated, competed, or engaged with one another in order to address collective issues, and the difficulties and various tensions arising from their interactions.

Second, we outline the formal and informal institutions resulting from our examination of the GMHSC Partnership as stewards of the health commons. Lastly, we summarise the findings according to Ostrom's 7-rules typology and draw lessons on how we can apply the results of this study to the future consideration of using the health commons as a theoretical lens to sustain the NHS.

7.2 Three levels of partnership activities

The Partnership activities are mainly divided into three phases: (1) Strategic building; (2) Delivery and implementation; and (3) Monitoring and assurance. During the initial years (2015-2017) of the Partnership, majority of the activities involved writing strategic documents and establishing agreements between organisations on how to coordinate with each other within the system after signing the Devolution agreement. This meant that the Partnership was focused on engaging with the key stakeholders and making sure they are on board with what the Partnership is committed to achieve. Then from 2018 onwards, as the Transformation fund was slowly allocated to various parts of the system, the Partnership's activities shifted to the implementation and delivery phase. This included assurance and regulation of the activities, and the maintenance of relationships between the participants.

In order for us to situate the institutional rules that emerged and how participants interact in each phase, we return to the assumptions of Ostrom's IAD framework and how it recognises that institutional choices in the action situation can occur in multiple levels. Ostrom's multiple levels of analysis illustrate how all rules are nested in another set of rules (Ostrom, 2005:58), where one level of actions and outcomes obtained from the previous level affect the proceeding level. For example, *constitutional* rules refer to who, when, and how can participants engage. These then affect the *collective-choice* activities, where choices about which institutions or strategies should be used in

resolving collective decisions. These collective-choice rules then influence how day-to-day transactions and decisions are made by the participants in *operational* situations.

This approach is a particularly useful way of examining how various rules and interactions emerged from the GMHSC Partnership and the organisations involved in it, and how the decision-making processes at different levels of Partnership activities occurred. In the *operational* situation, we focus on how the key stakeholders and partner organisations interacted with one another to deliver and implement the GM Strategic Plan. In the *collective-choice* situation, we look at how the Partnership acted as the steward to GM's health economy and how it fulfilled its oversight role in strategy building, delivery, and monitoring and assurance. We also want to explore how various participants come together in the collective-choice action arena to make decisions collaboratively and collectively. Lastly, the *constitutional* situation refers to the role of NHS England as a key player to the GMHSC Devolution agreement and how it controlled the collective-choice activities by implying national mandates and regulatory roles.

This section particularly addresses our third research question:

- How are institutional arrangements influencing the different levels of collaborative processes in the governance of the health commons?
    a. How is the interaction of formal and informal institutions affecting the different levels of relationships between the participants?
    b. How are the rules-in-use (informal) utilised to facilitate the relationships within the collaborative governance?
    c. What are the collaborative mechanisms used by the decision-makers to enforce collective action?

7.2.1 Constitutional situations

In this section, we look at the constitutional activities, which are primarily the events leading to Devolution and how emerging institutions (i.e. constitutional rules-in-use) potentially impacted the facilitation of the GMHSC Partnership in the collective-choice level. We focus on the role that NHS England played in the constitution level and how this affected the interactions in the collective-choice and operational situations.

7.2.1.1 Formal institutions

In order for Health Devo to materialise, formal institutions (e.g. rule of law or binding legal documents) were put in place. As we recall, formal institutions play an important role in fostering local and regional economic development and legitimising collaborative governance (Feiock, 2008; Rodríguez-pose, 2013; Pike et al., 2015). The Devolution agreement is an example of a formal institution examined in the local economic development setting, where powers are shared or decentralised across specific multi-agent geographical levels. Pike et al. (2015) described that the extent and nature of decentralisation within governance systems play an important role in explaining the types of institutions that shape and regulate the behaviour and relations.

As illustrated in the previous sections, the Health Devo in GM emerged with no statutory basis. Unlike the 2012 Lansley reforms, the overarching legislative framework supporting Health Devo was through the 'Warner amendments' (The King's Fund, 2015) to the *National Health Service Act 2006* via the *Cities and Local Government Devolution Act 2016*. This only outlines the range of devolved NHS functions to combined authorities or local NHS organisations acting together through a joint committee, but in itself does not transfer the 'N' out of the NHS to ensure that the national standards and assurance processes are not lost in the devolution process.

7.2.1.1.1 De facto meta-governance

Formal institutions also act as an incentive for collaboration, particularly in agency-based collaborations where participation is oftentimes mandated by legislature, which in turn creates legitimacy (Moore and Koontz, 2003; Diaz-Kope et al., 2015). In the case of the Partnership, the absence of the statutory basis to drive "true" devolution of NHS functions to GM fails to mirror the full effect of the city-region Devolution agreement. This reflects the weakened local autonomy characterised by centrally-controlled policies, described as "contractual localism" by Deas (2014) and "centrally orchestrated localism" by Shaw and Tewdwr-jones (2017).

The outcomes of the negotiation for the Devolution agreement illustrate that NHS England is still playing the role of a "meta-governor" (Jessop, 2014) orchestrating control mechanisms to assert political authority whilst also indirectly influencing the practices and preferences of distal networks and hierarchies to promote their agenda. This was visible throughout the institutionalisation of the GHMSC Partnership. An MoU was used as a formal institution to define the joint-working relationships between the local organisations involved in the GMHSC Partnership. The absence of legislation meant that NHS England was able to preserve the national characteristic of the NHS by ensuring that not all statutory responsibilities were fully discharged to the GM. It was a hands-off mechanism that allowed them to exercise influence whilst giving the Partnership some level of autonomy in defining their own paths and setting their own strategic agenda. This was demonstrated by some studies on the English devolution deals (Bailey and Wood, 2017; Ayres et al., 2018) as a way of the central government regaining control and exerting an arms-length influence over the devolved regions.

The established institutional arrangements were met by a mixture of reactions amongst the different stakeholders. NHS England remained very much involved during the negotiation stages and the delegation of functions was the prescribed route instead

of full devolution. The reason behind this is that NHS England wanted to preserve the national characteristic of the NHS by ensuring that not all statutory responsibilities are fully discharged to the GMHSC Partnership (The King's Fund, 2015).

A few were rather critical about the central government's lack of enthusiasm or general interest to create primary statute to fuel devolution, mainly because of the fact that the Parliament has other things to worry about (i.e. Brexit) or that the NHS is reluctant for another restructuring of the system (G05, L05, P03, P04). It was also running the same time the parliamentary process around Cities and Devolution Bill was happening, so it was important for GM leaders to continue negotiating for Devo Health without breaking the momentum of securing the agreement (G17).

Given that the government did not really have the best track record when it comes to restructuring the HSC system as demonstrated in previous chapters, it was almost understandable that GM had to settle for the delegation route rather than plead for further devolved powers. They practically took whatever was offered in the table (G05, G12, G17, L05). An interviewee depicted the NHS as an "oil tanker" (L05), where once you set it in course towards a particular destination, it is very difficult to steer it or change its direction. This meant that it takes a lot of time and effort to advocate for a statutory change within the NHS, especially after the current system is not fit for purpose as a result of the HSCA 2012. Time is, therefore, of the essence, and with the current complexities presented in changing legislation, GM leaders accepted the deal instead of spending resources to convince the NHS to take the legal devolution route. They had to take the route of forming a non-statutory body through partnership or joint working agreements forged by the signing of an MoU (G05).

> *"The restrictions on what we could do was first of all there was no change in the structure of the NHS for Manchester. So, we had to take in all of the arrangements that existed… We didn't really have a legal vehicle for devolution at that point… We didn't want to lose the momentum. So, we went for the next*

available option… which means that… we're not a statutory body, you know, we're a partnership of all the organisations." (G17)

That being said, some participants felt like GM Devo Health deal it was being enforced or mandated rather than encouraged (P03, P04). Since without written statues, NHS responsibilities cannot be devolved legally, thus, the MoUs were put in place "to push collaborative work despite the statutes separating it" (P03, P04). This only caused misunderstanding as to what the true meaning of Devolution is about especially when on a hindsight, devolution does not really entail what it's meant to be.

"So practically it's devolved but they can't say legally there, because legally we require primary statutes to change, unpick all the Lansley reforms and to do all of that, parliament have got something else on their plate, appears to be bit busy doing something else at the moment. So, we're pushing integration as far as we can despite statute, actually not promoting it. So legally nothing." (P03, P04)

The power awarded to GM was therefore, in some respects, an illusion (G03). Whilst it alleviates the GMHSC Partnership from the bureaucratic processes and enables them some level of freedom to do things differently, the irony is that GM is still subjected to NHS constitution and mandate. This was illustrated in the GM Strategic Plan, where transformation programmes such as decreasing A&E waiting times and the implementation of the locality plans were patterned against the NHS Five-Year Plan. A Partnership project management director said, "The central national governments said yes it's something that we're prepared to consider, but we want to see a coherent Five-Year Plan for Greater Manchester." (G05). This was a way of NHS England practicing its meta-governor role by "steering, not rowing" (Hammond et al., 2019) and making sure that GM still complies to national policy.

A senior local authority leader, however, highlighted that the intention of the NHS to preserve the 'N' is problematic in a way that not everything has to be implemented on a national level across the rest of the country (L05). The NHS needed to acknowledge that different regions have different needs in terms of addressing their population's own health outcomes, thus making it quite difficult to achieve improvement if devolved regions are still subjected to national assurance and control.

> *"One of the weaknesses of the NHS is that N, the national. We're trying to have everything done the same across the country. But we're the only part of that England that has this devolved part. It's not full devolution. We're still subject to all the controls that other parts of the country are from NHS England, but we do have more powers to do things differently in Greater Manchester." (L05)*

As part of the Devolution agreements, lines of accountabilities and statutory responsibilities were retained. We have illustrated in the previous chapters how this has affected the formal institutions that the Partnership has created in order to facilitate the working relationships and lines of reporting between its member organisations or key stakeholders. Governance arrangements were established, and in effect, the core Partnership team became a regional office of the NHS England. Some statutory functions were delegated through the Chief Officer, and the Chief Officer reports back to NHS England, ensuring that the GMHSC Partnership delivers what was agreed in the MoU and GM Strategic Plan.

These formal institutions were created to add another layer of complexity to the health and social care system, only for NHS England to play a domineering role and create constraints on how the local NHS organisations interact. Although GM was able to draft their own devolution proposals and set boundaries on how they want to take control of the system, NHS England was still able to set the 'rules of the game' on how much power is to be situated at the collective-choice level. The language of "devolution"

and “partnership” also caused an atmosphere of confusion and fragility to the local stakeholders (Lorne et al., 2018), masking it as a way to cultivate a collaborative and integrated atmosphere (P03, P04) when in reality, GM was only given limited power and autonomy.

7.2.1.2 The presence of key leadership roles

The conversation on devolution of health responsibilities started as part of the initial Devo Manc package. At that time, the debates were focused on other areas like skills and transport, and the potential of health devolution was recognised. It was referenced on the 2014 Devo Manc deal and within two months, Devo Health was quickly secured (G17).

Political leadership played an important role in driving the devolution deals forward for GM (C04). Gray (1989) and Wood and Gray (1991) identified the presence of leadership roles in collaborative settings could bring and assemble the necessary stakeholders to the table. Moreover, the presence of powerful and influential may also encourage trust amongst the participants, thus ensuring a more successful collective action (Ostrom, 2000). Since health was not initially offered when Devo Manc landed on the table, key local political and NHS figures worked relentlessly to push for delegation of health functions to be included in the NHS agenda. “There were a couple of key people that kind of came together and started discussing, lobbying George Osborne, help him seeing some of the local NHS players,” a Partnership senior director narrated (G13). Ian Williamson, who was then the Chief Officer of Central Manchester CCG, was brought in to lead the NHS side of the work to set-up and to begin driving conversations on what Devo Manc might mean for health, (G13) along with Sir Howard Bernstein, Chief Executive of Manchester City Council, who represented the local authorities (LAs) and played an influential role in securing Devo Manc (L05, G17). Other local leaders and key figures from the GM Combined Authority also emerged for the negotiations. Simon

Stevens, Chief Executive of NHS England, was also invited to attend a number of those meetings to work on what became the Memorandum of Understanding (MoU), which was eventually signed off by the 37 GM NHS organisations and local councils.

Because of the way GM has evolved over the past decades after the abolition of the GM City Council (GMCC) and the formation of the Association of GM Authorities (AGMA), it was only natural for a leader to emerge and lead the city-region to transformational success. This figure was Sir Howard Bernstein, and for most, he was regarded as a "star of British local government" (Halliday, 2016) and "the lead chief executive for the whole of Greater Manchester" (L05). Sir Howard Bernstein's presence and influence over the years helped him build a local reputation, which eventually led for GM leaders to trust his skills and decisions. A CCG board member says, "locally in Manchester, when he said I'd like something to happen, people usually went that's a good idea." He played an influential role in not only securing the devolution deals for GM, but also the additional £450 million Transformation fund to boost the GMHSC economy and change the direction of the NHS (G13, L05). "It was his skill really that helped to get the devolution deal across the line, he's very clever to do that," says an LA Senior leader (L05).

Almost without any consultation from the public and with the health deal being secured in a matter of months (G13, G17), the decisions were agreed upon by a small number of key officials from the government, NHS England, and the GM Combined Authority. This was a common theme in the English devolution deals, which illustrated the presence of court politics (Ayres et al., 2018) where policy is driven by a single person, in this case, Sir Howard Bernstein, with a small following of key individuals to form the decision-making political elite.

Whilst Devo Health was being negotiated, Devo Manc was also running in parallel. With the introduction of the newly elected Mayor of GM Andy Burnham in 2017, it was questioned as to how he will situate himself in the devolution of health and social care in GM. When the Devolution deal was being struck, the government insisted for GM to have an elected Mayor and not everyone was keen on this idea. However, in order for Health Devo to push through, GM had to accept the package deal being offered (G17, L05). The Mayor has formally no influence nor any statutory responsibility for health, which means he has no decision-making power over the decisions that is being made by the Partnership (see *Cities and Local Government Devolution Act 2016*; GMCA, 2016). The absence of this, however, does not discount that it is a mechanism for depoliticisation by NHS England (Lorne et al., 2018; Hammond et al., 2019). The Mayor still sits in the Health and Care board meetings, although his presence is merely to show a united front and agreed representation between GMCA and the Partnership regarding public service reform (G16).

In short, the Mayor has soft powers and has no statutory control as to what happens in the GMHSC system (G14). They do, however, have joint working relationships with the GMHSC Partnership to make sure that the transformation programmes, such as Population Health and Workforce Development, are aligned with GM's public service reform plans.

> *"What makes Manchester unique is the two of them existing. Because there are other levels of devolved health out there, we are not as unique as we like to think. There are other health structures out there and there are other devolved sort of combined authorities. What there isn't is the two of them mirrors and connected together. That is the perfect storm that makes Manchester unique." (P05)*

Andy Burnham's entrance to the GMHSC Partnership created a unique and almost synchronic link with the GMCA (G03, P05), which in effect, impacted the way participants interact in the activities in the collective-choice level. The newly established governance structures ensured that the Partnership has a link with the GMCA through the Reform board, which is the committee in charge of providing strategic leadership in developing integrated public services in GM (GMCA, 2016c). Whilst gluing the two pieces together may be ideal, it did not really reflect in practice. The GM Health and Care board and Reform board have very similar membership, although their functions and governance styles are different making it more difficult to link up together. HCB merely reports a summary of their meetings into the Reform board, which is then reported into the GMCA and the office of the Mayor. Some of the Partnership staff report to both Partnership and Reform boards, but they are not accountable to the GMCA nor the office of the Mayor. A Partnership project management lead reflected, "what we know is if somebody is not accountable then generally, stuff doesn't end up going their way," (G14) leading to difficulties in discussion with separate parts of the system working in parallel governance and resulting into further fragmentation. The Partnership is not adequately influencing the Reform board at this stage, and this eventually became an inherent weakness in GM since there is little integration for public service and health reform.

At the same time, another key figure emerged to take command in steering the direction of the GM health and social care economy. As mentioned in the previous chapter, governance studies suggest that strong and flexible leadership is crucial in ensuring the success of the collaborative process (Ansell and Gash, 2008; Heikkila and Gerlak, 2018). When the shadow governance transitioned to the operationalisation of the GMHSC Partnership in April 2016, Jon Rouse was appointed by NHS England to take on the role of Chief Officer. He is ultimately accountable to NHS England ensuring that the key stakeholders deliver the NHS Constitution, and has received delegated NHS functions, such as strategic leadership, direct management, and CCG assurance to

name a few. More importantly, he plays a key role in terms of providing a solid leadership status within the Partnership, which created a huge impact as to how participants behave and make decisions in the collective-choice level.

Jon Rouse's appointment was mostly met with praise by the interviewees. He was regarded as a key driver of the team and an inspirational figure, who motivates the key stakeholders and partner organisations to work harder and collaborate together (G04, L04, L06). He has the vision to drive things forward and has the ability to facilitate conversations, making his addition to the GMHSC Partnership all the more prolific. Some believe his influential presence bred a positive mindset of "working differently" within and between organisations (G04, F01, P05), making it easier for the Partnership to navigate through the governance structures. For instance, a Partnership program management lead suggested that "if we sometimes say Jon Rouse is really keen on this, and Jon Rouse wants this to happen, that makes a difference," in terms of implementing programmes of work (G04). Another also shared that Jon Rouse's impact to collaborative working across NHS organisations led to opportunities and conversations that they never had before Devolution. An FT Senior project director was asked to draft a letter addressing Jon Rouse to promote their programme of work to the NHS GM institutions and described, "…I have an opportunity. I'd never get that opportunity in London to do that." (F02)

Interviewees think that the presence of both Jon Rouse and Andy Burnham were key to breeding successful relationships within the GMHSC Partnership (L04, P05). They were the two pillars of Devo Manc, holding the entire city-region together and putting it on a pedestal for the rest of the country to see. Both of their outstanding reputation as leaders have created a magnet effect across different areas by attracting a high calibre of professionals who would want to work with the various localities and NHS organisations in GM (L04). These coincide with what literature suggests about the

presence of influential leaders that could help sustain the collaborative governance as they continued to evolve (Gray, 1989).

> *"And that also is very interesting dichotomy, that relationship between GMHSC and the work that John Rouse is doing, Jon Rouse's vision, and then alongside Andy Burnham. The vision where that's going and how the two of them interlink, that is the uniqueness of Greater Manchester. The fact that both of them are existing in synchronicity with each other. That's what's unique about it." (P05)*

7.2.2 Collective-choice situations

GM already has an inherent culture of collaborative working where local NHS organisations and local councils have already forged collective informal networks; but Devo Health became an institutional vehicle to formalise these existing relationships and facilitate new ways of joint working. From the constitutional level, we learned how NHS England played a domineering role in setting the rules on how the GMHSC Partnership governs the health and social care economy of Greater Manchester. Whilst the Partnership was given some level of autonomy to create internal frameworks to guide their collaborative working, NHS England still exercised a high degree of control through the transfer of some NHS functions to the Chief Officer. The Chief Officer is an NHS England employee, who inherited the responsibilities of a delegated accountable officer of the GMHSC system to the NHS. At the same time, the entrance of the elected Mayor of GM also moulded new working relationships between the Partnership and GMCA.

In this section, we look at how all of these impacted the activities in the collective-choice level. We review how the GMHSC Partnership crafted, enforced, changed, and monitored more rules in order to take responsibility for the stewardship of the health and care economy of GM and to facilitate the collective action behaviour and decision-making process of its participating members.

7.2.2.1 Formal powers

In the previous chapters, we illustrated that the GMHSC Partnership was formed as a governing body responsible for the collective management of the GM health and care economy. However, it was not established as a statutory body and only received limited delegated powers from NHS England through legislative amendments to the *National Health Service Act 2006* via the *Cities and Local Government Devolution Act 2016* Schedule 4. This meant that a significant degree of national oversight and control remained with NHS England and the Secretary of the State, and existing organisational statutory responsibilities and lines of accountability remained. The lack of legislative vehicle to create a 'hard structure' for Devo Health meant that other forms of mechanisms were used to formalise the newly formed GMHSC Partnership. The Memorandum of Understanding was the only formal institution representing the agreement between the partner organisations, outlining the common intent of Devo Health and identifying the roles and responsibilities of those involved. This set-up meant that GM still remains part of the NHS social care system subject to the NHS constitution and mandate.

Table 15: Partnership crafted and enforced rules in collective-choice level

Activity	Crafted and enforced rules
Membership	Signing of MoU to signify commitment to the collective vision of GM
Employment arrangements	Secondment; fixed-term contract; appointment on a permanent basis
Shared resources	Transformation fund; delegated responsibilities from NHS; pooled budgets and shared workforce
Strategic direction	GM Strategic Plan 'Taking Charge' and 10 locality plans
Operation	Established evolving governance structures suitable to current needs
Decision-making entities	Health and Care board and Partnership Executive
Access to resources	Transformation fund assessment; locality plans

Representation	Key stakeholders and partner organisations occupying positions within the governance structures
Monitoring and enforcement	Assurance and monitoring framework; formal reporting lines

These constitutional level rules restricted the way participants in the collective-choice situation interact. The key stakeholders of the devolution agreement were all statutory bodies (i.e. 'hard structures') with existing responsibilities and reporting lines, hence, the Partnership had to resort to collaborative mechanisms or informal institutions in order to overcome the absence of legal power to exercise mandate or enforcement over the partner organisations (i.e. CCGs, Trusts and FTs, etc.). This was supported by overarching governance structures to order the relationships and organise powers and collective behaviour of the participating organisations. Strategic oversight, decision-making, and monitoring and assurance frameworks were also set to suit their local needs. To complement these, the Partnership strengthened collaborative working by utilising the existing informal networks (i.e. 'soft structures') as channels of information and exchange of knowledge. Primarily built on trust, reputation, and reciprocity, the Partnership core team used unwritten shared understandings (i.e. norms or social arrangements) to structure patterns of interaction with the key stakeholders and partner organisations.

7.2.2.2 Soft powers

The Partnership has no legal mandate or mandatory requirement to enforce the GM Strategic Plan to the key stakeholders and partner organisations; thus, to create order and mobilisation of relationships, governance structures and guiding frameworks were established (Thomson and Perry, 2006; Imperial and Koontz, 2007). Each stakeholder occupied a position in the decision-making arenas (i.e. Health and Care Board, and Partnership Executive) to create equal representation, and internal staff team members

from various NHS organisations were brought in to provide leadership and project management roles.

Our evidence suggests that there was a predominantly top-down approach on two of the Partnership activities, particularly during the (1) strategy building; and (2) monitoring and assurance. Whilst in theory, the Partnership wanted to empower the key stakeholders (i.e. the providers of service) and allow them to take ownership on the implementation of the strategy, they instead played a dominant leadership role in directing the member organisations to agree and sign-up to the strategy or proposals and in monitoring the progress of the programmes. The Partnership relied heavily on face-to-face dialogue to build up the relationships and as the collaborative process matures from the direction-setting to the implementation stage (Ansell and Gash, 2008).

During the planning phases, the activities were focused on building and developing a strategy that will guide the driving purpose of the Partnership. During its formal operation in April 2016, a lot of the governance structures were already in place; however, majority of the strategic documents and protocols for quality assurance, regulation, etc. were still being developed. Project proposals were being distributed across the governance as part of the engagement process and the Partnership's role was concentrated on ensuring that all affected or involved stakeholders will sign up for it. The activity occurred at the lower levels of the governance and climbs up the middle tier (e.g. advisory boards) for recommendation, then onto the upper tier (e.g. decision-making bodies) for deliberation and final approval.

To illustrate, let's say a project management group is assigned to develop and design a programme strategy. It is comprised of multiple Partnership staff whose roles are focused in creating a single document that summarises the case for change for a certain policy area and ensuring that all the group stakeholders are aware and are signed up for it. A programme strategy is usually informed by the GM Strategic Plan 'Taking Charge',

which already outlined programmes focused on national targets, a previous GM agenda pre-dating devolution, or an issue that has recently became apparent. It goes through a series of iterations, making sure that everyone that needed to be involved were aware of what's going in the strategy, what role they play in, and how is it going to impact their respective organisations if the strategy is implemented.

Although majority of the proposals, at that time, were co-designed with the participating partners, it was mostly influenced by an overarching national strategy (i.e. The Five-Year Forward View) or a national must-do or 'ask'. The strategies were driven by project managers and programme leads employed by the Partnership. They created, coordinated, and socialised the overall GM strategy to the wider community in order to raise awareness and engage the operational levels (i.e. the providers of service) into committing to the overall collective vision towards the GMHSC economy. The interviewees emphasised this aspect of strategic building as co-production and co-designing (C01, G01), where it particularly focuses on the level of involvement of the different stakeholders in the creation and development of the strategies and programmes. The Partnership made sure that all levels of the governance structure have seen, read, engaged, and discussed all project proposals, strategic documents, and frameworks prior to approval by the decision-making bodies. This allows not only an opportunity for the participating organisations to identify best practice, share their expertise, and provide collaborative input, but also a way for them to incorporate their local needs to the overall collective direction of the GMHSC economy (G01, G04, C02). A CCG integration lead shared, "if it's co-designed and they reach out to localities in the development of it, you help with the strategy and it has a strong flavour from each area." (C02)

Once everything is set and approved for by the HCB, it trickles back down to the operational level for implementation. The co-designing of the strategy and frameworks,

in addition to the signing of the MoU, provided a leverage for the Partnership to have some teeth in terms of implementation, monitoring, and assurance. Because they have no hard mandatory powers to enforce the strategy, they used it as a buy-in mechanism for all participating organisations to take ownership and collective responsibility of what they originally signed up for (C01, L04). However, a Foundation Trust officer explained that they don't necessarily sign in agreement with a project proposal to fund it or guarantee implementation; but rather it's more of an "…agreement to actually do the changes because it's for quality and service and it's for patient outcomes" (F02).

Whilst the Partnership tried to play a passive role by allowing the key stakeholders to co-produce majority of the frameworks (i.e. crafting their own rules), majority of the initiatives and key decisions were made by the HCB and Partnership Executive. They still applied a top-down approach in terms of enforcing and monitoring who follows the rules of the game. NHS England delegated some monitoring and assurance functions to the Partnership, including driving the improvement of quality and maintaining the constitutional and mandated requirements. Documents clarifying accountability and monitoring principles were drafted in order to arrange how positions and actions will be scrutinised. Moreover, when the Partnership took responsibility of collectively governing their own health and social care economy, it also included looking after some of its shared resources (i.e. the Transformation Fund). The Transformation Fund was an important source of financial flow across all localities and arrangements had to be put in place in order for the Partnership to decide who can acquire from this resource, how do they become eligible to receive it, and how do they monitor if the receiving party is utilising it as initially agreed.

Although NHS England limited the level of autonomy that the Partnership can exercise towards the health and social care economy of the city-region, the Partnership team has crafted formal structures (e.g. governance, operating frameworks, monitoring

principles, etc.) to guide how participants position themselves in the decision-making arenas, which actions or information to take based on their motivation or incentives, how to order their relationships and interact with one another, and how to monitor each other's progress and compliance with national and local mandates.

7.2.2.3 Trust, reputation, and reciprocity

Collective action theory posited that institutions, including rules, norms, and strategies, structure the behaviour of the participants in a collaborative and collective agreement (Ostrom, 2005, 2011). As participants continue to interact, they adopt rules and norms that govern their collaborative activities. Whilst formal rules were used to structure the relationships, informal institutions like shared norms were also found useful in facilitating the collaborative processes (Rodríguez-pose, 2013; Heikkila and Gerlak, 2018).

Our evidence suggests that although the Partnership operated in a hierarchical manner supported by formal structures such as governance and operational frameworks, they also relied on informal institutions to order their relationships and overcome the limitations brought by the formal structures. For instance, the Partnership exhibited a strong foundation of organic cooperation built from decades of trust and reputation building. They displayed high levels of interdependence by coming together in order to accomplish something as a collective, which they are unable to do so on their own.

The Partnership took advantage of the informal networks formed pre-dating Devolution and used it as a channel to bridge the gaps in the system. Because these relationships were already built in decades of mutual trust and reciprocity, it was easier for the Partnership to bring sectoral groups together and provide a forum for them to generate a collective voice. For example, the formation of the Advisory Groups incorporated the GM Association of CCGs, Provider Federation Board, Primary Care Advisory Board, LCO Network, and Joint Commissioning Board, and gave them a role

in terms of providing non-binding advice to the main decision-making bodies of the Partnership. They share an advisory capacity to facilitate discussions and provide recommendations based on their knowledge and expertise on their particular sector or field of work. This was particularly evident during the strategy building phase, where the Advisory Groups were engaged in refining the documents presented to them. Since these groups have already existed long before Devolution was formed, incorporating them in the Partnership governance helped facilitate relationships between existing groups and newly formed streams of programmes.

More importantly, informal networking became a useful tool for the Partnership to facilitate conversations, engage in discussions, resolve conflict, and monitor compliance between the members. We illustrated in the previous chapters how the Partnership used principled engagement and face-to-face dialogue outside the formal forums (i.e. meetings, etc.) as collaborative mechanisms to getting the right people to come to the table and sort out their issues or differences before any decision reaches the Partnership Executive board or Health and Care board. This was the Partnership's way of playing the role of a mediator, but also establishing trust amongst each other and earning the key stakeholders' respect at the same time. By creating new rules on how to exercise joint working in a different manner, the Partnership was able to overcome the limitations and organisational barriers that was brought about by the existing fragmentation in the GM NHS system.

Whilst there were some pockets of resistance and tensions during the establishment of the Partnership from different key stakeholder groups, there was still a strong presence of collective ambition. Although GM already displayed exemplary collective behaviour in the past as illustrated by their decades of organic cooperation and formation of soft networks, Devo Health provided a new vehicle for the Partnership to make a difference. Having this strong collective interest and shared understanding of what they

can achieve collectively created positive incentives for them to engage in collaborative working. A lot of the driving force comes from the leadership groups, particularly Jon Rouse and his executive team, who encourage its members to work collaboratively in order to share best practice and create better outcomes for GM. “I think it's brought a spotlight on a new and innovative way of working that we're really lucky to be part of,” an LA councillor illustrated (L03). There is a great desire to lift the standards up and improve health outcomes for the population of the city-region and put GM on the map as a pioneer model for Health Devolution across England.

There was also a level of “we signed up for this” attitude or co-ownership of problems and decisions became a useful mechanism for the Partnership to enforce rules in monitoring and assurance, whilst also fostering strong community roots. Interviewees suggest that the Partnership has given them an opportunity to work differently. For some, it was quite empowering just to have ownership and to take charge of their own health and social care economy (C01, F01, G08, L04, P08). For localities that are so tired of getting dictated by NHS England on what to do and how to handle their resources, it was a breath of fresh air for them to be given the responsibility and encouragement to come together and do what they think is best for their area (C01). Because the Partnership and its participating members have ownership on its plans and the rules that they crafted to facilitate their decisions and interactions, it fostered a new atmosphere of collaboration that has not been done before in GM or anywhere else in the country.

> *“More subtly, I think it's given us permission to behave differently, to think at scale, to be innovative, to use a different language in a way that we couldn't before. And I think it also allow us to do is take action at a different scale than we ever could have previously. You hope that by taking action at scale, you have a scale impact as well in a way that we couldn't do before.” (G14)*

This built up reciprocity between the members, wherein there is almost an immediate sense of pride that supported the way they interact in the collective-choice level. “When I speak to my colleagues in Merseyside or in London, they say ‘You're so lucky to have GM devolution,’” an LA councillor said (L03). It enabled for stronger links between one organisation to another, which provides opportunities for mutual exchanges to occur. It also helped build a collective reputation for GM and brought other similar city-region’s attention to GM’s innovative way of working.

Some people were not too keen in signing up for Devo Health and were a bit sceptical on what it can achieve collectively. Because the NHS is exercising an arms-length influence over the devolved combine authority by retaining the same accountability lines and without statutory basis, clinicians and general practitioners alike have expressed their pessimism regarding the change it will actually bring (P02, P03, P04). The Partnership, therefore, had to find ways to overcome this barrier by portraying different roles in order to earn trust and reciprocity, and gain a positive reputation amongst its members.

One of the roles that they played was an influencer. This is one of the rules-in-use that evolved as a response to the constrained interactions within and outside the collective-choice level. Partnership members used this as a mechanism to bridge relationships at different levels within the Partnership, especially in areas where there are existing tensions between local NHS organisations and local authorities. Influencing was used in various Partnership activities to persuade people to change their opinions, lobby for ideas, or get their foot in the door to bring together and speak with the right people. Some believe that the Partnership also brought in members with influential status, like Jon Rouse and his executive team, who have the ability and power to get things done and breed a new organisational culture of collaborative working. This further solidified the existing relationships that have already been cultivated in GM for decades.

Another role that the Partnership played was a broker. The Partnership acted as negotiators across the different sectors in order to facilitate conversations and resolve issues before it reaches any formal decision-making venues. They were the middlemen during discussions, where they practically diffuse or rectify any source of conflict or consolidate opposing views in order to avoid friction in relationships and further escalation. This ultimately helped in making difficult conversations happen through informal conversations outside meetings. Since the system was used to a competitive way of working, the Partnership had to proactively manage the fragmented relationships and join the dots by bringing all the right people in the same room and facilitate debates or discussions.

Being a broker was mostly helpful during the monitoring and assurance phase, when the Partnership find it difficult to sanction any partner organisations or localities who were not complying with the agreed proposals or programmes that they were expected to deliver. They used this as a hand-holding mechanism to walk the member organisations through on how they can get from point A to point B and achieve the necessary outcomes that they collectively signed up for. Formal mechanisms were also put in place, such as monitoring and evaluation frameworks established, to formally evaluate the performance and quality of its participating organisations, the work programmes being implemented, and compliance to the NHS constitution. Although for as much as possible, the Partnership wanted to avoid any form of formal escalation and preferred to resolve any difficulties before a recovery plan is put in place. They step in and assess the severity of the situation and enter a negotiation process with the parties involved to address the issue before it reaches the decision-making bodies.

McGinnis (2013) suggested that relying on formal mechanisms is costly, which is why smaller communities with elite leaders usually rely on informal ways (such as social shaming) to exercise monitoring power. Although the Partnership’s conditions were not

really ideal to promote social shaming as a mechanism for monitoring compliance, it relied on its partnership organisations' commitment or "social contract" (P05) to agree with the working principles outlined in the MoU. Because none of the Devolution agreement has any legal mandates, the organisations who signed up for Devo Health were all working based on their existing social attributes (i.e. trust, reputation, reciprocity) and working relationships (i.e. built-in informal networks, tensions within the system), which they have formed from their previous experiences

Perhaps the most important role that the Partnership played is being an enabler. They, first and foremost, brought closer a new funding stream (i.e. the Transformation Fund) to enable transformative projects to take place within localities and give the opportunity to deliver better outcomes and close the financial gap. Second, the evidence suggests that it is the Partnership's role to enable the system to achieve the outcomes outlined in 'Taking Charge' in as many was as possible. Whether they engage, influence, socialise, or facilitate conversations, they needed to craft their own rules and enforce it in innovative ways in order to maintain collaboration and foster trust amongst its members.

Whilst the importance of having a legal route would have been ideal, this does not mean that polycentric systems like the GM health and social care system would fail or not be sustainable. Drawing comparisons with the existing devolved nations (i.e. Scotland, Wales, and Northern Ireland), a Partnership senior director (G08) said that, "statutory devolution doesn't make people work together" despite the appetite to pursue the legislative route. Our research shows that the GMHSC Partnership was able to overcome the existing fragmented and/or competitive relationships by devising institutions that rely mostly on social attributes and complemented by hard structures. The Partnership's lack of hard powers was complemented by utilising the existing levels of hierarchies, markets, and networks as a foundation to building bridges and forging

better relationships. Whilst they did not have the mandatory legal power to enforce any of their strategic proposals or programmes of work or exercise any formal sanctions to rectify their members' non-compliance behaviour, they used collaborative mechanisms primary relying on trust, reciprocity, and reputation to facilitate relationships and promote collective behaviour.

> *"I think at the moment what we're really struggling with at the moment is the various different power dynamics that exist in the system. The hard and soft power that exists. So ironically enough the only hard power in the system exists within GMCA and the DPHs, but those driving the agenda are the partnership who only have soft power around health and wellbeing and population health. And the mayoral office which only has a soft power here has no statutory powers around health and wellbeing. So, there's a lot of power dynamics playing out at the moment and lots of kind of storming, norming and forming around the way that different parts of the system work collectively together. Who has primacy? Who has leadership? Who has the ability to set an agenda or veto agenda items? All that's playing out at the moment and it's really a major challenge but something that was always going to be a challenge. But we will come out to the other side of it. It's an interesting one." (G14)*

7.2.3 Operational situations

In the previous section, we examined the collective-choice level and how the Partnership reacted to the constraints set by the constitutional level. We learned that although the Partnership relied on its soft powers and top-down approach to impose the rules that they set to govern themselves and the GM health and social care economy, they still had to resort to informal institutions to facilitate the collective behaviour and interaction of the participants in order to attain their intended outcomes. This was characterised by establishing high levels of trust through various collaborative mechanisms, utilising existing networks to bridge relationships, and creating new ways of integration and joint working.

In this section, we explore how the organisational level (i.e. the providers of service, the key stakeholders, etc.) reacted to the emergence of the Partnership and how it constrained or improved their interaction both in the operational and collective-choice levels. Whilst we focused on the strategy-building and monitoring and enforcement in the previous sections, the operational level primarily focuses on the Partnership's activity of implementing the work programmes. We dive into the existing tensions between stakeholders and if the Partnership has addressed them, and how organisational culture played a big role in preventing them from fully experiencing the new ways of working that the Partnership is advocating for.

7.2.3.1 Localities

Localities are the core of the delivery process (GMCA and NHS in GM, 2015g). They drive the outcomes for change in GM's collective ambition and their participation is crucial to the success of Devo Health. Evidence suggests that the Partnership did not want to impose a single, centrally led strategic plan without having to consult each of the 10 localities and asking them how they will contribute to shape the delivery of services within their own geographical footprints (G05). In order to orchestrate this, each of the 10 localities in GM drafted their own locality plans focusing on delivering integrated care in the community-based rather than hospital settings. These eventually became the foundation to the overall GM Strategic Plan 'Taking Charge', driven mostly by the transformation themes. Injected by the Transformation Fund, the 10 localities of GM had the task of delivering local needs through integrated provision of services to eventually improve the overall population health outcomes of the 2.8 million residents of the city-region.

The locality plans acted as strategic support to realising the overall GM vision. Theme 2 of 'Taking Charge' focused on transforming community-based care and support, which was led by the 10 localities to support the integration of community health and social

care services into place-based approach. In order to operationalise and govern these proposed changes, Local Care Organisations (LCOs) were established as a form a multi-agency partnership between the LAs, local NHS organisations, third sector providers, and other public services within their respective areas. Whilst these arrangements were already existing nationally prior to devolution through Accountable Care Organisations (ACO) and Integrated Care Partnerships (ICP), LCOs were standalone organisations which acted as a local adaptation to these existing policy initiatives. They were intended to provide an alternative to the hospital culture and reduce existing service fragmentation in GM inherited from previous health and social care reforms as part of the Devolution reform (G05, Walshe et al., 2018).

One of the positive contributions of this initiative was that it gave the communities to work at scale and coordinate local services in order to reduce costs and hospital admissions and create a sustainable health and social care system. To illustrate, person and community-centred approaches were developed to transfer acute care closer to the homes and neighbourhoods. “You'll be treated at home closer to your family, in your own environment, there will be specialist staff within your neighbourhood who will come and look after, you don't need to go to a hospital,” a Partnership project management director described (G06). In some places where there is a lack of NHS organisations to support this to happen, third sector organisations (i.e. voluntary, community and social enterprise or VCSEs) come into play. They act as providers of non-clinical care and support services and become crucial part of the LCO architecture. They usually exist outside the formal health and social care structures, but deliver a range of community-based services and support to localities that are oftentimes far cheaper than hospital services can do (G07).

Another positive impact was the Transformation Fund bringing in an extra bootstrap of cash that allowed localities to bid for and capitalise their locality plans. Rather than

having to bid for a national fund and compete with other localities for a single pot of money, Health Devo allowed GM to receive a pot of cash fully devolved to them (i.e. the Transformation Fund) and give the 10 localities access to it through a secure process that the Partnership devised. Incentivisation has become a common theme to encourage competition between neighbouring areas, where poorer areas lose out on more affluent areas over funding allocation (Ayres and Pearce, 2013; Deas, 2014; Bailey and Wood, 2017). The TF therefore acted as an incentive for localities to put forward a strong locality plan that aligns with the GM Strategic Plan 'Taking Charge'. Collaborative governance literature suggests that incentives influence an individual's level participation and motivation to contribute towards the collective action (Ostrom, 1999; Ansell and Gash, 2008). When there is a reasonable expectation for participants to enjoy the benefits from it, then the more likely they are to be motivated to contribute to the collaboration. In the case of the Transformation Fund, localities receiving the money are incentivised to take part and contribute to the collective vision of GM and use the extra cash to boost their local services at the same time. "The devolution deal has actually provided us a source of funding to help us drive transformation," a CCG board member shared (C03). Given austerity and budgetary pressures, it was a "drop in the ocean" (G04) that allowed localities to "shift things around" (L01) and enable them to implement their plans, make transformations, and improve health outcomes to their local population.

In the collective-choice level, the Partnership wanted to emphasise the importance of the bottom-up approach, where the localities proclaim ownership of solutions to their problems with no solutions overlaid on a top-down GM basis (G03, G05, L04). The problem, however, was that localities face different adversaries brought by the existing tensions already within the system, making it more challenging to implement the locality plans and operationalise the LCOs. This brings us to whether Devo Health actually addresed the fragmentation of services in GM by pushing for integrative, bottom-up initiatives or whether it added an extra layer to an already complex system.

On a hindsight, despite the various incentives that the Partnership have set-up to drive transformational changes at the operational level, the truth is that the localities have different needs with a variation of health outcomes (C01, C02) making it more challenging to drive collective action and generate collective outcomes. As a CCG board member describes, "…so one of the challenges is translating something that might be developed as GM level into a local context, because each locality is different." (C02). Whilst the intention and vision of the LCOs were well-received in the operational level (L04), there were varying degrees in terms of their development. Some emerged quicker than the others, whilst others took longer than expected to establish formal structures. Since LCOs follow a wider footprint beyond their what the local authority would normally cover (L04), others had to deal with the complexity of organising the governance and configuring an integrated way of working together. For example, Bury LCO was only established on 1 April 2019 including a formal alliance with the Northern Care Alliance NHS Group, which made up of Salford Royal and Pennine Acute Hospital NHS Trusts. Both secondary care providers are located outside Bury and offers wider services to Manchester, Oldham, and Salford respectively (The Pennine Acutes Hospital NHS Trust, 2019).

The Transformation Fund also generated an atmosphere of local competition between the localities. Because the funding is limited, the Partnership devised a tedious process on how various workstreams can have access to the funding. This again illustrates that collective-choice crafted rules can affect how participants interact within the operational levels. Localities were made aware of the kind of conditions in which they could apply to the funding, which included application, assessment, awarding, and monitoring stages (G02). Whilst some were fortunate to be able to bid during the initial stages, others weren't as lucky. One described how they were only awarded a fraction of what they originally bid for, which makes it more problematic to implement the proposals for their transformational themes (C01, F02). Another said that the bidding

process was difficult enough to go through, where they had to justify their costings and proposed outcomes in front a panel (F01). Currently, all of the Transformation money has been distributed and localities are under pressure to deliver the outcomes they have promised in their locality plans. They have to keep up with monthly monitoring and assurance checkpoints with the Partnership team to make sure that they are performing as expected of them.

On top of this, local authorities are still under budgetary pressure and austerity measures, creating an unsustainable gap in council funding and causing a significant impact in the delivery of adult social care services and support (*see* latest figures in Local Government Association, 2019). LCO leaders believe that whilst the Partnership has brought in new monies to incentivise the system to collaborate, outcomes still show that GM has still not kept enough people out of hospital (L02). “There's a bit of tension at the minute because hospital activity levels are still haven't improved from before that happened (sic),” a Trust Senior officer said (F03).

Pearce and Ayres (2012) explain that the devolution deals were being pursued alongside a government target to eliminate the public sector budget deficit, which means that local authorities relying on central government grants face substantial cuts. This pressured local councils to absorb public service cuts in exchange of the promise of additional powers and future funds from the Devolution deals (Shaw and Tewdwr-jones, 2017). This was described by Bailey and Wood (2017) as network framing, where fiscal conditions were used by the central government to exert influence over local authorities. This also represented the arms-length influence of the state in terms of the proportion of local government spending, “taking one hand and giving with the other with strings attached” (Bailey and Wood, 2017:978).

Evidence suggests that the operational level was less receptive to the changes brought by the Devolution movement, despite the efforts made on the collective-choice

level to bridge the relationship gaps and fragmented system. Local councils, for example, are more pessimistic that the Partnership is bringing something new to the table. They believe nothing is truly devolved because the £6 billion delegated to the Partnership has always existed in the system and nothing new is being brought in. One referred to it as "creative accountancy" (L01) where money is just being reshuffled and redistributed within the system and all the Partnership does is re-managing what has already been there in the first place. Moreover, because the NHS is still exercising an arms-length influence over the devolved combine authority by retaining the same accountability lines and without statutory basis, clinicians and general practitioners alike have expressed their pessimism regarding the change it will actually bring (P02, P03, P04).

7.2.3.2 The NHS organisational culture

Because of the added layer brought about by the establishment of the GMHSC Partnership, some were initially concerned that these institutional arrangements will only bring further fragmentation to the already complex system. "We've got lots of individual organisations that when you've added them together, it's the NHS, but they don't necessarily work in that way," a CCG Senior leader states (C01). Given that the former HSC reforms bred a culture of competition and disjointed services, the system became disjointed that organisations were operating in a separate fashion.

> *"There is really an important point in that if you think of, let's think of four types of organisations and you've got and think of the way in which their attention and their focus draw in particular directions that are not necessarily aligned. You've got clinical commissioning groups, who feel responsible to their GP membership but feel accountable to NHS England as their regulator. You've got NHS trusts and foundation trusts, who feel deeply internally organisationally accountable but recognise an accountability to NHS improvement as their regulator. You've got local government that feels locally democratically accountable but has a kind of political leadership that it needs to be able to satisfy. And if we took something like the Voluntary and community organisations you've got to set there that feels*

like its accountability is entirely atomise but recognise it needs to co-ordinate itself in order to get to the table." (G17)

One of the biggest challenges that Health Devo needed to overcome was the culture of fragmented working within the NHS system. We illustrated in the previous chapters that each organisation is used to working differently, where the existing structures created by the Health and Social Care reforms in 2012 brought difficulties in terms of coordinating decisions and being on the same page with LAs, CCGs, Trusts, Primary care providers, and the voluntary sector. Differences in organisational culture can indeed aggravate the difficulty in collaboration because everyone works in entirely different professional languages and procedures (Himmelman, 1996; Huxham, 1996). Each stakeholder group is used to working a certain way that some felt that Devolution is mandating them to collaborate (P03, P04).

Different organisations occupy different positions within the Partnership governance, which perhaps makes collective participation more diverse and heterogeneous. In collective action theory, heterogeneity of participants shape the motivation and interests in achieving collaboration (Olson, 1965; Ostrom, 2000). Some individuals may have stronger self-interests in achieving more benefits than others, whilst some may exercise deterrent behaviour to cooperation. The retained lines of accountability and the lack of statutory changes within the NHS system resulted in organisations clinging onto their own procedures and representing their own organisational interests when they come to the collective Partnership decision-making arena. This was illustrated by Olson (1971) when he stated that rational individuals will act on their own self-interests and will not act to achieve group interests when participating in collective group decision-making, especially when there are multiple incentives to collaborate, competing interests, and blurred lines of accountability.

This was also supported by the evidence presented in previous chapters, where decisions are influenced by partisan motives demonstrated by their attachments from the organisations' own discipline or the geographical area they represent (P03, P04, C01). There will always be an element of competition arising from the retention of market principles inherited from the Thatcher government. This led to a level of difficulty in trying to change the way organisations operate because they have always been used to working in a certain manner, i.e. competing with each other. For instance, Trusts are deeply accountable to their board of members, where they are used to competing with one another in order to be sustainable. They are subject to quality control and performance checks from NHS England, which are crucial to their survival if they are to risk making collective decisions with other Trusts in GM. If decisions are to negatively impact one's Trust or changes of service will have a disadvantage on another, then they are more likely to make a choice that benefits their own organisation thus making it less likely for a collective unit to reach a joint unbiased decision.

The Lansley reforms resulted in intra-organisational conflict between the various NHS organisations, which affected the way they interact with one another when Devolution was introduced. Resistance to collaboration is inevitable, especially when organisations operating within bureaucracies needed to change their ways of working and challenge longstanding rules, regulations and attitudes (Himmelman, 1996). For instance, we illustrated in the previous chapters that there has always been a divide between hospital trusts and primary care providers (e.g. general practitioners, etc.) where each operate differently based on how they are structured. GPs are more collaborative by nature because they are small businesses working collaboratively and less competitively in the same neighbourhoods, whilst Trusts are statutory bodies that are organisationally profiled/structured (G15). Primary care providers have always felt that hospitals have always been favoured, although it wasn't expected that when the

Health Devo MoU was originally signed, Primary Care providers were not included in the official list of signatories.

> *"That's a really bad start point to have. 37 statutory organisations have signed an MoU to something new and probably the most, the largest provider in terms of activity has not even heard about it. So, it tells you something about how the system is dictated." (G15)*

There is an obvious tug of war in terms of who has more power to make the decisions and which decisions to prioritise, heightening the split caused by the NHS internal market and Lansley reforms. "Where statutory bodies are set to gain, those decisions tend to make quite easy and things move quite fast," GP senior officers described (P03, P04). Decisions were made in isolation and without public engagement, where some pockets of the lower tier of the system find out about it later on. Influential leaders have to step up and engage in the collective-choice level in order to negotiate representation of their stakeholder group within the Partnership, and this shows again, how the operational level have to bend the existing rules in order to gain advantage in the collective decision-making arena.

Such difficulties in the system created more friction between groups and make joint decision-making more challenging at a local level. The main challenge, perhaps, is the different organisational cultures, where you've got people from the NHS who are used to working in a certain way and then you've got people in local government working a different way (L01, L02). The commissioning culture has always been competitive where CCGs are being run by people with health backgrounds that tend to make decisions defaulting back to the "medical fixing" model; whilst LAs continue to battle budget cuts and prioritise to deliver public health and social care functions at a neighbourhood-level. Smaller organisations like the voluntary and community sector groups also have to compete in terms of receiving contracts from CCGs to deliver such community-centred

services. And then there are GPs who, on the other hand, are struggling to find a representative voice in the system and are competing against big hospitals, to the point where they are used to a system of incentivising or receiving a small reward for doing something beyond their contracts (P05, L02, G07, F01).

There will always be tensions between priority-setting amongst the different types of organisations within the system – the local government who wants to promote place-based community approaches and bring services closer to the population; the provider trusts who want to decrease A&E waiting times and are pressured to reach nationally-mandated NHS targets; and the CCGs who hold majority of the budget and control which services get commissioned. A CCG board member described, “there was too much silo working and people were not thinking across the whole system about the whole issue. So, they were only looking at their part.” (C03) We see bigger cracks in the health and social care system that make it more challenging to forge a culture of collaboration, especially when the organisations are used to competing against each other for the sake of accountability, performance management, and vested interests. There is also the divide between health and social care as a separate aspect of the public services, where the Mayor of Greater Manchester has no power on what happens in the health and social care and this remit still lies within the Partnership led by the Chief Officer who is an NHS England employee.

Not all, however, were as critical with the entrance of the Partnership and Devolution in the system. Despite the scepticism to the delegated arrangements dictated in the constitutional level which in turn limited the levels of action and interaction in the collective-choice and operational levels, the participants recognise the added value or immediate outcomes that Devolution has brought to the GMHSC system. Many acknowledged how Health Devo has enabled the system in so many ways, particularly in creating new formal avenues to meet and work together. Some also believed that

although there has been no increase in shared resources, particularly the alleged £6 billion budget for health and social care, Devolution allowed the localities some level of collective control to managing their own existing resources. “It's not new money, no. But it is having control of the resources and having the opportunity to bend it and use it,” an LA councillor explained (L04).

7.2.4 Summary

In the previous sections, we demonstrated how formal and informal rules interacted at each level and how one affected the other. At the constitutional level, NHS England orchestrated centrally controlled rules on how the Partnership will be formed and how they will be monitored. Amendments to the statutory legislation were made to make way for a limited Devo Health and formal leaderships roles were created to draw links of accountability back to the top tier. At the collective-choice level, the Partnership crafted another set of rules based on the guidelines set by NHS England at the constitutional level. Because of these constraints, the Partnership had to resort to other forms of informal institutional arrangements (i.e. gentleman’s agreement, cooperation, etc.) to overcome the barriers to collaboration. The Partnership drew links of accountability down to the lower tier (e.g. CCGs, LAs, Trusts) to strengthen the network connections and use it to their advantage when they are exercising their regulatory role. Lastly, at the operational level, the key stakeholders were bounded by the agreement that they signed with the Partnership, making them to compulsory comply with the rules imposed by the Partnership. However, since they retained their statutory roles and lines of accountability as outlined in the constitutional level, they exercised a higher degree of local autonomy. This meant that they are tied to their own organisational rules, which prevented them to fully collaborate and participate at the collective decision-making arena.

Table 16: Summary of key findings based on multiple level analysis

			Institutions	
Level of analysis	*Key Actors*	*Partnership activity*	Formal	Informal
Constitutional	NHS England	Formation and emergence of Devolution	'Warner amendments' to the National Health Service Act 2006 via the Cities and Local Government Devolution Act 2016	De-facto meta-governance; role of powerful influential leaderships
Collective choice	GMHSC Partnership core team	Strategy-building; monitoring and enforcement	Memorandum of Understanding; governance structure; working frameworks	Gentleman's agreement; organic cooperation; informal networks; levels of trust and reciprocity; consensus decision-making
Operational	Stakeholders	Implementation	Statutory bodies retain their existing lines of accountability	Informal networks; conflict resolution; organisational culture

7.3 Formal and informal institutions to address the collective action problem

In the previous section, we illustrated how all rules are nested in another set of rules (Ostrom, 2005:58), where one level of actions and outcomes obtained from the previous level affect the proceeding level. The Partnership became a collective action arena that brings together both constitutional and operational actors. Constrained by the rules on each level, the Partnership used both formal and informal institutions to address the collective action dilemma of sustaining the GM health and social care economy.

We contextualised the action situation in the collective choice level and explored the seven elements of the action situation and how they affected the individual behaviours and rules configurations over time. We also identified that one of the analytical powers of the IAD framework is being able to identify the types of rules-in-use utilised by the

participants to facilitate their behaviour and interaction in the action arena (Ostrom, 2005; Heikkila and Andersson, 2018). Ostrom (2005) developed a typology for rules-in-use, where each is interrelated with a specific function in the action situation. In this section, we summarise these institutional arrangements from Chapter 5 and link them with Ostrom's rules typology in order to identify the rules-in-form (formal) and rules-in-use (informal) that were formulated, and the collaborative mechanisms used by the decision-makers to enforce collective action.

This section particularly addresses our second research question:

- What are the formal and informal institutions that emerged as a response to collective action dilemmas?
    a. What are the rules-in-form (formal) and rules-in-use (informal) that were formulated?
    b. How are they crafted, monitored, and enforced?

7.3.1 Boundary

Boundary rules determine the entry, succession, and exit of actors (Ostrom, 2005). These identify who are the actors involved in the Partnership and how they enter and potentially exit the agreement. Since the Partnership was set-up as a collaborative governance, it involved two or more organisations who intend to create public value by working together rather than separately (Imperial and Koontz, 2007; Von Wald and Boyes, 2010). Our findings show that there are three groups of actors who entered in agreement to be members of the GMHSC Partnership. These are the following: (1) the key stakeholders, who comprise of the organisations who signed up to participate in Devo Health in GM, which are the CCGs, the Trusts and FTs, the Primary Care providers, and the LAs; (2) the partner organisations, who also signed the MoU to co-deliver key programmes outlined in the GM strategic plan; and (3) the core staff of the GMHSC Partnership team, who are employed to manage, oversee, and deliver some of

the delegated responsibilities to the Partnership, including operational, monitoring, and implementation and delivery of the GM Strategic Plan.

All actors entered a formal agreement through the signing of the MoU. The document outlined the framework for achieving the devolution of health and social care responsibilities to the participating organisations in GM. As mentioned previously, MoUs are oftentimes used in the NHS to record joint working agreements that are not legally binding (NHS Improvement, 2018). Whilst it is not a legal document, MoUs institutionalised the common intent and agreement between the parties in question and also identified the roles and responsibilities of those involved. Since the Partnership was also formed on a non-statutory basis, this meant that all member organisations retained their lines of accountability and responsibility (e.g. budgetary and funding for overspends) with their original function holder. However, since staff were recruited to form the core GMHSC Partnership team, these staff members were employed either on secondment, fixed contract, or appointed on a permanent basis.

7.3.2 Position

Position rules determine types and roles of decision-makers (Ostrom, 2005). Each participant takes a position in the action situation where each has diverse options for a combination of resources, opportunities, preferences, and skills. Our findings show that members of the Partnership occupy the following positions: (1) Provider of service (mostly occupied by the four key stakeholders); (2) Internal and external regulators (NHS England, and Partnership's assurance groups and senior management team i.e. Executives); (3) Taskforce groups (Partnership programme delivery group); (4) Decision-making bodies (Health and Care Board and Executive board); and (5) Advisory groups. Due to the complexity of the positions available and to ensure that all participants have opportunities to be equally represented in the decision-making arena, a formal governance structure was established.

Establishing governing arrangements is important especially in settings where multiple actors have overlapping roles and have competing statutory responsibilities (Ostrom et al., 1961). Moreover, the heterogenous mix of the Partnership, which comprised of both public and non-public organisations, meant that hybrid arrangements were needed to fit the evolving needs of the collaborating participants (Donahue, 2004; O'Brien, 2012). This was demonstrated by the formal governance transitioning three times, which reflect the evolutionary phases of the Partnership activities: from a shadow group (emergence of the Partnership – April 2015 to April 2016); to an initial operational structure (strategic planning – April 2016 to December 2017); and a revised version (delivery and implementation – January 2018 to present). The arrangements set up by the shadow government were geared towards strategic planning of the work programmes to be delivered. As the Partnership entered the delivery phase of the programmes, they had to employ more staff and re-shuffle the governance structure to have clearer lines of responsibilities and accountabilities at all levels.

7.3.3 Choice

Choice rules define the set of actions assigned to each actor (Ostrom, 2005). These prescribed actions could be attributed to what the participants are allowed to do or not to do, and under what circumstances these actions might be allowed in the decision process (Cole, 2014; Heikkila and Gerlak, 2018). Our findings show that participants occupy positions and refer to different set of prescribed actions based on the three phases of Partnership activities, i.e. strategic building, delivery and implementation, and monitoring and assurance. Since not all stakeholders are able to participate in all positions in the Partnership at the same time, levels of participation had to be decided to indicate how responsibilities and benefits are to be distributed (Gray, 1989).

First, the member organisations of the GMHSC Partnership have important roles to play during decision-making. The rationale behind this is that all significant decisions

taken at the Partnership level must include the input of the stakeholders, therefore, all stakeholders should be involved in all stages of the decision-making process (Ansell and Gash, 2008). Moreover, by identifying the critical and rightful participants who are affected by a shared problem, and ensuring that all collaborating organisations are equally represented, the legitimacy of and commitment to the process are preserved (Gray, 1989; Imperial and Koontz, 2007). The governance structures, therefore, ensured that all members of the Partnership are all well-represented through various boards and work programmes. By choosing to this action (i.e. represent their organisation in the Partnership), they choose to play an active role in various Partnership activities, such as the formulation of the strategy, engagement in meetings, networks, or steering groups, and implementation and delivery of a programme to name a few. This is also considered the default action because they signed an MoU, which represents their agreement to join the Partnership.

Second, whilst all key stakeholders are represented in each group, the core Partnership team is tasked to a specific set of actions that are exclusive to them. Their role is to have oversight on strategy and delivery of the GM strategic plan, where they fulfil leadership, delivery, and assurance roles, or administration and operational responsibilities. Literature suggested that leaders sometimes facilitate rather than directing (O'Brien, 2012), which was evident when our interviewees expressed that they facilitate conversations and relationships rather than focusing on managing or directing the project itself. This also included monitoring and assurance roles, where the Partnership relied on both formal and informal institutions to fulfil these actions. Because the Partnership still has to adhere to national standards and the NHS constitution, the Partnership had to devise their own rules to make sure that all member organisations are complying with both constitutional and collective-choice level rules. Evidence from the interviews suggested that mechanisms like brokering and negotiating, and arranging formal meetings were the established rules-in-use.

7.3.4 Aggregation

Aggregation rules determine the collective agreement rules (Ostrom, 2005). Collaboration is inherently political, which involves a lot of negotiation, bargaining, and extensive discussion (Himmelman, 1996; Moore and Koontz, 2003). Our evidence suggested that all collective agreements were guided by the overarching fact that the members entered a gentleman's agreement to enter the Partnership and work towards a collective goal; hence, they should honour that commitment by voluntarily complying to the rules that they agreed as a unit. This was usually conducted via a formal decision-making arena where participants come together, meet on a regular basis, and set the level of control on how actions are to be translated into outcomes (McGinnis, 2011a; O'Brien, 2012).

The Partnership has two distinct decision-making bodies (i.e. HCB and the Partnership Executive), who were in charge of making collective decisions, and achieving direction, control and coordination of the participating stakeholders (Imperial and Koontz, 2007; Ansell et al., 2017). The aggregation rule is that all decisions should be agreed as a consensus and based on majority via formal voting arrangements. Partnership decisions usually involved challenging discussions and pre-approval at the Partnership Executive level, and ratification and final endorsements at the HCB level. Interviewees identified that most difficult conversations happen at the Partnership Executive meetings through debates and engaging discussions. Emerson et al. (2012) highlighted that this deliberation process is important in every forum so that conflicts are resolved at the lowest level. All final decisions are approved at the HCB, where a stamp of approval and a final endorsement are given.

7.3.5 Information

Information rules define information access (Ostrom, 2005). Collective decisions rely upon the information that is handed to them, based on the perceived incentives of the

participants (Agrawal, 2001; Kopelman et al., 2002; Poteete et al., 2010). In the Partnership, information is disseminated across the structures through a variety of channels, such as formal assurance meetings and reports, and informal networks. Because GM has a history of cooperation, built-in networks have existed long before Devolution arrived; therefore, it was easier for the member organisations to communicate and take advantage of these networks rather than going through formal channels. Ostrom (1998) explained that as individuals engage in repeated interactions with one another for a period of time, they acquire good reputation that lead to developing levels of trusts and higher levels of cooperation. This also became a cheaper and more cost-effective way of sharing information amongst various pockets of the GMHSC system, especially when it is difficult to get the right people in the same room. Our empirical findings, therefore, suggested that navigating through the Partnership system is all about relationship management and informal networking. Whilst there are formal governance routes and communications engagement framework set-up to guide these relationships, resorting to informal forms of information sharing became a more effective way of navigating around the system.

7.3.6 Payoff

Payoff rules identify the rewards and sanctions associated with outcomes of actions (Ostrom, 2005). In this research, we associate payoff rules with the incentives to collaborate, and the associated sanctions if they don't participate in the various activities in the Partnership. Collaboration and collective action theory suggested that motivation can be influenced by factors such as shared problem or common purpose (Koontz, 2006; Emerson et al., 2012) and gain control financially and personally (Imperial and Koontz, 2007).

This was demonstrated by the empirical findings where we suggested that the member organisations agreed to engage in the Partnership because their senior leaders

signed the MoU on their behalf, and they were bound by a social contract that has no legal implications. The Partnership had also set-up both formal and informal mechanisms to make sure that there is some level of assurance between the member organisations at the operational level, the Partnership at the collective-choice level, and NHS England at the constitutional level. However, our evidence showed that participants were constrained by their own vested interests and lines of accountability to their respective organisations. They make decisions based on whether it will benefit themselves or not, and this acted as a barrier to achieving full collective action. This illustrated that individuals behave out of their self-interest where they do not realise the implications of collective actions (Olson, 1965). The Partnership, therefore, had to moderate this rational choice behaviour by creating Advisory boards that will incorporate the groupthink decisions of such factions into the governance. For instance, the PFB is a formal arrangement between the 15 NHS Trusts and FT Senior leaders, where they have strategic oversight amongst all the local Trusts and FTs in GM. This was demonstrated by Huxham (1996) and Huxham et al. (2000), where they suggested that countermeasures like this can be put in place to mitigate power struggles and avoid an unsuccessful collaboration process.

7.4 Design principles to addressing the health commons

One of the objectives of this thesis is to extend the theory of collective action and common property regimes and apply them in the health policy context. In Chapter 3, we posited that under conditions analogous to Ostrom (1990) and Cox, Arnold and Tomás' (2010) design principles to managing sustainable common pool resources, we can replicate this to a health commons setting. In this section, we summarise our findings and address how the GMHSC Partnership was able to successfully craft, enforce, and monitor their own institutional arrangements and take charge of their own health and care economy.

This section aims to address our first research question:

- Under what circumstances can collaborative governance mechanisms create a system of stewardship in governing the health commons?
    a. What are the external factors that influence decision-making bodies to collaborate and act as a collective unit?

Heikkila and Gerlak (2018) outlined that in large-scale regional collaborations selection, having a big group of actors creates a heterogenous group with diverse interests, and distinct backgrounds and experiences. However, others believed that larger groups may be more prone to free riding and struggle to employ collaborative mechanisms (Agrawal and Goyal, 2001). Our analysis showed that this is not always the case and we explain why. First, our evidence suggested that whilst it was challenging to orchestrate the formal structures due to the constraints that NHS England and the government have put to prevent full devolution, the Partnership was able to overcome this because of the strong history of collaboration amongst the various organisations and health sectors within GM. The initial MoU was agreed upon by more than 30 organisations, and that in itself, is already a proof that large-scale regional collaborations can be established despite the heterogeneity of the participants as identified in the literature.

Second, NHS England and a small group of local influential leaders came together to craft the initial governance arrangements of the Partnership. This included which resources are to be shared (e.g. budget, human capital, social capital, estates, etc.), how they are going to be shared upon, and who can access these resources. However, this did not occur without any challenges. The Devo Manc agreement came with a list of do's and don't's, including rules on the limited level of autonomy that the new Partnership entity can exercise, the retained statutory functions and funding flows of its member

organisations, and the lines of accountability back to NHS England. On top of that, there are existing tensions within the local health and care system of GM, which resulted in a fragmented relationships and organisations working in isolation and competing with one another. These external factors contributed to the level of difficulty in establishing joint collective action. However, the role of key leaderships during the negotiation stages of the establishment of the Partnership helped in overcoming this barrier and was able to successfully transition a shadow governance into its full operation.

Table 17: External factors influencing the formation of the Partnership

Exogenous variables	GMHSC Partnership
Physical attributes	Well-defined boundaries: 10 LAs of the GM city-region
	Level of autonomy: Limited by NHS England to delegation not full devolution
	Accountability arrangements: Lines of accountability remain to respective organisations
	Financial arrangements: £6 billion health and care economy; £4.5 million TF
Community attributes	GM history of cooperation; strong interest for joint collective action; presence of influential leaders; existing tensions in the HSC system brought about by the culture of choice and competition during the Thatcher era
Rules-in-use	Initial governance arrangements during the transition period

Lastly, the Partnership was able to successfully craft, enforce, and monitor their own set of formal and informal institutional arrangements in order to govern their shared health resources. These circumstances can be summarised through the following design principles.

Well-defined user and resource boundaries. The GMHSC Partnership covers the 10 local authorities of the city-region of GM. These physical geographical boundaries made

it easier to define who gets to participate in the collaborative decision-making and which resources are to be shared across the city-region. The boundaries also identify the inclusion and exclusion criteria on who and how are groups allowed to enter and/or exit the Partnership and which roles do they play in the collective forum, which we highlighted under the boundary and choice rules.

Congruence with local conditions. Local conditions surrounding the resource involved oftentimes drive congruence to the rules being formed (Ostrom, 1997). In the case of the Partnership, the common property in question is the overall health and social care economy of GM. This represents the overall stock of physical, financial, and human capital in the city-region that is being looked after by Partnership. This meant that the Partnership gets to strategically decide where and how to spend the £6 billion budget of the local NHS organisations and LAs within their boundaries. In addition to this, GM received a one-off access to £450 million TF, which can be used directly into to boost transformative changes on the delivery of health and social care services within the city-region.

In addition to these *physical* attributes, we must also acknowledge the *community* attributes of GM. The city-region has a long history of collaborative arrangements that existed long before Devolution was introduced. This made it easier for organic relationships to come together and create a joint collective action to form a collaborative governance. However, we should also acknowledge that there are prevailing local tensions within the HSC system of GM brought about by the culture of choice and competition from the Thatcher era. This has constrained the full potential of local NHS organisations to succeed in fully participating in collaborative efforts due to the multiple layers of governance already existing within the system.

Collective choice agreements. The physical attributes of the resource and community attributes of the users of the resource influence the rules of the game. These rules-in-

use shape the behaviour of the those who decided to participate in the collective action (Ostrom, 2005). As demonstrated in the previous sections, the Partnership was able to craft their own institutional arrangements to regulate the entry of actors, the use of the resources, the patterns of interaction, and the costs and benefits associated with the actions and outcomes (Imperial, 1999). In order to facilitate these arrangements, the Partnership relied on high levels of mutual trust and reciprocity amongst the participating members in terms of compliance to the collectively agreed rules. This was primarily the foundation of the collective choice rules and the source of joint collective action within the Partnership. Our evidence demonstrated this by using the "we signed up for this" attitude or co-ownership of problems and decisions as one of the informal mechanisms used to foster joint collective action. More importantly, governance structures were created at the collective choice level in order to facilitate both national and local accountability and organise the vertical and horizontal relationships within and across the different levels within the GMHSC system.

Monitoring mechanisms, graduated sanctions and conflict resolution. The Partnership exercised caution when sanctioning its members. This was demonstrated by the choice, information, and aggregation rules. Our interviews demonstrated that formal protocols were in place to punish those who do not comply with whatever is expected of them as per the MoU, e.g. implementing of work programmes, reaching nationally or locally mandated targets, improving the quality of services and health outcomes, etc., through formal meetings with the Partnership Executive or the respective Project Management team. These also include recovery and intervention plans, outcomes framework, or performance metrics. NHS England does not have any direct power to intervene any of these monitoring processes because this function was delegated through the Chief Executive of the Partnership.

Since the Partnership is under a magnifying glass, they would want to avoid any form of bad attention towards them. Therefore, as much as possible, the Partnership would want to use formal protocols only as progress or milestones check and not to escalate to the final option for punishment. They utilised informal institutions to resolve any conflicts or any performance issues before reaching any high-level escalation procedures. Graduated sanctions were used instead, where they constructed enough barriers for key stakeholders or partner organisations to get through, such as deliberations and problem-solving mechanisms, the performance management boards, etc., before any conflict or performance issues reach the highest tier of the governance. Daily or monthly assurance meetings are also in place as monitoring mechanisms to make sure that members are up to date with their individual tasks.

Informal avenues via face-to-face dialogues were also available to resolve conflicts and was highly favoured by most of the interviewees. This was facilitated mostly by the Partnership team, who proactively engaged in meaningful conversations with the stakeholders in order to address any issues prior to reaching the Partnership Executive table.

7.5 Lessons from the GMHSC Partnership as stewards of the health commons

In this section, we examine the outcomes and implications of the GMHSC Partnership as stewards of the commons as a result of the external factors, formal and informal institutional arrangements, interactions, incentives, and sharing of information that shaped their behaviour within the collective action arena. Whilst this research is not an evaluation on whether Devolution was an effective policy or not (instead, see Communities and Local Government, 2016; Walshe et al., 2018; Sandford, 2019), our aim in this section is to look at the process outcomes resulting from the formation of institutional structures of the Partnership to sustaining the health commons.

7.5.1 A polycentric and fragmented NHS

Over the past few decades, the health and social care system has been subjected to ever increasing demand and dwindling supply of resources and unprecedented slowdown on funding growth due to pressures from austerity, leading to poorer health outcomes and raising questions on whether the NHS can sustain for the future generation (The King's Fund, 2017). As we have illustrated in Chapter 3, the government resorted to multiple overhauls and reorganisation of the NHS, characterised by hierarchies, markets, and networks, and a constant pendulum swing between managerial, integrated, and collaborative approaches. This resulted into a highly fragmented and complex NHS system – almost like a labyrinth that leads to different nodes and levels of decision-making.

When the GM Health Devo deals were being arranged, it was agreed that the delegation of health functions from NHS England to Greater Manchester only involves a limited degree of autonomy. Statutory functions, lines of accountabilities, and existing responsibilities within organisations were all retained as set out in the HSCA 2012. With the formation of the GMHSC Partnership adding another layer of complexity to the governance structures, it raised questions on whether this addresses any of the existing tensions in the system created by previous system reforms, and whether this set-up will be sustainable in the long run.

7.5.1.1 Centrally orchestrated localism

At the constitutional level, our evidence shows that despite the delegation of some NHS functions to the Partnership, NHS England retained a strong level of control in setting the limitations on how the Partnership governs its local health economy. However, NHS England also wanted to empower the city-region by awarding them some level of autonomy but not fully devolved NHS functions. The Devolution deal was like "smoke and mirrors" (C04) because in reality, there was not "true" devolution. Rather,

GM received a deal with limited autonomy and delegated functions that truly do not represent fully devolved functions, as in the case of the devolved NHS in Scotland, Wales, and Northern Ireland. Moreover, there was no statutory legislation to formalise the creation of the new Partnership entity, but rather an MoU was substituted as a means of formal agreement.

This demonstrated the strong central influence with weak local nodes that has been existing within the political landscape in English governance (Pike et al., 2015; Bailey and Wood, 2017; Shaw and Tewdwr-jones, 2017). The Partnership Executive team, for instance, remained to have links to NHS England via the Chief Executive, who is an NHSE employee. Local NHS organisations such as CCGs and Trusts were still governed by the structural powers surrounding NHS bodies. This meant that member organisations were still subjected to national mandates and the NHS constitution, displaying a level of local paternalism with national accountability that was already present prior to Devolution (Greener and Powell, 2008). This is not surprising, given that the overarching City Devolution deals were driven by temporary political and territorial fixes with an overriding objective of devolved local responsibilities determined by the centre (Pike et al., 2015; Bailey and Wood, 2017; Shaw and Tewdwr-jones, 2017; Ayres et al., 2018).

7.5.1.2 Stewards with a collective intention

Despite the influencing role of NHS England in driving forward a Devolution deal, key influential roles and local GM leaders rose to negotiate a better deal. Within months, the Devo Health was secured by a small number of key officials from the government, NHS England, and the GM Combined Authority. This was an indication of local elite assimilation and centre court politics that has contributed to the weak citizen mobilisation and lack of legitimation of the Devolution process (Deas, 2014; Kenealy, 2016; Prosser et al., 2017; Ayres et al., 2018). This, however, can also be interpreted as a

demonstration of the strong political networks in GM that has long existed following the abolition of metropolitan councils during the late 1980s (The Economist, 2013; Deas, 2014; Holden and Harding, 2015; Haughton et al., 2016). This resulted in decades of organic cooperation with high levels of mutual trust and respect, contributing to the successful securement of Devo Health.

GM has, indeed, all the key ingredients to become stewards of its own health commons. Given the constraints posed by NHS England at the constitutional level, as identified in the previous sections, the Partnership was able to demonstrate that formal and informal institutional arrangements can be crafted and enforced to overcome adversaries and generate collective action. This has already been proven in studies on polycentric settings where multiple actors have overlapping roles and have competing statutory responsibilities to protect different constituencies, where collaborative mechanisms have been developed by state and non-state actors to work together and resolve conflict (Ostrom et al., 1961; Ostrom, 2008; Aligica and Tarko, 2012; Carlisle and Gruby, 2017).

Our evidence also demonstrated that organisations who signed up for Devolution were all working based on their existing social attributes (i.e. trust, reputation, reciprocity) and working relationships (i.e. built-in informal networks, tensions within the system), which they have known from their previous experiences. They were holding each other accountable in a way that they are honouring the MoU that they all originally signed up for. Given that Devo Health did not have any legal mandates to force organisations to comply with the agreements, everybody was pretty much working with each other via a social contract and altruism.

7.5.1.3 Local paternalism with national accountability

Devo Health was part of the localism agenda of the Conservatives to bolster city-regional ambitions and foster a more collaborative way working via the Devolution deals.

This was, however, not a new initiative; but rather a newer version of previously repackaged or rebranded policies, e.g. LEPs, City Deals, Combined Authorities, and now Devolution Deals to name a few. It did signal the entrance of departure from the traditional centralist approaches of top-down imposition of planning and strategic vision to empowered local regions with stronger local autonomy. Devo Health, however, failed to institutionalise this in some respects.

The creation of the GMHSC Partnership meant that a new layer of decision-making has been added at a 'meso-level' (Quilter-Pinner, 2016) – which instead of bringing decisions closer to the local communities as envisioned by the Five Year Forward View (NHS England, 2014), it imposed a top-down approach on strategic planning at a central and collective level. This meant that rather than local NHS organisations and local councils making separate decisions to meet their local needs, some decisions have to be made at a GM-level in order to address the health and wellbeing of the entire GM population as a whole, i.e. making decisions at the most appropriate level (AGMA et al., 2015). The Partnership constructed formal modes of governance to organise reporting structures, which also demonstrated that this new way of working still has elements of the hierarchical and centralist approaches that has existed within the NHS culture for decades.

On the other hand, the Partnership was still able to fulfil its collective ambition of addressing GM problems by GM decision-makers. They promoted co-ownership of bottom-up solutions, where the localities were encouraged to contribute to the overall GM strategy. They were, however, to be held accountable to delivering what they signed up for and to commit to the collectively agreed deliverables, especially if their respective locality or programme area has been awarded with some Transformation Funding. It is, therefore, still under the remit of the localities to deliver these plans and be accountable to their respective constituents and individual organisations. This demonstrated a shift

back to national paternalism with local accountability, where strategic decisions are controlled centrally whilst relying on the local nodes to deliver them.

7.6 Summary

This chapter aims to synthesise the empirical findings from Chapters 6 and 7 and examine the outcomes and implications of the GMHSC Partnership as stewards of the commons as a result of the external factors, formal and informal institutional arrangements, interactions, incentives, and sharing of information that shaped their behaviour within the collective action arena.

Our findings suggested that the Partnership was able to successfully craft, enforce, and monitor their own institutional arrangements despite the constraints set by the formal rules at the constitutional level. By constructing informal institutions, the Partnership was able to overcome the limitations of the formal rules and to use them as countermeasures to free-riding and self-seeking behaviour. The Partnership was also able to devise their own rules to incentivise and motivate collective behaviour from the member organisations. This confirms the arguments presented in our theoretical framework (Chapter 2.7).

The GMHSC Partnership illustrated that being stewards of your own health and social care economy can be advantageous in terms of having more control to your resources and being able to create and use various institutional mechanisms to facilitate collaboration across the system. Table 19 summarises our conceptualisation of what constitutes the GM health commons, based on our empirical findings. This conceptualisation is one of our key contributions to the theoretical discourse on the study of stewardship of the commons.

Table 18: The GM health commons

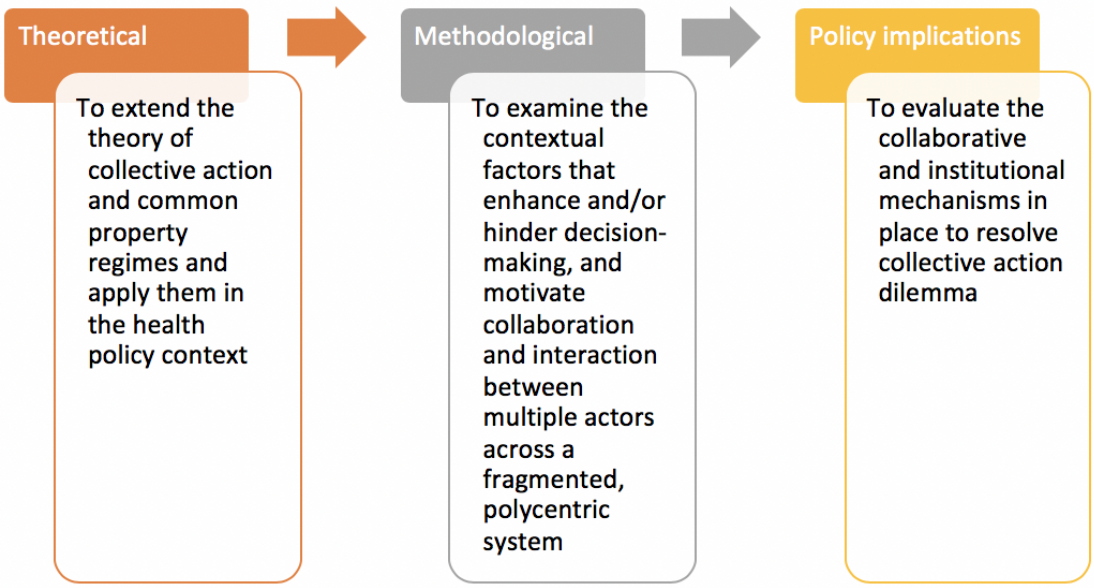
	Common pool resources	Health commons	Greater Manchester health commons
Common property regime	Joint ownership of the fish in the lake	Joint access to the commons via stewardship of health resources	Devo Health; Delegated NHS functions; to make decisions on their own HSC economy
Common pool resource	Population of fish in a lake	Overall stock of health resources in the region	The overall health and social care economy of GM
Resource unit	A fish once it has been caught	Access to health services	£6 billion overall spending for health and social care in GM
Appropriation	Extraction of fish from the lake	Access to health services	Use of health and social care services
Actors		Stewardship team acting on behalf of population as a whole	GMHSC Partnership
	Appropriators: Fishermen who harvest from the lake	Providers: Health care professionals; Users: patients	Users and providers: Key stakeholders (NHS organisations + LAs) + 2.8 million population of GM
Provision	Replenish resource or maintain infrastructure	Allocative efficiency in producing and maintaining health resources	Transformation fund + pooled integrated budgets
Rules	Rules restricting appropriating behaviour of the actors	Rules that shape how decisions are made by the stewards and how to access the resources	Devolution agreement (Cities and Local Government Bill 2016) + MoU
Provision rules	Contributions to replenishment or maintenance of the resource	Limitations on how parties can spend savings from programs or what initiatives they should undertake (e.g. NICE guidelines)	Initial institutional arrangements (including monitoring and accountability frameworks, governance structures, and access to TF) established by the Partnership
Rule-making activities	Self-organising communities create rules	Stewardship team sets priorities for programmes	GM Strategic Plan “Taking Charge”
Higher-level public authorities	State intervening to local users	Regulations from the state	NHS England; CQC; NHS Improvement
Tragedy of the commons	Degradation or destruction of the resource	Rising health care costs reducing overall economic productivity	Increasing financial deficit with poorer health outcomes
Sustainability	Ensure future access to resource	Financial viability, improved health outcomes, lower costs, productivity and equity	Improved health outcomes for the population, reduced financial deficits, integration of health and social care services

8 Conclusions

8.1 Introduction

This chapter presents the overall contributions of this thesis into existing theoretical knowledge and policy context. As outlined in the objectives of this research (Figure 25), this research aims to contribute to the research gap in the study of commons applied in the health policy context. It particularly explores the notion that multi-sectoral organisations can take charge of their own health commons and function as a collective unit by crafting and enforcing their own institutions to order relationships and govern decision-making behaviours of its constituents. Using the IAD Framework as an analytical tool, this research highlights the formation of formal and informal institutions as a response of the Partnership to the devolution of health responsibilities to GM.

Figure 25: Contributions of the thesis based on the research objectives



First, we begin this chapter by outlining the key findings of the study and why this research is significant to the discourse of health devolution in the UK context. It reviews how the aims and objectives were achieved, with respect to addressing the research

gap. Second, we highlight the contribution of this thesis to the theoretical discourse in collective action and collaborative governance by exploring the concept of governing the commons applied outside the US context. We also outline how the GM setting contributed to the application of the health commons and how it advances knowledge and methodology through the examination of institutional arrangements in a multi-sectoral partnership. Third, we identify the implications of this research to the policy context of sustaining the NHS. We look at the lessons drawn from our empirical findings and examine how the central government can learn from the GM model of setting up of the 'rules of the game'. Lastly, the chapter concludes with a discussion of the limitations of the study and how scholars can apply the concept of the health commons in other policy contexts moving forward.

8.2 Key findings of the thesis

This thesis investigates how formal and informal institutions emerged as a response to collective action dilemmas in the health policy context. We posited that the health commons can be looked after by a group of stewards that represents both the appropriators and providers as a whole in order to preserve and sustain their shared resources for the use of future generations.

Following this line of thought, we argued that the local decision-makers of GM through the GMHSC Partnership are the stewards of the health commons – a group that asserts responsibility for overseeing and making decisions of the health and care system on behalf of its population. They have established governance mechanisms and institutional arrangements in place in order to dictate who can participate in drawing resources from the health commons, and which, how, where, and when resources can be used. Aside from planning and providing strategic direction, the Partnership also monitored the outcomes and enforce graduated sanctions to any stakeholder who fails to follow the collectively agreed rules.

The Partnership was in-charge of their health commons, which represented the overall stock of physical, financial, human, and social capital resources within their defined boundary, i.e. the 10 LAs of GM (Chapter 5.2). This was oftentimes described in strategic documents as the overall health and social care economy of GM (Walshe et al., 2018), encompassing the £6 billion overall spending allocated to the local NHS organisations and all the relevant physical, human, and financial structures that were likely to be shared between the city-region. Our research suggested that the Devolution of health functions paved way for GM to draw a well-defined user boundary to their local pool of health care resources. Having well-defined user and resource boundaries (Chapter 7.4) allowed the Partnership to define who gets to participate in the collaborative decision-making and which resources are shared. The Partnership crafted boundary and choice rules (Chapters 7.3.1, 7.3.3), which identified the inclusion and exclusion criteria on who and how are groups allowed to enter and/or exit the Partnership agreement and which roles do they play in the collective forum.

Analogous to the theory of CPR, the GM health commons have a set of actors who were in charge of making decisions on behalf of the population, overseeing the strategic planning of transformation programmes, and monitoring collective participation of its members (Chapter 6.2, 6.4, 6.5). Although the role of the Partnership was not really to control who gets to withdraw or use the health commons, they are primarily there to act as stewards and generate collective action on how to make better decisions about improving their health outcomes, improve productivity, and provide better services for the HSC economy. Most of the members of the Partnership are also providers of service, who make contributions to the sustainability of their commons.

Our conceptualisation of the health commons in the GM context gave us a new perspective in sustaining the NHS. We compared the doomsday scenario of the Tragedy of the Commons to the rising health care costs with poorer health outcomes and lower

economic productivity that was occurring in the NHS. Moreover, we described that the labyrinth of NHS reforms from centralist to marketisation to partnership working led to further fragmentation in the system (Chapter 3.3). Our research, therefore, offered an alternative perspective and suggested a new framework for managing the health commons.

Table 19: Summary of key findings

Action Situation	**Rules**		***GMHSC Partnership***	
			Formal	Informal
Actors	Boundary	The entry, succession, and exit of actors	Signing of MoU; retained lines of accountability to respective organisations; core staff employed on secondment or contractual basis;	
Positions	Position	Types and roles of decision-makers	Provider of service; Internal and external regulators; Taskforce groups; Decision-making bodies; Advisory groups	
Actions	Choice	The set of actions assigned to each actor	Representation; Oversight on strategy and delivery; Monitoring and assurance	Facilitating relationships; Enabling informal conversations; Brokering; Negotiating
Control	Aggregation	Collective agreement	Voting arrangements; Consensus decision-making via HCB and Partnership Exec; Rubber stamping	Hard conversations; Conflict resolution via debates
Information	Information	Information access	Monthly or weekly face-to-face assurance meetings; Reports	Networking; Influencing; Socialising; Principled engagement
Net Costs and Benefits	Pay-off	The rewards and sanctions associated with outcomes of actions	Financial gains; Monitoring and assurance	Conflict resolution; informal conversations

Overall, this thesis showed that as stewards of the regional economy of GM, the GMHSC Partnership was able to craft, monitor, and enforce their own formal and informal institutional arrangements in order to not only successfully govern their health commons, but also to foster and facilitate collaborative relationships across their multisectoral and fragmented system. They were able to fulfil their collective ambition to address their own local problems by promoting a collaborative governance that incorporated all parts of the health system and made decisions as a collective unit.

This research drew together the rules that informed the participants to modify and regulate their behaviour. We particularly explored the seven elements which make up the internal structure of the action situation, namely: participants, positions, potential outcomes, set of allowable actions, control in function, information available to participants, and perceived costs and benefits. Each of these elements corresponds with a set of rules, which emerges as an outcome of the interactions from the action situation. This is the rules configuration stage of the process, where they craft, monitor, and enforce formal and informal institutions to facilitate their relationships.

As illustrated in the previous chapters, our evidence suggested that the Partnership was able to successfully devise their own formal and informal institutional arrangements in order to shape the behaviour of their participants. In order to avoid free-riding or any form of abusive behaviour towards the appropriation from the commons, the Partnership was governed by formal and informal institutions to shape and incentivise behaviour (Chapter 6.5, 6.6, 6.7, 7.3). These rule-making activities allowed the regulation of interaction amongst the participating members and also fostered/hindered collaboration and collective action (Chapter 7.2). They relied on soft structures, such as frameworks, strategic plans, governance structures, assurance and monitoring guidelines, and the MoU, to substitute to the absence of statutory legislation. This was used to create order

and mobilise the relationships amongst its participants. More importantly, the Partnership resorted to informal institutions like shared norms, trust, and reciprocity, in order to overcome the limitations of the absence of formal institutions. They took advantage of the strong history of collaboration by the embedded networks and used this to facilitate debates and enable conversations that are difficult to conduct in a formal forum.

Our evidence suggested that the creation of the GMHSC Partnership resulted into three key significant outcomes. We demonstrated this by exploring how formal and informal rules interacted at each level, namely the constitutional, collective choice, and operational levels, and how each layer affected the other.

First, there are still traces of centralist approach in the system. At the constitutional level, NHS England orchestrated centrally controlled rules on how the Partnership will be formed and how they will be monitored. Amendments to the statutory legislation were made to make way for a limited Devo Health and formal leaderships roles were created to draw links of accountability back to the top tier. NHS England and the government, therefore, played the role of meta-governors by masking the Devolution movement as a repackaged version of localism. In reality, they retained central control and continued to exert arms' length influence over the devolved city-region.

Second, the aim of Devolution was to bring decision-making closer to the citizens, and yet, the creation of this new layer of decision-making meant that some decisions have to be made at a city-region rather than local level. At the collective-choice level, the Partnership crafted another set of rules based on the guidelines set by NHS England at the constitutional level. Because of these constraints, the Partnership had to resort to other forms of informal institutional arrangements (i.e. gentleman's agreement, cooperation, etc.) to overcome the barriers to collaboration. The Partnership drew links of accountability down to the lower tier (e.g. CCGs, LAs, Trusts) to strengthen the network connections and use it to their advantage when they are exercising their

regulatory role. This implied that the Partnership exercised a top-down approach where decisions are made centrally in and on behalf of GM. With the existing partisan behaviours, inherited organisational culture of competition, and lack of statutory basis and national mandate, the Partnership found it challenging to implement it.

Third, the Partnership helped transitioned GM to shift from local paternalism with national accountability to national paternalism with local accountability. Prior to Devo Health, local NHS organisations had more control in terms of strategic planning as per their population needs and were accountable to the NHS for their decisions and outcomes. However, the entrance of the Partnership created a collective vision of making decisions that is best for GM as a whole but putting the local NHS organisations responsible and accountable to delivering it. At the operational level, the key stakeholders were bounded by the agreement that they signed with the Partnership, making them to compulsory comply with the rules imposed by the Partnership. However, since they retained their statutory roles and lines of accountability as outlined in the constitutional level, they exercised a higher degree of local autonomy. This meant that they are tied to their own organisational rules, which prevented them to fully collaborate and participate at the collective decision-making arena. Whilst the locality levels get to contribute on how the programmes will be delivered based on their local needs, i.e. creating bottom-up solutions, the Partnership was merely just an instrument to facilitate and enable these solutions to happen. At the end of the day, it is still under the remit of the localities to deliver the collectively agreed plans. All of these findings coincide with previously published evaluation reports of Communities and Local Government (2016), Walshe et al., (2018) and Sandford (2019).

This is not to say, however, that Devo Health failed to resolve the problems it aimed to address. In fact, our evidence suggested that the formation of the GMHSC Partnership resulted in a successful effort to collectively manage their well-defined and bounded

health resources by overcoming the barriers set at the constitutional level by devising their own institutional arrangements at the collective-choice level. They took advantage of the strong social networks and history of collaboration already existing within GM and utilised various forms of collaborative mechanisms to continue to build a stronger foundation of relationships within the system. Despite the challenges, the Partnership demonstrated that with the right combination of leadership, trust, and collective intention to resolve joint problems, then it is possible to overcome the political barriers of Devolution.

8.3 Theoretical contributions

Building on the theoretical foundations of the common pool resources or the 'commons', the theory of collective action, and collaborative governance, we identified that there is a research gap that needed to be explored. The key theoretical contribution of this thesis is the application of the health commons outside the US context, where we extended the by applying them in the UK health policy setting.

In the literature review (Chapter 3.2), we examined the conceptualisation and working assumptions of the health commons. Although it has always been present in the literature, earlier studies were very limited to conceptualisation and not much on empirical examination. It wasn't until Michael McGinnis and his colleagues from ReThink Health Initiative offered an emerging perspective on how we can view health resources as a common property regime and how regional and local governances can act as stewards of the health commons by initiating and facilitating institutional arrangements in order to take charge of their own health resources. Upon their examination of small health community in Grand Junction, Colorado (McGinnis and Brink, 2012; McGinnis, 2013a, 2018), we discovered that the formation of a leadership team and a health care collaborative consortium exercising informal institutions led to positive health outcomes and the long-term sustainability of their bounded health care resources. Because of the

existing strong social ties beyond the community's geographical boundary, the leadership team was able to successfully exercise some level of substantial control to monitoring the appropriation of their health commons.

The application of this theoretical framework was, however, challenging due to the limited applicability of the health commons in the US health care context, particularly on a small community like Grand Junction where it is driven by a top-down collaboration on health care stewardship and largely operated by the private sector. Further studies showed failed attempts to foster collective action amongst local communities in the US as a result of poor regionalised health policy reforms at the state and national levels. Whilst we were aware that this set-up is widely incomparable to the way the UK health care system works, both US and the UK do share the problematic narrative in addressing their dwindling finite resources and financial sustainability.

Our study, however, is not the first to explore this phenomenon. The application of the health commons drew attention to whether countries outside the US with universal health coverage will perform similarly to that of Grand Junction's. For instance, Wong et al.'s (2014) examined a small tight-knit indigenous groups in Malaysia and examined the success of their health commons through the effective management of their shared natural resources and strong knowledge base on how to preserve their health systems for future generations. Universal health coverages in indigenous populations pose unique challenges to supply, access, and infrastructure. The lack of state support and insufficient supply in medical facilities and personnel led to this small indigenous community to manage their own health commons. They took advantage of their strong social and knowledge base to empower their local citizens to take ownership and control of their health care resources. Similarly, Palumbo (2017) examined the conditions of European publicly-funded health care systems and how the health commons can be applied to managing opportunistic behaviours in accessing free health care. The author

sparked an interesting debate on how universal health care systems are comparable to the properties of common pool resources and highlighted the parallelism between the appropriation and sustainability issues between both concepts. Outcomes from such case studies have set-up future studies to provide empirical contributions to the discourse. This has proved the need for the exploration of the research gap, which strengthened our narrative to test whether we can draw lessons from the current conditions of the English health devolution agenda in managing a portion of their bounded health commons.

The outcomes of our case study were significant in advancing the debate in sustaining the health commons through carefully crafted institutions, particularly outside the US context. Our research's empirical contributions to the theoretical knowledge illustrate that the conceptualisation of the health commons is evolving and that we should continuously test it in various health systems. The uniqueness of the GM case shows that when given the chance (i.e if neither privatisation nor full state control is an option), local governments can replicate the conditions found in local communities that face social dilemmas on the commons.

Akin to Ostrom's design principles and drawing from the limitations of the empirical findings of McGinnis and his team, our research was able to successfully replicate their findings and extend it in the UK health settings. First, our findings suggested that the heterogenous multi-sectoral nature of the Partnership contributed to a pool of actors that have diverse interests and distinct backgrounds. With more than 30 organisations from public, private, and third sector, the Partnership was able to incentivise its members and forge cooperation through soft powers. In contrary with previous studies in CPR that preferred smaller groups (Agrawal and Goyal, 2001; Heikkila and Andersson, 2018) as opposed to larger and more heterogenous groups, the Partnership took advantage of its

history of cooperation and trust to glue the fragmented relationships and cracks in the GM health and social care system.

Second, our findings coincided with McGinnis' (2013b) and Wong et al.'s (2014) studies on the emergent use of informal institutions as a countermeasure to state involvement and potential political tensions. In Wong et al.'s (2014) study in particular, social protection and altruism played a key role in garnering collective interest amongst the members to pool their resources for the benefit of the indigenous community. Given that this study was in a context outside the US and in a small tight-knit community in a rural area in Southeast Asia, the role of informal institutions were important to informing the way local governments would respond to collective action dilemmas. Similarly, McGinnis' (2013b) found the value of exercising informal sanctions as a means of conflict resolution mechanisms. Rather than imposing an authoritative form of punishment to those who do not abide by the “rules”, the Grand Junction health leaders used gentler forms of communication to modify each other's behaviours.

Summarised as the design principles to addressing the health commons (Chapter 7.5) in Table 19, we found that GM was able to mimic the outcomes of previous studies through the use of informal institutions as countermeasures to the formal restrictions posed by NHS England. Although NHS England awarded delegated responsibilities to GM, they were still subjected to national mandates and regulations. With the limited level of autonomy, GM created formal structures (such as governance and frameworks) in order to operate in a hierarchical manner and create a chain of command across the conurbation. However, informal institutions were vital to bridge the fragmented cracks of the system. Informal modes of networking, which were built on trust and reputation, were utilised in order to facilitate conversations, engage in discussions, resolve conflict, and monitor compliance between the members.

Lastly, our findings corroborated the existing studies on the health commons. As it appears, communities with existing levels of cooperation and collective intention – regardless of their size and location – thrive in collaborative settings and can successfully craft, enforce, and monitor their own bounded resources. GM possessed the right key ingredients (i.e. history of cooperation; trust and reputation building; strong interest for joint collective action; and presence of influential leaders) to take charge of their health commons, which then guided the formation of their formal and informal institutional arrangements. The presence of influential leaders, more importantly, played a key role in steering the direction of the collaborative governance during its early stages. All of these guided and regulated their decision-making and relationship-building. Whilst there were still existing tensions in some pockets of the system, the Partnership banked on GM's strong history of cooperation as a form of buy-in mechanism and encourage its members to participate in Partnership-level activities.

8.4 Methodological contributions

Another objective of this research is to examine the factors that hinder or enhance collaboration and interaction. By using the theoretical lens of the role of institutions in governing the commons, this research was able to offer a pragmatic and more practical way of using and analysing rules configuration in the health commons context. First, we offered a unique research design and methodological approach that combines the strengths and weaknesses of case study research using a critical realist approach. Second, we took advantage of the explanatory power of the IAD framework to contextualise complex policy situations and identify mechanisms that led to a given outcome.

Studies on the commons and collective action utilised a diverse set of methodological approaches in order to prove that sustainability can be attained if self-organising communities establish their own institutional arrangements, as opposed with state-led or

private-owned approaches. We examined the methodological debates that dominated the field of social science and how the studies in the field of commons contributed to this discourse by using a variety of sophisticated analytical methods (Chapter 4.2). Ranging from case study methods, field-based research, meta-analysis, action research, experiments in the laboratory and field, and agent-based modelling, the study in the commons acknowledged that there is no single prescribed method that can fully address collective action problems.

By applying an institutional approach to examining the health commons in the UK setting, we advanced the theoretical inquiry and empirical evidence on the effectiveness of institutions as a solution to addressing collective action dilemmas. This research contributes to the rich database of empirical studies on rules configuration by employing a critical realist approach using qualitative methods (Chapter 4.3, 4.4). Our unique approach to examining the health commons particularly also contributes to the growing field of understanding the governance of common property regimes across a multidisciplinary context.

The IAD framework has been applied in numerous contexts in examining the commons including large-scale ecosystems (Heikkila and Gerlak, 2005, 2018; Gerlak and Heikkila, 2006), watershed partnerships (Moore and Koontz, 2003; Imperial and Koontz, 2007; Hardy and Koontz, 2009), fisheries (Rudd, 2004; Imperial and Yandle, 2005), forestry management (Koontz, 2003), and polycentric settings (Whaley and Weatherhead, 2014); however, it has yet been explored in the health commons context.

This research was able to contribute to this methodological gap by successfully examining the role of institutions in governing the health commons through the utilisation of the IAD framework. We identified this framework as the best and most appropriate analytical tool to assist us in organising the complex situations that occurred to establish the institutional arrangements that emerged before (Chapter 5), during (Chapter 6), and

as a result (Chapter 7) of the collective action in governing the health commons. It had the explanatory advantage to investigate the collaborative and institutional mechanisms associated with collective action efforts, particularly with its focus on rules configuration (Chapter 6, 7.3). Moreover, we used the IAD's multiple levels of analysis to be able to compare how the rules obtained from one level affect the rules configuration of the proceeding level (Chapter 7.2). This advantage enabled us to extend the application of the IAD framework in the health commons setting.

The IAD framework helped us to (1) identify the exogenous variables that set up how participants interact within an action arena (Chapter 5); (2) configure the different types of rules that emerged as a response to their interactions and given the constraints on information and incentives (Chapter 6, 7.3) (3) explore the interaction of rules and how they are nested from one level to another through the multiple level of analysis (Chapter 6.8, 7.2); and (4) identify the process outcomes arising from the interactions (Chapter 7.5). Through these, we were able to configure the circumstances which can foster collective action and stewardship of the health commons, which we summarised as the design principles analogous to that of Ostrom's (1990) and McGinnis' (2013a) original contributions (Chapter 7.4).

8.5 Policy contributions

One of the rationales for conducting this research is the need to propose an alternative solution on how the NHS can sustain the system. Although we did not conduct a thorough outcomes evaluation regarding the effectiveness of Health Devo (as identified earlier, this can be found elsewhere, see Walshe et al., 2018), this thesis instead was able to offer an unconventional perspective in managing the health commons by crafting and monitoring institutional arrangements to address collective action problems. This section, therefore, explores the policy contributions of this research and how key players

(e.g. other Combined Authorities, etc.) can learn how to best set up the “rules of the game” for optimal outcomes.

In terms of health outcomes, this thesis did not aim to evaluate the impact of the GMHSC Partnership on the GM population. However, we should still acknowledge their achievements and shortcomings in terms of the immediate outcomes of their transformational programmes. Devo Health in Greater Manchester is currently in its 4th year of operation and the Partnership still has so much to offer. Within these 4 years, GM has managed to fulfil one of their key visions of establishing a Joint Commissioning Board (JCB), which began its full operation in December 2018. They were meant to bring together all commissioning bodies in GM to carry out GM-wide binding decisions (NHS in GM and GMCA, 2018). Recent reports (NHS in GM and GMCA, 2019b, 2019c) also showed the following improvements in the system performance: general waiting time for referral to treatment in NHS Trusts and FTs has dramatically improved and is well above the England performance, and referrals in primary care has improved showing a more effective management in demand within the community. There are also notable improvements in the overall population health of the city-region; however, there are still performance variations across the system, particularly in A&E waiting times and delayed transfer of care. The most recent business plan aims to focus on the acceleration on progress talks with GMCA regarding integration of health and social care with all other policy areas and the promotion of a single commissioning system with coordinated local care organisations that deliver coordinated care to the population (NHS in GM and GMCA, 2019a).

We should not, however, isolate the situation in Greater Manchester as the only case. Devolution of NHS functions is happening elsewhere in various forms and in different parts of England. London, for instance, also received devolution agreements to also take some level of control to their health and social care economy. This was again driven by

the political agenda of localism as a means of decentralising powers and responsibilities back to the local authorities (Department of Health and HM Treasury, 2017; Mayor of London, 2017; Naylor, 2017). Moreover, far from the political side of devolution but similar in agenda is NHS England's contentious advocation for place-based and person-centred approach to delivering care. This was highlighted in their 2014 national strategic plan, the Five Year Forward View, which promoted new models of care to put more emphasis on preventative care at a community level, integration of health and social care services, and empowering patients to take control of their health (NHS England, 2014).

The integrated care systems (ICS), for example, is one of the models for care currently being promoted. This aims to reduce costs and encourage collaboration across different parts of the HSC system through shared pooled budgets between local councils and CCGs, joint governance structures, and joint planning responsibilities (NHS England, 2014; Checkland et al., 2015). NHS organisations (i.e. CCGs, Trusts, and Foundation Trusts) and local authorities are to submit Sustainability and Transformation Plans (STPs) outlining how place-based approach can be applied within their geographic scope (also known as STP footprints). They have to bid nationally, put forward a quality application, and essentially compete with the rest of the country in order to receive extra cash from the £2.1 billion pot of Sustainability and Transformation Fund (STF) (*see* NHS England et al., 2015). This single application and central approval process system was intended to support collaboration and to reduce bureaucracy.

GMHSC Partnership, in many ways, is essentially a repackaged version of the ICS – except the Devolution agreements enabled them to do more. Perhaps we could compare it as a double-edged sword; where in one hand, Devolution has granted GM some level of autonomy to make decisions at a city-region level through new ways of

collaborating, whilst on the other hand, this set-up has constrained them to adhere to the NHS constitution and comply to centralist policies set by NHS England[15].

Our research offers a new way of examining the continuing evolving policies to bridge the fragmented system of the NHS and eventually sustain it for the future generation. We offer a critical departure point for examining the impact of Devo Health and the NHS integration policies through rules configuration and perhaps, an alternative recommendation for future policies and managing ACOs and ICPs.

In the literature review (Chapter 2.3), we identified that Ostrom offered an alternative individualistic conception to collective action. She established that communities can exercise self-governance of their commons through the aid of institutions, without the involvement of the state nor without the aid of privatisation. However, theory also suggested that whilst self-organised systems are more effective than government regulation and intervention, it is not necessarily a panacea to resource management. State intervention, in fact, can sometimes be a key set piece to the success of managing the commons as we have illustrated in this thesis.

Our empirical findings demonstrated that whilst some responsibilities were delegated to GM, NHS England still played a key role in regulating and monitoring the activities occurring in the Partnership level. Moreover, Whitehall was key to passing the legislation that paved way to the devolution agreements between GM and NHS England. This resulting arrangement is rather common in CPR studies where the government plays an intervening role not only to mediate disputes, but also as ultimate guarantor of property rights arrangements (Agrawal, 2002; Mansbridge, 2014).

[15] We should always exercise caution when interpreting this because of the controversial labelling of Devo Health policies as ‘devolution’ when in fact, it is merely just delegation of some NHS responsibilities.

Consequently, Sarker (2013) stated that where polycentric governance exists, 'state-reinforced self-governance' is a recommended alternative. As we outlined in the introductory chapter of this thesis (Chapter 1.2.2), we identified how the multiple overhauls of the NHS over the last two decades resulted into a complex system. Ostrom et al. (1961) denoted this as polycentric governance, where there are many centres of decision-making that are formally independent of each other with overlapping domains of responsibilities. Sarker (2013:728) argued that a cooperative relationship between the state and non-state actors in polycentric settings is encouraged through institutional arrangements. In this case, the state offers substantial financial, technological, statutory, and political support, but without exercising coercive and authoritative involvement.

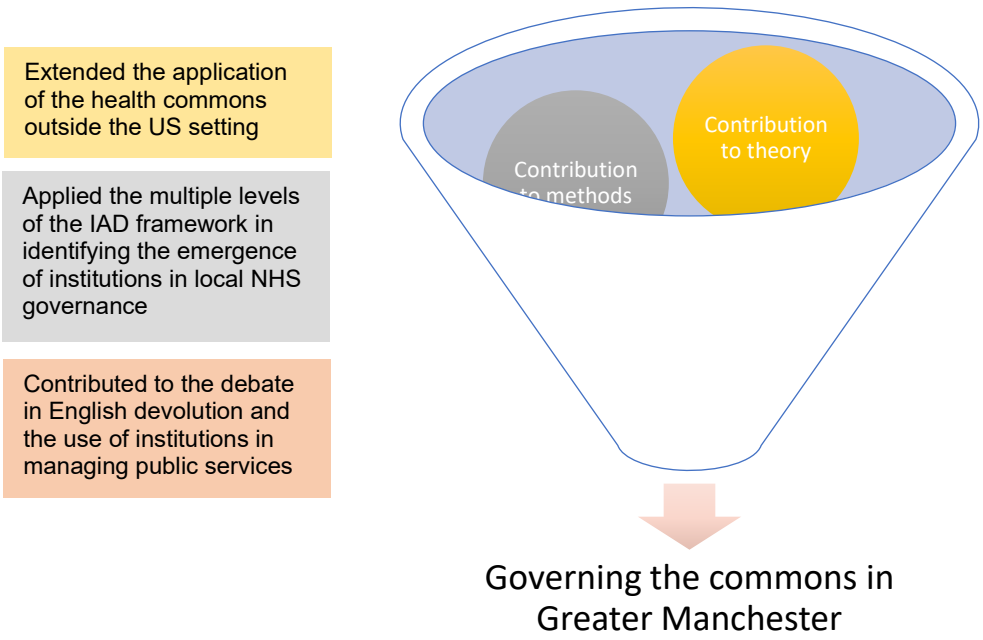
In some ways, we could draw parallelisms from Sarker's (2013) study and argue that our findings illustrated that the GM health devolution model is a 'state-reinforced self-governance'. To avert the tragedy of the commons in the NHS, this thesis believes that should the government and NHS England award further delegated responsibilities to combined authorities or metropolitan regions, they should take into consideration the: (i) level of authority that they exercise with regards to monitoring and regulating the performance and activities at the collective tiers; and (ii) the amount of ownership of the health commons that are being awarded to the collective and operational levels. Perhaps this set-up will allow devolved English regions to flourish and craft their own institutional arrangements that will suit their local needs, but also maintain a collaborative relationship with the central government.

8.6 Limitations and recommendations

The key contributions of this thesis are summarised in Figure 26. The thesis is an examination of the emergence of formal and informal institutions as a response to collective action dilemmas. In particular, we used the theory of collective action to unravel the factors that could help sustain the health commons of a devolved region in the UK.

Our findings had theoretically contributed to the application of the health commons by using a case study outside the US setting. We advance the debate on whether publicly-funded health systems are comparable to that of a small community in Grand Junction, Colorado. Our empirical results show that regardless of the size, location, or contextual setting, communities with existing levels of cooperation and collective intention thrive in collaborative settings and can successfully craft, enforce, and monitor their own bounded resources. In order for us to execute this, our study applied the multiple levels of analysis of the IAD framework in order to identify the collaborative mechanisms that led to such institutional outcomes. This methodological contribution allowed us to extend the application of the IAD framework in the health commons setting.

Figure 26: Summary of contributions



Lastly, our research offered an alternative perspective in looking at the health devolution policy in England. We recommended that NHS England re-examine their position in the devolution process and allow devolved combined authorities to function as a 'state-reinforced self-governance'. The central government can still play an active role in providing political and financial support, but without authoritative involvement in

monitoring and regulation process. This will allow devolved English regions the flexibility that they needed to craft their own institutional arrangements suited to their local needs, but also receive collaborative support from the government and NHS England when needed.

This research has limitations, both in the theoretical and methodological aspects. First, our views on managing the commons were mainly driven by Ostrom's advancement on the common pool resources and the role of institutions in addressing sustainability problems. We focused on neo-institutionalist theories of rational behaviour, collective action, and collaborative governance as the key drivers of our model. However, we failed to explore other theories that could also potentially explain individual behaviour and the need for collaborative mechanisms to organise relationships, such as principal-agent theory, network theory, organisational theory, and new institutional economics. This could perhaps be explored and applied in future research when examining factors other than institutions. Second, our interpretation of the health commons was limited to McGinnis' definition and his application of Ostrom's design principles. Since our focus was to compare health systems similar to the commons, other concepts such as health governance were not compatible to our research focus. Moreover, our conceptualisation of the health commons was also constrained by the limited empirical evidence that explored other health systems outside the US. Because of this, we were not able to evaluate the full extent of the health commons in diverse settings.

Third, we encountered several methodological issues when conducting this research. Our research design focused only in a single case, which we have already justified previously (Chapter 4.4.3). Whilst we have been successful in identifying how GM has managed to create institutional arrangements and use collaborative mechanisms to govern their local health systems, it remains that GM is an extreme case that exhibited strong models of cooperation and collaboration. We recommend future

studies to expand the cases being examined and conduct a comparative analysis to further diversify the results. Perhaps other methods could also be explored, such as action research or ethnography, where the researcher can immerse in the system and make observations. Field study would have been a perfect data collection technique for this research; however, due to the constraints resulting from the amount of time spent for the HRA application and the fact that the Partnership already commissioned University of Manchester to conduct a qualitative and quantitative evaluation, this was removed as an option.

Given these limitations, we are hoping that more policy scholars in the UK and Europe will take interest in applying an institutional approach the health commons and advance the empirical evidence using more innovative methodological approaches. We are also hoping that this research was able to inspire an alternative solution to examining regional and community-based collaborative health settings.

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Appendix A: HRA Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Matthew Gobey
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Room 4.22 Business School, All Saints Campus
Oxford Rd
Manchester
M15 6BH

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

20 June 2018

Dear Dr Gobey

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Practice to policy: assessing evidence-based decision-making in health policy in Greater Manchester**
IRAS project ID:	**237073**
REC reference:	**19/HRA/0037**
Sponsor	**Manchester Metropolitan University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum

website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: **Whale33**). The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document "*After HRA Approval – guidance for sponsors and investigators*" gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

IRAS project ID	237073

Name: Ms Ramona Statache
Tel: 0161 247 2852
Email: ethics@mmu.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **237073**. Please quote this on all correspondence.

Yours sincerely

Joanna Ho
Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Ramona Statache, Sponsor Representative, Manchester Metropolitan University*
Dr Gillian Heap, Lead NHS R&D Contact, The Christie NHS Foundation Trust
Ms Kimberly Camille Lazo, Student, Manchester Metropolitan University

IRAS project ID	237073

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Covering letter on headed paper [Cover letter v1.0]	1.0	19 April 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]		16 April 2018
HRA Schedule of Events	1	05 June 2018
HRA Statement of Activities	1	05 June 2018
Interview schedules or topic guides for participants [Topic guides for participants]	1.0	12 March 2018
Interview schedules or topic guides for participants [Topic guides for participants v1.0]	1.0	19 April 2018
IRAS Application Form [IRAS_Form_24042018]		24 April 2018
IRAS Application Form XML file [IRAS_Form_24042018]		24 April 2018
IRAS Checklist XML [Checklist_24042018]		24 April 2018
Letter from sponsor [Letter from sponsor]	1.0	19 April 2018
Letters of invitation to participant [Letters of invitation to participant v1.0]	1.0	19 April 2018
Non-validated questionnaire [Non-validated questionnaire v1.0]	1.0	19 April 2018
Participant consent form [Participant consent form v1.0]	1.0	19 April 2018
Participant information sheet (PIS) [participant information sheet 1]	1.0	19 April 2018
Participant information sheet (PIS) [participant information sheet 2]	1.0	19 April 2018
Research protocol or project proposal [Project protocol v1.0]	1.0	19 April 2018
Summary CV for Chief Investigator (CI) [Summary CV for Chief Investigator v1.0]	1.0	19 April 2018
Summary CV for student [Summary CV for student v1.0]	1.0	19 April 2018
Summary CV for supervisor (student research) [Summary CV for supervisor v1.0]	1.0	19 April 2018

IRAS project ID	237073

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	Sponsor has updated the participant information and consent documents to align with HRA assessment criteria and standards and to ensure compliance with the General Data Protection Regulation (GDPR).
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will act as an agreement of an NHS organisation to participate. No other study agreement is expected for this study.
4.2	Insurance/indemnity arrangements assessed	Yes	Sponsor indemnity applies to the management, design and conduct of the study.
4.3	Financial arrangements assessed	Yes	No application for external funding has been made for this study. No funding will be provided to the participating NHS organisation as indicated in the Statement of Activities.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Not Applicable	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	This study is exempt from REC review as the research is limited to involvement of staff as participants only.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a non-commercial multicentre study where all participating NHS organisations will be undertaking all research activities as described in the IRAS application. There is therefore only one site-type in this study. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

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Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A Principal Investigator should be in place at each participating NHS organisation. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Local staff substantively employed by the participating NHS organisation will be undertaking research activities as described in the IRAS application. No HR access arrangements are therefore expected for this study. Where arrangements are not already in place, network staff employed by another Trust or University (or similar) undertaking any of the research activities listed in A18 or A19 of the IRAS form (except for administration of questionnaires or surveys), would be expected to obtain an honorary research contract from one NHS organisation (if university employed), followed by Letters of Access for subsequent organisations. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm enhanced DBS checks, including appropriate barred list checks, and occupational health clearance. For research team members only administering questionnaires or surveys, a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix B: Invitation to research

Kimberly Camille Lazo
PhD student
Dept. of Economics, Policy, and International Business
Faculty of Business and Law
Manchester Metropolitan University

Interview for Research

"Practice to policy: Assessing evidence-based decision-making in health policy in Greater Manchester"

I would like to invite you to take part in the above research study, but before you decide, it is important that you understand why the research is being done and what it would involve for you.

Please take the time to read the following information sheet, which will help you decide if you would like to take part. It sets out why we are doing the study, what your participation would involve, and how this information will be used. I will go through this sheet with you and answer any questions you may have. If there is anything that is not clear, or if you would like more information, please feel free to ask me.

What is the purpose of this study?

The aim of this interview is to gather as much information as possible about the overall decision-making process in a local context, the factors that influence knowledge translation, and to provide an overall picture of how actors/organisations involved in a collaborative set-up interact in order to produce policy outcomes. The information that I will collect from these interviews will help me analyse 'who', 'what', 'why', and 'how' decisions are made in a local decision-making level.

Who is doing the study?

The study is being carried out by Kimberly Lazo, a 2nd year PhD student from the Faculty of Business and Law at Manchester Metropolitan University. The study is being supervised by Dr Matthew Gobey of the Department of Economics, Policy, and International Business.

Who is being asked to participate?

You have been invited as a participant because of your position/job description in your current organisation.
In particular, you:

- Must be a staff of the Greater Manchester Health and Social Care Partnership or Greater Manchester Combined Authority; or, must be a staff of the NHS
- Must be holding a position in either the NHS or in the council that has a role in decision-making. Position may vary from councillor, public health director, public health policy associate, project lead, commissioner, etc.
- Must be working in Greater Manchester directly affecting public health policy, such as gathering data, analysing data, developing policy, implementing policy, commissioning, or evaluating programmes.

What will be involved if I take part in this study?

I will be conducting face-to-face interviews with individuals who have direct experience on evidence-based decision-making, contributing to the overall policy process. This interview is part of the pilot study of this research. The interview may last from 1 to 1.5 hours and the conversations will be audio recorded. You will be asked open questions about the factors that influence your decision-making, the outcomes of this decision, the level of interaction with other actors in this process, and your opinion on the impact of collaboration with other organisations. The interview will take place in any available space within the vicinity of the Manchester city centre.

Will the information obtained in the study be confidential?

Manchester Metropolitan University is the sponsor for this study based in Manchester, England. We will be using your information in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Manchester Metropolitan University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting us (see contact details below).

How will my information be handled?

Data handling will be in accordance with the General Data Protection Regulation 2018. This means that when you agree to take part in a research study, we will use your data in the ways needed to conduct and analyse the research study. We will keep your name, contact details, and other personal information and will not pass this information to the university. We will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Certain individuals from the university and regulatory organisations may look at your research records to check the accuracy of the research study. The university will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, or any other details.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. We will use the minimum personally-identifiable information possible. This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

Can I withdraw from the study at any time?

Yes. You will be able to withdraw or discontinue participation in research at any time without giving any reason. All identifiable data will be destroyed, and anonymised data will be kept and will be treated with confidentiality.

What will happen to the results of the study?

The results from this interview will be part of the study's analysis. It will form the basis of my PhD thesis to be submitted to Manchester Metropolitan University. Your information could be used for research in any aspect and could be combined with information about you from other sources held by researchers, the NHS or government. Where this information could identify you, the information will be held securely with strict arrangements about who can access the information. Should you want to receive the results or outcomes of this study, kindly fill in your contact information on the consent form.

If you agree to take part and would like more information or have any questions or concerns about the study please contact Kimberly Lazo, researcher, by email (kimberly.c.lazo@stu.mmu.ac.uk). Any incident (i.e. complaints, misconduct, etc.) that occurs during the study should be directed to the researcher in the first instance, otherwise, contact Dr Matthew Gobey (m.gobey@mmu.ac.uk, 01612 473872) or Ramona Statache (ethics@mmu.ac.uk, 0161 2472853) (Manchester Metropolitan University, Manchester, M15 6BH) for any other complaints about this study.

Thank you for taking the time to read this information sheet.

Appendix C: Initial interview schedule before pilot study

Kimberly Camille Lazo
PhD student
Dept. of Economics, Policy, and International Business
Faculty of Business and Law
Manchester Metropolitan University

Interview Topic Guide Outline

"Practice to policy: Assessing evidence-based decision-making in health policy in Greater Manchester"

For interviews:

1. About yourself

Tell me about yourself.
- Name
- Educational background

Tell me about your job and your duties in the organisation.
- Job title
- Affiliated organisation
- Duties & responsibilities
- Job before your current position (GP? Nurse? Etc.)

2. About public health

Tell me about your experience in the public health policy area
- Years in your current role
- Years in the public health policy area
- Any related experience to public health and policy

3. (For Cancer Vanguard Innovation staff) About Gateway-C

What is the project you're involved in?
- Name of project *Gateway-C*
- Role in the project

4. (For Cancer Vanguard Innovation staff) Decision-making

Could you please describe your role in the project?
How did this role come about?
What is your major contribution to the project?
Did you do any similar tasks to other Vanguard projects?
Did you have any role in formulating, designing, implementing, and/or evaluating the 'Gateway-C' project?

Formulating/designing: Did you have any role in how Gateway-C was created? Discuss. (i.e. deciding to do it on Moodle, designing the website, etc.)

- How did Gateway-C come about?
- How did you decide that online learning will be effective?
- What kinds of sources or types of information did you look at to support your decision?
- Why was Gateway-C designed like this?
- What is the rationale behind it? (e.g. identifying the problem)
- What kind of outcome were you expecting from Gateway-C?

Implementing: Did you have any role in how Gateway-C was administered? Discuss. (i.e. finding GPs, etc.)
- Where did you decide to implement Gateway-C?
- What are the reasons behind choosing them?
- How did you choose the participants?
- How did you design measuring the outcome of the project?
- What kinds of sources or types of information did you look at to support your decision?

Evaluating: Did you have any role in how Gateway-C was evaluated? Discuss. (i.e. post-administering, verifying survey results, cost evaluation, etc.)
- What were the main outcomes of Gateway-C?
- Do you think it achieved its objective? Discuss.
- Do you think it will be effective? Why do you think so?
- What happens next to Gateway-C?
- What kind of evidence do you think did Gateway-C produce? New evidence? Supporting to existing evidence? Etc.

Who are involved in this process?
To whom do you intend this project is for? Designed for public or for policy makers?
Did you receive advice (external or internal) re: designing, implementing, evaluating Gateway-C?

5. (For both Cancer Vanguard Innovation and Greater Manchester Health and Social care staff)

Evidence-based policy

I am now going to ask questions about Evidence-based policy.
- Ask if participant is familiar with the term.
- A brief description of what evidence-based policy is will be provided.

Understanding of what constitutes as 'evidence'
- Participant may list what they think are the types of evidence
- What do you think are the types of evidence regularly used by people similar to your role?
- What types of sources of information are regularly used by people similar to your role?
- What types of evidence do you think will be most useful by people similar to your role?

Attitudes towards evidence
- How often do you access evidence to inform your work?
- To what extent do you think these ways of accessing evidence are directly useful to the work you do?
- How often do you use evidence produced by these sources to inform your work?
- Thinking about the job you currently do, how much importance is placed on using evidence to inform… your own job, the work of your colleagues, the sector that you work in