Title

'It's a whole cultural shift': Understanding Learning in Cultural Commissioning from a Qualitative Process Evaluation.

Authors

Crone, D.*, Professor, Exercise and Health, School of Sport and Health Sciences, Cardiff Metropolitan University, Cardiff, CF23 6XD, UK. Email: dmcrone@cardiffmet.ac.uk

Ellis, L., Research Assistant, School of Health and Social Care, University of Gloucestershire, Cheltenham, GL50 4AZ, UK.

Bryan, H., Professor, Education, School of Education, University of Gloucestershire, Cheltenham, GL50 4AZ, UK. Email: hbryan@glos.ac.uk

Pearce, M., Senior Programme Manager, Gloucestershire Clinical Commissioning Group, Sanger House, Gloucester, GL3 4FE, UK. Email: matthew.pearce4@nhs.net

Ford, J., Senior Programme Manager, Gloucestershire Clinical Commissioning Group, Sanger House, Gloucester, GL3 4FE, UK. Email: jules.ford@nhs.net

Key words

Co-production, commissioning, arts, health, qualitative,

Acknowledgments

We are grateful to all the respondents who shared their experiences with us and who provided such valuable insight. We are also grateful to colleagues from Create Gloucestershire and the Gloucestershire Clinical Commissioning Group for their critique of findings used in the preparation of this paper.

Funding Declaration

This work was commissioned by NHS Gloucestershire Clinical Commissioning Group (CCG).

Ethical Approval

The study received approval from the Gloucestershire Clinical Commissioning Group through the Gloucestershire Research Support Service (R & D ref: 16/008/CCG).

*Corresponding author

Word count: 7998 inc. footnote but not inc. references or figures.
Abstract: 116 words
Figures: 3

Abstract

This qualitative process evaluation investigated learning from stakeholders (patient representatives, art managers/artists, clinicians and commissioners) involved in a co-produced cultural commissioning grant scheme. The scheme was devised as a mechanism to foster learning between, and within, stakeholder groups and to embed co-production in decision-making in clinical commissioning. The evaluation included respondents (n=36) from four stakeholder groups in three sequential stages. Findings identified themes centred on outcomes, learning, co-production, and cultural and political change, specifically that stakeholder roles need to be clearly defined and understood and that co-production takes a significant time commitment. Co-production in innovative projects is both complex and challenging. However, despite this, involving stakeholders has benefits for service design and the clinical commissioning process.

Introduction

In 2015, a national Cultural Commissioning Programme, funded by Arts Council England, was developed to support public sector commissioners understand how to improve outcomes by integrating arts and cultural activities into services, including mental health and wellbeing, older people and place-based commissioning (Consilium, 2016). One of the pilot sites for this programme was Gloucestershire; hosted and supported by NHS Gloucestershire Clinical Commissioning Group (CCG). Other strategic partners included Create Gloucestershire (the county's umbrella organisation for art organisations and artists), three lower tier district councils, the County Council, Gloucestershire Voluntary and Community Sector Alliance and the local University. In order to develop a tangible way to conceptualise the commissioning of arts and culture for health and well-being, this partnership developed a grant scheme. This aimed to act as an avenue for feasibility projects to gather learning about how arts and health interventions could improve outcomes as an adjunct to standard NHS interventions. Clinical Programme Groups (CPG's), which included commissioners, clinicians, health providers and patient representatives, identified outcomes that were hard to achieve through standard NHS interventions. These outcomes were diverse ranging from men of working age living with chronic pain and experiencing a loss of role, to self-esteem and social connection for children and teenagers with Type 1 diabetes not taking up self-management advice.

Bespoke grant criteria and application processes were developed, co-productively to address the outcomes identified by the CPG's. Following a series of engagement events to review grant processes and procedures projects were advertised to the arts and culture sector inviting creative responses to the clinical outcome requirements identified by the CPG's. Advertising of the scheme was followed by market testing and engagement with the voluntary sector and following receipt of applications, a selection process with commissioners, art specialists and clinicians. In total 12 innovation projects were funded. Stakeholders involved in those projects, plus members of the strategic partnership managing the scheme, were the targeted respondents[1] for this process evaluation. The aim of adopting a co-production

[1] We use the terms 'stakeholders' to denote those involved in the commissioning, design and delivery of the programme, and who were respondents in this research. 'Participants' are people who engaged in the interventions, some, but not all of whom were patients.

approach enabled clinicians, commissioners, arts managers/artists and patient representatives, to be part of a distributed leadership structure overseeing the selection, design and implementation and evaluation of the innovation projects (Crone, Ellis, & Bryan, 2017).

Understandings and definitions of co-production

Co-production has a long tradition within public services, is key to public policy reform, and central to this scheme (C4CC, 2015). However, co-production is often badly formulated with multiple and conflicting definitions of co-production ranging from '… *the voluntary or involuntary involvement of public service users in any of the design, management, delivery and/or evaluation of public* services' (Osborne, Radnor, & Strokosch, 2016), to positioning co-production at the top of Arnstein's (Arnstein, 1969) ladder of participation in which power is delegated to, or controlled by, citizens rather than professionals (Munoz, Farmer, Warburton, & Hall, 2014).

Co-production it could be argued can therefore be seen as a continuum in that it is described as being on three levels (Needham & Carr, 2009):

Descriptive:	Services in which there is the bare minimum of service user involvement
Intermediate:	In which service users' views are taken into account and fed back to providers who may make changes
Transformative:	The relocation of power and control in which there is reciprocity between professionals and communities.

However, whilst this typology is useful in order to conceptualise co-production, it is problematic on two counts. Firstly, it fails to recognise the messy reality of co-production in practice; co-productive endeavours seldom fit neatly along such a continuum. Secondly, as will be shown, creating typologies of co-production creates corresponding expectations about what is 'true' co-production, making co-produced processes laden with fears of tokenism and failure. Whilst a key aspect of co-production is the disruption that comes from sharing power with non-professionals to develop new ways of doing things, this disruption is risky and can

result in projects over-running or even failing to get off the ground in the first place. Budgetary controls, time constraints, dominant voices and human nature, all create the perfect conditions for a fraught and difficult process. Thus taking a genuine or 'true' co-productive approach (as opposed to a tokenistic use of the term), means that an endeavour may or may not *appear* to fit into any of the commonly understood and accepted definitions of what co-production *looks* like, despite being co-produced. It follows therefore that co-production processes do not fit into neat levels of participation along a more or less linear continuum, but rather co-production is a *spectrum* which may have strengths and weaknesses in different areas and points in time. Penny and colleagues (Penny, Slay, & Stephens, 2012) capture some of the complexity of this co-production process by suggesting that it is underpinned by six principles:

1. Assets: Transforming the perception of people from passive recipients to equal partners.
2. Capabilities: Building on what people can do and supporting them to put this to work.
3. Mutuality: Reciprocal relationships with mutual responsibilities and expectations.
4. Networks: Engaging a range of networks, inside and outside 'services' including peer support, to transfer knowledge.
5. Blur roles: Removing tightly defined boundaries between professionals and recipients to enable shared responsibility and control.
6. Catalysts: Shifting from 'delivering' services to supporting things to happen and catalysing other action. (Penny et al., 2012 p7)

Penny et al. combine these principles with Needham & Carr's (2009) typography to develop a reflexive assessment tool with the case studies providing an illustration of how co-produced the process has been. There are naturally caveats in the use of such a subjective tool and the elasticity of co-production, whilst being a strength is also a limitation; thus, when it comes to evaluation, the relational dimension of co-production can make it a poor fit (Durose, Needham, Mangan, & Rees, 2017). As such, evaluating co-productively the co-production process of a large and multifaceted project such as the GCCP grant scheme posed significant challenges, not least because, as will be shown later, some projects faced more challenges in working co-productively than others. Therefore, this process evaluation

investigated how the grant scheme worked in practice for the various design and delivery stakeholders. It was not designed to assess how 'true' or 'real' the co-production was, but sought to draw out learning from the process and identify, where possible, what, if any, culture shifts resulted from the NHS commissioning interventions coproduced with and delivered by, the arts and culture sector. It was considered that learning from this pilot programme could both inform commissioning practice in the future (Consilium, 2016) and contribute to the growing evidence of the potential for arts and cultural activities to meet clinical outcomes (APPG, 2017).

Research design

The process evaluation adopted an iterative, qualitative framework (Polkinghorne, 2005). Through three distinct but related stages, it aimed to investigate using interviews, workshops and member checking, stakeholders' experiences and perspectives of the learning that occurred, through their involvement in the grant scheme. Of particular interest was learning in respect to process and change in commissioning, and both the political and cultural environment of arts for health from the perspectives of all stakeholders. Adopting an iterative qualitative approach to data collection and analysis provides the opportunity for frequent reviewing of emerging themes, through triangulation and study design, which ensures trustworthiness and rigor of the findings (Creswell & Miller, 2000; Mays & Pope, 2000). The methodological framework was designed to have the voice of the individual stakeholder at the centre of the evaluation, thus positioning them at the start and heart of the process. To achieve this, in the analysis of the interviews as much weight was given to the voices of patient representatives (artists and clinicians,) as arts managers and commissioners. The workshop was also designed to support the different stakeholder groups to articulate their experiences and then share them. This was central to the co-production approach taken by the grant scheme itself, but also supported calls for qualitative evaluation approaches and of the importance of involving multiple stakeholders into the whole process of evidence generation and interventions design in the arts and health context (Staricoff, 2006).

In terms of methods, the use of both interviews and workshops was designed to enhance the capture of rich data and, with respondent validation, support the triangulation of data for a comprehensive understanding of the findings, from all perspectives (Lambert & Loiselle, 2008). This iterative approach aimed to draw all stakeholders into the arena of evidence generation to understand the multiple perspectives of the scheme and to help inform future cultural commissioning practice.

It was designed to consider the following questions in the area of cultural commissioning in health which include:

- The worth and value of commissioning arts for health programmes
- The lessons learnt for health commissioners, clinicians, arts and culture sector
- The lessons learned from patient participation
- The potential to shift power in the commissioning process

Summary of the data collection process

A total number of n=36 respondents took part in the study and were classified as stakeholders who included commissioners, clinicians, arts manager/artists, health providers and patient representatives. There were three stages as follows:

Stage 1

Interviewing: N=43 stakeholders involved in the grant scheme were invited to take part in 1:1 interviews. N=23 agreed to take part as follows: commissioners (invited n=6; n= 4 interviewed), clinicians (invited n=8; n=5 interviewed), arts manager/artists (invited n=14; n=11 interviewed) and patient representatives (invited n=6; n= 3 interviewed). This explored stakeholder perspectives around roles; perceptions and opinions of the project; learning from the process and involvement; factors enabling/hindering involvement; opinions on sustainability and future working practices in order to produce rich data. The initial themes from the analysis formed the basis for the workshops in stage 2

Stage 2

Workshops: 43 stakeholders were invited (including all those who were interviewed in stage 1) with a total of 30 respondents taking part in stage 2 (commissioners n=3; clinicians n=3; arts managers n=8; artists n=8; patient representatives n=2; steering group 6). The first stage of the workshop included a presentation of the initial findings from the interviews. This was followed by group discussions in the second stage.

These second stage group discussions were in two parts and consisted of two discussions with respondents grouped firstly by stakeholder role and then by CPG as shown in figures 1 & 2.

Figure 1 here

Figure 2 here

Respondents were provided with pre-prepared A0 worksheets to record responses to a series of questions. These were centred on understanding their experiences and learning from the projects, co-production as a way of working, and future directions. The workshop was designed so that stakeholder peer groups could share their experiences of working on their different projects with each other (e.g. commissioner to commissioner) and then in the second part, discuss how their own experiences differed, within their specific intervention group. In this way learning across the different peer stakeholder groups *and* between the various intervention groups was shared by all respondents.

Stage 3

Consolidation: Six out of the eleven invited stakeholders took part in stage 3 where stakeholders were asked to member check the final themes and review these findings in the broader context of arts for health in commissioning.

Thematic analysis was used at each of the stages (Braun & Clarke, 2006).

Data analysis

Data from the interviews and the text responses from the workshop were analysed using inductive thematic analysis techniques (Braun and Clarke 2006). Taking a realist epistemological position, interview transcripts and the outputs from the workshops were coded manually and in Nvivo before being provisionally themed semantically.

For stage 3, the consolidation stage, the provisional themes from stages 1 and 2 were summarised and presented to respondents in a word document format. Respondents were asked to review and comment on these themes. Outcomes from these discussions were noted and considered in the formulation of the final themes and their properties. Themes presented below represent the themes from the three iterative stages of data collection, collation and analysis.

Results

Five main themes were developed from the analysis: (i) outcomes from participation in the scheme (ii) learning from peer stakeholders and project participants; (iii) learning from the management and delivery of projects; (iv) awareness, perceptions and understanding of co-production; and (v) cultural and political change. These themes are explained below and include quotations from respondents' interviews and recorded notes from the workshop. Quotations, where possible are identified as specific stakeholder groups, but in some cases, where the authors felt it compromised respondents' anonymity (because of the small number of respondents), this has not been disclosed. To help preserve anonymity, gender neutral pronouns have been used throughout

Outcomes from participation in the scheme

Engagement provided a range of outcomes and benefits for respondents. Engagement, i.e. having multiple stakeholders involved, provided a means by which cultural shifts in mind-set and power differentials, can be effected. This differed depending on which stakeholder group was expressing this observed change. For example, the two quotations below, from a commissioner, refer to the place of the patient, and the art manager, refers to the perspective of the clinician:

> *Having the patients there shifted that power and it also gave them a voice, which they don't always have*. (Commissioner)

What was really nice is we did a sharing of that particular project [name of project], and a number of different practitioners, including [clinical practitioners], etc., from the service came, and they got it [laughter] and the feedback was brilliant. (Arts Manager)

Interactions between the stakeholders, and in fact their presence in the process per se, enabled a change in viewpoints, and for others, in this case a clinician, to experience first-hand the benefits to patients of the creative approach:

I think the [intervention process] is really good and when I've been to various communities about their views on the [artist] who went out to see them, they were really, sort of, full of it and really enjoyed [the artist's] company and I think they worked really well with them. So that changed my view of it and yes. (Clinician)

For these outcomes to be achieved however, it was acknowledged that there was a need for positive dynamics between stakeholders and a shared understanding of roles of each stakeholder, for this to be maximised:

I don't think we would have engaged anybody, had we not been able to actually book a room in the hospital, and meet participants, and enable them to access the project in a location that they were familiar with. Subsequently then, they've come to work at [name of arts organisation] and they've met us out at different venues and locations. But having that access to actually working in the clinical environment is actually important too. (Arts manager)

I think that [name] in particular who is the [clinician] at the [clinical area],.. really gets the impact that the arts can have on patients. So, we were all singing from the same hymn sheet. I think we were really lucky in that respect and obviously one of the challenges is that not every health practitioner might have that understanding of the arts. (Arts manager)

Learning from peer stakeholders and participants

This theme comprises three subthemes; (i) transparency; (ii) understanding processes and roles; and (iii) reciprocal learning.

Transparency

Working in co-production enabled close working and personal interactions with other stakeholders and participants which had not previously been experienced. This helped to develop an insight into both the nature of other stakeholders' work, and also how they worked. For many respondents, the involvement resulted in new

understandings around the complex processes within the National Health Service (NHS) including the commissioning process. Whilst this was previously often seen as economically driven, with commissioners seen negatively, by working co-productively the process became both transparent and human:

> *You know, I always thought they [the commissioners] don't really care about me, but the main thing I've learned is actually, they do. I just don't think they know how to do it in the right way. I think it's changed my whole perspective of the way I thought it worked, I always believed that the NHS was run by accountants, but I think that now I've learned that they're not, that maybe their hands are tied to some extent.* (Patient representative)

Understanding the role of the commissioner by clinicians, also shifted so rather than being regarded as remote, they were understood to have the interests of patients at the heart of the decision-making process:

> *I am very much involved with the patients and I think initially, I was thinking about commissioners making decisions in boardrooms and you know, well, nobody takes any notice of what we [clinicians] say. But I felt that I was really involved right from the beginning. It's made me feel like the commissioners are interested in what's happening in the lives of our patients.* (Clinician)

Gaining an insight into commissioning had a particular impact on clinicians:

> *How commissioning works, that's not something that I particularly understood before. I think commissioners are actually in touch with what's going on at ground-level, which I'm impressed by.* (Clinician)

It appears that the commissioning process has been made more transparent to stakeholders through the co-production working in the project:

> *Learning about the whole bidding process, the panel, how things are decided, being involved in the meetings so yes, how these things are funded perhaps, what does the project need to show. I wouldn't normally have anything to do with the commissioners.* (Clinician)

Understanding processes and roles

Co-production enabled the arts and culture sector, and in particular arts managers, to gain an understanding of how the NHS operates for both commissioning and clinical referrers. In terms of understanding commissioning an arts manager reflected,

> *I now understand much better how that works, how the health world works. That was useful.* (Arts manager)

In considering the processes involved in delivery, another arts manager reflected on the value of learning about processes from other perspectives:

> *Working with the [clinical] referrers as well and kind of learning about their side of things – how they were under time pressures, how things could actually work better from the recruitment point of view, for example.* (Arts manager)

These insights into the NHS functioning by managers were also shared to a lesser extent by the artists delivering the projects:

> *This is really my first project in co-production working with other professionals. I've learnt a great deal. … We've learnt a lot about the best way to deliver [the intervention] in this way as well to these people.* (Artist)

Reciprocal learning

Learning seemed to be mutual for the stakeholders. For example, commissioners and clinical staff reported learning from the artists, welcoming new approaches outside the medical field, in addition to art stakeholders learning from NHS stakeholders and project participants, particularly in terms of their specific conditions:

> *Learning from participants I'd say has been a really big thing for us. We really did gain an understanding of how little confidence someone might have, and how difficult it is for them to just regularly turn up to activities in venues that they're not familiar with, or in locations that they don't usually go to. … I'd say it's largely the participants we've learned more from, or most from*. (Arts manager)

Learning for NHS professionals took place both by observing the artist working with patients and by working together with them:

> *I think I know* [names their clinical area] *pretty well and from a clinical perspective and a medical perspective, perhaps I understand* [the impact of the condition on symptoms for the patients]. *But they've* [artists] *got a very different approach and we can learn as clinicians from their approaches.* (Clinician)

> *We did a training session [with other stakeholders] and it felt really helpful to hear the different perspectives on physical health and mental health. You hear the same perspectives from colleagues because we've all had the same*

sort of training, so it was really useful to hear sociological perspectives and artistic, creative take on things. (Clinician)

Co-production also resulted in challenging prejudices in some respondents who were not familiar with some areas of clinical practice, challenge their own prejudices:

Because this specific project was to do with [clinical area]…, it has changed my perceptions… it's really made me look at my personal response to [clinical area]… It's been very formative. (Artist)

In conclusion, learning has taken place between stakeholders in a symbiotic manner. Respondents have learned directly from each other, via their involvement in the grant scheme, in terms of how they understand the process of commissioning, the creative process itself, and in some cases, this has challenged attitudes towards marginalized groups.

Learning from the management and delivery of the projects

This theme had two subthemes, flexibility, and structure and process.

Flexibility

A flexible approach was essential to the management and working of the group, and for the design of projects and in the adapting to situations and changes as they arose during the process. For example:

The other thing was that we had to be quite flexible within the setting up of the project because there were some changes that we hadn't foreseen through the referral process, … So basically, what we decided at the outset changed and flexed through the process of liaising with the team. (Arts manager)

The need for the artists, as deliverers to be flexible, organised and adaptable was identified and valued by other stakeholders:

I think as a pilot, this was ideal, because [name of artist] *was willing to say, 'I'm not coming here with an agenda, we will just see how it works' and I think that was really important, because if he had come with 'you're going to do this and that' it wouldn't have worked.* (Patient representative)

Structure and process

The flexibility afforded by the co-production process was valued and most reference to it was made in relation to arts organisations. There was also a recognition that the

structure and process of the projects, and the grant scheme itself, needed to be flexible, especially for future commissioning:

> *I also do think that we'd need to have a fairly light structure and framework for investing in, cultural commissioning.* (Commissioner)

However, for some health professionals, the flexibility of the co-production process created difficulties:

> *I think there would need to be some sort of framework within which it's sat, so that people have some sort of guidance about what could be part of this and what really wasn't. … because of the flexibility of it, some people can take advantage of that … So with flexibility comes some sort of ownership from the organisations running a project to actually do what they said they were going to do.* (Commissioner)

In terms of the process, pressures on clinicians' time made recruitment difficult and slow, which impacted on arts delivery:

> *Because we weren't able to actually recruit our own participants, we were held in limbo, we just needed help to signpost those people to our project. I think that it's that process that could have been smoother, if we'd have got the people coming our way and referred on to the project, we would have started much quicker.* (Arts manager)

The time required to recruit patients onto such schemes was also noted by clinicians, as challenging. Clinicians were largely responsible for recruitment, but they also had difficulty in this process, resulting in frustration, especially when promoting the project to other clinicians perhaps due to the newness of the concept of cultural commissioning in health services:

> *I think that's where we have difficulty in recruiting people from the clinical side, because they [clinicians] don't get it [arts for health], if you see what I mean.* (Clinician)

Lessons learnt for the future with regard to process and structure included allowing suitable time allocated for the recruitment process, and both the time and resource to promote the projects to patients:

> *I think needing more tailored information earlier on and having longer to recruit. I think the unrealistic timeframe for recruiting populations that might not be on board, won't be expecting it, have loads on their plate, because they're maybe not well. I think if they were able to work more from the outset*

to give better info and a longer period to recruit, I think that would help a lot. (Clinician)

The time required by clinicians to recruit patients and the perceived lack of resources that these projects demanded in addition to their clinical workload, was acknowledged and understood by arts organisations who expressed empathy regarding the capacity of clinicians:

I don't know whether I'm right, but I was under the impression that the health teams and practitioners didn't really have any sort of additional funding or support in relation to their involvement with the project, so even though they were open to working with arts organisations there was obviously a real issue with capacity. (Arts manager)

Part of the process for some of the projects, involved taster sessions for both staff and patients, which were developed to promote, and thereby improve recruitment and promote a culture shift in clinicians. Taster sessions worked in two ways, to promote and help engage clinicians in the project, and allow them to better explain what the project was about to patients, and to provide some experience for patients who might want to be referred. These were received positively:

Staff taster session was brilliant... Really positive having a staff taster so they could understand what the activity was. (Workshop response)

It was also acknowledged that the taster session for participants needed to be appropriate and not challenging in respect to their perceptions, in one case the taster session was not well received by participants who then felt the project was not for them.

Feedback from patients who came to the taster session, most of them did not want to participate in the project and the feedback from them was that it was just too different from what they were expecting. It just challenged their perceptions, it just didn't appeal to them. I think we had a problem with how it was promoted to them, how it was advertised. (Clinician)

Awareness, perceptions and understanding of co-production

The theme has two subthemes; (i) understanding and perception of co-production, and (ii) challenges in engagement in the process.

Understanding and perception of co-production

Respondents' understanding of what co-production meant, and how well the co-production element worked, varied. Findings are summarised in Figure 3.

Insert Figure 3

Patient representatives seemed to grasp the concept of co-production, the opportunity this presented for them, and appeared to appreciate the way of working in areas that were important to them:

> *So, they* [patients] *have decisions made for them and things done to them, but seldom indeed have the opportunity to participate in the decision-making process. And this whole co-production process enabled them to be involved in the decision-making process and to talk about matters that were close to their heart.* (Patient representative)

Most stakeholder groups in the workshop sessions understood co-production as different individuals working together, and a diffusing of power within the decision-making process. The peer group of clinicians, when discussing co-production reflected on their own experience of co-production, which they described as *difficult (workshop response),* with time identified as a problem for them.

In individual interviews, respondents talked about their meaning of what 'true' co-production was, and there was a sense that the process of co-production and intent, was in fact central to whether it took place or not:

> *But is running things past someone co-production? I don't know. For me 'true' co-production is sitting down with people in one room.* (Commissioner)

Participation in the project has resulted in respondents understanding more about what co-production is, and also challenged their conceptions of it previously. For example:

> *I think about 18 months ago I was probably quite naïve about what co-production meant and I probably thought it was more ticking a box to say that something was co-produced ... I now see co-production as a potentially useful approach. But at that time, I saw it as a term that we used when we were working together, rather than true co-production.* (Clinician)

This quote suggests that co-production is seen as something discrete from previous practice, however co-production often takes place in clinical settings, even if it is not called as such:

> *Normally we have quite a bit [of patient engagement]. So we have two services, [intervention A] and [intervention B], so for [A] we do an educational course and on the third session we always get patients who've had [A] to come and talk to other patients and share their experiences. … we're looking at setting up a patient-led peer support network…. so we've included patient reps pretty much from the start of the service.* (Clinician)

This scenario would, as per Needham & Carr's (2009) typography count as co-production, but the clinician did not recognise it as such, suggesting that there was variance in the understanding of what co-production was.

However, despite respondents' understanding of it, and a subsequent change in perception, there were challenges with how this was actually achieved within the project. One respondent stated that without fully engaging in what co-production actually meant at the start of such a project, there would be challenges to it actually taking place in practice:

> *Co-production is just a word that's thrown around. I don't think people really understand what it is. You know, co-production might just be engaging with patients and we talked about patient engagement, patients at the heart of decision-making, community-centred approaches, person-centred approaches and we've talked about this for a long time and there's a lot of rhetoric in national policy, but understanding what that means is a whole different world, I think.* (Commissioner)

Clearly, with any new approach there are challenges, people's understanding of co-production developed through the scheme, but due to the challenges identified previously, such as time and resources for stakeholders, these were a hindrance for some. In the experiences of one arts manager, their understanding of co-production did not match the process in practice:

> *I think that I assumed that the co-production element would be a little bit more involved. So, I think that originally, we were advised that this co-production phase would mean that potentially health practitioners would want some input into how we ran the project.* (Arts Manager)

What this perhaps highlights are how expectations of roles and involvement can often be obscured, particularly in an ambitious and multifaceted programme such as the GCCP. There are other examples of respondents being unaware of other stakeholders, particularly patient representatives, involvement in the process. This again goes back to a shared understanding that co-production involves all stakeholders in all parts of the process.

Challenges in engagement in the process

Engagement in the process of co-production was varied. Most respondents in the evaluation, from both arts and health, experienced some level of difficulty in engaging in co-production. Sometimes this was due to respondents having little or no prior experience or understanding of co-production. The challenges of co-production were mostly centred around time and capacity, which had the greatest impact upon the co-production process. This often resulted in a perception that co-production was not evident, or that it was not effective in how it could have been undertaken. For example, the clinicians below reported that for them, the co-production element was either not present at all, or was largely exclusive of them:

> *I think there's a sense that it's supposed to be a co-production, but my sense as the clinician involved, was that it didn't really feel like a co-production. It felt like we had some contact sometimes and then the project felt quite distant. So, if there had been closer involvement, I think it would have been more opportunity to learn.* (Clinician)

> *I think that was a case of everybody pulling together and, you know, working together really well to produce a really good event for people. But prior to that* [the output], *I would say it hadn't worked at all. In all honesty, I felt that the artists kept the professionals at a bit of an arm's length. ... I felt that they didn't want to engage with us directly at all after the initial meeting.* (Clinician)

Some artists and arts managers expressed disappointment that clinicians' involvement in the process was sometimes minimal, but this was recognised as often being beyond their control due to the demands of their role:

> *I genuinely think it's due to lack of time and resources on their part. I know that it must be a real struggle working in the NHS and trying to find time to come to meetings about an art project.* (Arts manager)

Investigating where the difficulties in co-production had arisen from, it is possible that some of these had their origins in the very early stages of the programme as identified by one of the arts managers involved in writing bids:

> *we were in competition with other organisations, and we had to write really good bids. … it was quite a challenge writing a bid, writing up a project and making the case to do that project, with an awareness it was gonna be a co-production process, and that might change. … It seems quite a strange thing to do, to write something and then to put something together, consult with our users, consult with your practitioners, back it up with research and then be prepared to just put that completely to one side when you get to co-production phase.* (Arts manager)

The arts manager highlights what is perhaps one of the key difficulties with co-production arose as part of the bid writing process – in particular the lack of patient voices involved in writing the bid. Whilst many arts managers involved claimed a good knowledge of co-production, often what was meant was working collaboratively with other professionals. Another manager, took a more radical and arguably transformative approach to their bid:

> *One of the things I was really, very, very keen to have the artist I chose to work as a project manager on this programme – that they had lived experience of [impairment] so that they could relate and be empathic towards people that were referred on to the programme, because I think having that in-depth understanding is really important.* (Arts Manager)

Here the manager is taking an approach which, though they do not explicitly reference co-production, takes one of the central tenets from disability studies of privileging lived experience, by ensuring that patients/service users not only design the intervention, but also deliver it.

The challenge of co-production in the scheme was complex in that it involved four key stakeholder groups from disparate areas, with some stakeholders working across two or three interventions. In view of this, the respondents' difficulties, challenges and frustrations presented should be viewed in the context of what was a wide-ranging, complex, ambitious and innovative pilot project.

Cultural, Political and Individual Change

Change was observed or experienced by respondents in respect to the culture within and between the stakeholder groups, potentially within policy, and also at an individual level. Stakeholders perceived that the culture within the NHS was beginning to change, resulting in a higher profile and value of arts-based activities, despite challenges of time and or scepticism. For example:

> *The first thing is the cultural change in the NHS so the medical professionals see it as an appropriate thing to do. That's changing a lot, you get more people seeing the value of creative activities, but there are still a lot who don't or are so busy with other things that it's not uppermost in their minds, they don't think of it.* (Arts Manager)

Change was perceived as occurring for all stakeholders, including understanding more about the worlds of the other stakeholders, and that the opportunity for involvement in such projects presented that potential:

> *The other thing is for the arts groups to recognise what's important to the NHS as well. If it's not working as well as other interventions, then it doesn't get funded. So, it is mostly culture change but not just from the NHS but from the arts organisations as well.* (Arts Manager)

There was an acknowledgement of the contemporary nature of such a project, and that despite the concept being unusual in the current context, sustainability was likely longer term, once a cultural change had occurred:

> *But I think at the moment it is thought to be something a bit way out there, a bit wacky. But we've got the evidence to show it's beneficial, so we need to do it and I think if we do have that culture shift, then that will be when it becomes sustainable.* (Clinician)

In respect to policy change, respondents related this to the relationship between evidence-based practice and policy in commissioning services, and for change to occur, recognition of the developing nature of these for the use of arts in health. For example:

> *We would need really clear outcomes, evidence that they were better able to engage in things we were offering, impacting on their health care. It would almost need to be quite circular, that one thing improves another, to be able to justify taking time away from more urgent clinical work, to promote something that is innovative, maybe doesn't have a great evidence base at the moment, is part of a developing area and with a small number of people.* (Clinician)

Individual change happened either within a stakeholder group or observed from another stakeholder group. Commissioners observed that within the working groups for the projects, having patients represented affected the dynamics of the discussions by changing the power balance, and that this was reflective of a cultural shift occurring within commissioners to work more with communities. For example:

> *Having the patient there shifted that power and it also gave them a voice which they don't always have. ... It's a whole cultural shift in terms of there has to be a willingness of commissioners to be more open to listen to people and communities and to work with communities. And not always assume that we know best.* (Commissioner)

Another commissioner acknowledged however that changing perspectives of the value of arts for health was challenging, but that change occurred over the duration of the programme:

> *Getting commissioners to see the value of art and health, because often they see it as quite woolly and potentially some things were on a small scale. So, I'm not sure how much of a priority it was for them in the beginning and I think that changed over time. ... We are changing hearts and minds and it's not an overnight success.* (Commissioner)

Arts managers also concluded that commissioners and clinicians were changing their perspective, partly as a consequence of a developing evidence base, and in the case of clinicians, as they observed the change on their patients:

> *It does seem that commissioners are increasingly more interested in interventions like creative or landscape based interventions, and the sort of evidence base that we've gleamed in the last 25 years would suggest that it's a really cost effective and a great way of working with people who have got physical or mental health problems.* (Arts Manager)

> *And I think it was only really at the end point that they started to understand both the benefits and the process. But I think for them it's such a, kind of, step into the unknown, that they [clinicians] almost had to see what it is first, before they could get it.* (Arts Manager)

Patients representatives also saw that this was a change process, but one that was cost effective, and this was a learning opportunity for the NHS:

Well, consultants are far dearer than running little projects like this ... and maybe it is re-educating the whole of the NHS. (Patient representative)

For a structural, political and cultural change to occur however, education was also needed to support clinicians to consider other suggestions to treatment rather than the traditional existing options. This openness to other options was seen as a particular issue for clinicians, but education and evidence seen as the key in addition to personal experience of the benefits to their patient:

Somehow being able to educate clinicians to the benefits, that would then change their way of thinking, so they don't just always think, oh this person just needs to see the OT [occupational therapist] or needs physio. It's trying to widen how they think – I don't know how you would do that though, maybe if someone at the top experiences it and gets it, maybe then they'll promote it, won't they? I think it's a particular issue with clinicians. (Clinician)

In respect to patients and clinicians, both stakeholder groups were viewed by others as requiring a culture shift:

Yeah, I think it absolutely does [need a culture shift], I think it needs to be a culture shift from patients and clinicians so that we do see it as part of an evidence-based toolkit that we have got to offer. (Clinician)

Discussion

Findings conclude that co-production was found to be a way of working that was highly valued by all stakeholder groups. It was acknowledged that in order to do this well, stakeholders needed a clear understanding of roles, responsibilities and terminology. Findings also indicated that spending time on these essential aspects is best invested in the early stages.

The process of co-production in this cultural commissioning context provided evidence that a shared understanding of stakeholder roles and responsibilities could be fostered. Importantly, in respect to the balance of power, findings confirm that co-production as an approach – with multiple stakeholders including service users or patients - has the potential to change the power balance in decision making in commissioning in this context, create a cultural shift, and thus blurs the hierarchical boundaries of traditional stakeholder roles.

Respondents found the process of co-production resulted in cultural change at individual and organisational level within some of the projects but argued that there needed to be better evidence for co-production and the use of arts for health in order to create more systematic change. Systematic change is difficult to implement however, and as others observe in addition to the financially higher costs of co-production because of the increased number of participants and time involved, there are also policy and credibility costs; for example, when service change fails to be implemented or when the process is dominated by louder voices or interests (Oliver, Kothari, & Mays, 2019).

Whilst respondents experienced considerable learning, it was also evident that respondents found the process of co-production challenging, at times difficult and often time-consuming. There was a clear need for stakeholders to be flexible, but findings provide supporting evidence that existing working structures, processes and traditions challenge the capacity for people to have that flexibility. As Penny et al.'s principles suggest, co-production as a process is underpinned by flexibility and responsiveness. Whilst acknowledging that, others warn that this flexibility in co-production as a process, can in itself also create difficulties in forming the collaborations necessary for projects to flourish (Filipe, Renedo, & Marston, 2017). Further, Oliver et al. (2019) highlight that the burden of co-production in terms of time and reputation often falls on those least able to bear it, specifically stakeholders who are junior and/or temporary staff and thus precariously employed. These observations are echoed in the findings of this study particularly for the artists involved who were engaged on a self-employed basis and consequently were precariously employed by the programme, or indeed for clinicians who were constrained by time due to clinical commitments.

Felipe et al. (2017) further suggest that because co-production often has to fit into pre-existing practice, and as a consequence the process becomes entangled with traditional service provision. Such challenges can often result in resistance from stakeholders (Alakeson, Bunnin, & Miller, 2013; Harris, Penny, & Slay, 2013). Resistance to co-production by professional stakeholders is well recognised within the literature (Beresford & Carr, 2016; Bovaird, 2007; Needham & Carr, 2009; Pestoff, 2014) but, as Harris et al. (2013) note, the impact of austerity heightened

fears of a loss of professional roles, leading to significant cultural resistance for a large part of their study. However, over time, the need to work differently in a continued climate of austerity could result in the acceptance of new ways of working, such as co-production, and may see levels of this resistance diminish. This study did not find obvious resistance from professional groups, but by the nature of its qualitative design, such individuals may have chosen not to engage rather than display resistance. Not taking part in itself, could be perceived as a form of resistance to the project. However, without actively seeking these non-responders for inclusion in the study, no assumptions can be made here.

In respect to the key questions addressed in this study, the conclusions and lessons learnt for future practice are summarised below, alongside those questions. This focussed summary provides some implications for future working in co-production in the context of cultural commissioning.

What are the worth and value of commissioning arts for health programmes? (from the perspectives of all the stakeholder groups)?

- highly worthwhile to involve all stakeholder groups, especially groups which are seldom heard;
- a feeling of involvement for all groups was empowering for some and useful for all;
- co-production enables stakeholders to learn about the best way to deliver an intervention;
- the importance of understanding people's roles, responsibilities and terminology.

What are the lessons for health commissioners, clinicians, arts and culture sector?

- influential professionals understanding the role they can play in effecting such a shift in culture;
- awareness that co-production is a new concept for most stakeholders and plan accordingly for that learning curve;
- an acknowledgement that co-production is challenging - often due to time constraints and to undertake properly requires commitment of resources and 'buy-in';

- build in practical support for clinicians to have time in their schedule to engage;
- challenges and transparency of bid writing, using co-production, in the commissioning process;
- build in social and emotional support for artists when working with some clinical groups.

What is the learning from patient participation?

- enabled patient representatives to be involved in decision making;
- learning of the commissioning process;
- opportunity to influence change.

Can this way of working have an influence on power shifts in the commissioning process?

- involvement of stakeholders and the use of co-production enabled a diffusion of power in decision making and a shifti n perspectives;
- patients have the potential to shape commissioners' thinking;
- patient representatives shift the power and enable others to be more open, and willing to listen.

In assessing against Penny et al.'s (2012) six principles, there were significant challenges to co-production arising from the complex and ambitious nature of the GCCP. One of the significant problems, in common with many other co-produced endeavours, was time – time to establish relationships and time to allow the process to mature and establish itself, rather than being constrained by arbitrary time limits. The learning points from the original pilot were used as a springboard to deepen understanding and practice in the current second phase which ran until 2019.

Methodological challenges and limitations

The iterative, three stage approach was devised to ensure that there were multiple opportunities for respondents to be involved in the process evaluation. However, due to the constraints of stakeholder time, for example clinicians and their clinical commitments, and artists because of their self-employed nature, it was difficult to ensure continuity of engagement of respondents throughout the process. In defence

of this, 36 respondents took part overall, and 11 respondents took part in more than one of the stages with three respondents engaged in all three stages. We are therefore confident the data is both rich and the process sufficiently iterative to capture how differing stakeholder perspectives intersect with each other at each of the stages. The adoption of telephone interviews was due to ease of contact and availability of respondents. Furthermore, the order of the discussion groups in stage 2 was considered carefully, and subsequently designed to support potentially less empowered respondents to have the confidence to voice their stakeholder perspective with others, where there may have been potential power differentials.

References

Alakeson, V., Bunnin, A., & Miller, C. (2013). Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care. *London: OPM*.

APPG. (2017). *All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry Report Creative Health: The Arts for Health and Wellbeing* Retrieved from http://www.artshealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_Inquiry_Report_2017_-_Second_Edition.pdf

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of planners, 35*(4), 216-224.

Beresford, P., & Carr, S. (2016). Social care, service users and user involvement. *Aotearoa New Zealand Social Work, 28*(2), 95.

Bovaird, T. (2007). Beyond Engagement and Participation : User and Community Coproduction of Public Services. *Public administration review*(October), 846-860.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

C4CC. (2015). *A Co-Production Model: Coalition for Collaborative Care*. Retrieved from http://coalitionforcollaborativecare.org.uk/a-co-production-model/.

Consilium. (2016). *Evaluation of the Cultural Commissioning Programme Final Report*. Retrieved from London: https://www.ncvo.org.uk/practical-support/public-services/cultural-commissioning-programme

Crenshaw, E. (1991). Foreign investment as a dependent variable: Determinants of foreign investment and capital penetration in developing nations, 1967–1978. *Social Forces, 69*(4), 1169-1182.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice, 39*(3), 124-130.

Crone, D., Ellis, L., & Bryan, H. (2017). *Understanding Learning in Cultural Commissioning: A qualitative process evaluation of the NHS Gloucestershire Cultural Commissioning Grant Programme.* Retrieved from UK:

Durose, C., Needham, C., Mangan, C., & Rees, J. (2017). Generating 'good enough' evidence for co-production. *Evidence & Policy: A Journal of Research, Debate and Practice, 13*(1), 135-151. doi:10.1332/174426415X14440619792955

Filipe, A., Renedo, A., & Marston, C. (2017). The co-production of what? Knowledge, values, and social relations in health care. *PLoS biology, 15*(5), 1-6. doi:10.1371/journal.pbio.2001403

Harris, M., Penny, J., & Slay, J. (2013). Doing Services Differently: Local innovations for disabled people and their families: New Economics Foundation/Scope.

Lambert, S. D., & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing, 62*(2), 228-237. doi:10.1111/j.1365-2648.2007.04559.x

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *BMJ: British Medical Journal, 320*(7226), 50.

Munoz, S.-A., Farmer, J., Warburton, J., & Hall, J. (2014). Involving rural older people in service co-production: Is there an untapped pool of potential

participants? *Journal of rural studies, 34*, 212-222. doi:10.1016/j.jrurstud.2014.02.001
Needham, C., & Carr, S. (2009). *Co-production: an emerging evidence base for adult social care transformation*: Social Care Institute for Excellence.
Oliver, K., Kothari, A., & Mays, N. (2019). The dark side of coproduction: do the costs outweigh the benefits for health research? *Health Research Policy and Systems, 17*(1), 33. doi:10.1186/s12961-019-0432-3
Osborne, S. P., Radnor, Z., & Strokosch, K. (2016). Co-Production and the Co-Creation of Value in Public Services: A suitable case for treatment? *Public Management Review, 18*(5), 639-653. doi:10.1080/14719037.2015.1111927
Penny, J., Slay, J., & Stephens, L. (2012). *People Powered Health Co-production Catalogue*. London: Nesta.
Pestoff, V. (2014). Collective Action and the Sustainability of Co-Production. *Public Management Review, 16*(3), 383-401. doi:10.1080/14719037.2013.841460
Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of counseling psychology, 52*(2), 137.
Rose, D., & Kalathil, J. (2019). Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental 'Health'. *Frontiers in Sociology, 4*, 57.
Staricoff, R. L. (2006). Arts in health: the value of evaluation. *The journal of the Royal Society for the Promotion of Health, 126*(3), 116-120.

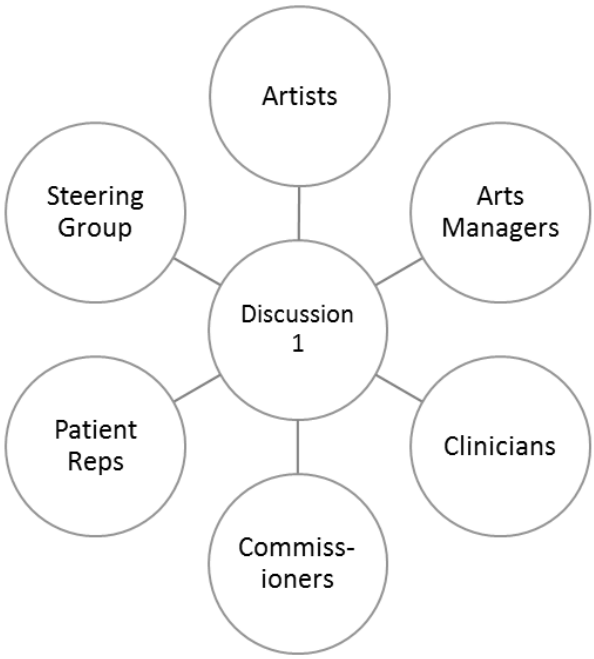

Figure 1: Stage 2, Discussion 1 stakeholder groupings

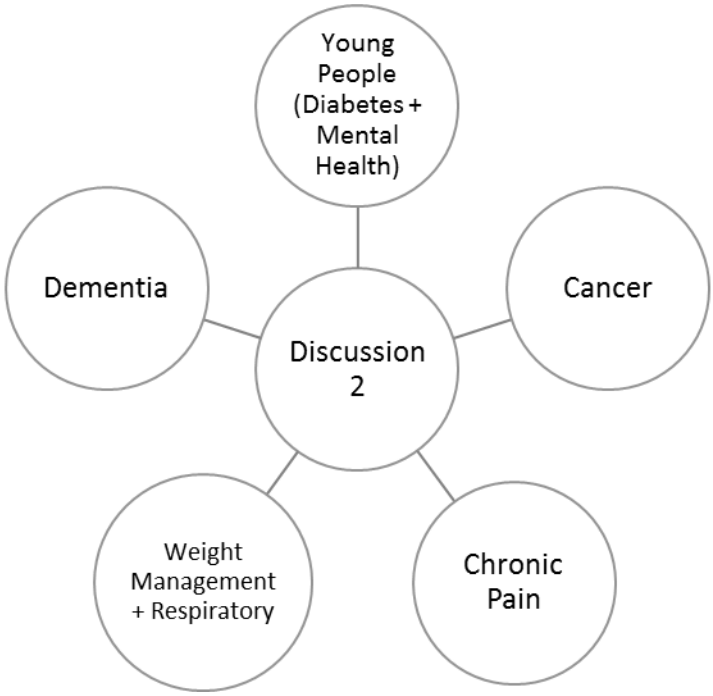

Figure 2: Stage 2, Discussion 2 stakeholder groupings (N.B. some groups were combined due to small numbers of respondents)

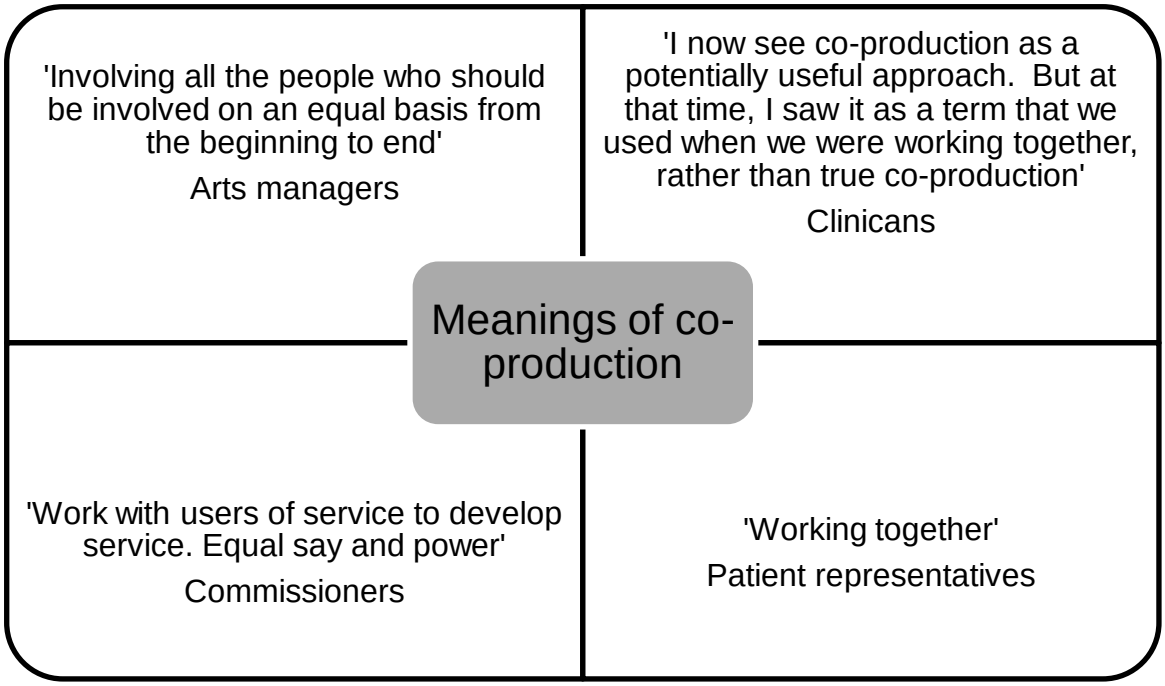

Figure 3: Perspectives of co-production from the four stakeholder groups.