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Overlooking the front line: Impacts of front-line worker inclusion on implementation and outcomes of collaborative innovation

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Abstract

Policymakers acknowledge the need to drive innovation in health and social care, given the complex, "wicked" problems that such services are tasked with solving and the concept of collaborative innovation is proposed as a tool in which to reach solutions to these problems. Prior case studies have overlooked the element of front-line worker inclusion on processes of collaborative innovation. This research explores this element through a case study of an intermediate care facility in Scotland. This collaboration produced innovation, but the strength of the innovative solution was diluted by the omission of front-line workers in key phases of the innovation process. This paper contributes to the broader public administration literature by operationalizing a novel conceptual framework of collaborative innovation and by exploring the problematic implications of neglecting to include front line worker perspectives throughout the process of collaborative innovation.

1 | INTRODUCTION

Policymakers recognize a growing demand for innovation in public services, including in the domain of health and social care. Interest in public service innovation has risen in response to a series of mounting pressures: society's increasing demand for high-quality personalized public services (Alves, 2013; Windrum, 2008); budgetary constraints due to financial instability and/or crisis, such that innovation is seen as a superior alternative to broad cuts to services (Sørensen & Torfing, 2017); and the call to respond to "wicked problems"—which in health and social care have

in recent times been the aging of populations and the exacerbation of service gaps by the COVID-19 pandemic (Bekkers & Tummers, 2018; Coen et al., 2020). This paper employs the concept of collaborative innovation to analyze the case of the journey to implementing the Bellfield Centre, an integrative intermediate care facility in Stirling, a city in central Scotland, designed to bridge the gaps in service delivery between hospital and community for older adults, with an approach focusing on rehabilitation and reablement. *Collaborative innovation* is defined here as the processes that result from diverse, interdependent, and relevant actors that commit to collectively solve a "wicked" shared problem and take joint ownership over its implementation and outcomes (Torfing, 2016). Innovation, in this context, entails a discontinuous, clear break from what preceded it including how services are delivered and their impacts (van Acker, 2018). Through this case study research, the authors seek answers to the following research questions: (1) *How effectively do collaborative innovation processes support innovative changes in organizations and services??* (2) *How does the role of front-line workers in the different stages of a collaborative innovation process affect the outcome and impact of collaborative innovation processes?*

Following this introduction, the background of collaborative innovation in public services is considered along with its components and the argument it presents for superior public innovation. The context for the research is then discussed followed by a description of research methods informing the analysis of this case. Next, the findings of the case are presented through the lens of a conceptual framework of collaborative innovation. The article concludes with a discussion of how this case contributes to the larger theoretical literature of public administration through its operationalization of a novel conceptual framework of collaborative innovation and through its exploration of how institutional power imbalances in these processes are reflected in workers' experiences and in the implementation of collaborative innovations.

2 | BACKGROUND

Collaborative innovation arose out of a relatively recently developed public administration paradigm known as New Public Governance (NPG), based out of dissatisfaction with the previous paradigm, New Public Management (NPM) which was itself borne out of critiques of the preceding paradigm (Liddle, 2018; Torfing, 2016). Although collaboration as a means to innovation has become more accepted in the public sector discourse, the stickiness of NPM's legacy has left several barriers to collaborative innovation (Torfing, 2013). In contrast to NPM's more transactional approach to public sector management, NPG emphasizes collaborative governance, relationships, negotiation and trust and promotes innovation through collaboration (Eriksson, 2019; Osborne et al., 2015; Torfing, 2016). It is within the paradigm of NPG that the concept of collaborative innovation began to gain acceptance, through an emerging evidence base of successful case studies. Case studies in fields such as urban development (Dente et al., 2005), crime prevention (Aagaard, 2012), public schools (Roberts & King, 1996), pharmacy services (Lindsay et al., 2018), and digital government (Kattel et al., 2020) have shown that collaborative innovation processes can have a positive impact.

In this era of widespread public austerity and reduced public trust in government, there is an argument to be made that collaboration is the better vehicle for producing innovative solutions to complex, "wicked" problems (Sørensen & Torfing, 2011; Torfing, 2016). Collaborative innovation describes the process of creating innovative solutions to complex "wicked" problems through multi-actor collaboration (Torfing, 2016). Collaborative innovation has an emerged as an important framework for trying to understand how public services can best respond to wicked problems and provides practical guidance for collaborative actors on the ground (Krogh & Torfing, 2015; Lindsay et al., 2018). It is rooted within the paradigm of NPG and draws on institutional and network theory to suggest that collaboration networking is required to overcome institutional logics and biases and develop holistic solutions complex policy problems (Hartley et al., 2013; Peters, 2011; Torfing, 2016). While some of the theoretical literature touches on the impact of actors' power relations on collaborative innovation (Lindsay et al., 2018; Torfing, 2016) and calls for the inclusion of front-line workers in the processes of collaborative innovation to maximize the strength of

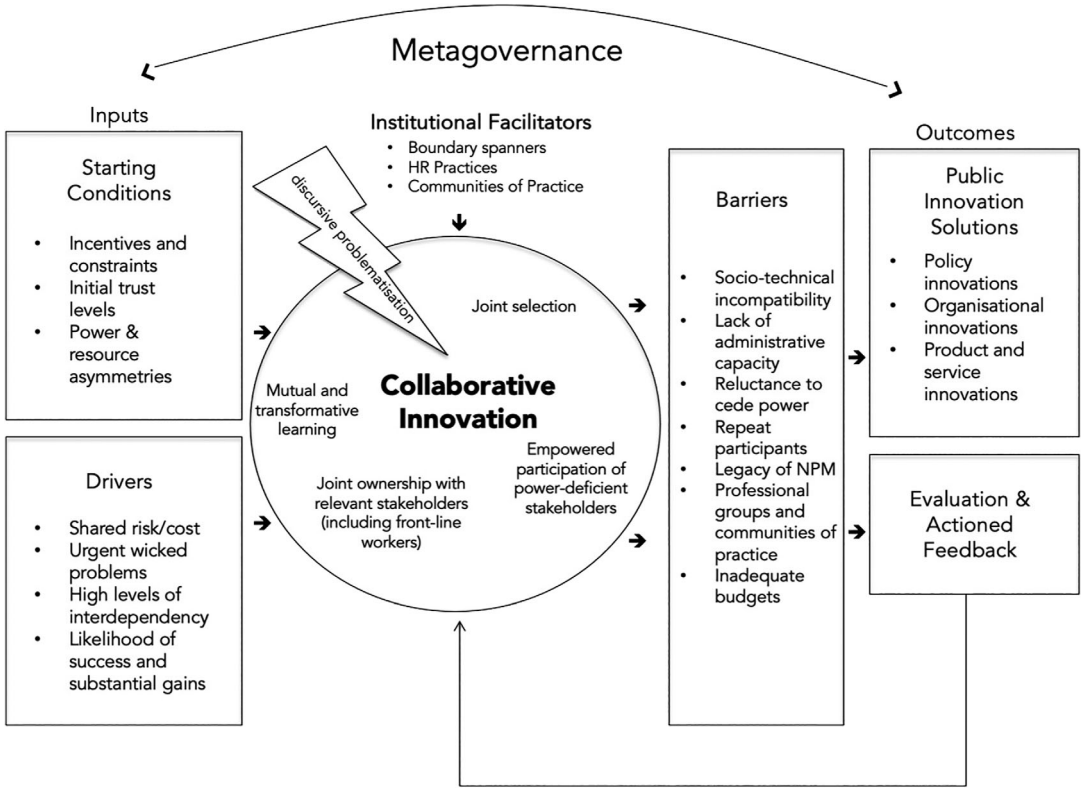

FIGURE 1 Conceptual framework of collaborative innovation in public services, adapted from Ansell and Gash (2008) and Sørensen and Torfing (2011)

implementation and outcomes (Ansell et al., 2017; Osborne, 2006; Torfing, 2016), the impact of the degree of front-line worker inclusion has on implementation has been underexplored empirically (Ansell et al., 2017).

Drawing on the collaborative innovation and public administration literatures, this article puts forth a framework of collaborative innovation adapted from those of Ansell and Gash (2008) and Sørensen and Torfing (2011). This framework serves a lens through which to explore the inter-connected components and outcomes of collaborative innovation, drawing on evidence from a case study of an integrated intermediate care facility in central Scotland, and to evaluate the extent to which the inclusion of front-line workers at different stages of the innovation process impacted the implementation and outcomes. Figure 1 presents a framework of collaborative innovation drawing on Ansell and Gash (2008) and Sørensen and Torfing (2011).

3 | A FRAMEWORK OF COLLABORATIVE INNOVATION IN PUBLIC SERVICES

3.1 | Key processes of collaborative innovation

The broader literature on collaborative innovation in public services indicates four key collaborative innovation processes—empowered participation of power deficient stakeholders, mutual and transformative learning, joint ownership with relevant stakeholders (including front-line workers), and joint selection—and they together constitute the core of the framework (Torfing, 2016; Touati & Maillet, 2018).

In many ways, the study of collaborative innovation is a study of power in collaborative networks and whether they are aware of it or not stakeholders exist in a hierarchy of power with power being the available resources and relative influence of individual stakeholder groups. One way to soften this imbalance of power and the uneven influence of stakeholders on collaborative decision making depending on their relative power is through empowered participation of power deficient stakeholders. Empowered participation is about mitigating the effects of power asymmetries such that all actors are encouraged and given a voice as equally competent collaborators (Agger, 2012; Torfing, 2016; Trivellato et al., 2020). Actors convened for the process of creating innovative solutions can only do so collaboratively if power asymmetries are not overpowering and steering the conversation and collaborators (Agger, 2012; Torfing, 2016). While a perfect balance of power between actors is not possible, the collective problem solving of actors is enhanced by the empowerment of some actors and, if necessary, the disempowerment of others—particularly powerful, dominant actors (Gray, 1989; Torfing, 2016).

Mutual and transformative learning describes the presence of learning between stakeholders and the extent to which the learning is transformative in how those stakeholders view the problem and its possible solutions (Lindsay et al., 2018; Torfing, 2016). The promise of collaborative innovation is premised upon creativity and new ways of thinking about and framing problems and solutions that arise from the clash of diverse and affected actors deliberating with one another (Torfing, 2016). To do so actors must critically and reflectively identify, evaluate, and (if necessary) revise their knowledge, beliefs, assumptions, bias, and ideology as well as those of their fellow actors (Crosby et al., 2017; Mezirow, 2003). Collaborative innovation aims to lever the disturbance created by ideational diversity of social and political actors to stimulate expansive and transformation learning (Engeström, 1987; Hofstad & Torfing, 2015).

Joint ownership with relevant stakeholders (including front-line workers) is the extent to which actors hold accountability over one another to execute implementing the agreed upon solution (Hartley et al., 2013; Neumann et al., 2019; Sørensen & Torfing, 2011). Sørensen and Torfing (2011) propose that the implementation phase is strengthened when the relevant and affects actors share in the ownership over the selected idea. When the participants feel that they were part of the creative process of designing but also selecting a solution to a problem affecting their community, they are more likely to embrace it and ensure it implemented, and this is especially the case for front-line workers who will tend to oppose or even sabotage innovation seen as top-down (Timeus, 2019; Torfing, 2016).

Joint selection is the ideally democratic process of ensuring collaborative actors, following discussions on the problem, agree on what they are going to do to address said problem. Many collaborative innovation efforts contain a collaborative element, but selection is arguably the most political and democratic element (Bommert, 2010). This is an element that Torfing (2016) does not include in his framework but is argued here to be essential to the successful implementation of collaborative innovation.

3.2 | Further influential factors of collaborative innovation

The processes that shape collaborative innovation are deeply contextualized processes and it is imperative researchers understand the discursive and governance context underpinning relations between actors. Discursive problematization refers to the process of identifying and defining the complexity of wicked problems verbally as well as deliberating and comparing viewpoints on the perceived root of these problems (Mirabueno & Yujuico, 2014; Torfing, 2016). To begin designing an innovative solution in hopes of solving or helping to eradicate a wicked problem, the majority of actors must define and agree upon the problem (Sørensen & Torfing, 2017). Metagovernance is the governing of governance and reflects the self-governing nature of interorganisational networks (Osborne et al., 2015). Metagovernance is a deliberate, reflexive, and innately political form of governance that supports and frames collaborative policy and service processes, gathers diverse actors together, facilitates collaboration, intervenes in cases of conflict, guides actors in collaborative decision making, and enforces the implementation of

negotiated and jointly owned solutions (Jessop, 2003; Taylor & Lips, 2008). As metagovernors are responsible for convening the actors, it is imperative that they consider the consequences of the inclusion as well as omission of particular actors—for example, front-line staff may be skeptical of innovation perceived as top-down and work against its successful implementation (Ansell & Torfing, 2014).

When the chosen actors enter the arenas of collaborative innovation, their starting conditions affect how they will proceed in the collaborative innovation process (Ansell & Gash, 2008). Each actor possesses their own set of incentives and constraints, initial trust levels, and power & resource asymmetries (Ansell & Gash, 2008). Drivers of collaborative innovation include the lure of sharing and thus reducing risk and cost over several stakeholders, the existence of deeply urgent wicked problems, high levels of interdependencies among actors, and the perceived likelihood of substantial gains from participation (Torfing, 2016). Facilitators help to optimize collaborative innovation but are not so integral that they are considered key processes (Torfing, 2016). Although many factors can facilitate collaborative attempts at innovation, our interest is on the relational processes between actors and the workplace practices that institutionalize this facilitation. Facilitating collaborative innovation is the work of boundary spanners, HRM practices, and the creation of a community of practice (Bos-Nehles et al., 2017; Torfing, 2016; Williams, 2002).

The collaborative innovation literature has identified a number of barriers to collaborative innovation, and of particular interest to our research are the relational issues of power and resources between actors and how these play out at the institutional and workplace level. Commonly referenced barriers in the extant literature are lack of administrative capacity (McCrea, 2019), sociotechnical incompatibility (Wilson et al., 2012), reluctance of actors to cede power to the collaborative arena (Lund, 2018), repeat collaborators (Torfing, 2016), legacies of prior paradigms (Lindsay et al., 2018), risk aversion (Mulgan & Albury, 2003), inadequate budgets (Hood, 2006), and professional groups and communities of practice (Jones & Noble, 2008).

The outcome of collaborative innovation processes should be genuine innovation in the design or delivery of public services and not simply incremental changes to ways of working. Collaborative innovation solutions generally come in three forms: policy, organizational, and product and service innovation. As far as judging specific innovation projects, it is challenging to ascertain the degree to which any innovation is a 'success', but as far as collaborative innovation is concerned, successful innovation is one that the relevant stakeholders affected by it judge it to be successful and that addresses the wicked problem in ways that reflects the needs and preferences of participant actors (Mischen, 2015; Sørensen & Torfing, 2011). The iterative nature of innovation and the application of feedback loops are emphasized in collaborative innovation to improve implemented solutions and respond to change and public reactions (Mischen, 2015; Sørensen & Torfing, 2011).

3.3 | Front-line workers in collaborative innovation in public services

This section explores the literature of the role of front-line workers in collaborative innovation in public services. The role of front-line workers in the process of collaborative innovation in public services is underexplored in the extant empirical literature, but theoretical conceptualisations of collaborative innovation have weighed in on their involvement and its implications (Bekkers & Noordegraaf, 2016; Sørensen & Torfing, 2016). One of the most compelling elements of collaborative innovation is that it argues that answers to complex societal problems might be best solved by combining perspectives of all the relevant and affected actors and in doing so reducing biases and blind spots of participant actors (Sørensen & Torfing, 2016). It follows then that the perspectives of front-line workers can be seen as an invaluable resource for innovation and knowledge creation (Edvardsson et al., 2000; Sørensen & Jensen, 2015). For service innovations in particular, front-line workers often are the service and thus service innovations will only succeed insofar as front-line workers embrace and execute them and if said workers perceive the change as being imposed from the top down, they may resist or even sabotage the innovation (Ansell & Torfing, 2014; Cadwallader et al., 2010).

The empirical literature on involvement of front-line workers in collaborative innovations, however, is sparse. Empirical studies sometimes discuss the inclusion of front-line workers and their impact on the innovation process (Breit et al., 2018; Sørensen & Jensen, 2015), but their omission from idea formation and planning phases and what implication that might have for implementation remain overlooked. This is problematic as the reflexive and practical epistemology of collaborative innovation implies that the perspectives and experiences of actors, including front-line workers, are genuine sources of knowledge that might aid in the development of innovative solutions (Breit et al., 2018; Rashman et al., 2009). A question unexplored in the literature is what implications we can expect on implementation and outcomes from the omission of front-line workers from earlier phases of innovation that are later expected to be at the front line of implementing said innovation.

4 | CONTEXT

To put the extent of Scotland's wicked problem of demographic change into context, it is projected that the retired population of Scotland will increase by 27% from 2012 to 2037 and the working age population by 4% (Audit Scotland, 2016; Wraw et al., 2020). Healthcare in Scotland is devolved from the UK parliament and provided by 14 regional health boards (SPICe, 2016). Health care and prescription medication are free in Scotland at the point of need, as is personal care to those over 65 years of age (Scottish Government Health Directorates Capital and Facilities, 2017). Social care and health care became legally integrated with the passing of the Public Bodies (Joint Working)(Scotland) Act 2014 (Scottish Government, 2019). Most regions of Scotland opted to form "integrated joint boards" (IJBs) to plan and commission delegated functions and oversees the partnership of the regional health board and local authorities (known as Health and Social Care Partnerships or HSCPs) responsible for service delivery (Audit Scotland, 2018). Previous to integration, local authorities were responsible for adult social care services. The legislation came into effect in 2016, and since that time, HSCPs across Scotland have been working to integrate health and social care in line with the legislative framework, to various degrees of success (Scottish Government, 2019).

5 | METHODS

This study employed the case study method with a single block of fieldwork being conducted from September–December 2019. The choice to study the Bellfield Centre came after a series of informal scoping discussions conducted with national stakeholders involved in health and social care. The case of the Bellfield was first suggested by an NHS Scotland research director who spoke about the first Scottish integrated facility incorporating intermediate care at scale, reshaping the pathway of care for older adults and addressing one of Scotland's most wicked problems. This is a study of implementation, but in doing so there are evaluative elements, as understanding the project's stated aims and if they have been met is important to understanding the case.

Subsequent to receiving ethical approval, semi-structured "key stakeholders" interviews were conducted with 27 individuals involved in the Bellfield Centre either in terms of either the planning of the project or employment relevant to its current implementation. A purposive, snow-ball style approach was taken to sampling, making note of what stakeholders and actors were most referenced by successive participants and reviewing documentation to determine relevant contacts. Interviews included senior and middle management of NHS Forth Valley—the local health board; Stirling Council—the local council; Stirling and Clackmannanshire HSCP—the health and social care partnership comprised of NHS Forth Valley, Stirling Council, and Clackmannanshire Council; and Artlink Central—a third sector arts organization. Interviews were also conducted with members of professional groups that provide services in the Bellfield Centre; front-line workers employed by both NHS and Stirling Council; and influential members of relevant planning committees, including some individuals no longer employed at stakeholder organizations.

The primary data collection technique of these case studies was semi-structured interviews, with secondary data in the form of publicly available as well as some privately shared documentation about the facility and relevant actors in the form of business cases, organizational charts, strategy and operational documents, performance reports, audits and inspections from reporting bodies. Semi-structured interviews were chosen as the primary data collection technique as the researcher can simultaneously center conversation on the important and relevant questions of the research while allowing the conversation to flow inductively. Twenty-eight semi-structured interviews were conducted with permanent, temporary, former and current staff of the Bellfield and those considered key to its planning and governance, including all stakeholder groups and multiple hierarchical levels. Interviews explored a number of themes relevant to the development and delivery of collaborative innovation corresponding to the framework. Each interview spanned from 30 to 90 min and interviewees skewed female, with only six men interviewed. It is important to acknowledge the self-selection bias inherent in this study as only those willing to be participate were included. Interviews were conducted with participants in person at their place of work—or lack thereof as one participant was retired—and all but two interviews were recorded using a professional recording device. These interviews were then transcribed and analyzed thematically using Nvivo software. An abductive approach was taken to data analysis, seeking to understand the link between individual action and underlying social mechanisms (Bertilsson, 2004). Data were coded corresponding to the major thematic components of collaborative innovation as well as trends that not discussed in the framework but that emerged through the process of initial reading of data followed by preliminary coding and the systematic assemblage of data for each code. The justification for case studies for this research is that the complex, relational study of collaborative innovation requires methods that capture its contextual richness, and is best served by multi-source, in-depth data to provide deeper insights into intricate, contextualized inter-relationships, problems, and (Douglas et al., 2020; Yin, 2017). This research thus does not seek to generalize empirically, but rather to derive analytical generalizations. Understanding how collaborative innovation works in health and social care and why certain factors hinder or help the development and implementation of innovative solutions is central to this research. How and why are exploratory questions, which need rich contextual data to answer, and case studies are a good strategy for generating contextual data (Yin, 2017). The selected case study of the Bellfield Centre was assessed to be well suited for studying the role of front-line staff as the local authorities' own evaluation report determined that front-line workers were not involved pre-implementation and that this was an oversight that impacted implementation.

5.1 | Case study: The Bellfield Centre

On the site of the former Stirling Community Hospital in Scotland sits the Stirling Health and Care Village and within it the Bellfield Centre, a first of its kind (within Scotland) hub of intermediate integrated health and social care services. Intermediate care is defined by the British Geriatric Society (2001, as cited in Melis et al., 2004) as the "range of services designed to facilitate transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patients' discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired" (Melis et al., 2004, p. 2). The project brought together stakeholders including Scottish Government, NHS Forth Valley, Stirling Council, and the Stirling and Clackmannanshire HSCP, as well as third sector organizations Artlink Central and the Royal Voluntary Service. These participant stakeholders included in the collaborative arena together amount to the "collaborators."

The primary outcomes sought by collaborators were to help people live independently at home as long as possible, prevent unnecessary hospital admissions, and provide proper assessment to get people the right care at the right time for them. Initially, the idea of an intermediate care service to get older people inappropriate for long-term care back home began with a pilot at a care home in Stirling. The success of the intermediate care pilot led Stirling Council to look into scaling up the service into an intermediate care facility. Simultaneously, NHS Forth Valley had

determined that the Stirling Community Hospital was no longer fit for purpose. Both stakeholders realized that both would need a new facilities of similar size and type and so instead, they decided to collaborate.

This case study seeks to operationalize the conceptual framework of collaborative innovation in public services, and to identify the relational factors that shaped, facilitated, and constrained the innovation process and determine how effectively collaborative innovation processes supported innovative changes. Scotland's health and care, like many other systems dealing with complex problems, is shifting toward NPG and collaborative approaches to governance, therefore collaborative innovation is an appropriate lens from which to analyze innovation processes, challenges and outcomes. The findings examine how the project embodied the four key processes of collaborative innovation, what barriers were encountered, and how these processes and barriers ultimately effected innovation implementation and outcomes. The findings also discuss the contextual relevance front-line worker involvement on each key process of collaborative innovation, their relationship to some of the barriers encountered during the project and the implications of pre-implementation exclusion of front-line workers on collaborative innovation implementation and outcomes. Finally, the case study is discussed within the context of the collaborative innovation literature and the research questions and conclusion drawn.

6 | FINDINGS

The findings from the case study are summarized in Table 1, below.

TABLE 1 Summary of findings from Bellfield Centre case study

Element of collaborative innovation	Finding
Metagovernance	Multiple overlapping layers metagovernance with multiple accountabilities oversaw the planning and implementation of the Bellfield combining hands-on and hands-off approaches. While metagovernance was crucial to seeing the project through, challenges surfaced in terms of ambiguity of authority and accountability that led to friction.
Discursive problematization	Discursive problematization was initially achieved and largely shared by participant actors but views on important details splintered over the lengthy project timeline.
Empowered participation	At the managerial level, stakeholders were given a voice and empowered to participate fairly equally, especially accounting for the notable power discrepancy between stakeholders. However, front-line workers were not empowered to participate until the facility was in the implementation stage, and thus their knowledge and expertise were not factored in until very late, if at all.
Mutual and transformative learning	As this collaborative involved integration of health and social care, actors were forced to learn about and assimilate the medical model with the social care model and while participant actors described this as challenging, learning did lead to transformation of perspectives in several cases. Because front-line workers were not involved until later in the process, however, their learning of each others' worlds occurred during implementation and entangled them into a separate period of friction that lead to learning that was sometimes transformative, but quite unpleasant.
Joint ownership	Joint ownership of the project was demonstrated on the managerial level of stakeholders and involved the sharing of resources, the ceding of planning power to the joint health and care project planning team, and the decision to jointly manage the integrated facility as an active collaboration of health and care. However, interviews with front-line workers indicated that this sense of joint ownership did not extend to the front lines of service delivery.

TABLE 1 (Continued)

Element of collaborative innovation	Finding
Joint selection	Those interviewed who were involved during early planning phases expressed the opinion that the decision to erect an integrated intermediate care facility was made jointly between collaborators.
Barriers	Notable barriers to successful implementation considerable regulatory barriers including half a decade spent in the business case process. While this barrier was eventually overcome, the implementation of the facility has struggled with determining adequate levels of staffing and having to fill gaps with temporary agency workers because of insufficient budgeted finances and lack of administrative capacity.
Outcomes	Overall interviewed participants saw the Bellfield as successfully implemented and a project that set out what it aimed to achieve. However, divergence of views remains on whether the facility is integrated enough and what sorts of service users should be prioritized for admission.

6.1 | Metagovernance and discursive problematization

In terms of metagovernance, the Stirling Health and Social Care village, of which the Bellfield was part, was governed pre-implementation by a project board made up of Stirling Council and NHS Forth Valley executives. Underneath the project board was a project team, beneath which were several subgroups. The workforce planning subgroup is of particular interest as they were responsible for execution of the staffing model. This workforce planning group was assembled a little under 12 months prior to the opening of the Bellfield and was composed of only a small group of primarily health and care managers, the majority of whom had undertaken this work alongside their regular workload.

Presently, the Bellfield's care manager oversees the activities of the entire building and reports to Stirling Council's locality manager, a direct report of the HSCP's chief officer. Many staff at the Bellfield said that the care manager was not receiving adequate support from higher management and that conflicts between the hospital discharge team and Bellfield team stayed unresolved due to an unwillingness from metagovernors to interfere, for example:

> "In some ways this void of strong leadership has created, or absence I suppose… has allowed people to take control or direction of things that were never really theirs to take." —Bellfield staff member employed by Stirling Council

It is important to note that the challenges of ambiguity regarding authority and multiple accountabilities are not uncommon in the literature on distributed leadership of multi-agency organizations (Williams, 2012) as well as the inherent tension in governing across multiple scales (Torfing & Ansell, 2017).

The discursive problematization at the conception of the project was described similarly by participants involved at that time, however, maintaining that shared narrative and understanding, as well as the energy and momentum surrounding it, would prove difficult over the 5–6 years it took to get through the NHS business case process. There is a tug of war between the idea that everyone deserves to come to the Bellfield and can benefit from its services on one hand, and there are only so many beds and to optimize outcomes, people who could most benefit from the service should be admitted, with an even mix of referrals from community (step up) and hospital (step down). For example, when a care worker was asked if there were sometimes inappropriate admissions, they said:

> "Yes. Definitely. Cause it's not—it doesn't fit what we're actually meant to be doing. We're not—some people are coming in that are not able to be rehabilitated."

6.2 | Key processes

6.2.1 | Empowered participation of power deficient stakeholders

Regarding power and resource asymmetries, NHS Forth Valley was the bigger holder of power in terms of organizational size and their larger financial stake in the building's construction as well as the control afforded to them in the contract delineating the funding scheme arranged through Scottish Government. Although the power imbalance between collaborators was apparent, governance structures, processes and a common discourse were in place to try to continuously govern the venture collaboratively. Despite the signs of empowered participation among participant actors, this process suffered from failing to involve one of the most insight-rich and power deficient stakeholders, front-line workers.

> "So all of that was a huge Challenge and I think that made it a struggle to bring people with—I don't think we brought all the staff with us on the model. Don't think they moved into something where they really clearly knew what the model was all about."—NHS planning manager.

Front-line workers were not consulted about the project and not involved until implementation. Both health and care staff expressed feelings of disconnection from the project and spoke of the difficulty of the transition to the Bellfield due to the lack of communication to front-line workers about the future of their employment. Front-line workers have an in-depth understanding of the needs of patients and service users and problems with services that goes beyond what quantitative surveys and data analysis of the population can assess. Omission of their voices assumes that all important insights will filter up to the managerial level, but the incidents of tension between health and care staff, as well as small mistakes made by planning managers during the planning of the Bellfield, indicate that this assumption was inaccurate and that managers do indeed have blind spots.

6.2.2 | Mutual and transformative learning

Mutual learning was present over the course of this project, and it was transformational in the sense that improved understanding of the problem and the perspectives of their fellow stakeholders may influence how they operate going forward, as well as the power and possibilities of a collaborative approach. An NHS manager on the project team discussed having to unlearn assumptions about the social care workforce and the intermediate care pathway when trying to devise a workforce model for the facility. Interviews with current Bellfield employees determined that incidents of conflict between front-line health and care workers contributed to transformative mutual learning, for example:

> "So I've had to alter my way of looking at them and how I treat them and how I speak to them differently because what would have been acceptable within a nursing community hospital setting might not be acceptable within this setting".—NHS clinician.

The collaborative endeavor to produce this project together and the colocation of the health and care staff has meant that staff have had to learn how to coexist peacefully, and through productive conflict learning has occurred which transformed front line workers understanding of each other's professions and their value to the service. This mutual learning between front-line workers of different backgrounds might have happened much sooner and created less conflict and tension, however, had front-line workers been included in the workforce planning group itself.

6.2.3 | Joint ownership with relevant stakeholders (including front-line workers)

There was a strong sense, according to participants involved in early planning stages of the project, that this was to be an integrated, joint project, that health and care were driving this forward together, and that they would be working together within the Bellfield. One participant interviewed described the care village as offering an opportunity for a joint planning approach, an integrated and completely new workforce model, with the view of outcomes being:

> "If you couldn't go home from acute hospital or you couldn't stay at home but didn't need an acute hospital—than a very short, well-managed, functioning intermediate care unit should be able to meet your needs in a home-simulated environment with a workforce that is there to meet your needs"—NHS manager.

The joint ownership of the project was demonstrated in terms of the sharing of resources, the ceding of power to joint management teams, and the joint accountability to the project board (during planning) and IJB (during implementation).

Although the project was overall one that was jointly owned by participant actors, the sense of joint ownership was not expressed as strongly by the front-line workers of the Bellfield. Inclusion of front-line workers earlier in the planning of the Bellfield might have led to a more holistic sense of joint ownership over the project and a common discursive framing of the Bellfield and its place in the overall pathway.

6.2.4 | Joint selection

The selection of what innovative solution actors should choose to address the wicked problem was not a straightforward exercise that happened quickly. Participants interviewed expressed that the process evolved through a series of conversations and began in Stirling Council with the intermediate care pilots. A former member of the project team explained it as such:

> "So we had 90 beds, the council had a plan for 90 beds. 180 beds. Would've been a two parallel process model. Those of us in the middle said that's crazy. We're doing the same thing."

Recognizing that they had similar plans and aims and that there was a potential for mutual gains and fiscal savings, NHSFV and Stirling Council made the joint decision to collaborate on a joined-up facility.

6.2.5 | Barriers and outcomes

Significant barriers arose in the journey to realize the Bellfield Centre. Many of those working on-site in interviews reported that, from their perception, there was often not enough care staff at the Bellfield for the number of residents and the level of care that those residents required. Several participants involved in early planning from both NHS and Stirling Council spoke about how this partially can be attributed to the fact that the number of staff employed was based on assumptions that most residents would not have complex care needs. A workforce planning group member said that they realized there would not be enough staff but were brushed off about it, saying:

> "So we knew—I knew that and was telling everybody who weren't listening, that we don't have enough staff."

Unfortunately, staffing gaps remain and reportedly agency staff have been filling these gaps, sometimes with most staff in a suite being agency staff. For example, an on-site manager said:

> "And I think, well, first of all, we've got. I won't say how much, but X amount, hundreds of thousands of pounds overspent on agency staff, and if that's how much agency staff, we've got people working in the area who have come from a bank pool of staff who have no knowledge of reablement, no knowledge of what the ethos is of that building."

The lack of adequate care staff due to inadequate or inflexible budgets coupled with the overuse of the agency budget to compensate represents a lack of administrative capacity to adapt to the needs of a new service such as this, but it also an example of how inclusion of front-line workers might have brought more attention to this issue earlier in the planning process.

A significant barrier to the planning and implementation of the innovative aims of the Bellfield Centre were regulatory bodies external to the collaborative process. Most notably was the confusion around whether the final business case could be approved and align with the changes to the European System of Accounts that came into effect in September 2014 (ESA 10), the assessment of which was a major undertaking spanning nearly 2 years during which time project progress stalled. The Bellfield facility also had to comply with NHS standards for a health facility as well as Care Inspectorate and Scottish Social Services Council standards for a care facility. Planners of the building spoke about how they were forced to plan to the higher both standards, even when those standards did not make logical sense for the type of care and services planned there, with one NHS employed planner saying:

> "One of the problems that we had is because its shared and integrated, you've got 2 sets of standards to meet."

These regulatory barriers, as necessary has they may have been, slowed the momentum of joint ownership and significantly stalled implementation.

In terms of the outcome of this innovation project, the Bellfield opened a facility that was the first of its kind in Stirling in terms of intermediate care and integration and involved a range of stakeholders in the planning of this facility. The radically different facility and its on-site health and social care workforce integration had not seen before within one facility nationally, and the approach to intermediate care had not been done anywhere near this scale in Scotland. In terms of the success of the Bellfield in achieving its objectives, the most recent Clackmannanshire & Stirling HSCP performance report (2020) notes that the opening of the Stirling Health and Care Village, of which Bellfield is part, has transformed short-stay bed-based care assessment. Since the Bellfield's opening, significant improvement in terms of "proportion of last 6 months of life spent at home or in a community setting" (Clackmannanshire and Stirling HSCP, 2020, p. 30) was reported for the region, with this metric now surpassing the Scottish average, as well as 37.5% of reablement clients able to reduce their care hours because of reablement intervention. The Care Inspectorate produced a report scoring the Bellfield as a 4 or "Good" out of 6 or "Excellent" (a 3 is a pass) and within this report it was noted that service users and their families spoke highly of the Bellfield's services and staff—although concern was relayed about the overreliance on agency staff. In terms of whether the Bellfield achieved what it sought to do, responses varied, but participants did agree that it was a discontinuous step-change that had improved the care of service users and the efficiency of the care pathway.

7 | DISCUSSION

In this case, diverse collaborators came together to do something different and succeeded in that regard. However, the perspectives and experiences of front-line workers, those of both health and care professions, was not treated

as one of importance until the implementation stage, where actors recognized it was a misstep to not have that inclusion or even appropriate communication to help front-line workers understand this new service, why it was needed, and what their place in it would be. The exclusion of front-line workers from discursive ideation and planning stages meant that there were several knowledge gaps that had to be remedied during the implementation stage, from small things like remembering to order silverware to larger things like properly calculating the care worker staffing to patient ratio. Additionally, the hospital discharge team and the care managers in charge of admission had different ideas about what sort of patient would and should benefit from a stay at the Bellfield, and this discursive understanding of what function the Bellfield serves in the wider pathway continued to be negotiated a year into implementation of the facility. While the theoretical collaborative innovation and NPG literatures address how inter-and intraorganisational power relations impact the collaborative arena (Lindsay et al., 2018) and the need to include front-line workers to maximize the likelihood of implementation success (Ansell et al., 2017; Osborne, 2006; Torfing, 2016), the case study literature has yet to explore sufficiently the consequences of excluding the front-line from the collaborative arena (Ansell et al., 2017). Collaborative innovation research regularly stresses the need to include the relevant and affected stakeholders, but this research has revealed that when frontline workers are overlooked, it undermines the strength of the overall implementation both by neglecting front-line insights and imposing innovation upon workers that they were not a part of creating, and thus will not fully embrace. This case furthers the argument that front line worker inclusion in the collaborative arena can no longer be framed as an ideal but must be pushed as an imperative for optimal implementation of collaborative innovation.

8 | CONCLUSION

This research contributes to the growing theoretical literature that frames collaborative innovation as a means to address complex policy problems and provides a critical lens to the need to include and account for power asymmetries between stakeholders and particularly the need to include front-line service workers in collaborative innovation processes. The first research question asks how effectively collaborative innovation processes support innovative changes in policy and organizations. This case was a clear demonstration of stakeholders that came together to address a wicked policy problem by doing something different and were able to achieve better outcomes for people and streamline services more effectively than they would have done in isolation. Although this project was also supported by contractual agreements to work together, without the processes of collaborative innovation this project might have just been a patchwork building of health and care services rather than a first-of-its-kind integrated, intermediate care facility. The mutual and transformative learning between actors was supported by their empowered participation and through this learning, actors came to the shared discursive framing that this project would take a holistic and preventative approach to care.

The second research question asks how the role of front-line staff in the different stages of a collaborative innovation process affects the outcome and impact of collaborative innovation processes. While the theoretical collaborative innovation and NPG literatures address how inter-and intraorganisational power relations impact the collaborative arena, (Lindsay et al., 2018) as well as the need to include front-line workers to maximize the likelihood of implementation success (Ansell et al., 2017; Osborne, 2006; Torfing, 2016), the case study literature has yet to explore sufficiently the consequences of excluding the front-line from decision-making stages of innovation (Ansell et al., 2017). The decision to exclude front-line workers from earlier innovation phases did not appear to extensively harm outcomes in this case as eventually most barriers were resolved, it was clear that implementation could have been smoother, joint ownership stronger, and service delivery and job quality optimized for front-line workers had they been included earlier. Thus the exclusion of front-line workers from early decision-making phases of this innovation was indeed problematic because it hampered implementation and potentially lessened the optimal quality of the innovation.

This article provides evidence for the promise of more holistic, person-centerd public services through collaborative innovation, but also takes a critical lens to how power imbalances shape implementation. Although this study has furthered the knowledge base on the relationship between the collaborative innovation process and front-line workers, further research is needed to understand this relationship at different levels of involvement and in different contexts. Future studies should examine the inclusion and exclusion of front-line workers from different parts of the collaborative innovation process in different public service contexts to better understand the relationship between front-line worker involvement and success.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the author. The data are not publicly available due to its containing of information that could compromise the privacy of research participants.

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