Framing Value Based Healthcare for the Complex Case

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Abstract

The aim of this thesis is to progress the question of how to frame value based complex case management by grounding an empirical exploration in a series of case examples, in order to elicit a complex case management framework. Three investigations, as papers intended for publication, are undertaken framed by an overarching pragmatic stance.

A series of care programme approach (CPA) case management reviews are used as a meta-theoretical sample and as the focus for each study. Each investigation uses a thematic template analysis to explore the range of practices within the case series. Further analysis is supported by set theoretic methods. The first investigation explores the process of forming the service participant context. The second investigation explores the process of value making within complex case management. The third investigation appropriates and revises the widely used Wagner's Chronic Care Model (CCM) for use in complex case level management. This proposed Complex Case Management Framework (Complex CMF) is tested against practices within the case series and further revisions made. Finally, the themes and insights developed across the three studies are collated and synthesised as a platform to develop value-based complex case management.

The key finding is that the diversity of practices relating to value realisation underlines the need to develop suitable service platforms for case management. Five principles are developed. First, the individual complex care project should be the focus of interest for value based healthcare. Second, the care project is formed at the intersection of direct participant networks (i.e patient, clinician and commissioner networks), as represented by a unique service delivery network (SDN). Third, each case review within the care process functions as an opportunity for a service valuation, within a style of co-valuation that is determined by the nature of the collaboration. Fourthly, the valued outcome that emerges from such reviews can be seen as a meaningful construction of what matters to the participants, as well as an element that can be aggregated across case reviews in a way that has currency for wider service management. Finally, the proposed Complex CMF integrates these components into an accessible format as a basis both for supporting development of local platforms for service and as a foundation for further research.

Declaration

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List of Abbreviations

BBC	The British Broadcasting Corporation
CCaRM	The Complex Case and Recovery Management Framework
CCM	Chronic Care Model
Complex CMF	Complex Case Management Framework
CTR	Care and Treatment Review
CPA	The Care Programme Approach
DBA	Doctor of Business Administration
DoH	Department of Health
F&F	Friends and Family
fsQCA	Fuzzy Set Qualitative Comparative Analysis
fs/QCA	Fuzzy Set Qualitative Comparative Analysis and/or Qualitative Comparative Analysis
HoNOS	Health of the Nation Outcome Scale
I	Integrated valuation practice
ICHOM	International Consortium for Health Outcome Measures
MDT	Multi-disciplinary team
N	No valuation
NHS	National Health Service (UK)
RO	Results orientated valuation practice
OS	Other stakeholders
OT	Occupational Therapist
P	Professional reflection valuation practice
PP	Principal provider
RC	Responsible Clinician

RP	Rich picture valuation practice
RQ	Research question
QCA	Qualitative Comparative Analysis
SDL	Service Dominant Logic
SDN	Service Delivery Network
SU	Service user
UK	United Kingdom
VBH	Value Based Healthcare

Dedication

Dedicated To

Janet Spurrell (1958-2012)

Lovingly Remembered

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Chapter 1: Introduction

For complex individual cases in healthcare, there is a gap in support for patients, practitioners and other stakeholders who wish to structure the generation of valued outcomes to best effect. There is a chorus of voices, from different backgrounds, that suggest that some notion of value is a critical organising idea in healthcare (Coulter & Dixon, 2013; Porter, 2008; Porter, Pabo & Lee, 2013; Osborne, Radnor & Nasi, 2012). Porter (2008), for example, argues that organising healthcare around what matters to patients first is likely to bring satisfaction to other stakeholders too. There are important ideas associated with this position, such as seeing the patient as an active participant in the process (Coulter & Collins, 2011; de Silva, 2011; de Silva, 2012), and developing the service capabilities to individualise the care process (Swinglehurst et al, 2014) and learn from the individual case (Baker, 2011). However, the concept of value in healthcare, and in services generally, is subject to many interpretations and uses, and a degree of confusion prevails in the literature (Hardyman, Daunt & Kitchener, 2014; Grönroos & Gummerus, 2014). Meanwhile, there is growing importance being given to optimising the management of complex and long-term conditions in stretched healthcare systems (Edwards, 2011). Nevertheless, the focus of attention in key areas of literature has been predominantly on services and populations (meso and macro levels) and not the micro case level (Hardyman, Daunt & Kitchener, 2014). As Edwards (2011) notes, there is a challenge to put the aspiration for person-centred care into practice. In this context, Bohmer & Lawrence (2008) argue that work should be done to develop care platforms that are better suited to supporting complex case management.

The aim of this thesis is therefore to break down the issue of supporting case level complex management into a number of distinct areas of concern. These are: how to understand the service context in case level complex care; how to understand the value generating system at the micro level in case level complex care; and how to assemble a framework that practically supports complex case management and enables the development of suitable care platforms. As outlined below, these all reflect different but relevant conceptual preoccupations in the literature, which might be of concern or assistance in reaching these aims.

This project is grounded in the area of complex case management in a particular UK learning disability service. The service in question is responsible for patients with a learning disability associated with complex needs, outlined in more detail below. Patients are supported by a system of case management (The Care Programme Approach (CPA): Department of Health, 1990; Department of Health, 2008). This area of interest is important as an identified focus for improvement for the host organisation for this DBA project. Meanwhile, it is a phenomenon that has wider relevance, not just for UK mental health and learning disability care, but also for complex case management in the wider health sector more generally. A series of cases from the case management system form the basis for the case study work.

This thesis advances from the perspective of a pragmatic stance. The nature of a pragmatic stance is outlined in more detail below (Section1.7.1). However in brief, a pragmatic stance is distinguished by not adopting a strong a priori theoretical position. It is accepted that both the conceptual landscape and the area of practical interest are each sources of tension and uncertainty. In this context, a pragmatic inquiry seeks to explore, via directed, structured inquiry, the interplay between the phenomenon of interest and available conceptual tools to suggest developments that might prove practical and useful. It is possible to draw on a number of conceptual resources to support the inquiry, leading to a multiple paradigmatic approach (Lewis & Grimes, 1999). Following the framework suggested by Lewis & Grimes, this project proceeds first with an introductory stage that develops the groundwork for the project. Next, there is the exploration and data analysis stage, followed, finally, by a process of theory building and reconceptualisation.

In this thesis, the introduction stage commences the groundwork by defining the phenomenon of interest, and developing a view from the literature of the tensions within the paradigmatic landscape. This landscape includes the troubled state of mental healthcare and learning disability care as it pertains to CPA case management. This includes an outline of the CPA case management process and its linkages to wider case management. This conceptual landscape further covers tensions in the understanding of service context in the literature, and tensions in the understanding of value and value realisation for complex cases in healthcare.

This leads to the framing of the research questions for the thesis, and the adoption of CPA case management case reviews as a common focus of interest. The data analysis and theory building stages are then introduced as envisaged by Lewis & Grimes (1999).

In the introduction for the data analysis stage, it is explained that this is performed through a process of three parallel investigations of different aspects of CPA case management reviews, supported by set theoretic techniques. The justification of these pragmatic investigations is that each makes a practical contribution. Therefore, each investigation is in the form of research papers intended for publication. The three papers are introduced as each focusing on distinct but inter-related elements necessary for operationalising value based healthcare within complex case management. The view taken is that these key elements are how to understand the service context, how to understand the value generating system at the micro level, and how to assemble a framework to practically support practitioners and service managers in promoting collaborative complex case management in services. Within the overarching stance of this thesis, each paper is itself undertaken as a pragmatic inquiry. The interplay between the three papers, and further interaction with relevant literature, provides important opportunities for critical reflection and conceptual triangulation.

For the theory building stage, following Lewis & Grimes (1999), it is explained that the key contributions from each of the three proposed papers are collated and synthesised to address three further key reflexive issues that arise across the three papers. The first issue is how do the insights gained across the project interact with local practice with a view to improving local service practice. The second issue is to develop a critical reflection across the project, and to explore the possibility of a more relevant and comprehensive meta-theoretical framework that accommodates the identified tensions within the case management, contextual and value realisation landscapes. The third issue is how the interaction with the worked examples of complex managements might shift and transform the currently available conceptual resources, and contribute to a widening understanding of case level service process more generally.

Mindful of the diversity of use and meaning of terms relating to value in the literature (Grönroos & Gummerus, 2014), it is important to set out the use of

terminology in this thesis. ‘Value’ is taken to mean that, after the receipt of a service, the user perceives that they are better off (Grönroos, 2008; 2011). This has more flexibility than the definition used in Grönroos & Gummerus (2014). However, from Grönroos & Gummerus (2014), ‘value creation’ refers to value made for themselves by the beneficiary, which then becomes ‘value in use’. ‘Value generation’ refers to the whole system that allows value to be created (Grönroos & Gummerus, 2014). In addition, it is considered that ‘value generation’ has two dimensions. ‘Value realisation’ is proposed to refer to how value is made explicit in the service process, and ‘valued outcome’ is the representation of realised value that can be seen as having currency amongst stakeholders, and more widely. These usages are intended to anchor the development of understanding of value in this thesis. Other usages of terms can be found and are defined in context. These may derive from other schools of thought, and comparisons and contrasts with these core terms will be highlighted wherever appropriate.

It is also important to note that diverse sets of actors are implicated in complex service exchanges, and in healthcare in particular. There is a fluidity of terminology to be found across the diverse literatures, and there can be sensitivities about nomenclature in healthcare in some regions of practice. No disrespect is intended. The broad view taken in this thesis is that ‘all are actors’ (Vargo & Lusch, 2011). How those actors are termed across this project will draw on what makes best sense of the pertinent literature, and that serves consistency and clarity in context. Thus, the nomenclature of ‘patient’ as the focus of healthcare services has been retained for the most part, although in some circumstances the term of ‘service user’ is preferred. Meanwhile, there will be circumstances where those directly engaged in the service process will be termed ‘participants’. In some circumstances, the term ‘stakeholder’ is preferred. It is intended that this interchangeability will be clear in context.

In summary, there are five chapters to this thesis, and an appendix. Chapter 1 represents this introduction. Sections 1.1-1.5 outline the relevant bodies of literature, and frame the broad research objectives. There will be a section outlining the troubled state of mental healthcare and learning disability care as it pertains to CPA case management. The section includes a detailed outline of the CPA case management process (Section 1.2). The next section develops a view

of the wider case management literature (Section 1.3), followed by an outlining of service context in complex healthcare (Section 1.4). A further section outlines the conceptual overview in relation to understanding the value in healthcare landscape (Section 1.5).

Following this overview, the research questions for this thesis are presented (Section 1.6), and an introduction of the methodological approach set out. Since this thesis is in the format of a series of papers for publication, Section 1.7 provides a relatively rich account. This includes a more detailed outline of the pragmatic stance as it has been developed for the papers presented, as well as for the thesis as a whole (Section 1.7.1). In addition, there is a section with a more detailed introduction to set theoretic methods, which has been a key element of the methodologies for the presented papers (Section 1.7.2.4). This section is supplemented by a methodological reflection (Section 1.7.3), and there is a separate appendix to this thesis containing material from an exemplar case (Section 6). The three papers forming the core of this thesis are then introduced (Section 1.7.4) It is in this section that the three papers are introduced, since in the context of the pragmatic stance these are the principal means by which the investigations of the proposed research questions are enacted.

Chapters 2, 3 and 4 are the accepted or draft journal papers, drawing on a common source to develop three distinct perspectives.

- Chapter 2: Paper 1: “Capturing Context: An exploration of service delivery networks in complex case management.” (Spurrell, Araujo & Proudlove, 2018)
- Chapter 3: Paper 2: “An Exploration of Valuation Practices in Complex Case Reviews in Healthcare” (Spurrell, Araujo & Proudlove, 2017: conference paper and draft journal paper)
- Chapter 4: Paper 3: “The Complex Case Management Framework: structuring the relationship between stakeholder activation and value realisation in complex healthcare.” (Draft journal paper: the abstract was accepted for the Frontiers in Service Conference 2018, Austin, Texas).

The section includes a brief introduction to each paper, and a reflection on progress through the publication process.

Chapter 5 presents the discussion and conclusions in which the key contributions from each paper are summarised. The themes and insights developed across the three studies are collated and synthesised as a framework from which value-based complex case management platforms can be developed. This framework better accommodates the identified tensions within the literature, and from this a template for further theory building work and research can progress. There follows a reflection on the implications from this project for service theory, and a reflection on the impact of this project as a DBA on the host organisation. Finally, in concluding, suggestions for a programme of further research are presented.

1.1. Introduction to the Research

A DBA project is characterised by its being grounded in an area of concern for a particular sector. However, although the primary requirement is to make a local practical contribution, it is expected that such a project will also make a contribution to service management more widely, with the development of models and frameworks and so on that have broader applicability. It is also expected that there will be a contribution to theory development and the research literature as the empirical exploration throws up challenges to the assumptions built into the available conceptual tools. There are therefore two constituencies to be addressed. The practitioner constituency can be thought of as those, in principle, who are directly engaged with the service exchange. This is a broad constituency, and, in particular, it is intended to include service users and carers as relevant actors, as well as relevant professionals and managers. The service improvement constituency consists of service researchers, designers and service managers who are concerned with the effective structuring and optimisation of service for people. This would include both those concerned with healthcare, and those concerned with services more generally. In this section, the aim is first to explain the focus of interest in CPA case management in a complex learning disability service. Then, to outline some key conceptual landscapes which commentators and researchers have previously been drawing on as likely sources of support. The section concludes by identifying and evaluating the gap in support for complex case management in healthcare, leading into outlining the proposed investigation. The potential implications for theory are also highlighted at that stage.

1.2. Overview of CPA Case Management

The Care Programme Approach (CPA) is a case management system used in England, which is intended to support the delivery of service for people with complex mental health problems (Department of Health 1990; 2008). The system applies to the broad sweep of mental health care, including learning disability care. The threshold for cases moving onto the CPA is something that has been somewhat fluid in practice. Indeed, there are local clinical interpretations of this, as well as local organisational factors that can be applied differently in different areas. Practically, however, eligibility for CPA case management is used by localities to define their most complex cases. In particular, individuals needing prolonged admission to hospital under the 1983 UK Mental Health Act would be generally expected to fall within the CPA case management system.

The nature of the CPA system is straightforward. The local healthcare system is required to keep track of individuals registered as under CPA, and each person has an assigned care coordinator and a senior clinician involved in their case. The process requires that there is a broad, holistic assessment of the service user and the development of a care plan that identifies the key care themes, and that an agreed plan is specified. The CPA is intended to be a collaborative process. In addition to individual meetings with the care coordinator, the senior clinician (usually psychiatrist) and other care workers, the process calls for a regular collaborative review meeting. Here, all the relevant stakeholders are convened to review progress and to further refine the plan. The CPA review meetings typically occur 3-6 monthly, and can be held wherever is most convenient. Typically though, the location would be healthcare premises, if the service were in the community, and within the hospital, if the service user has been admitted. There is an open view as to who the other relevant parties to invite might be, but commonly family members would be included, along with social workers, multi-disciplinary professionals and sometimes representation from commissioning. Commissioning representation has increasingly become the norm, though, for learning disability service users in a hospital setting.

The operation of the CPA system sits with the clinical service provider, and is governed by local organisational policies. The service provider has the primary responsibility for convening and administering the CPA process, including inviting participants to CPA case reviews. From the national policy perspective, there is an obligation for all other public systems to cooperate with the process. This is a policy that is actively reviewed from time to time. In the latest review (Department of Health, 2008) adjustments were made to further refocus resources on the most complex of cases. The system has been long established practice, and is widely accepted and relied upon by clinicians to support the care process (Kingdon & Amanullah, 2005). Therefore, the CPA process is embedded in the English mental healthcare system, and the CPA case review is a key phenomenon in the evaluation of the process.

1.2.1. The Complex Case in CPA

The approach to what might be termed a complex case is essentially pragmatic, and is built up from a number of sources. First, it is established practice to understand the individual clinical case in terms of a number of dimensions of need. Wing and colleagues, for example, developed the widely used Health of the Nation Outcome Scale (HoNOS) as one way of structuring complexity in mental health (Wing et al, 1998). This framework pays attention to assessing a range of clinical factors, behavioural or risk factors, physical factors, and social and functional factors. Second, where in the system care is provided is also important. People who are in-patients or on mental health team case-loads, or who are patients in hospital under the mental health act add further weighting to being deemed complex. There are additional considerations too that come into play, for example where there are legal matters, offence allegations, public protection issues and so on. Political factors can also be relevant from time to time, for example where there might be a degree of external scrutiny, or where there are tensions between resource availability and numbers of complex cases on case-loads. The nature of complexity may vary to some extent across sub-specialties of mental health, for example there are particular issues and obligations for children's mental healthcare. For learning disability care, the issue of capacity to make judgments, whilst not exclusive to this field, is often a prominent issue. In summary, there is no set way of determining case complexity, and it is hard to discriminate where the

boundary lies between complex and not complex. Nevertheless, being on the CPA is a good pragmatic marker to signify a definite complex case.

1.2.2. The Predicament of CPA Case Management

The focus of this DBA is the practice of complex case management in UK learning disability care, which relies on the Care Programme Approach (CPA) case management system. This focus is driven by important local concerns, and by its importance as an exemplar of complex care and complex service exchange more generally. Local interest in this issue was activated from three sources. First, there is contemporary literature that highlights widespread variability in practice and patient experience with the CPA case management system. Second, a serious case review was held into the care and treatment of patients in Winterborne View hospital in which the lack of effective functioning of CPA case reviews was implicated (Flynn & Citerella, 2012). Third, local qualitative audits highlighted a level of concern amongst commissioners and patient advocates about the variability of quality of CPA case reviews within the specialist learning disability service hosting this project. Meanwhile, it is argued that learning from the example of CPA case management is an important opportunity that could also benefit the wider service sector (Goodwin & Lawton-Smith, 2010).

1.2.3. The Troubled State of CPA Research

There are a number of areas of unsettlement relating to CPA. First, CPA has been an under–researched area, but such research that there has been suggests its configuration within organisations needs improving (Carpenter et al, 2004). Goodwin and Lawton-Smith (2010) studied 262 cases subject to CPA in the community. In this study CPA was generally viewed as valuable by patients, but with variation in that experience between districts, related to different service configurations. From a study of 221 cases, Rose (2003) found that CPA generally wasn't always engaging service users, although when it did it was welcomed as making a difference. Rose argued that despite intentions to be service-user focused, CPA had defaulted to something influencing organisations who applied systems *to* (rather than *with*) service users. Meanwhile, Simpson, Miller, and Bowers (2003a, 2003b) comment on the poor implementation, the lack of unifying philosophy and the dis-connect from the wider case management literature.

Therefore, despite the merits of CPA, as it is enacted in services there is evidence that it is both conceptually and practically poorly configured in many services.

1.2.4. Winterbourne View and the Policy Environment

In addition to the within speciality concerns, there is a further dimension of public confidence and policy to take into account. On the 31st May 2011, the BBC broadcast a Panorama programme on television entitled “Undercover Care: The Abuse Exposed”. The programme highlighted widespread mistreatment of patients with a Learning Disability being cared for at Winterbourne View Hospital in South Gloucestershire, UK. In the Serious Case Review, commissioned by South Gloucestershire’s Adult Safeguarding Board, one of the key aspects of service that failed to function was the CPA case review.

> “Reviews for patients at Winterbourne View Hospital were ineffective and did not bring to light either concerns about the quality of assessment and treatment or detail of abusive practices. Care Programme Approach (CPA) reviews were driven by Winterbourne View Hospital which arranged and chaired meetings, thus undermining the vital safeguards of the process. Important events such as First Tier Tribunal Mental Health meetings were not taken into account in the timetabling of the CPA, nor were meetings arranged in response to incidents or concerns. This was wrong. As the NHS South of England review notes, the CPA did not include wider quality and performance monitoring of the service or any wider perspective of the welfare or needs of the patient. It would therefore appear that the care coordinators were operating outwith national CPA guidelines.” (Flynn & Citerella, 2012, p125).

In response to the findings of various reports following Winterbourne (Bubb, 2014), a change in policy was introduced. Noting that of 921 patients in hospital, 691 were viewed as not ready for discharge (NHS England, 2015), a fresh form of case management was mandated. Described as Care and Treatment Reviews (CTR), these were to be commissioner led panels that would review progress in care pathways for individuals in hospital in England with learning disability and complex needs (CTR Care and Treatment Review: Policy and Guidance, version 2.0, NHS

England, 2015). The stated aim of the policy was the reduction of admissions and reducing of length of stay for patients with learning disability and autism in hospital. The intention would be to promote a person-centred and individualised approach, along with an intention to challenge any barriers to care pathway progress. The details of the proposal were that the CTR process would interlink with the existing CPA case management system. Unfortunately, as for the CPA itself, there was no conceptual underpinning to the proposed CTR initiative, or of operationalising what an individualised person centred approach might mean and how in practice CPA and CTR might work together. In this context, it can be argued that there are two concerns. First, the introduction of a second case management system alongside CPA, without being carefully operationalised, could lead to an impairment of co-ordination. Secondly, that introducing a second case management system, without understanding why the original CPA system might not be working as expected, could make an understanding of variability in CPA even harder to unravel. It is important, therefore, that this project was undertaken before CTR was implemented in order avoid that additional confusion, and with a view to being able to inform how to interplay CPA and CTR in the fullness of time.

1.2.5. Local Experience: Findings from a Local Qualitative Survey

In the context of developing concerns about CPA, particularly in learning disability services, the organisation was interested to explore the functioning of CPA further. In 2015, before CTR was initiated, there was a survey of 5 commissioners who regularly placed patients in the service and all the 5 patient advocates who were retained to support patients with their care process. Their responses were obtained in relation to their experience of the last CPA review that they had attended. The advocates reported that they saw the purpose of the CPA review as being to provide space for collaboration, with patients having involvement in and responsibility for their lives. It was to develop a rich, holistic picture of progress, and it was to provide a platform and discipline to support the care process. For example:

> "It enables the service user to have involvement and responsibility for their lives" (Advocate 1),

and,

> “It was an excellent platform in which to mark the progress of the service user and map out the next step in the service user’s journey through the service.” (Advocate 2)

Advocates expressed concern about the quality of the participation that they had seen, and about the need for a more user-friendly format. Commissioners took a rather narrower view of the purpose of CPA, viewing it more simply as a forum for discussion, and as being for task planning with a view to moving people on. Commissioners were more positive about the quality of participation, but recognised a need for more family involvement. For both sets, there was a view that progress as a result of the review could be seen in one form or another. However, there were further elements to suggest that what was valued about reviews was more complex. For example, there was evidence of valuing the fact of richly engaging the patient or demonstrating a good understanding of the case as being helpful outcomes in their own right. Meanwhile, there was agreement on themes for improvement. These included, for example, issues such as the administration and co-ordination of reviews, the quality of participation and engagement in reviews, and improving the effectiveness of reviews:

> “I would like to see more use of teleconferencing and video conferencing to enable more involvement from external professionals and families. The voice of the patient needs to improve and I would like to see more person centred delivery - family involvement - if not able to attend they could be encouraged to write a short piece that can be read out at the beginning of the CPA. I would like CPAs to reflect more clearly the goals and outcomes of care and treatment”. (Commissioner)

1.2.6. Summary

In summary, the functioning of CPA is an absolutely critical element in the organisation of care for complex cases in learning disability. On the one hand, it is a recognised focus of concern for improving both collaboration and generating valued outcomes for the host organisation. Not only that, this element of service architecture has been flagged as having not functioned when a high profile instance of catastrophic service failure in UK learning disability care was

investigated. It sits within a context of limited research and evaluation of its functioning and policy implications. Such research as there is suggests that problems feature widely in UK mental healthcare services.

On the other hand, the CPA process provides a pragmatic operationalisation of the complex in healthcare, making the population of CPA cases a useful area to study complex service management issues. In that process, the phenomenon of the CPA case review is a pivotal element which has the virtue of providing a focal mechanism for both, providing a window onto the service process, and, for weighing up how and whether progress is being made. This is a fruitful focus, therefore, for studying how value realisation is happening in practice in a complex service environment. In these terms, it serves as a good object of study that would have relevance to understanding complex case management more generally.

1.3. The Wider Healthcare Landscape

If, as indicated above, CPA has something to say about complex case management more widely (Goodwin & Lawton-Smith, 2010), it is useful to see how it sits within the wider healthcare landscape. This perspective hinges on exploring further the concept of the complex case in healthcare, and the wider literature on case management support, and current models or frameworks in use.

1.3.1. The Long Term Complex Case

There is growing recognition that understanding and supporting management of the long term, complex case has important implications for healthcare. The interest lies in two main directions. First, there is an aspiration to make care more person centred, with a shift towards empowerment and more collaborative working, with the service users taking more responsibility for themselves. Second, there is a recognised need to move away from a focus on simply improving acute care, when such a key driver for healthcare outcomes is how to cost effectively manage long term complex conditions. In fact, acute care is often an exacerbation or complication of such an underlying long term condition.

The emphasis in the literature to date has been on a relatively narrow group of single long term conditions, and less so on what might be termed complex cases (Coleman et al, 2009; De Bruin et al, 2012; Nolte & McKee, 2008). Long term conditions might for example be represented by work to improve collaborative management of a condition such as diabetes (Stellefson, Dipnarine & Stopka, 2013). Porter and colleagues are strong advocates of the condition focused approach in earlier work on value based healthcare (Porter, 2008; Porter & Teisberg, 2007). There is a much less clearly delineated concern to define and consider the management of the complex case, which might involve management of multiple conditions (Haggerty, 2012; Johnson, 2013).

Whilst there is no uniformly agreed approach to defining the problem of the complex case, there are some moves in the literature to consider the distinction. Thus, within the single condition literature, there has been recognition of factors such as additional complicating disorders and social difficulties as also needing attention. A broader, more functional approach has been seen in projects concerned with old age care (Sendall, McCosker & Crossley, 2016). Meanwhile, in later work, Porter and colleagues proposed developing clusters of case with similar characteristics, where the specialist condition led focus was not appropriate (Porter, Pabo & Lee, 2013). Porter and colleagues do not provide a framework for spelling out what elements go to making up a complex case, and no general definition is in use. However, beyond the longevity of a particular condition, a number of further themes can be found in the literature. There is reference, for example, to the difficulties engendered for cases with multiple health conditions to be managed, along with sources of stress or social difficulty. There is complexity that arises from difficulty with agency for patients, which may arise where factors impair the capacity of patients to make decisions for themselves, or where other wider system imperatives impose constraints (Ewert & Evers, 2014; Barile, Saviano & Polese, 2014). Further, account needs to be taken of patient disposition to the service, which might range from being pro-actively committed to being disinclined to engage, or even to being unwilling participants (Osborne & Strokosch, 2013). In fact, a disinclination to engage has characterised a meaningful proportion of patients where attempts have been made to develop more collaborative models (Batalden et al, 2016).

As illustrated in Figure 1-1, rather than formally defining the complex case, an alternative is to represent cases on a dimension of complexity. On the one hand Ahmad et al (2014), for example, confine their research report on planning person centred care to the single long-term condition case. On the other hand, cases can be, for example, represented as not just multiple morbidity, but with a full spectrum of other themes also in play that add further complexity (Haggerty, 2012; Johnson, 2013). In this context, in line with Johnson (2013), the position in this thesis is that cases in mental health and learning disability that are subject to the CPA will fall on the complex end of the spectrum. They will in some measure be useful exemplars for a variety of other specialist areas, including primary care and old age medicine for example. As proposed by Haggerty (2012), therefore, there is much more intricacy to how such care is optimised and supported.

1.3.2. Case Management Support, Care Frameworks

The other dimension to consider in the literature is the approach to framing and managing the individual case. One important tension is that between seeking organisational effectiveness through standardising care approaches, and pursuing the spirit of individualising care through customisation approaches (Swinglehurst et al, 2014; Meehan et al, 2008). This dimension is again represented in Figure 1-1. A standardised approach would, for example, follow the lead of Porter, Pabo & Lee (2013) by establishing a meaningful clustering of patient cases in order that standardised care approaches might best be applied. In this landscape, care options can be collaboratively produced with patients, but the emphasis in the literature is rather on involving patients in designing the general service features that would be welcome to them (c.f. “People Powered Health”: Horne, Khan & Corrigan, 2013). The patient voice can be further heard through paying attention to patient reported feedback on their experiences of service, which can then further feature in refining the standard service proposition.

In contrast, an individualised focus is rather concerned with collaborating directly with the particular patient to customise the service experience, “knitting together care from many sources” (Goodwin & Lawton-Smith, 2010, p.2). There is therefore an immediate weighting to what that particular patient thinks suits them at that moment in time. This harnessing of the patient centred view is accepted as an important aspiration in mental health and learning disability care, which

commentators argue could be fruitful sources of innovation and care system development (Appleby, 2000; Simpson et al 2003a).

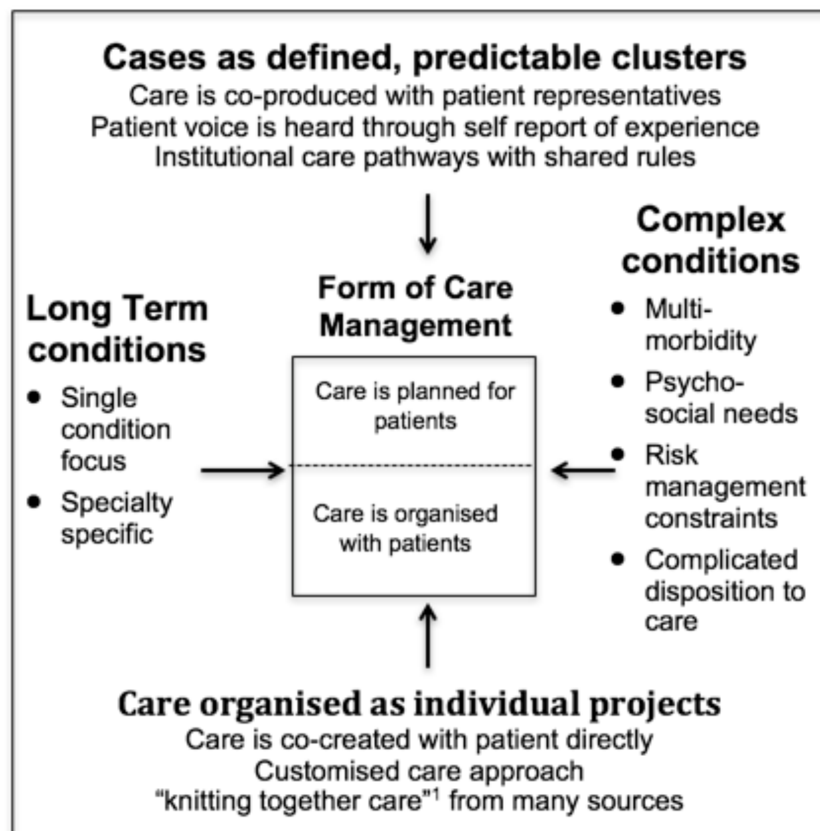

Figure 1-1 Healthcare Landscape

This tension between care focused on patient clusters or groupings, or care as individual projects, is reflected in the organising systems that have developed. Freire & Sangiorgi (2010, p2-3) point out how in the UK the healthcare paradigm has shifted to encompass "mass-production" to "mass-customisation" to "mass-collaboration". However, they do not bring the individual case into focus as the project of interest. Meanwhile, Osborne & Strokosch (2013) describe a continuum of modes of co-production in public services such as healthcare. They argue that this ranges from a relatively passive service user empowerment in the process, to more active participative planning, and to a much more pro-active position of user-led innovation.

If a case management perspective is adopted, Goodwin & Lawton-Smith (2010) argue that the range is between standard, integrated approaches for well defined, more predictable groups of cases, and more fluid approaches for less predictable

cases. For the former, contributors are integrated within established institutional arrangements. On the other hand, for less predictable, more variable cases with multiple and/or complex conditions, the form taken of care management is that of care co-ordination, involving brokerage across multiple providers. In this latter instance, as indicated above, the task is seen as "knitting together appropriate care from a range of providers" (ibid, p 2). It is this latter perspective that is the domain of the Care Programme Approach for mental health in the UK, and which forms the focus of interest in this thesis.

Meanwhile, in terms of supporting frameworks of care systems, the most widely used service framework is Wagner's chronic care model (CCM: Wagner, 1998; Wagner et al, 2001). The CCM marks an early initiative to reframe care away from a preoccupation with traditional provision of acute care, towards a broader view of collaborative management of the long term condition. This included an emphasis on training patients in self-management, and accessing broader community resources as part of the care project. It was revisited by Batalden et al (2016), who recast the framework to be more reflective of care as a process of value co-creation, centred on care planning, and who brought in the additional perspective of the wider healthcare system as having a stake. Meanwhile, a further widely referenced framework is the House of Care (Coulter, Roberts & Dixon, 2013), which similarly centres on care planning. All these examples are characterised by focusing on abstract system qualities, rather than operationalising practices that make sense of the individual patient predicament. In other words, they are focused on the generalities of care. In contrast, there is a pressing need to develop individual case projects that more explicitly balance the personalised viewpoint against concerns of other stakeholders (Meehan et al, 2008). Thus, there is a tension between forms of case management that deal with the generalities of planning care for patients, and the aspiration to collaboratively organise care with patients, and putting that into practice (Edwards, 2011). This aligns with the focus in this thesis of exploring the organisational forms supporting the individual CPA case management reviews.

1.4. Understanding the Service Context in Complex Healthcare

There is momentum in the literature behind boosting an emphasis on the importance of context to value generation in the service process (Edvardsson, Skålén & Tronvoll, 2012; Vargo et al, 2017). Much emerging literature has in mind the public sector, including healthcare (Hardyman, Daunt & Kitchener, 2014; Frow et al, 2016). However, the literature representing this aspect to service functioning gives rise to a somewhat disjointed landscape, with a number of contrasting vantage points in play (Figure 1-2). Thus, in some instances the perspective might be described as 'context-light'. For example, in UK health policy directed toward supporting people with longer term conditions (Department of Health, 2013), the emphasis is on rather vaguely looking at people 'in the full context of how they live their lives', rather than drawing the boundaries of context as a more collaborative construction. Meanwhile in other literature, context is a simple series of discrete individual dyadic exchanges, which may be aggregated to generate the context for service (Tax, McCutcheon & Wilkinson, 2013). In contrast, some see the dyadic perspective is problematic (Philips et al, 2006). Context rich literature sees it as more diversely shaped by sets of practices that mediate the inter-connection, interaction and collaboration between multiple actors (Ciasullo et al, 2017; Palumbo, 2016; Edvardsson, Skålén & Tronvoll, 2012).

In terms of how context is framed, there is growing interest in adopting a service eco-system approach. This perspective is developed from a variety of sources, for example the viable systems approach and network theory (Barile et al, 2016). There is a generally determined view of service architecture that sees the micro level of service embedded in the wider, meso, macro and even mega service systems (Frow et al, 2016). However, there are different ways that complex service systems are represented, with different emphases to the fluidity and focus on the practices involved (Ng & Andreu, 2012). One perspective proposed, is that through a process of structuration (Vargo & Lusch, 2016; Akaka, Vargo & Lusch, 2013; Edvardsson, Skålén & Tronvoll, 2012), there is a dynamic interplay between the constraints from the wider eco-system on actors in the micro exchange, and the influence of experiences within the micro level that lead to evolution of wider structural constraints. In contrast, from the network theory perspective, without assuming a pre-determined architecture, the shapes formed by patterns of nodes

and their interactions are simply to be discovered (Borgatti & Halgin, 2011). From this vantage point it is possible to adopt a more customised perspective on context formation. Thus, from a chosen vantage point, how the nature and shape of the network might generate context for a service process can be reflected upon on a case by case basis. The tension across the literature between more fluid and more fixed conceptualisations of context is illustrated in Figure 1-2.

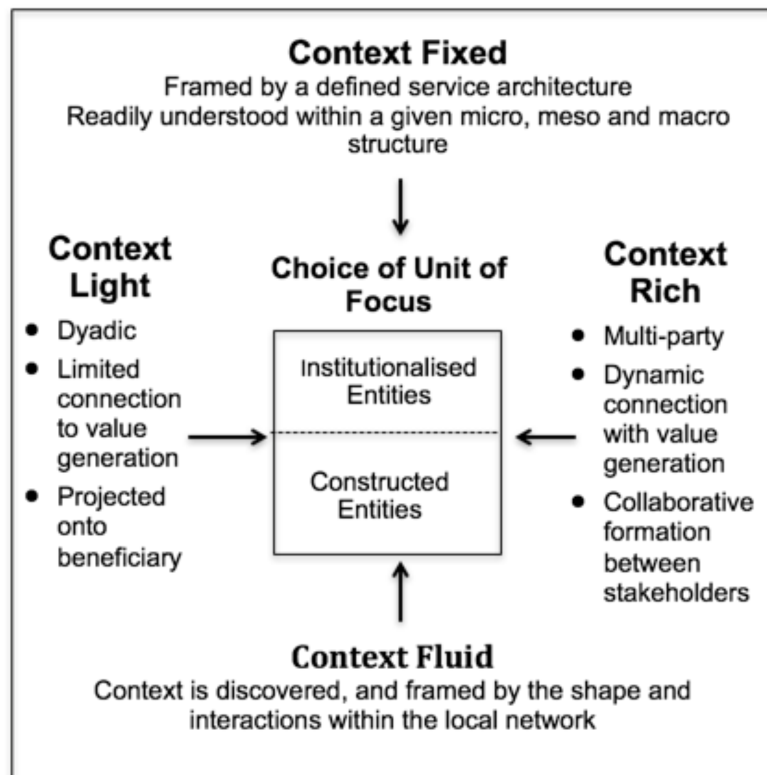

Figure 1-2 Context Generation Landscape

Choosing and locating a focus of interest within this more complex contextualisation landscape, as seen at the heart of Figure 1-2, requires consideration of how the tensions of these different perspectives resolve to best suit the particular case (Patrício et al, 2011). For example, where the focus of interest is a service sector, a more fixed structural view of context might apply. This more institutionalised view would usefully set the tone for influencing policy or regulatory development. This sits well with the idea of structuration and prevailing service eco-system views (Vargo & Lusch, 2016; Akaka, Vargo & Lusch, 2013). It fits well with the approach to healthcare taken by Frow et al (2016).

On the other hand, where context is viewed as focused on an individual service beneficiary, a more locally constructed entity with direct connection with the

process of value co-creation process might be expected (Moeller et al, 2013). This perspective is for, example, seen in the work of McColl-Kennedy and colleagues in healthcare, where they link a patients' network of family and friends as being integral to the process of value co-creation (McColl-Kennedy et al, 2012; McColl-Kennedy et al, 2017). In fact, it can be argued that a whole range of different loci might be considered as the service focus. In healthcare, the range might be, for example, just the patient; the patient and their family; the patient, family and their supporting clinicians; or indeed a defined particular sub-group or segment of patients (Porter, Pabo & Lee, 2013, p517), and so on (Hardyman, Daunt & Kitchener, 2014).

In summary, context generation sits within a complex landscape (Figure 1-2). With the predicament of complex case management in mind, there is work to do to clarify how best to approach an understanding of context and how it relates to value generation (Edvardsson, Skålén, Tronvoll, 2012). As pointed out by Vargo & Lusch (2016), there are not as yet mid-range theories to support this work. 'zooming in', as they put it, with the focus of interest as the individual case, the work involves clarifying how much the case is positioned as occupying a niche within a service architecture, and how much it is co-constructed by local practices. Meanwhile, how richly developed does the contextual environment need to be, and by what practices does this link to value generation? It is this angle which is further explored within this thesis.

1.5. The Value Landscape

This section sets out the landscape in relation to three ways of viewing the generation of valued outcomes that occur in the literature. These distinct perspectives are summarised in Figure 1-3. The common theme to all these approaches is a focus on "what matters to patients", which is a powerful organising idea in contemporary healthcare (Porter, 2010; Porter & Teisberg, 2007; Cornwell & Goodrich, 2011). The issue is that it is capable of a number of different interpretations, and there has yet to be a consensus on how this might be practically realised in healthcare (Edwards, 2011), or indeed in services more widely (Korkman, Storbacka & Harald (2010). Figure 1-3 highlights the three

different ways such a practical realisation might be approached. "What matters to me", adopts an ideographic, subjective stance; "what matters to them" adopts a more objective, normative stance, and "what matters to us" is a pragmatic stance on the collaborative view of value realisation.

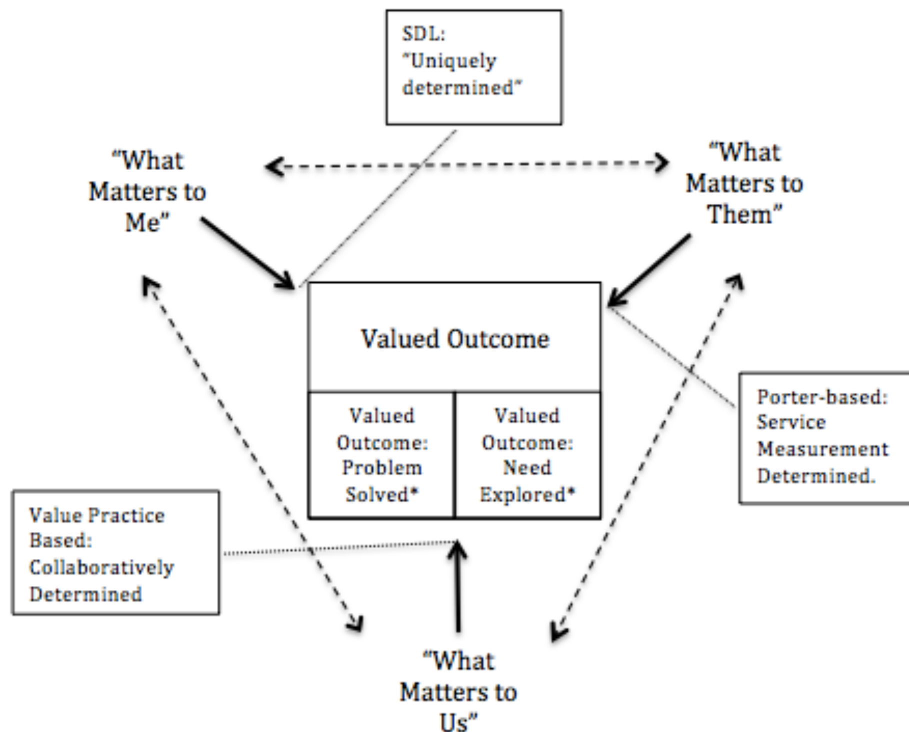

Figure 1-3 Valued Outcome Realisation in Healthcare

In this thesis, 'what matters' is taken as an expression of value. Value is realised as a result of a service process, where service can be seen as the integration of knowledge and skills for benefit, described in the service dominant logic (SDL) literature (Vargo & Lusch, 2004; 2008). In practice, how that value realisation is represented and given currency to inform service management and service evaluation, can be thought of as the valued outcome. From a design perspective, Kimbell (2011) describes two tensions in play that characterise the mode of outcome. One of these dimensions is to distinguish between a service for the patient, and (in line with SDL) a service collaboration with the patient, where the valued outcomes are co-produced. The other dimension is the distinction between a process to address a defined, known problem, and a service to explore and

develop understanding where a known outcome cannot be defined. In healthcare, the former is associated with the tailoring and application of known solutions, perhaps as captured by available practice guidelines. The latter, with making sense of and finding a way through complex predicaments, where new solutions may need to be found. Therefore, different modes of valued outcome might be applicable for different kinds of cases.

In this context, as indicated above, there are three routes to the realisation of valued outcomes discussed in the literature. Most prominently (Ciasullo et al, 2017), there is a debate around either developing what matters to the patient subjectively ("what matters to me"), or by being able to objectively represent valued outcomes that have currency for the wider healthcare system: "what matters to them". The third perspective which has received much less attention in the literature can be characterised as "what matters to us". This important perspective argues that collaboratively making value in service can be conceived of as performative, and often contiguous with valuation (Roscoe & Townley, 2016, p121). These different approaches are briefly outlined below.

1.5.1. What Matters to Me

The strength of this perspective can be seen though its critical role in contemporary service thinking. For Service Dominant Logic (SDL):

> "Value is uniquely and phenomenologically determined by the beneficiary" (Vargo & Lusch, 2008, p9).

From this standpoint, therefore, the SDL view of the realisation of valued outcomes is a matter of subjective determination. This is represented as "what matters to me", as seen in Figure 1-3. This perspective is the remit of individual case study, where subjective experience can be canvassed (Helkkula, Kelleher & Philström, 2012). Alternatively, it becomes accessible through a study of value creation practices (c.f. McColl-Kennedy et al 2012; McColl-Kennedy et al, 2017), or through patient satisfaction survey (cf. Payne, Storbacka & Frow, 2008). The disadvantage of this perspective is that the valued outcome remains private knowledge, which has to be inferred from other sources. This raises difficulties with understanding how to interpret outcomes and manage services to best effect. Further, the question of how "what matters to me" is connected to the process of

value realisation remains difficult to elucidate, and requires more attention within the study of micro service level exchange (Storbacka et al, 2016). Meanwhile, whilst the literature proposes a process of value co-creation as the means of value generation, there are problems with that conceptualisation. For example, there is much concern about the varied uses of terms such as co-creation, co-production, and indeed the way that value as an outcome is expressed (value in use, value in context etc.). Grönroos & Voima (2012) provides a helpful general framework. However, a key point made by Grönroos & Gummerus (2014) is the distinction between value co-creation as a metaphor to capture the spirit of collaborative alignment in service, and understanding precisely the process of value creation through the interactions in the service environment. Therefore, "what matters to me" necessarily remains uncertain and only indirectly accessible.

1.5.2. What Matters to Them

This perspective is prominently represented in value based healthcare, associated with the work of Porter and colleagues. The ideal of 'what matters to the patient' is highly prized, insofar as it can be objectively represented to the wider service system:

> "Achieving high value for patients must become the over-arching goal of healthcare delivery, with value defined as the health outcomes achieved per dollar spent." (Porter, 2010, p2477).

The argument is that if value is achieved by delivering what matters for patients then all other stakeholders interests fall into line. Therefore, a focus on demonstrating outcomes for patients becomes the critical task. For Porter and others (Porter & Teisberg, 2007; Ciasullo et al, 2017), outcomes are measurable features that can be referenced against normative expectations for the defined medical condition, and which therefore are seen as carrying weight in the context of the wider healthcare system ("What matters to them"). Porter (2010) proposes a framework to define what is likely to matter to patients. The elements include a view on technical progress (e.g. reduction of symptoms), social recovery, avoidance of harm, sustainability of benefit (e.g. low re-admission rates) and a timeliness to the service experience. This perspective on outcomes, with

associated costs, is taken over a holistic cycle of care and recovery, and not constrained to short term procedural outcomes for example.

Therefore, although what matters to the patient is said to be at the heart of value based healthcare, in practice this view is filtered through a framework that generalises what *ought* to matter to patients. However, Entwistle et al (2012) point out that this covers a diverse array of possible experiences for patients, which available frameworks do not comprehensively cover. Further, whilst it is important to develop measures to reflect different aspects of patient experience, there is a disparity between the perspective generated by normative measurement tools, and the particular view of an individual patient at a point in time.

Finally, value based healthcare is focused on the normative profile of particular conditions over episodes of care. In the cases of multiple conditions, associated with other complicating social factors, with open ended care needs, the normative model becomes more problematic. Meanwhile, the approach is not able to consider how patients make value for themselves, and how interactions with others assist that process or otherwise.

1.5.3. What Matters to Us

It is a feature of Value Based Healthcare that the focus of interest is the individual case as a distinct care project. There is therefore a perspective on value that reflects how the participants in that project (patients, carers, professionals etc.) share an idea of value between them. In order for care to progress there has to be a continual exchange of view as to what is working and what is not working in order to realise value together (Jaakola & Matthew, 2014; Echeverri & Skalen, 2011). As indicated above (Section 1.5), this perspective on "what matters to us" can be found in the notion of valuation, where "…*valuation is at the very least an organisational project*" (Roscoe & Townley, 2016, p122). This perspective is explored further in the valuographic literature (e.g. Dussauge et al, 2015). This literature concerns itself with understanding the different systems of value that participants bring, how they are put into play, and how they are reconciled in practice to achieve moments of valuation. This is a pragmatic approach, distinct from the normative or ideographic stance taken to represent "what matters to them" and "what matters to me". Thus, valued outcomes are represented by such

moments of valuation. Collaborative case reviews in healthcare are good instances of such valuation moments. Dussauge et al (2015) highlight the importance of this approach for healthcare, however the literature remains at an early stage of development. In summary, whilst there is a growing emphasis on the nature of service as a collaborative undertaking, the realisation of valued outcome as a collaborative phenomenon is an area of developing interest, which will be taken as a key focus in this thesis.

1.6. The Research Questions

As outlined, on the one hand there is a significant and pressing concern to better organise service in relation to the complex case in healthcare. On the other hand, in terms of conceptual tools available, there are complexities to be accommodated in drawing on them to assist with improving service design. In problematising CPA case management in a UK learning disability service, an opportunity is generated to explore how this gap in support might be pragmatically addressed. In this context, the conceptual landscape poses three questions for research:

RQ1 First, how might the complex case be best contextualised within the service environment?

RQ2 Second, what model for the realisation of valued outcomes best captures the reality of such a complex, multi-party service exchange environment?

RQ3 Third, how can the current leading framework for supporting single condition cases (the CCM) be best adapted to the predicament of complex case management?

From the above outline, it can be seen that the predicament of the individual complex case sits at the intersection of these key questions. This introduces a second order question:

RQ4 How might the three perspectives of context, value realisation and practice framework development within the three papers be best integrated to offer a generic platform that meets the needs not just of this local sector issue, but also to make a contribution to complex case management more broadly, whether in healthcare or indeed within the wider service sector.

The process of adapting available conceptualisations is itself also a form or research enquiry. The testing of applicability of concepts for practical service predicaments is one avenue of service theory development (Christensen, 2006). Meanwhile, it is important to also consider the interplay between this project and the host organisation. The making of a more immediate and practical contribution to the host organisation is an important feature of a DBA thesis. Therefore, these two further reflexive research questions are:

RQ5 What contribution is made to theory as a result of this series of investigations?

RQ6 What impact did this project have on the host organisation for the project in terms of developing a service improvement initiative?

1.7. Methodology

This is a thesis by publication, developed within a pragmatic stance. In that context, the approach to the research questions has been to make each of the three primary questions (RQ1, RQ2, RQ3) a focus of a research paper intended for publication. Meanwhile, the further research questions (RQ5, RQ6, RQ7) are framed within the broader structure of the thesis as an overarching inquiry. This section commences with explaining further the epistemological stance. Next, each paper adopts a different research angle in relation to a common core empirical sample. There are therefore methodological commonalities relating to the sample, the methodological approach and analysis. Therefore, the next section provides a more detailed methodological overview before introducing the three papers that form the core investigation. Next, an outline is provided to how the overarching analysis is conducted, and how that relates to the issues of practice and theory that are the focus of this project. Finally, it should be noted that in such a structure all of the chapters of this thesis represent a source of analysis and contribution. As such, each chapter is independently referenced. Inevitably there will be some overlapping references between the chapters.

1.7.1. Epistemology

This thesis is structured within a pragmatic epistemological stance. Drawing on the school of American Pragmatism, particularly as articulated by John Dewey, the adoption of a pragmatic approach to value in the complex world of healthcare and the life sciences is seen as of increasing interest (Dussauge et al, 2015, p7), and some commentators see such approaches as addressing difficulties with the prevailing world view associated with new public management (Hauge, 2017; Whitford, 2002). Drawing on Dewey is particularly apt as the metaphor of the clinical encounter features prominently in his thinking (Miller, Fins & Bacchetta, 1996), and there are reasons for thinking more about that given the fact that greater complexity forms a more prominent feature in contemporary approaches to healthcare (Pedersen, 2018). To put this in context, the pragmatic stance is seen as having applicability in a number of ways to various aspects of public good, including science, society, policy, law and education. However, in practice there has previously been less attention paid to its potential role in healthcare (Cornish & Gillespie, 2009). Therefore, it is helpful for there to be further work in healthcare within a pragmatic stance.

This section outlines the pragmatic stance in more detail, drawing mainly on the spirit of Dewey's contribution, but drawing in others too. It explains how a commitment to that approach translates to the specific pragmatic stance enacted in this project. It is beyond the scope of this introduction to undertake a detailed examination of pragmatism and the pragmatic stance, but what is drawn here from the literature are the key features of what makes up the pragmatic stance, the process of inquiry, and, in the light of subsequent refinement, the interplay with the material vantage point to the pragmatic inquiry as it might apply in complex multi-level institutional settings (Sabel, 2012).

1.7.1.1. Background

William James points out that there is nothing fundamentally new about pragmatism. The contrast is that it is useful to bring the pragmatic stance into focus as a method of inquiry, as distinct from an attempt to define an objective reality a priori within either a purely idealistic or empiricist stance (James, 1907a, p212, in Thayer, 1982). This approach is seen as particularly apt for areas of

interest that are complex where the quest for certainty does not apply (Ansell & Geyer, 2003), which is germane for complex healthcare. According to James (ibid, p213), what is looked for from the pragmatic stance is not a solution, but a "smoothing out" of inconsistencies or tensions in existing understanding, or suggesting ways of change. It is intended to determine a programme for more work, and sees the process of verification as itself the source of validity in terms of being able to make concrete differences (James, 1907b, in Thayer, 1982, p228). For James, the core idea is that veracity lies in the process of its exploration such that it leads to something better, either intellectually or practically (ibid, p234). It thus has a pluralistic basis, and is inherently able to be a complementary mode of enquiry to other approaches. From this vantage point it can be argued that pragmatism provides a framework for integrating different types of knowledge together (Ansell & Geyer, 2003; Popa, Guillermin & Dedeurwaerdere, 2015). James directs attention to the work of Dewey for the realisation of the pragmatic stance and the inquiry process and Dewey is widely seen as the starting point by many researchers, such as Dussauge et al (2015).

Picking up this broad theme, the key features that characterise the pragmatic stance for Dewey are most prominently a focus on the practical, with an orientation to practices and learning "with the end in mind" (Whitford, 2002). It is the identified problem focus that anchors inquiry, and it is the process of inquiry itself which forms the stance. Knowledge is constructed in a collaborative, experimental context, as judged by contribution to distinct, practical opportunities (Miller, Fins & Bacchetta, 1996), which is enacted through the inquiry process.

1.7.1.2. The Process of Inquiry

Dewey (1938, in Thayer, 1982) outlines a clear framework for the process of inquiry, stating that inquiry is:

> "…the directed or controlled transformation of an indeterminate situation into a determinately unified one" (p332).

According to Dewey, it is necessary first to structure the area of uncertainty, elucidating the areas of doubt (it is no enough to just propose general uncertainty). Next there is a process of instituting the problem as the focus of inquiry, which in itself commences the process of transformation of understanding (ibid, p322).

Subsequently, within the context of an understanding of elements that are viewed as fixed for working purposes, there is a process of progressive interplay between the unsettled elements and possible solutions. The process of pragmatic inquiry can be set out as follows:

i. The scripting of a troubled or problem area (Background)
ii. Developing the interplay between relevant propositional resources (conceptual tools), empirical effects and idea generation (Analysis)
iii. Developing a potential transformation in understanding for relevant stakeholders, judged by its coherence and practical applicability (Theory Building).

There are a number of further key details for Dewey in this process, which are beyond the scope of this introduction, and which others explore in more detail (Hauge, 2017).

However, it is important to note that the inquiry process avoids dichotomisation (Ansell & Geyer, 2003), for example between 'science' versus 'common sense' (Dewey, 1938: in Thayer, 1982) or 'nomothetic versus ideographic' (Cox & Hassard, 2005), or 'fact' versus 'value' (Dussauge et al, 2015). The inquiry is a performance within a social context. The scripting process sets out, in the particular instance of the inquiry, the shape and relationship between those aspects that are taken as relatively fixed for working purposes, and those aspects that are unstable or in flux. Thus, within the introduction, this thesis prepares the ground by paying attention to scripting the troubled area of complex case management in healthcare on the one hand, whilst on the other hand mapping out diverse sets of conceptual resources within relevant fields of interest. Each of these fields of interest themselves embody areas of uncertainty and tension, which in turn represent opportunities for practical benefit from the inquiry process. The performance continues through the structured, thoughtful reflection on the interplay between available conceptual resources and the empirical material.

What is achieved through the process of inquiry is a transformation in understanding amongst the actors and the wider audiences, judged by its coherence and practical applicability within a community of knowledge and practice (Popa, Guillermin & Dedeurwaerdere, 2014). The issue is not whether

the single performance engenders ‘the right understanding’, but whether there is progress in functional capability. This is most emphatically not a position of ‘whatever works’, as some have criticised (Ansell & Geyer, 2003). Dewey’s argument is that existential observed facts are essentially irreconcilable with non-existential ideational propositions, except in their convergence on improving solutions to problems (Dewey, 1938, in Thayer, 1982, p327). As a progressive process, the inquiry continues from performance to performance, assembling elements as their worth is tested and the possible solution options gain meaning within the participant community. It can be argued that this stance parallels the modes of thinking found in emerging collaborative service and health improvement literature (cf. “People powered health”, Horne, Khan & Corrigan, 2013), and forms an apt foundational approach for this thesis. With this in mind, there are two communities of practice of interest. These are participants in complex healthcare case management, and participants in service theory development, management and design. In this spirit therefore, this phase of the inquiry process has itself been framed as a series of research papers intended for publication.

1.7.1.3. Institutional Vantage Point

In terms of the adopting the pragmatic stance in relation to the configuration of services in general, and to complex healthcare in particular, there are further aspects to consider. First, Dewey’s approach is grounded in understanding the inquiry process in its social context. In that spirit, Popa et al describe the pragmatic stance as “open-ended processes of inquiry geared towards a broadening of the community of practice through social innovation and experimentation” (Popa, Guillermin & Dedeurwaerdere, 2014, 48). In this regard, Dewey envisaged this operating as a form of democratic process, as he saw it, which has particular applicability for healthcare (Miller, Fins & Bacchetta, 1996). Sabel however points out that Dewey vacillates between social context being formed as a local phenomenon, and the social context as a wider societal phenomenon (Sabel, 2012). There is therefore an important issue for the applicability of a pragmatic stance in stabilising the contextual vantage point for the inquiry to be conducted. Sabel (2012) proposes that this uncertainty is itself amenable to a pragmatic treatment, and he proposes that the vantage point within the institutional context itself becomes included as a field of interest in the process

of pragmatic inquiry. Thus, the accommodation of the social context in this thesis pays attention to clarifying the collaborative focus and its institutional position within the service system to form an important component of the pragmatic stance.

1.7.1.4. The Specific Healthcare Case

Returning to the emerging track record of pragmatism within healthcare, previously it has been applied predominantly to the troubled area of medical ethics (Steinkamp & Gordijn, 2003), or under the heading of "Clinical Pragmatism" to areas of tension between ethics and the clinical (Fins & Miller, 2000; Miller, Fins & Bacchetta, 1996). Here ethics denotes the social predicament of the patient, in contra-distinction to the medical predicament of the patient. However as indicated above, it is part of the pragmatic tradition to challenge such dichotomisation (Ansell & Geyer, 2003). More recent healthcare work has seen pragmatic approaches being applied to reconciling such distinctions. Dussauge et al (2015) adopt a pragmatic stance to address tensions between the sociological, economic and life science perspectives on value(s) in healthcare, which shifts the perspective to include the consideration of all the systems of value in play within the healthcare setting. Meanwhile, Hauge (2017) adopts a pragmatic stance in relation to exploring the organisation of public sector organisations, using healthcare as a worked example. This lends credibility to healthcare in its more complex forms as a service organisation exemplar, within a pragmatic stance. Further, the work considers clinical practice and organisational practice within the same field of inquiry. In a similar vein, Pederson (2018) applies a pragmatic stance to the study of risk management in the Danish healthcare system.

Pedersen (2018), in fact, offers a much more detailed and systematic working through of a pragmatic stance in relation to the chosen focus of concern of risk management in healthcare. As with others, Pedersen draws significantly on Dewey for her approach. For Pedersen, the key feature of the pragmatic stance for healthcare is the attending to the actual clinical situation (Pedersen, 2018, p18). There is a rejection of a priori, dichotomous assumptions that might pre-empt understanding. Rather the inquiry is open to both internal and external conditions as they may be relevant, with a perspective that sees clinical practices as inseparable from organisational practices. In keeping with the pluralistic spirit of pragmatism, Pedersen's approach is to embrace a diverse range of conceptual

tools and methodologies to achieve different angles on the risk management system as it is practiced (Pedersen, 2018, 19). The net result is that Pedersen's treatise on risk management is formed by the assemblage of a series of distinct papers investigating aspects of risk management, all within the defined pragmatic stance. Pedersen is thus able to direct attention to how limitations to the contemporary principles of clinical risk management might be improved, with implications both for case level and system level management. This work illustrates how the application of a pragmatic stance within healthcare is evolving towards a more pluralistic and multi-level field of inquiry.

Pedersen's (2018) work drew on the broad span of the Danish Healthcare System as the focus of concern, and was able to bring a rich and diverse body of theoretical and empirical work into play. This project is less ambitious and more locally defined than Pedersen's work, with the much narrower span of CPA case reviews in a particular complex service setting as being the focus. Nevertheless, this focus has similarly given rise to a diverse set of relevant conceptual tools, covering approaches and methodologies that can be pragmatically brought together with the empirical diversity of found practices in case management reviews. As for Hauge (2017) and Pedersen (2018), it is proposed that this focus of study works as a helpful and more holistic exemplar for healthcare systems. This thesis appropriates Pedersen's approach by conducting the inquiry through the assemblage of a set of distinct particular investigations into aspects of complex case management practice. Similarly, each of the three investigations that form this set are conducted as a series of case based inquiries within a pragmatic stance, and as a collective set they form the exploratory component to the overarching pragmatic stance of the thesis as a whole, as indicated above.

1.7.1.5. Enacting This Pragmatic Stance.

As outlined above, the pragmatic stance is formed by the interplay between propositional resources and the chosen practical area of concern. It involves a creative exploration of how tensions might be resolved to better practical effect. In this thesis, the overarching focus of concern is how pragmatic actor(s) might practice value based healthcare in a complex setting. The nature of the concern pertains both to the troubled state of care practice as it has been empirically discovered, and to the tensions, gaps and inconsistences to be found within

relevant available conceptual tools. As illustrated in Figure 1-4, relevant conceptual tools can relate to assisting and framing the field of inquiry, and they can also relate to the range of conceptualisations that inform the inquiry process itself. A further distinct area of conceptualisation to draw on that has also emerged, is that of understanding the inquiry vantage point and its potential relationship with institutional levels within service systems (Sabel, 2012). This therefore is a diverse and multi-paradigmatic landscape, operating within multiple organisational levels.

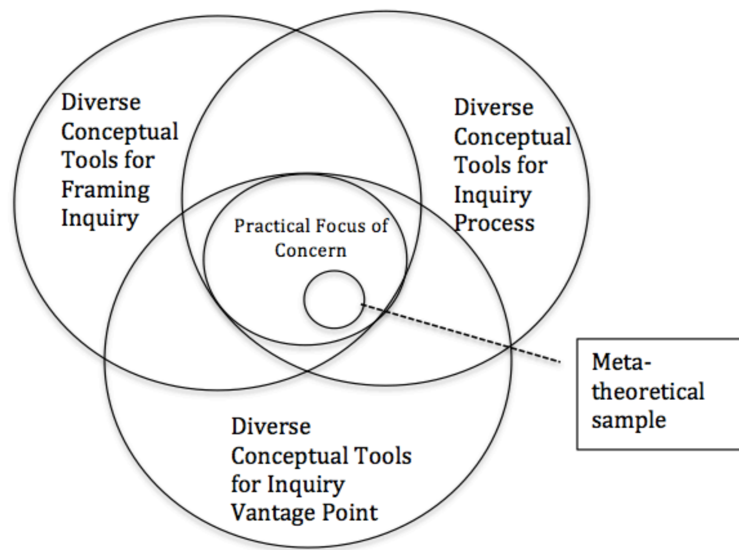

Figure 1-4 A pragmatic stance formed at the intersection between sets of conceptual resources and a meta-theoretical sample representing a practical focus of concern

As described above, Pedersen (2018) addresses this kind of complexity by capturing and assembling over time insights from a series of explorations of the Danish risk management system in healthcare, within an overarching pragmatic stance. An alternative multi-paradigmatic approach is to conduct a set of investigations in parallel. To this end, Lewis & Grimes (1999) describe the use of a meta-theoretic sample as a common focus for a series of investigations in parallel, as illustrated in Figure 1-4. This is seen as helpful for eliciting the merits of contrasting perspectives of diverse conceptualisations (Lewis & Grimes, 1999). It is this alternative, parallel approach that has been adopted in this thesis. In practical terms this parallel multi-paradigmatic approach means that each of the pragmatic investigation into the meta-theoretical sample of interest offers a

different perspective on the core practical focus of concern. Through the interplay (meta-triangulation) generated by these different perspectives, and further referencing relevant literature, an overarching meta-theoretical position on the phenomenon of interest can be developed. The fields of relevant conceptual resource are elucidated and brought into play as each investigation unfolds, and within the overarching thesis development. Assembling these elements together forms this thesis.

With regard to the specific conceptual tools for framing value based healthcare for the complex case, and capturing the vantage point of the inquiry, a series of conceptual landscapes have been outlined above. These comprised an outline of the case management landscape (Section 1.3), an outline of service context and vantage point (Section 1.4), and an outline of the conceptual landscape for capturing value (Section1.5). These together set the stage for the specific angles of inquiry that form the basis for three distinct, but related, parallel investigations as the next part of the thesis.

For the conceptual tools for the inquiry process, these are developed in more detail in the methodological section below (Section 1.7.2). In outline, drawing on Lewis & Grimes (1999), each investigation is in the form of a case study series, with a distinct angle on the common focus of concern. A pragmatic stance within a case study paradigm is recognised as a legitimate angle of inquiry (Cox & Hassard, 2005). A suitable meta-theoretic sample on which to base the case study investigation is specified (a series of CPA case reviews within a specific UK complex learning disability service). Other methodological resources that align well with the pragmatic stance are also drawn on across this project and are detailed within this thesis, such as the use of qualitative comparative analysis (Ragin, 2008), and the valuographic approach for example (Dussauge et al, 2015; Hauge, 2017). The task therefore for each parallel investigation is to integrate a selection of relevant conceptual resources from each area with the empirical findings from within the focus of concerns, as represented by the diversity of practice found within the meta-theoretic sample of CPA case management reviews.

Thus, in the main body of this thesis, three papers, each conducted within a pragmatic stance, represent an enactment of the interplay between propositional resources, the practical focus of complex case management and a structured

process of ideation. For each particular angle, there is a seeking to expand understanding and insight into how practically it might be otherwise (Ansell & Geyer, 2003; Dussauge et al, 2015), both for the case management participant constituency and for the service management and theory constituency. Finally, the discussion and conclusion assembles the emergent findings across the three papers into a further analysis and synthesis that achieves for the thesis as a whole the objectives of the pragmatic stance (James, 1907a; 1907b, in Thayer, 1982):

i. A “smoothing out” of tensions by way of seeing how existing realities may be changed, or thought about differently (p213)
ii. Defining and instigating a relevant programme for more work (p213)
iii. Progressing a process of verification that:
    a. Establishes something distinctly better, either practically or conceptually (p228)
    b. Is a reflexive process, the coherence of which over time engenders validity (p229).

This thesis therefore closes by reflecting on its contribution for care participants and service improvement constituencies in these terms, and by reflecting on the usefulness of the approach taken in this thesis. Finally, a suggested programme for more relevant work is captured within the conclusion.

1.7.2. Methodological Considerations

Within the outlined pragmatic stance, a clear research focus has been developed that consists of identifying the management of the complex case in healthcare as a phenomenon of interest, framed by a literature that draws on multiple paradigms. Lewis and Grimes (1999) propose a framework for approaching multiple paradigm investigation that supports the exploration of a series of exemplar cases as a suitable approach. The framework Lewis & Grimes (1999) set out involves three phases: groundwork, data analysis and theory building. It is important that the process incorporates a process of critical reflection.

1.7.2.1. Groundwork

The groundwork has in large measure been addressed in the introductory section above. The key features of the approach are, first, the suitable framing of the conceptual literature, highlighting the tensions and areas of transition, and the

development of the research questions. The distinct conceptual landscapes applying to case management, value realisation and context generation, as described, provide the conceptual lenses for the subsequent analysis. Meanwhile, the next issue to address is the data source. A series of case studies is viewed as a suitable object of study for multi-paradigm research. It is important that the case series functions as a 'meta-theoretical sample' (Lewis & Grimes, 1999, p679), whose importance is to represent the range and variation to the phenomenon of interest within the field of study (c.f. Eisenhardt, 1989).

1.7.2.2. The Case Series Sample

The case series chosen for this project consisted of a series of CPA case management reviews within the host organisation. As highlighted above, CPA case reviews are good exemplars from which wider lessons can be drawn. First, they represent instances of a national case management policy (the CPA), which parallels aspects of wider case management practice in other healthcare systems. Second, conceptually, by focusing on these as instances of collaborative case management review, these cases become service entities which can shed light on how the case management, context generation and value realisation landscapes might function. Therefore, in principle, CPA case reviews represent a suitable meta-theoretical sample.

The source of the cases that formed the heart of this inquiry was a UK specialist learning disability hospital. The size of the service has been in flux, but at the time of the project (2014-15) it comprised some 200 beds. The hospital acted as a source of tertiary specialist care within the region, and focused on four broad service areas. These areas featured care for individuals with a learning disability and a range of additional conditions and disorders needing hospital assessment and treatment under the UK 1983 Mental Health Act. The four broad areas consisted of medium secure forensic care, low secure care for individuals with complex and challenging presentation, a specialist women's service, and the enhanced support or rehabilitation service where the focus was on supporting community resettlement.

In selecting cases the focus was on being able to capture the breadth of practice across the hospital and to draw systemically useful inferences as part of an

exploratory investigation. The sampling approach was not therefore intended to address population representation, as might be the case for a theory testing paradigm (cf Eisenhardt, 1989). On these terms, and in order to avoid unconscious bias, cases were drawn as the first 5 cases for each of the four service areas following receipt of approval to carry out the investigation. It was not found that the service area a case was drawn from played a role in understanding the patterns of practice that were discovered. A condition of undertaking the investigation was the avoidance of disclosing details that might lead to patient identification.

1.7.2.3. Data Analysis

The process of the multi-paradigm approach is to investigate the same phenomenon through different conceptual lenses. This might be through a series of investigations in sequence, using comparable samples, or by using a common sample for undertaking the different investigations in parallel, which is the approach taken in this thesis. In this context, the nature of the data collected was the cross sectional documentary record of the CPA case review in the case series. A key feature for Lewis & Grimes (1999) is the consistent coding of the data and the structured reflexive approach. This has been achieved by adopting set theoretic approaches to the management, coding and analysis of the data, and by structuring three different inquiries as a process of developing an empirical paper for publication.

1.7.2.4. Set Theoretic Methods

This thesis consists of an investigation of practices in a healthcare setting, revealed within the documentary reality (Atkinson & Coffey, 2010). In terms of the sets of practices involved in CPA case reviews, there has not been previous work to categorise or develop ways of measuring or quantifying such practices. Therefore, the nature of the data in this exploratory phase is that it is for the investigator to bring structure and sense to the variety of practices seen. In keeping with the pragmatic stance that underpins this thesis, it is intrinsic to the methodology that there should be an interplay between the literature concepts and empirical data. The subjective involvement of the investigator is permitted, but framed within a consistent and methodical process of ongoing reflection. In the papers presented in this thesis, this is achieved through undertaking a thematic

template analysis (King, 2012), which allows a movement between relevant literature and the data to identify stable patterns of practice within and across cases that can be made available for comparison. Therefore, the nature of the data is in the form of qualitative degrees of 'richness of practice' for each identified theme, or sub-theme. This kind of investigation lends itself to set theoretic approaches. In other words, an approach built on judgments as to the extent to which cases might be classed as sitting within the set of 'rich practice' for that particular theme or sub-theme. For each theme or sub-theme there will be cases that can be judged by the investigator, technically experienced in the field of study, as having a range of qualitatively desirable features, and those that conspicuously do not. On that basis, a pragmatic classification of 'richness of practice' can be built. 'Richness of practice' therefore stems from comparing cases that can be included in a set of desirable practices, and those in the set without desirable practices. What those desirable practices might be is set out further below. The issue that set theoretic methods supports is to accomplish that in a systematic and consistent fashion, paying attention to developing conceptual stability within the data (Verkuilen, 2005). The thesis appendix provides illustrative material for this process for an exemplar case, along with a consideration of the treatment of sensitive healthcare data (see section 6).

Set theoretic methods consist of a range of techniques that are particularly apt for case orientated comparative work (Ragin 1999; Fiss, 2007) and which all share three features (Schneider & Wagemann, 2012, p10):

i. They work with membership scores of cases in sets
ii. They perceive relations between social phenomena as set relations
iii. Set relations are interpreted in terms of sufficiency and necessity (or some derived combinational form of these).

(Schneider & Wagemann, 2012, p3)

It is helpful to draw out some of the distinctive features of set-theoretic approaches, as distinct from statistical approaches for example. First, set theoretic methods are not simply data analysis techniques: the gathering of the data is an integral part of the approach (Schneider & Wagemann, 2010, p10), with an ongoing process of moving back and forth between ideas and evidence (See

also Ragin, 2008). As such a deep engagement with the material is called for, as befits an exploratory paradigm. This is a recognised perspective within the process of theory building, described in the literature (Christensen, 2006), and fits well with the approach to data analysis proposed by Lewis & Grimes (1999) for multi-paradigm research.

Further advantages to the set theoretic methods are that the approach allows for equifinality, meaning several alternative factors can possibly lead to an outcome of interest (Ragin, 1999; 2006; 2008). In addition, the nature of set membership is asymmetric, meaning that a set defined as 'rich' is not the opposite to a set defined as 'poor' (Schneider & Wagemann, 2012, p5). Thus, the underpinning logic of case based research is quite distinct from variable based research Ragin, (1999). The emergence of first Qualitative Comparative Analysis (QCA) and subsequently fuzzy set Qualitative Comparative Analysis (fsQCA) represent important milestones in developing suitable analytic techniques which are sensitive to case based exploration (Ragin, 1999; 2008). Some argue in favour of this technique for use with relatively small case numbers (Rihoux, 2003, p. 353; Ragin, 2008, p7), although others see that as an irrelevant consideration (Thiem, 2014).

1.7.2.5. Fuzzy Set Qualitative Comparative Analysis (fsQCA)

The most developed form of set theoretic method is that of Fuzzy Set Qualitative Comparative Analysis (fsQCA). Developed by Ragin (2000; 2008), fsQCA applies a logical protocol to truth tables, which seeks to minimise the effects of irrelevant but theoretically possible truth combinations to focus on possible causal interpretations (Schneider & Wagemann, 2012, p8). There are those who criticise some of the underpinning assumptions, and the technique is under on-going review and development (Mendel & Korjani, 2013; Thiem, 2014; Roig-Tiernoa, Gonzalez-Cruzb & Llopis-Martinez, 2017). However, as a technique fsQCA is gaining increasing acceptance in a number of fields of enquiry, including marketing (Ordanini & Maglio, 2009) and areas of policy (Rihoux, Rezsöhazy & Bol, 2011; Blackman, Wistow & Byrne, 2013) and many areas of social science (Roig-Tiernoa, Gonzalez-Cruzb & Llopis-Martinez, 2017). It has not so far been widely used in practical healthcare however, nor indeed in valuation studies.

There are a number of particular features to fsQCA that are important to highlight with respect to the use of set theoretic techniques deployed in the papers in this thesis. First, Ragin developed the concept of fuzzy set membership to deal with the fact that in real world exploration there can be qualitative degrees to how set membership might be assigned. It might be that a feature such as gender is reasonably straightforward, and can be coded in crisp set terms as 1 or 0 for example. For other features, it can be less clear cut. An example used in the literature is the set of democratic countries (Ragin, 2008; Schneider & Wagemann, 2012). There are a variety of qualities that might be looked at as signifying being a democratic country. In these terms, there are countries that most definitely are democratic, and those that are definitely not. Meanwhile, others would have intermediate degrees of democratic practice and can thus be viewed as having partial set membership. Partial set membership is represented by a fuzzy set number, ranging from 0 definitely not in, to 1 definitely in. Other points depend on the nature of the gradations that can be plausibly determined, but an example might be partial set membership of 0.2, 0.4, 0,6 and 0.8. The point of equipoise between being in or out is represented as 0.5 (Ragin, 2008). To be clear, these numbers structure a calibration of conceptual precision, and are not representing a notion of measurement.

1.7.2.6. Casing and 'Richness of Practice'

An important principle is that "it is the responsibility of the researcher to find valid rules for assigning set-membership values to cases" (Schneider & Wagemann, 2012, p.32), a process which is termed casing. There are a number of methods offered in the literature for calibrating fuzzy set membership, most prominently the direct and the indirect methods described by Ragin (Ragin 2008; Ragin, 2009). The direct method involves triangulating other information available in the field to construct a framework from which to judge case membership. The indirect method involves making use of a previously developed rating scale applied to the phenomenon onto which the case series might be mapped. However, Basurto & Speer point out that in more grounded, exploratory inquiry such alternative perspectives might not be available (Basurto & Speer, 2012). The difficulty is that whilst it is possible to assign fuzzy set membership by judgement alone, this approach can be criticised (Verkuilen, 2005). Basurto & Speer outline a technique

for casing based on a field work vantage point. In these instances, the informed researcher develops a framework from within the range of qualitative features within the case series being studied, and constructs a framework for grading cases between the most and the least qualitatively rich. Each case is then contextualised within that span of phenomena. This goes some way to countering concerns raised by Verkuilen (2005), and it is this method of casing that is adopted in the papers in this thesis.

The definition of 'rich' that appears as a featured construct across this thesis is therefore pragmatically operationalised in relation to the set of practices found on the ground. Thus, the method adopted in these studies proceeds from an exploration of template themes derived from the literature, and from pilot work (Spurrell & Proudlove, 2014). For Paper 1, the template represents service delivery network (SDN) functioning as modes of participation in CPA case reviews by stakeholders. In Paper 2, the process of value realisation is represented by the discovery of valuation practices against a framework adapted from the pilot (ibid) and work within value based healthcare (e.g. Porter, Pabo & Lee, 2013, p521). The discovered data is coded to these themes as per the template methodology (King, 2012). The process of casing is described within each of the papers, but in principle 'richness' or 'not-richness' derives from building a picture for each case of the breadth of practice found across the template themes, and the depth of practice discovered within each of the respective themes. As described by Basurto & Speer (2012), the range of practices within the data forms the basis for a coding framework from which fuzzy set scores can then be allocated. Two dimensions of set membership data are therefore rendered, pertaining to SDN functioning and value realisation for each of Papers 1 and 2. Paper 3 relies on bringing both these dimensions of set membership into play together. The appendix provides further illustration of this process, using an exemplar case (Section 6.3).

The advantage of a systematic casing approach is that the consistency of the calibration approach is a key aspect of its internal validity. It is this consistency that is important, and it is thought that slight changes in the calibration method are not likely to be material (Schneider & Wagemann, 2012, p40). Then, once set calibration has been accomplished, fsQCA and related set theoretic techniques

supports the structured investigation of set relations as a means of discovering the patterns within the data. Within the pragmatic stance, this patterning is employed to address the research questions.

1.7.2.7. Interpreting Data

A more detailed explanation of how fsQCA might be used to interpret data can be found elsewhere (Roig-Tiernoa, Gonzalez-Cruzb & Llopis-Martinez, 2017). However, the key features to draw attention to are the investigation of propositions using set logic, set-based descriptive analytics, and the use of configurational analysis.

For set logic, in simple terms sets, or separately their null sets, may be unrelated, one might be necessary for the other, or one might be sufficient for the other (Schneider & Wagemann, 2012, p57). Sufficiency is where if a condition (X) is present, the outcome (Y) is always present (X → Y). Necessity is where the outcome is never present in the absence of the condition (X ← Y). An analysis considers numbers of possible configurations of conditions, which are sufficient in themselves for an outcome. Also, a configurational analysis considers combinations of conditions, which may for example be sufficient in combination with other conditions (Insufficient in itself but Necessary as part of a conjunction that is Unnecessary but Sufficient – 'INUS': Schneider & Wagemann, 2012, p57).

Use is made of configurational analysis within two of the three papers presented in this thesis (Papers 2 & 3). As outlined, configurational analysis refers to the methodology within fsQCA for testing causal hypotheses within set-theoretic data (Ragin, 2008; Fiss, 2011). The technique enables the investigator to evaluate the different ways conditions might be implicated in realising an outcome of interest, either in themselves or in combinations. There is a sophisticated calculation of the diverse relationships of necessity and sufficiency amongst conditions in such analyses. The degree of conceptual precision is calculated and labelled 'consistency'. The degree of relevance, the size of the effect of the condition or combination of conditions, is calculated as 'the coverage' (Schneider & Wagemann, 2012, p31: see also Ragin, 2008; Fiss, 2011). This enables the investigator to methodically look more deeply into the patterns within the qualitative data with a view to informing further theory development. A range of

validated software applications are available to assist with these analyses (e.g Ragin & Davey, 2014).

As with traditional quantitative methods, the visual representation of sets and their inter-relationships is also a powerful analytic tool. Some commentators note that this has been to some extent overlooked in the literature in favour of more sophisticated but more intricate analyses (Rantala, & Hellström, 2001). However, in this thesis, with its focus on exploratory enquiry and theory building, visually descriptive representations of the patterns within the data play a crucial role. Thus across all the papers there was particularly strong emphasis placed on the descriptive power of the set theoretic approach both as representing the qualitative range to the practices seen and to the hermeneutics expressed within the set diagrams, as Rantala & Hellström (2001) suggest.

1.7.3. Reflection on the Method

It is important at this point to reflect on some of the limitations of the proposed method. On the one hand, there are challenges and constraints arising from the particular focus of this investigation into a confidential and sensitive area of practice. On the other hand, the case study approach has been selected as an appropriate way of approaching a contemporary phenomenon in its real-world context. However, a reflection on the suitability of an approach is seen by Yin (2014) as an important aspect of case study design. This reflection considers these aspects and then considers how it might be otherwise, before drawing some wider conclusions.

1.7.3.1. Understanding the Particular Sensitivities to this Research

A simple definition of sensitive research would be "*…research which potentially poses a threat to those who are or have been involved in it."* (Lee, 1993, p4). Lee proposes that such threats might take three forms. First, there is "intrusive threat", where areas that are investigated are private, stressful or sacred. Second, threat may relate to the study of deviance or social control, and the study might reveal information that is stigmatising or incriminating. Third there is 'political threat', where the investigation trespasses into areas that are controversial or invoke social conflict. This research can be viewed as sensitive on all three counts. The

focus of investigation is situated within a hospital setting, where the focus includes the care of vulnerable adults with learning disability, which includes addressing issues of offending behaviour and public protection.

It is commented on by Hayes & Devaney that for example people with learning disability should be considered as particularly vulnerable to intrusion, as indeed are all involved in mental health or offender management systems (Hayes & Devaney, 2004). However, it not just those who are patients that must be considered as needing their interests protecting. This thesis focuses on practices not just relating to patients, but relating to a wider group of people interacting together, including both lay participants such as family members and professional participants associated with a range of different kinds of organisation. Moreover, there is a wider constituency of people to consider who may have been victims of offending behaviour, as well as the potential controversy and media interest that can stem from concerns about public protection, which may have implications for organisational reputations. Therefore, in these terms this thesis does focus on a domain of particularly high sensitivity.

This challenge requires the most careful attention to maintaining confidentiality and anonymity. In practice however, it has been commented that there is no system for agreeing what constitutes an anonymous record in relation to such sensitive research (Hayes & Devaney, 2004; see also the appendix, section 6.1). Meanwhile, in relation to researching dynamic interactions between multiple parties in sensitive healthcare settings, Watts (2010, p5) points out that there are practical difficulties in sufficiently engaging and consulting all parties in sufficient depth to completely mitigate the threats without disrupting the care process. Both these accounts indicate that it falls to the researcher to ensure the interests of all participants are safeguarded as a primary responsibility.

The approach taken in this project has been to adopt the documentary reality of CPA case reviews as the focus of inquiry. The advantage has been, first, that this emergent perspective is one way of achieving a focus on the phenomenon of interest that might be otherwise diffuse (cf. Hayes & Devaney, 2004). Second, it provides for a buffer between the research process and the sensitivities of the case reviews (cf. Tieze, 2012). There is no direct contact between the researcher and the people involved in case reviews, which enables the participants to be

uninfluenced and undisturbed by the process of inquiry. This addresses some of the concerns raised above (Lee, 1993; Watts, 2010). This research has involved privileged access to the organisation on condition of safeguarding the sensitivity of the data, and using documentary records helped this process. The issue of handling the confidentiality of the data is outlined further in the appendix (Section 6.1), where an exemplar case is judiciously presented to help with understanding the research process. However, the disadvantage of the documentary method has been that there are levels of detail to CPA case reviews that have not been captured, such as the verbal and non-verbal interactions between participants in the review. In addition, there have not been other angles of inquiry to compare and contrast with the documentary perspective. A further disadvantage has been that there is no to and fro between subjects and researcher to explore, check and further ratify meaning and understanding. A consideration of these limitations is further outlined below.

1.7.3.2. Reflecting on Limitations to the Proposed Research

A case based approach is suitable for exploring a research question where the aim is to develop a more in depth understanding of a phenomenon in its real-world context, especially where the boundary between the phenomenon and its context is not clear (Yin, 2014). This brings with it a broad scope in terms of how the researcher might adapt the approach to a particular inquiry. Indeed, the case based approach might be seen as a framework within which the particular methods to be used can be embedded (Buchanan, 2012, p355). Set against the advantage of this flexibility are two issues. First, whilst the expectation is to develop an in depth understanding of the phenomenon, it is up to the researcher to find ways to meet that expectation in practice. The second issue is that it is up to the ingenuity of the researcher to consider and develop an appropriate method or range of methods to be deployed in the case based inquiry (cf. Buchanan, 2012, p355).

There were distinct advantages in using documentation within a case based approach in this investigation. Not only does it help manage the constraints of investigating a privileged, sensitive, confidential phenomenon, but it also fits well with the limited resources available to a single researcher. However, there is always more that can be done to improve the depth of understanding of the

phenomenon in question. It is important to acknowledge that the investigation would have been strengthened by adding in other perspectives, such as more direct observations, surveys, interview data and so on. The investigation would also have been strengthened by reducing the reliance on a single researcher perspective.

Three initiatives were taken to mitigate the limitations identified above. First, instead of focussing on greater diversity of perspective in fewer cases, the decision was made to focus instead on elucidating data from a relatively larger number of cases. Second, as indicated earlier in the introduction, a survey of advocates for patients, and commissioners for patients was undertaken to elicit their experience of a recent CPA case review that they had attended which offered a helpful sense check. Third, there was a process of further sense checking of the findings through a series of presentations to multi-disciplinary colleagues within the organisation.

1.7.3.3. How it Might Have Been Otherwise

An acknowledgement of the methodological limitations is a key part of the research process. It is helpful in prompting a consideration of what else might have been done, particularly if there were fewer constraints. The key themes that have emerged within this discussion of limitations have therefore been around bringing more diversity to the sources of data and the methodologies used within the case based exploration, and to overcome the limitations of a single researcher perspective. Therefore, in order to bring a broader understanding to the phenomenon of CPA and CPA case reviews it would be helpful to review what other kinds of data and common methodologies might have been considered. In this context, Yin (2014, p12) draws attention particularly to interviews, observations and documentation as being common data sources in case based research, but more objectivist, quasi-experimental measurement can also be considered. Using documentary data as a source has already been discussed. However, it is important to reflect that leaving sensitivities and constraints aside, there were potentially wider sources of documentation that might have been considered. The history, or wider contextual description from the case record would have been one helpful example to consider (cf. Buchanan, 2012, p362). The constraints on furnishing a wider documentary perspective was that furnishing a

more elaborate set of profiles of a set of cases in a particular organisation at a particular point of time, with heightened media attention being present, provided sufficient possibility that identities of participants could have been worked out.

Another example of recorded material, had it been possible, would have been to have taken a tape recording of CPA case review sessions from which a transcript could have been developed for analysis, however this in practice would have had to be undertaken as part of a participant observation in order to manage the recording process. Direct experience of CPA and CPA case reviews, for example as participant observation would therefore have also been an alternative data source. Other sources of data might have been data elicited from accounts from participants of CPA such as interviews (and indeed surveys). In addition, within a quasi-experimental format, there was also the possibility of applying rating scales or other measurements of key aspects of experience to generate yet further data. Finally, it is worth drawing attention to the possibility of ethnographic approaches as offering a more integrated perspective of the phenomenon. After reflecting on documentary data above, the four further alternatives of participant observation, participant accounts, quasi-experimental approaches using various rating scales and ethnography are reflected on next.

1.7.3.4. Participant Observation as a Possible Alternative

Detailed observational evidence need not always feature in case based studies (Yin, 2014, p19), but it is often an option. To this end, data could have been gathered from CPA case reviews through direct observation. Participant observation covers specific approaches that gain information from direct contact with the object of study, ranging from the disinterested spectator (or “direct observation”) to forms involving both observation and pro-active involvement (Brannan & Oultram, 2012). Brannan & Oultram do not see direct observation as being categorically distinct from other modes of participant observation. It might be expected that to undertake participant observation the researcher would adopt a stance on what data would be most pertinent for the observer to record and analyse. In terms of the wider stance adopted in this thesis, the researcher perspective could be usefully structured using a thematic template, as used for the documentary methodology (King, 2012). There are a number of drawbacks to participant observation (Brannan & Oultram, 2012, p299; Watts, 2010). Concerns

include the potential for the researcher to influence the review. Participants might adjust how they approach the review as a consequence of being observed, particularly where potentially vulnerable participants are involved. More troubling from an ethical standpoint would be if the researcher presence inhibited the therapeutic process. As highlighted above, a further consideration would particularly apply for this project which involves a researcher investigating within their own organisation (Tieze, 2012).

The difficulty with this methodology for this thesis commences with that of the potential influence of the researcher as observer. In addition to the general concerns highlighted above, the researcher was an influential senior clinician within the organisation and it would have been hard to be seen as not intruding. Adopting participant observation as part of a more pro-active endeavour can mitigate some of these difficulties, with the researcher acting and reflecting as both observer and clinician, providing a more naturalistic and less intrusive role, although at the expense of increasing the inherent difficulty of research within one's own organisation by blurring the boundary between researcher and participant. Further, Watts (2010) offers some specific comments on participant observation in relation to researching a cancer drop in centre, which offers some useful parallels to the experience of this project on CPA case reviews. As for Watts' account, there are in fact multiple participants to take into account when considering both the quality of engagement with participants, safeguarding their interests, and the differing degrees of impact of the researcher presence. This increases the difficulty in managing the participant observer stance. For Watts, the researcher status was that of a service volunteer, in contrast to my status as an influential senior clinician. This could have been managed if I were researching my own clinical practice, but when given research permission it was specifically stated that I should not investigate my own case reviews when conducting this inquiry.

In summary, in order to progress an observational investigation a more clearly independent and unobtrusive observational approach would be ideal. In this context, this thesis can be viewed rather as undertaking some useful groundwork to facilitate a more robust future research design. In fact, it would make sense to consider a more substantive observational methodology, informed by this exploratory work, that set out to undertake a longer term, prospective investigation

of CPA and the care experience more widely. This would help to greatly enrich the current understanding of CPA case management per se. This is discussed further below with reference to ethnographic approaches.

1.7.3.5. Participant Accounts (Interviews and Surveys) as a Possible Alternative

Participant accounts, commonly as survey responses or interviews, are a widely used source of data in case based research. A detailed account of survey and interview methodologies are beyond the scope of this thesis. However, each of these methodologies brings a diversity of perspective to bear on the phenomenon of interest. As with observational approaches there are likely to be tensions around how these modes of enquiry are structured, ranging from open exploratory interviews through to more specific survey questionnaires. Again, it would be interesting to build the structure to surveys and interviews along thematic lines to compare and contrast with the template developed within the documentary investigations.

These approaches are likely to be the most readily applicable alternatives to the documentary approach taken in this thesis. There are however important practical considerations to bear in mind. Participant accounts are subjective, and different participants might have differing attitudes to engaging with the research. Survey based accounts are likely to be simpler to implement across the numbers of participants involved, however it can be difficult capture the complexity of a case within a survey structure (Yin, 2014, p16). Meanwhile a semi-structured interview would allow a more nuanced inquiry to be developed, but would be onerous to conduct across a large number of participants.

The particular difficulty with this methodology for this thesis is that the focus of inquiry has been on understanding a specific series of case reviews and the variability of practice across them, not the generalities of case review experiences. Therefore, to complement this line of inquiry surveys or interviews would ideally need to draw on the same participants at the same reviews. Meanwhile, the initial pilot exploration for this research indicated that there was likely to be a marked practice variation between cases within the organisation, and a series of 20 cases was adopted to better capture that perspective. A methodology involving parallel, contemporaneous survey or interview-based inquiry over 20 cases, to do justice to

this variability within the phenomenon of interest, would indeed have been a significant undertaking. This is further emphasised by the multiple participants involved in each review (for the case exemplar in the appendix it was 9 people at one review alone).

Nonetheless, these limitations might have been overcome, subject to addressing issues of sensitivity in this focus of inquiry. On the one hand, it might have been that a sub-group of cases could have been investigated in parallel through a mix of survey and interview to bring out other kinds of information about the case review experience that would enhance understanding. In particular, there are aspects of qualitative understanding such as the structuring of meaning and the quality of interpersonal interactions that take place in reviews that it has not been possible to do justice to within a documentary inquiry. On the other hand, a smaller number of cases could have been considered for a more substantial mixed approach from the outset, although that would have limited the perspective on inter-case practice variation. Therefore in conclusion, the concern in broadening the scope of the method in this way was that, despite the potential benefits, the trade-off might have been at the expense of research focus.

1.7.3.6. Quasi-Experimental Approaches as a Possible Alternative

Although this thesis is primarily an exploratory project, it could be helpful to consider techniques from within quasi-experimental methodologies, which concerns itself with the relationship between measured naturalistic variables (Gill & Johnson, 2010, p89). Such approaches involve a more objectivist stance, but which can be incorporated into case study design (Yin, 2014, p13). This would have offered an advantage to this thesis in two ways. First from previous literature, relevant and more objective rating scales might have already been developed to approximate to the themes that have emerged within this investigation. For example, there have been rating scales to cover themes such as patient participation that could stand as proxy for how patients engage in CPA case reviews, although there is work to be done to improve their reliability and suitability (Philips, Street & Haesler, 2016). Second, there are tools for measuring outcomes of service, some of which could be readily applied in this context. Indeed, the Health of the Nation Outcome Scale (HoNOS: Wing et al,1998) is routinely available within the service and was used in a number of the case reviews,

although not consistently so. A comparison of value realisation in this inquiry with standardised outcome measures would be a helpful source of validation.

The difficulty with this methodology is that it relies on the adequacy and consistency between the construct behind the rating scale and the qualitative themes of interest in this thesis. Meanwhile as outlined above for surveys, there are similar shortcomings to being able to capture the complex with this approach, and the issue of intrusion and consistency of response also needs bearing in mind. Further, it is by no means clear that there has been sufficient development of suitably validated scales to cover all the angles of interest in this complex multi-party phenomenon (see Philips, Street & Haesler, 2016). These concerns are not insurmountable, but would have had resource implications. Nevertheless, it would have been helpful to have had at least some rating scale based data as a comparator. Moreover, there has been interest in outcomes research in developing more flexible validated tools for capturing outcomes, as exemplified by The Clinical Global Impression Scale (CGI, Guy, 1976). The CGI has gained acceptance as widely useful for evaluating progress in complex mental health care, although it can be difficult to operationalise (Kadouri, Corruble & Falissard, 2007). It enables clinicians to reliably and consistently rate severity of patient illness, global improvement and an index of therapeutic efficacy. There are also similar patient self-report outcome scales in development (Black, 2013).

In conclusion, it is feasible to consider developing and embedding sensitive, evaluative tools more consistently into routine case review practice as a way forward, and the tension with the objectivist perspective would be informative. However, this was not the current state of development for this service. It was unfortunate that the more limited outcome measures such as the HoNOS that were available were not being routinely collated within case reviews at the time of the research. Finally, it is important to bear in mind that the vantage point of this thesis was to consider the more innovative position of there being networks of multiple participants, with a collaborative perspective distinct from the subjective or objective. This contrasts with the dyadic choice between patient self-report or clinician based objective assessments which characterises the quasi-experimental stance. In the end, this thesis is positioned as an exploratory work with a distinct, collaborative vantage point in mind, whilst there is work to do to be fully confident

in likely rating scale tools (see Black, 2013). Nevertheless, it is very much a key concern to progress to a more considered view of how to integrate and compare more objective measurement into a future research programme, as outlined in the thesis conclusion (Section 5.5.4.1).

1.7.3.7. The Ethnographic Approach as a Possible Alternative

Finally, it is important to give consideration to the alternative of an ethnographic approach (cf. Yanow, Ybema & van Hulst, 2012). As highlighted above, it is an assumption that the CPA case review can be viewed as a bounded object of study. Therefore, an approach which in contrast takes a more comprehensive, longitudinal perspective of the whole care journey and the role of CPA and CPA case reviews would be particularly informative. Ethnographic approaches are compatible with case based research. They are able to engage with the diversity of experience and interaction within the phenomenon of interest, and consider in more depth the interplay between participants and structural features of the organisation of care such as CPA and CPA case reviews. There is flexibility within ethnographic approaches to handle different sources of data, and differing degrees of theoretical commitment in how the exploration is structured.

The ethnographic approach however is most suited for the investigation of fewer cases over a longer term basis. They are demanding on research resource, requiring more sustained involvement and embedding within the field of research (Yanow, Ybema & van Hulst, 2012). As highlighted above with participant observation, they involve intrusion into the field of inquiry. It would have been difficult to develop an ethnographic perspective within this project. However, in an ideal world it would be helpful to have an ethnographic perspective on CPA practice to draw on for comparison with other methodological approaches.

1.7.3.8. Conclusion

Developing an expansive research programme is beyond the scope and resource for this exploratory DBA project. This research has been further constrained by the sensitivities of access to this particular research area. The resultant limitation to the diversity of data ideally available has been acknowledged. In this context consideration has been given to a range of alternative methodological approaches that might have brought some further depth and diversity to the inquiry. Leaving

aside the constraints of this sensitive area of research, for some approaches, or combination of approaches, alternatives would have been feasible with a significant relaxation of the resource constraints of this project. For others, they might have been feasible with a modest additional resource. In terms of less feasible options, the adoption of an ethnographic approach for example would greatly enrich understanding of CPA processes in healthcare, but it is more suited to substantial, longer term projects. Moreover, it is the research question that determines methodology in case based work (Yin, 2014). It would be more than likely that an ethnographic study would start from a broader and different set of research questions. Another example of a more difficult undertaking that has been highlighted was that of conducting an extensive interview based approach across multiple participants for all cases of interest. However, what emerges from this reflective discussion of alternative methodologies is that it might have been more feasible to adopt a mixed methods approach with more modest additional resource.

A mixed method approach would involve playing each of a range of approaches to their respective strengths. Thus, as highlighted above, the documentary perspective across the range of cases could be supplemented with a questionnaire based survey of participants along similar thematic lines. This might be further supplemented by embedding some rating scales prospectively into CPA practice that might include the Clinical Global Impression scale (CGI) for example, or a patient reported outcome measure (PROM: cf. Black, 2013). There could be further investigation of other available rating scales from the literature on a pragmatic basis, for example to rate patient participation (see Philips, Street & Haesler, 2016). Meanwhile a sub-sample of cases could be selected for more detailed and intrusive methodologies subject to additional permissions and safeguards. Along with a more detailed capturing of the story from the wider case record, these deep dives would assist in building a richer picture of the CPA case review phenomenon. However, if the attraction of a mixed method approach is evident, its implementation would need caution to check the approaches chosen would indeed help answer the intended research questions and advance the conceptual understanding of how to better frame value based healthcare.

1.7.4. Three Papers

Within the pragmatic stance of this thesis, there is less concern with pinning down what things are and more with the phenomenon of practices behind how things work. Such a mode of inquiry is distinguished by the deployment of diverse concepts to explore a focus of concern, but with on-going reflection on whether practical progress is being realised as its main source of justification (Cox & Hassard, 2005). In this context, the act of structuring a research inquiry, investigating the data in the light of available concepts, and developing a paper for publication is the enactment of a pragmatic stance.

From the introduction, three foci of conceptual interest have been developed as pertinent to the project of supporting the practice of collaborative complex case management to realise valued outcomes. These three foci are the functioning of service delivery network as representing the context generating process, the collaborative valuation practices that contribute to value realisation, and the further development of a suitable framework for supporting value generating practice, building on the format proposed by the Chronic Care Model (Wagner, 1998; Wagner et al, 2001). Each of these three foci have been developed as a separate research question (RQ1, RQ2, RQ3, Section 1.6), and the three investigations of these questions are the foci of the three research papers. The format of each paper conforms to the broader pragmatic stance within this thesis, and thus consists of the deployment of available, relevant conceptual tools to pursue a structured inquiry of the empirical data with a view to generating improvement insights.

There is a core methodological stem therefore for each of these papers as outlined above, and they investigate in parallel a common meta-theoretical sample. There is therefore an interplay within each paper between the adapted conceptualisation that structures the inquiry and the data. In addition, there is also a reading across the three papers which emerges. This will be carried forward to the discussion and conclusion section (Chapter 5).

1.7.4.1. Paper 1 (Chapter 2)

The first paper explores the context generating practices discovered within this series of CPA case reviews. The paper explores the nature of the predicament of

understanding context for case reviews. First, the paper outlines the conceptual importance of understanding the context in terms of how the ideal of a collaborative service approach might be enacted, and in terms of the role of context for supporting the wider value generating system. Second, the gap in the conceptual landscape that might lend support to capturing context for case level multi-party service exchange in such a public sector setting is explored. As fits the pragmatic approach, a fresh vantage point is proposed, adapting the concept of the service delivery network (SDN; Tax, McCutcheon & Wilkinson,2013). Through this process, the paper develops a rich picture of the variability of practice for stakeholder participation in CPA case reviews, which can be operationalised as individual SDN profiles. The contribution is therefore both to facilitate the sharing of best practice for local use, and to introduce a fresh conceptualisation to assist with understanding context generation in complex service exchange.

1.7.4.2. Paper 2 (Chapter 3)

The second paper applies a valuographic lens to the practices within the case series, with a view to exploring the process of value realisation within the case review process. The valuographic inquiry sits well within the pragmatic stance (Hague, 2017). The paper develops a framework from the value based healthcare literature with which to explore the range of valuation practices. Through an exploration of valuation practices elicited within the CPA case review series, the paper sets out how some case reviews are less orientated to value realisation, whilst others are rich with value making practices. Here, ‘rich’ is taken to mean that a wide spread of value making practices can be identified across themes identified from the literature as representing what matters to patients. Not only that, within these themes, richness of practice also involves the degree of structured inquiry manifest within reviews to explore what benefits were being realised in the care process. In these terms, the paper uses a set-theoretic approach to gauge the extent to which some reviews are richly orientated to value realisation within reviews, and some are less so. Where there is a rich orientation to value realisation, these practices can be configured to represent different styles of value realisation, reflecting different standpoints being taken amongst stakeholders in the review process. This exploration of valuation practice configuration is supported by the use of techniques from QCA (Ragin, 2008;

Rantala & Hellström, 2001). From that analysis, the paper draws out distinctions between what is valued as being a solving of problems, or what is valued as exploring a rich picture to deepen understanding (cf. Kimbell, 2011).

This paper therefore introduces a dimension of complexity to what might be seen as a valued outcome in healthcare. Thus, one view of CPA case reviews is as a device for performing a collaborative valuation of a complex service process, and that it is meaningful to the participants. Meanwhile, different styles of valuation performance occur across different cases, presumably reflecting the differing views of what matters to particular participants at that stage of evolution of the care process. This transforms the nature of what a valued outcome might mean in complex services such as healthcare. The paper makes a contribution in setting out how that fresh perspective can be captured and made available for service wide aggregation and analysis. This pragmatic approach to the value landscape responds to the shortcomings in the mainstream value literature where either the nomothetic or ideographic approaches prevail.

1.7.4.3. Paper 3 (Chapter 4)

The third paper is about using the insights generated from papers one and two to re-examine the chronic care model (CCM). On the one hand, the validity of the re-conceptualisations that emerge from papers one and two rest on their demonstrable impact on how in general terms complex healthcare should be managed. On the other hand, whilst the CCM is recognised to be the most widely used framework for long term condition management, its applicability for complex case management support remains in question. However, the core proposition of the CCM is that activated patients working with pro-active clinicians generate service outcomes. The basis for paper three, therefore, is that the conceptualisation of the SDN from paper 1 provides a framework for capturing activated patients and pro-active clinicians (and others). Meanwhile the valuographic framework for paper two provides a means of capturing the realisation of valued outcomes in the service process. Therefore for paper three, if the proposition behind the CCM is right, there should be a relationship between the case level SDN and the realisation of value through the CPA case review.

The investigation of this hypothesis in paper three can be seen in terms of two objectives. First an operationalisation of aspects of the CCM framework in order to empirically test its core proposition in a complex case setting. Second, combined with other literature, to explore how to translate conceptualisations from the world of contemporary service thinking into the troubled world of healthcare case management in a useful and impactful way. Supported by techniques from QCA, paper three therefore does illuminate a degree of sufficiency to the relationship between participant activation and valued outcomes. This extends understanding into some of the complexities of this relationship, and leads to important questions about the necessity of other factors to mediate the relationship which should inform service platform design. In addition, in terms of embedding service conceptualisations in healthcare practice, a revised complex case management framework is described as an improved approach for supporting complex collaborative case management in healthcare.

1.7.4.4. Overview

This research does not just consist of the three papers in sequence, but also a reading across the three papers. Each contributes insight to aspects of supporting complex case management. This sets the stage for a process of meta-triangulation (Lewis & Grimes, 1999), whereby the convergence of these three perspectives is used to identify 5 key principles that inform how complex case management can be supported. Set out in Chapter 5, these are:

i) Recognising the individual case as the unit of analysis. Thus, framing complex care means adopting a case level vantage point, where the case management project sits at the intersection of participant networks.
ii) Viewing that collaborative project as having its own distinct service delivery network. The optimisation of this might well be a new focus for improving empowerment.
iii) The case management review offers an opportunity for a collaborative service valuation to complement the more traditional subjective and objective approaches to recognising value.
iv) An application of individual co-valuation style and a process of valuographic evolution gives rise to a concept of valued outcome as a complex, qualitative output. This in turn gives rise to a fresh perspective on the

aggregation of valued outcomes over the course of care, and across cases within services, and its potential currency within services.

v) The principles of case level service platform co-design. The assemblage of a distinct case focused SDN, with collaborative value realisation practices over a process of a reflective care review performance offers the basis for developing a fresh framework to support local platforming of care to support the complex case.

These investigatory outcomes therefore form the basis for a process of further theory building.

1.7.5. Theory Building

Using the framework for multi-paradigm theory building proposed by Lewis & Grimes (1999), the groundwork has been laid down in this introduction, followed by the data analysis stage approached through three parallel exploratory papers as outlined. The theory building stage will be embodied in the discussion section of this project (Chapter 5). In conducting that stage, Lewis & Grimes emphasise the importance of conjectural techniques to explore the interplay between reviewed literature, the multi-paradigm analysis and the researchers own intuition to arrive at theoretical accommodations for both the coherence and the divisions that are manifest within the complex environment. In this context, drawing on Morgan (1983), they propose distinct criteria for evaluating new theory in such explorations in terms of the creativity, the relevance and the comprehensiveness of the resultant development.

The representation of creativity is seen in the additional richness of representation of the phenomenon of interest, the breakout of traditional frames of viewing the phenomenon and the introduction of fresh dimensions. In this context, the ability to accommodate previous contradictions and tensions in the conceptual landscape are explored. These tensions include, for example, notions such as standardisation versus individualisation of practice, aspiring to solve problems or develop more meaningful understandings of complex predicaments, viewing static moments of care compared with viewing a longitudinal evolution of the care experience, private notions of value and public notions of value.

Therefore, from within each of these investigations, a significant start has been made on the theory building process. The process continues within the synthesis of the 5 principles from across the 3 papers (Section 5.2). These are each explored in terms of how they might change local practice, how they change theory and how such insights meet the criteria of being creative, relevant and comprehensive (Morgan, 1983; Lewis & Grimes, 1999, p685). Finally, an overarching view of contribution is presented, first to theory (Section 5.3), and then to practice within the host organisation (Section 5.4).

As a DBA project, and as a pragmatic inquiry, the change to local practice is key. In Section 5.4.1 the in-house lessons for the local service are outlined. The section also outlines how the conceptual developments that have been realised benefit both local service improvement and complex case management in the health sector more widely. Finally, the argument is made for using the complex case management framework (Complex CMF) as a map for local services to be able to represent their own service environments. This has been realised in the host organisation as a 'Complex Care & Recovery Management Framework' (The CCaRM), which is outlined in brief for illustrative purposes. The impact locally therefore is the development of a system for local participants to co-develop care platforms for themselves which are both consistent across cases, but retain individualised value based focus.

1.7.6. Next Steps

This sets the stage for exploring how useful and relevant such an evolved meta-theoretical framework might prove for the predicament of complex case management. The next steps involve recognising the need to further establish capabilities of the key insights developed, and to further establish the transferability more generally of these conceptualisations across healthcare, and indeed the wider service sector. In this context, a proposed programme of further research is presented (Section 5.5.4), completing the theory building process for this project.

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Chapter 2: Paper 1

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The version included in this chapter is the author-accepted draft, but using the hierarchical section-heading structure and table- and figure-numbering system as the rest of this thesis.

Capturing Context: An Exploration of Service Delivery Networks in Complex Case Management

Abstract

The purpose of this paper is to explore how the participation practices of stakeholder networks inform an understanding of context functioning in complex service exchange settings. We adapt the concept of the service delivery network (SDN) as a suitable approach to investigate how context is made within collaborative healthcare projects. Case management reviews in a UK learning disability service are the focus of study as an area of significant practical interest, and as suitable exemplars of healthcare case management. Based on a template analysis, we describe the SDN related to stakeholder participation and co-participation at the intersection of patient, commissioner and clinician networks. We identify notable variations to SDN profiles and degrees of participation of the different stakeholder networks involved. Our findings suggest a fresh focus for researching complex service settings and for case management practice. We discuss the impact of this perspective for understanding and researching context functioning and developing service theory based on mid-range empirical studies.

2.1. Introduction

The need to better understand the role of context as part of the value generating process in service delivery has been identified as a key issue, particularly for healthcare (Ciasullo, Cosimato, Palumbo, & Storlazzi, 2017). How actors contribute to service exchange is one important dimension of the contextual architecture (Lusch & Nambisan, 2015). The argument pursued in this paper is that case-based empirical research is one way to progress theory-building in this domain.

There is a growing appetite for extending contemporary service thinking to complex service environments such as those found in the public sector (Osbourne, Radnor, & Nasi, 2012; Radnor & Osborne, 2013). Healthcare is considered to be a particularly fertile field for studying service concepts (Berry & Bendapudi, 2007).

However, choosing and empirically testing useful conceptualisations of context for service exchange, particularly for more complex settings, remains a challenge (Vargo et al, 2017; Barile et al, 2016). Existing conceptualisations, highlighted as particularly suited for public sector services, are either aimed too broadly within service level populations, or rely on a simplistic notion of the patient as a customer in dyadic exchanges (Hardyman, Daunt, & Kitchener, 2014). In recent examples of service failure reported in UK healthcare, the nature of the service context has been implicated in inquiry reports (Flynn & Citarella, 2012; Francis, 2013). Flynn & Citerella (2012) in particular, highlighted concerns in relation to stakeholder participation in Care Programme Approach (CPA) case reviews in a UK learning disability hospital in which patient mistreatment was discovered. UK learning disability services use a particular form of case management, the Care Programme Approach (CPA: Department of Health, 1990; 2008), and Flyn & Citerella (2012) highlight that the functioning of CPA case reviews was one issue that allowed the mistreatment of patients to go unnoticed. Therefore, CPA case management reviews in a UK learning disability service would be an important and topical example for an exploratory investigation of how stakeholders create contexts for service delivery. Moreover, it is argued that CPA represents a good exemplar of case management in healthcare more generally, with lessons to be learnt for other healthcare sectors of (Goodwin & Lawton-Smith, 2010).

CPA case management progresses through the enactment of a series of case management reviews that seek to involve all the stakeholders in the care process (Department of Health, 1990; 2008). In this paper we argue that network theory is a useful approach to look at how stakeholders are involved in CPA case management reviews. More specifically, the notion of a service delivery network (SDN), developed by Tax, McCutcheon, & Wilkinson (2013) provides a promising platform to examine how context works as one important element of the value generating system.

Our findings show that there was a rich diversity of SDN profiles across cases. This variation comprised two elements: the quality of participation from each stakeholder network, and the degree of alignment, or co-participation between stakeholder networks. In the first instance, this has important quality implications for case management practice and policy. In addition, our findings also contribute

to the increasing body of work investigating aspects of value generation practice in healthcare. The notable variation in characteristics of context functioning, as represented by SDN profile, is in keeping with the varying styles of value co-creation practice that they described. Moreover, the perspective on context functioning that we elicit presents a more dynamic picture than has recently been suggested for healthcare (Frow, McColl-Kennedy, & Payne, 2016).

For service theory, our findings add to the suite of tools and methodologies that can bridge the gap between generic service theory and empirical service practice, as called for by Vargo et al (2017). In this context, we have introduced a method for investigating how variation in context functioning might relate to variation in value co-creation practices as part of efforts to understand value generating system and developing empirically validated models.

The paper is structured as follows. First, we introduce the concept of case management and how it relates to service networks. We consider how CPA case management sits as an exemplar of case management more widely, and we review empirical work on how CPA is configured in the UK healthcare sector. Secondly, we introduce the concept of service networks in healthcare. We review the literature that adopts a public sector network perspective and contrast it with literature that adopts a customer journey, service delivery network (SDN) vantage point. We propose a novel concept of a collaborative service space as a suitable focus for investigating case management SDNs. Thirdly, using this approach we present an exploration of a series of CPA case review SDNs. Fourthly, we illustrate SDN quality as a range of characteristics across cases in terms of quality of participation and quality of alignment of stakeholders. We consider individual case factors, stakeholder participation styles and organisational service frameworks in relation to our findings. We then discuss the implications of this study for service theory and practice before offering a set of conclusions in the final section.

2.2. Case Management as Collaboration in Service Networks

In order to address the needs of health service users with long term conditions, a model of care is required that promotes working in partnership with service users

and other care agents to optimise outcomes (Nolte & McKee, 2008). This requires a process of collaborative planning (Lorig, 1993). Case management is essentially an integrative approach to collaborative planning, often associated with cases of multiple complex needs (Krumholz et al, 2006). The field of case management and care integration is fragmented and, as Nolte & McKee (2008) argue, it is difficult to define a generally accepted model that applies across all settings and contexts. The Chronic Care Model (CCM) has perhaps the widest acceptance amongst healthcare practitioners (Wagner, Austin, & von Korff, 1996; Wagner et al, 2001). A key feature of the CCM is the advocacy of a high quality interaction between a proactive clinical team and activated patients. The model incorporates strong links between the service delivery system and community resources, with a focus on both functional and clinical outcomes. Therefore, as exemplified by the CCM, case management is redolent with network undertones that have yet to be explored.

In this context, Goodwin & Lawton-Smith (2010) classify case management processes as falling between hierarchical and co-ordination case management approaches. Hierarchical case management is viewed as best suited for predictable, well-defined conditions, with the service process directed by service managers. In contrast, care co-ordination approaches feature collaboration and co-operation across organisations, “knitting together” care from multiple sources. Goodwin & Lawton-Smith (2010) present care co-ordination case management as best suited for complex settings such as mental healthcare. They propose that empirical study of the Care Programme Approach (CPA) in mental health provides a helpful exemplar for understanding this form of case management more generally.

The CPA case management system was introduced in the English health care system in 1991. The initiative calls for a named care co-ordinator and a person-centred process for assessing and reviewing patients with complex conditions. A series of case management reviews are regularly held, integrating necessary resources and working with patients, carers and stakeholders to best effect (UK Department of Health, 1990; 2008). CPA reviews form the basis of assessing patient progress, and collaborative planning is intended to sit at the heart of the process. All mental health and learning disability service providers in England are

required to deploy CPA in managing complex conditions, and it has general acceptance in clinical use (Kingdon & Amanullah, 2005).

There has been a number of criticisms of CPA, as experienced by service users. Although in many instances CPA is valued, it is reported as not being implemented as intended, with wide variations in practice (Carpenter et al, 2004; Rose, 2003). There have been examples of a loss of relationship and engagement with the service users, not addressing areas that matter to them and not sufficiently engaging family members (Goodwin & Lawton-Smith, 2010). Simpson, Miller, & Bowers (2003a, 2003b) relate these difficulties to a lack of conceptual underpinning for the CPA process. These findings resonate with the uncovering of an example of poor quality care at a UK learning disability hospital (Winterbourne View), widely reported in the press (UK Department of Health, 2012). In an analysis of this particular service failing, one important relevant feature was the failure of the stakeholder network (professionals, commissioners, family members) working through CPA case reviews to identify the difficulties (Flynn & Citarella, 2012). The empirical literature suggests there is a problem with the quality of CPA service network functioning, which needs to be explained. Our aim is thus to explore CPA case reviews through a SDN lens. In adopting the CPA case review as an exemplar of complex service exchange, there is also an opportunity to shed light on CPA service improvement and theory regarding case management.

2.3. Network Approaches in Healthcare

According to Borgatti & Halgin (2011), the concept of a network is well established, both in the business and public sector literatures. A network is a set of actors or nodes that are interconnected through specified ties (e.g. information, transactions). Nodes consist of an actor, or a group of actors with collective agency. Connections are reciprocal and relationships and interactions, which can take many forms and paths, indirectly link nodes with no direct connections.

Möller (2013) makes a helpful distinction between network theory and a theory of networks. Network theory assumes the existence of networks with certain properties and looks at the mechanisms and processes that interact with those structures to produce particular outcomes. In short, network theory looks at the

consequences of occupying particular network positions, such as centrality. By contrast, a theory of networks looks at network structures as outcomes and attempts to explain how those properties emerged in the first place.

In this paper we are concerned with network theory, or how different properties of networks affect a particular world. The network concept is broad and can accommodate loose, extensive collections of nodes and their interconnections, or be applied to very specific assemblies of nodes and connections. It is up to the researcher to define the vantage point and the network of interest (Borgatti & Halgin, 2011). It is the case level vantage point that is of interest in exploring CPA case management networks. Next, we consider two approaches from the literature and consider their usefulness in capturing this vantage point.

The role of service delivery networks in the public sector, including mental healthcare, have been previously studied by Provan & Lamaire (2012). In this context, a whole service delivery network is defined as three or more organisations connected in a way that facilitates a common good (Provan, Fish, & Sydow, 2007). A key theme is that these are consciously created, goal directed networks (Raab & Kennis, 2009). In this context, Provan & Milward (1995) report an exploration of community mental health service networks in four US cities. An in depth assessment of the available agencies for people with serious mental illness was undertaken and compared with indices of effectiveness elicited from patients relatives and case managers. One of the key findings at the service level was the importance of a centralised provider agent responsible for network integration in the care system. This insight may well have relevance to developing case management theory, as called for by Goodwin & Lawton-Smith (2010). However, this raises a further question: what practices promoted by the key agency are enacted at the service delivery network and the individual case level so that they are effective? So far the public sector network literature has failed to address the individual case experience.

Although Provan, Fish, & Sydow, (2007) are clear that their vantage point remains at the macro level, it is interesting to consider how in this literature, the conceptualisation of the case as embedded in a wider system in this literature is used. Provan & Milward (1999) present the individual case level as a triad of stakeholders of ‘principals’, ‘agents’ and ‘clients’ embedded in the wider service

delivery network. This perspective is also used by Zolkiewski & Turnbull (2002) in describing structural relationships in UK healthcare commissioning. In the context of healthcare, at the individual case level, a triad might be represented as a patient, clinician and commissioner participants, for example.

This perspective contrasts with work adopting the service eco-system perspective. Frow, McColl-Kennedy, & Payne (2016) offers a framework that sees patients, professionals, family and carers collaborating at the micro level. Hospitals, clinics and agencies operate at the super-ordinate meso level and the higher levels contain various other professional, regulatory, commissioning and governmental authorities. Thus, for Provan & Milward (2005), principals are engaged at the micro level, whilst for Frow, McColl-Kennedy, & Payne (2016) they are not. An important aspect of the network concept in this setting is that it is a deliberately created entity, which has fluidity and which spans the boundaries of the participating organisations (Raab & Kennis, 2009). Meanwhile, Frow, McColl-Kennedy, & Payne (2016) appear to view the service eco-system as an all-encompassing organisation, without the need to look at service networks. In the context of the wider service eco-system literature (Vargo & Akaka, 2012; Akaka, Vargo, & Lusch, 2013), Frow, McColl-Kennedy, & Payne (2016) present a more traditional hierarchy of participation in healthcare. There is thus an important empirical question as to how different participants actually engage in case level service networks in healthcare, and whether a network perspective can make a contribution in developing a case level perspective.

2.4. The Customer Journey Service Delivery Network Approach (SDN)

The public sector network literature privileging a macro vantage point tends to neglect the service user experience. By contrast, the ego-centric SDN described by Tax, McCutcheon, & Wilkinson (2013), has the potential to relate the case level network context to service experience. As a particular kind of strategic network, this SDN focuses on a customer journey, consisting of dyadic encounters with a series of providers or organisations. The stance adopted by Tax, McCutcheon, & Wilkinson (2013) is thus focused on the customer as a participant in an egocentric

network, and a SDN is defined as two or more organisations that are responsible for the provision of a connected, overall service. Healthcare, as a complex service encounter, is mentioned by Tax, McCutcheon, & Wilkinson (2013) as a setting where the concept of a SDN might be usefully applied. However, it is not clear why a SDN has to restrict itself to the customer space alone, or how the SDN might relate to the creation of value for the patient or the healthcare system more generally. This aspect is important when considering how to develop services to improve outcomes, for example.

In healthcare, there have been studies of value co-creation that have implicitly adopted a case level network perspective which resonate with the SDN concept (McColl-Kennedy et al, 2012; Sweeney, Danaher, & McColl-Kennedy, 2015). In McColl-Kennedy et al's (2012) study, part of the patient co-creation style consists of their relationships within their personal networks (e.g. friends and family), along with a set of relationships with clinicians. This is consistent with the SDN concept in that all the parties are viewed as potentially value-creating resources. Interestingly, the styles of relationship configurations identified are seen as important for achieving health outcomes. This early work supports the notion that SDN configurations are important factors in understanding value-generating systems in healthcare. However, a criticism that can be aimed at these studies is that they treat all parties in the service experience (alters) as equals. McColl-Kennedy et al (2012), for example, make no distinction between the nature and shape of relationships between say, friends and family from their personal networks and clinicians in their professional networks. We argue that this dimension is important to understand this service space, in that the networks that intersect within this space will have different morphologies and structures.

There are further issues to consider when applying the SDN concept in case management. First, like Tax, McCutcheon, & Wilkinson (2013), McColl-Kennedy et al (2012) assume the service user's ego-centric vantage point. However, in case management a legitimate alternative vantage point is the collaborative space between case level actors. In service marketing, Grönroos & Gummerus (2014) define three potential spaces or bubbles for interaction: the customer space, the provider space and a shared space where interaction takes place. Tax, McCutcheon, & Wilkinson (2013) also highlight the relevance of the collaborative

space for service co-ordination. We argue that it is important to define which of these vantage points are chosen, and that an SDN focused on the collaborative space is a suitable option for studying collaborative case management. Secondly, in terms of the interactions within that collaborative space, Grönroos & Gummerus (2014) agree with Tax, McCutcheon, & Wilkinson (2013) that value creation is based on a series of dyadic exchanges. However, this seems at odds with the multiplicity of interactions that are likely to be seen between agents in collaborative healthcare case management. We thus argue that the concept of the SDN needs to be amended to accommodate multi-party exchanges at the case level when applied to the collaborative space within complex service settings.

2.5. The Case Management Network Vantage Point

From the above discussions on service context we can conclude that the concept of SDN is better suited to understanding the case level network. As mentioned earlier, it is up to the investigator to define the network under consideration (Borgatti & Halgin, 2011) and we have modified the SDN concept to better accommodate the case management perspective. First, we have selected the vantage point of the collaborative space as the focus for the SDN. Secondly, we view exchanges in terms of multi-party interactions rather than a series of dyadic exchanges. Furthermore, we have highlighted that in healthcare the SDN is further characterised by actors belonging to distinct participant networks, rather than a single, undifferentiated network. Reflecting on the nature of case management and work in the public service network literature (Provan & Milward,1999; Zolkiewski & Turnbull, 2002) we define these networks as the patient, the commissioner and the clinician networks. We propose that an exploration of the SDN in a series of CPA Case Management reviews in a Learning Disability setting, from this vantage point, would therefore test the SDN concept in an apt but challenging domain. Furthermore, the empirical testing of the SDN notion in such a complex service area will contribute to the further development of the concept within the broad service management literature. Taken together, the practical and theoretical insights from this exploration would also be useful to the development of case management practices more generally.

2.6. Summary and Research Questions

In summary, we propose to explore the SDNs relating to a series of CPA case management reviews as a suitable approach for investigating context functioning in case level multi-party service exchange. Two research questions follow from the previous discussion:

We have argued that the SDN concept is well suited to capture context despite some of the limitations highlighted above. However, we are not aware of examples where this concept has been tested empirically or its implications discussed for service design or delivery in complex settings such as healthcare.

i. How should we capture context in complex service exchanges such as CPA case management?

Our second research question relates to our discussion of collaborative service spaces in CPA case management:

ii. How should we conceptualise and measure participation of different stakeholder networks in CPA case management?

We have argued above that one major limitation of the SDN notion is the assumption that all networks in service delivery are seen at the same level. Our argument is that this view is ill-suited to explain the interactions amongst participants involved in complex service settings. Our starting hypothesis is that different stakeholder networks will show different degrees of participation and that these differences are key to explain the outcomes of processes such as CPA case management.

2.7. Methodology

2.7.1. Introduction

The challenge to investigate a specific, local phenomenon is to ensure that it retains broader relevance and interest. Exploratory investigations are accepted as an important part of theory building and wider theory testing processes (George & Bennett, 2005; Christensen, 2006). Thus, with cases understood as relevant

exemplars within categories, case based methodologies allow theoretical inferences to be drawn from cases through a process of analytical generalisation (Mitchell, 1983; Yin, 2014). A case approach is also particularly useful when a strong link between theory and method is pursued (Dubois & Gibbert, 2010). In line with our use of the SDN notion as a platform for understanding CPA case reviews, a case approach enabled: a) the collection of rich data from all stakeholders involved in the multi-party interactions that characterise case reviews, and b) the understanding how important contextual information surrounding each review impacted on the multi-party exchanges in each case review.

For this study we collaborated with a UK Healthcare Trust. The Trust provides in-patient mental healthcare to patients with complex needs associated with learning disability and autism. Services are structured into four service areas: care in a medium-secure setting, care in a low-secure setting, a women's service and an enhanced-care (or rehabilitation) service. Patients within the services are all subject to CPA case management review and the Trust operates a protocol describing the process, underpinned by patient-centred values. Within that protocol, CPA case reviews take place at least every six months. All relevant stakeholders are invited to attend and participate in CPA case review meetings. These meetings therefore provide a useful focus for exploring stakeholder participation in CPA.

In this study we have adopted a multiple embedded case study methodology. Using template analysis (King, 2012) we explored the network context to a systemic cross sectional sample of 20 cases of CPA case reviews in the Trust. Within the case study literature, the focus of investigation can be a defined entity or phenomenon within an organisation (Woodside & Baxter, 2011; Yin, 2014). Approval was obtained from the Trust's Research Committee to undertake the study. No direct patient contact was required for the study and the investigation was structured as a service evaluation project, not as a clinical study. All records remained confidential and no information was extracted from which an individual patient would be identifiable.

2.7.2. Sample and Data

The sample selected consisted of the first five cases scheduled from each of the four service areas following research approval. This provided a sample large and diverse enough to reflect a broad view of CPA across the organisation. As a service-process study, apart from gender and service area, demographic data on patients were not included. For each CPA review, reports were tabled and the attendance and minutes of the meeting were recorded. The data obtained for study consisted of all documentation filed in the electronic case record for the most recent CPA care review for the selected cases. This documentation comprised the minuted record of the CPA review plus additional reports tabled by professionals and patients. This was a study of documentation as distinct from oral information or direct observation. Atkinson & Coffey (2010, p. 80) argue that "… documentary materials should be considered as evidence in their own right". The construction and conventions associated with documents, in this instance being the official record of the CPA review, are also part of the documentary record. This exploration of the official CPA meeting record with an interpretive approach, supported by the inter-textual consistency across cases, was therefore a valid perspective for investigating the functioning of CPA reviews.

2.7.3. The Template

The data obtained from the official CPA documentation was explored using a template analysis (King, 2012). As suggested by this method, we have used the literature to develop a suitable template for investigating network participation. The literature identifies the principal participant networks in health and public sector services as being a patient or service user network, a clinician network and a commissioner network as the dominant sources of agency (Zolkiewski & Turnbull, 2002; Provan & Milward, 1999). From this vantage point the participants could be grouped in their respective stakeholder networks, whilst the participation practices exhibited by stakeholders could be identified. As set out in the methodology (King, 2012), a preliminary exploration of the first 6 cases was undertaken. The emergent evidence of participation practices consisted of three themes: representation of stakeholders at CPA case reviews, the structuring of space for discussion and

evidence within the discourse recorded of active contribution (Spurrell & Proudlove, 2014). Collectively these practices were taken as key indicators of network participation, and the resultant template is shown in Table 2-1: Mature template for exploring network participation in CPA case reviews.Table 2-1.

The patient network encompassed the individual service user and their family and friends. In addition, it would also include those who might provide support in an advocacy role (e.g. mental health advocates, solicitors) and professionals from the service users home area community team (e.g. local care co-ordinator, community nurse, social worker). It might be argued that these professionals should be located in a different network, but from the patients' perspective, these are all agents whose primary purpose is to support the service users in their own communities. The clinician network was defined as the designated multidisciplinary team responsible for the case. The team might include a broad range of clinical disciplines, including a named responsible clinician, medical staff, nursing staff, occupational therapists, psychologists and other forms of specialist therapists.

Meanwhile, the commissioner network covered the service commissioners or their agents.

Template Theme	Template Sub-themes and Nature of Evidence
Network Context • Patient Network Perspective • Commissioner Network Perspective • Clinical Team Network Perspective	*Representation* o Personal attendance at CPA review by network members *Structuring* o Structured documentary space within agenda or demonstrated in discussion minutes. *Contribution* o Views reactively elicited in discussions and documentation o Pro-active expression of views in minutes and co-production of reports to inform the review process.

Table 2-1: Mature template for exploring network participation in CPA case reviews.

For the three participation practice themes for each network, '*representation'* captured the attendance of representatives from participant networks at the CPA case review. '*Structuring'* reflected the extent to which a structured space was built into the CPA discussion to encourage contribution from participant networks and '*contribution'* reflected the extent to which there was active or passive involvement evident in the documentation brought to the review from each network. These themes capture the participation practices for each stakeholder network through which the interactions and interconnections of multi-level service exchange are carried out.

2.7.4. Analysis

The data for each case was reviewed for accuracy and completeness. The template themes and subthemes were coded using NVivo version10 (2014). Each set of case documentation was imported into the NVivo project and the data was

examined and coded using the template nodes. As an exploratory investigation, data analysis was undertaken using pattern matching of the coded data, consistent with the cross-case synthesis approach advocated by Yin (2014). A rich picture was developed from the documentary data of the consistency and extent to which the template captured the network context to CPA case reviews. The range and richness of participation for each network was considered and described.

In order to examine the patterns of network participation in a more structured fashion, we drew on the principles of fuzzy set Qualitative Comparative Analysis (fs/QCA) as described by Ragin, (2006; 2008). This analytic technique makes use of set theory to represent qualitative data in a format whereby case level data can be aggregated and interactions and patterns evaluated. This technique is able to operate with both smaller and larger case samples and avoids some of the difficulties of using statistical techniques in qualitative research (Ragin, 2008). The technique relies on assessing the degree of membership of cases to the defined set of interest in a considered process, termed 'casing'. Some critics of QCA object to the role of the investigator in making structured judgments about inclusion of cases in set membership (cf. Bennett & Elman, 2006). However, the QCA approach is gaining credibility in many public sector settings (Rihoux, Rezsöhazy, & Bol, 2011). It is important to note that although the methodology does allow for potentially testing causal relationships using qualitative data (Ragin, 2008), it is also used, as in this study, for its sophisticated descriptive case comparison capabilities (Rantalla & Hellström, 2010).

In this study the primary set of interest is the set of rich participation practices, where participation practices have been operationalised as *representation*, *structuring* and *contribution*, as above. We followed a methodology on casing for investigating social phenomena at the micro level (Basurto & Speer, 2012), with definite set membership defined as 1, definite non set membership was defined as 0 and the transition point of equipoise between in and out was 0.5. We mapped the degree of rich participation practice set membership for each network for each case and charted the overlaps in practice variation for further examination.

2.8. Findings

Our findings demonstrated that there was considerable variation to the participation practices associated with each of the patient, clinician and commissioner networks, which ranged from some very rich profiles to more limited ones. After describing the key findings for each participant network, we used the QCA methodology to illustrate these variations, and the degree of concordance of participation between patient, clinician and commissioner networks.

2.8.1. The Patient Network

The findings for the patient network fell within a very broad range. In one case the only participation was partial attendance of the patient, with no support from other possible network members such as family, home team or advocates. At the other pole, patients pro-actively contributed, co-produced progress reports and included support from family members, solicitors, advocates and social worker or nurse from home area in their network. Generally structuring of space within the review for patient network contribution was limited. Figure 2-1 displays the quality of patient network participation for each case in terms of the aggregation of fuzzy set memberships for Representation, Structuring and Contribution. As suggested by QCA methodologies, using researcher (MS) judgment a cut off of .7 was proposed as a reasonable threshold for good participation practice. Only 6 out of the 20 cases achieved that threshold.

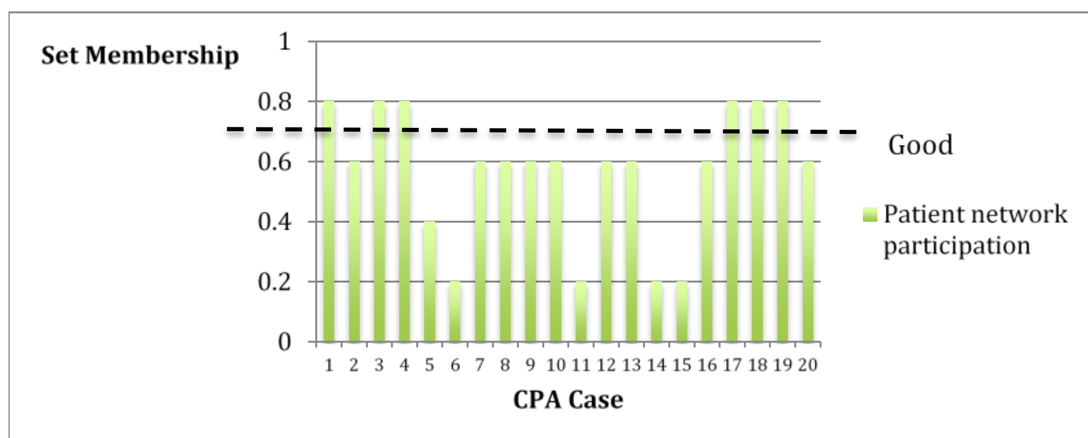

Figure 2-1 Chart of fuzzy set membership of rich participation for Patient Network

2.8.2. The Commissioner Network

Similarly, there was considerable variation in commissioner participation. A broad view was taken to allow that other parties such as social workers or community nurses might have roles in representing commissioners. Even allowing for that, commissioner attendance was limited for this cohort, although in a number of cases apologies were noted. Within the structuring of discussion space within CPA reviews there was not a clear sense of what might matter to commissioners as such, but for about half of cases there was a focus on care pathway progression, which some might assume coincides with what matters to commissioners. Again, the variation of commissioner participation is reflected in Figure 2-2, within the QCA framework. In this case only 4 cases reached the threshold we suggest as a reasonable quality of practice. Therefore, there is evidence that there is scope to improve both the involvement of commissioners in CPA and to give further attention to what matters to commissioners within the format.

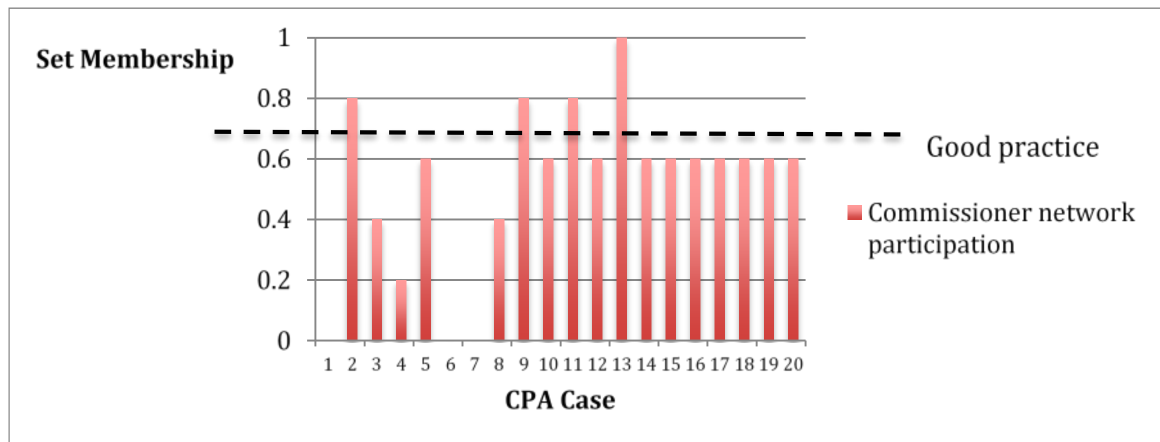

Figure 2-2 Chart of fuzzy set membership of rich participation for Commissioner Networks.

2.8.3. The Clinician Network

For the participation of clinicians, the key finding was the variation in richness of the multi-disciplinary team (MDT) representation and the level of collaborative practice that was seen. Thus, for some cases 'the MDT' consisted of just the responsible clinician (RC) and a nurse. This contrasted with other cases, which benefitted from the RC, a specialty doctor, the case manager and the unit

manager as well as occupational therapy (OT) and psychology or psychological therapist representation. Generally, there was OT input for the most part. The psychological service input was the most variable feature, being only available in about half of cases. Figure 2-3 represents the variation across cases taking into account attendance and degree of proactive contribution. Only 6 cases reached threshold for reasonably good participation, similar to above.

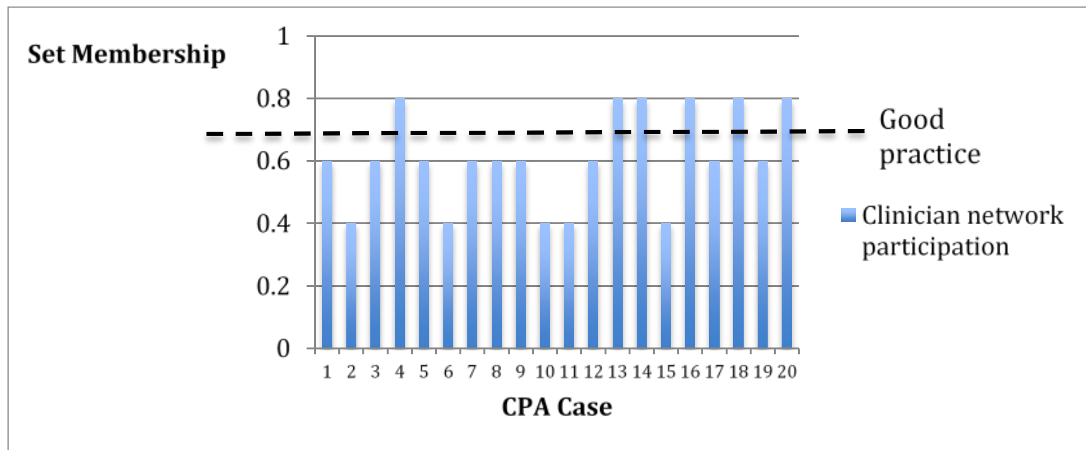

Figure 2-3 Chart of fuzzy set membership of rich participation for Clinician Network.

2.8.4. Network Interconnection

Having illustrated the variation in network participation across the sample using QCA, the interconnection between the networks at the case level can be seen by charting the set intersection for the three networks. Figure 2-4 integrates the variation in participation practices described above for each network to illustrate that different networks behaved differently at different times. In other words, there are not simply cases where everyone is engaged and participating together, leaving other cases where engagement and participation is poor. Rather a more complex and inconsistent picture appears between participating networks for each case.

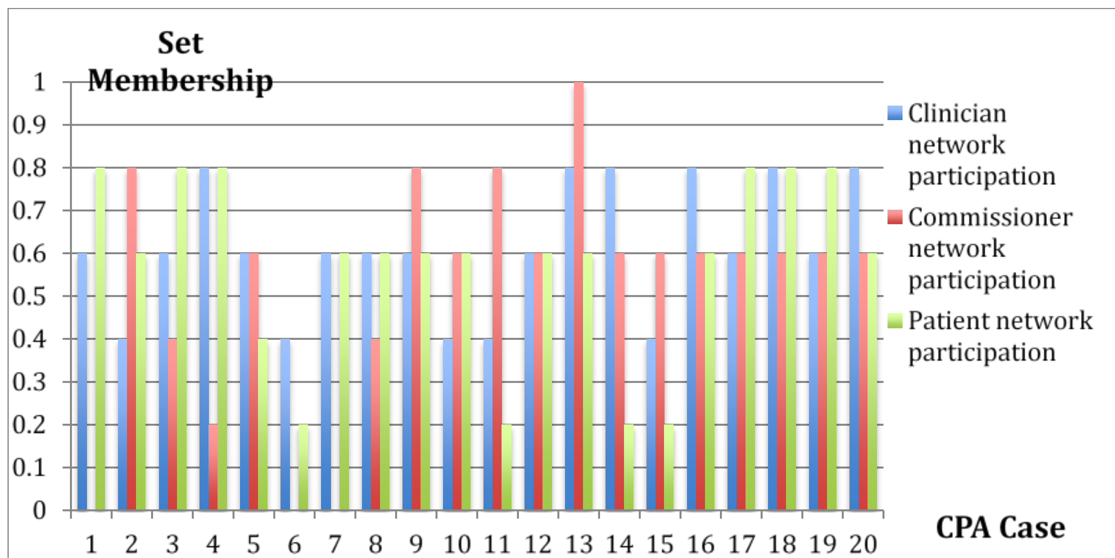

Figure 2-4 Chart of fuzzy set membership of rich network participation for each of patient, commissioner and clinician networks for a sample of CPA case reviews.

In order to examine this apparent disconnection across different networks, the degree of set overlap was calculated using fs/QCA software designed for the purpose (Ragin & Davey, 2014, Version 2.5). The coincidence of rich patient and commissioner participation was .58 (where 1 is complete coincidence), Patient and Clinician participation was .76 and clinician commissioner was .64. The degree of overlap of rich participation for all three was only .52. This is consistent with a greater disconnection for commissioner network engagement and overall, there does not appear to be a strong concordance in the alignment of participation quality across networks.

2.9. Discussion

In this investigation the SDN has been construed as the intersection of three networks participating in CPA case reviews, relating to patients, commissioners and clinicians, as evident in the review documentation. From this vantage point, a notable variation to the quality of participation was identified for each network across the series of cases. This variation in SDN profile consisted of two dimensions: the quality of participation from each of the contributing networks, and the alignment of these contributions (co-participation) at the individual case level.

Through the data analysis it is possible to describe the distinct quality and shape to the SDN profile for each case. In this discussion we discuss the nature of our findings, and possible explanations for the degree of variability in SDN profile that we found. We assess the extent to which the use of the SDN concept has indeed made a contribution to healthcare case management. Having developed a perspective on how context is generated by stakeholders for this case of a collaborative service project, we contrast that with the actor level view and assess the implications for wider case management theory and service theory development.

It was perhaps surprising to discover such a variation in SDN profiles within a single organisation. Participant network contribution is an aspect of quality in healthcare case management that has not previously been looked at. In the first instance we consider possible explanations for the degree of SDN profile variation that we found.

This study provided a cross-sectional view of cases at different stages of care. One explanation of the noted between case variation in SDN quality and shape may simply be that it reflects the evolution of engagement over time, or natural fluctuations in participation practices. Such fluctuations might for example reflect changes in patient confidence at different times and stages of care, or fluctuating availability of professionals to attend meetings. Thus it would be useful to consider whether a more consistent picture would emerge over an extended period. From our data, we would argue that such explanations are not sufficient to account for the marked level of variation identified. Aspects such as the way reviews were structured would not have been time dependent. Variation was seen just as markedly in professional practices as for patients and carers. The fact of the matter remains, at a point in time, for whatever reason we elicited this diversity of participation practice.

It was the case that the focus of this investigation was the documentary reality of a set of cases within a particular organisation, which in itself is a legitimate perspective (Atkinson & Coffey, 2010). Nevertheless, there may be other dimensions to context functioning that were not captured either within documentation, or within the SDN construct. Also, the sample was not structured to capture the diversity of functioning within the organisation that might have

differentially affected case management reviews. It would be helpful in further work to triangulate aspects of context generating practices with other data sources to strengthen the findings. However, all cases were subject to the same policies and protocols and we did not find any indication other than that this variation was a generalised feature across the organisation within the parameters we used. The importance of the exploratory perspective is that it allows the researcher to frame the area of interest (Borgatti & Halgin, 2011; King, 2012), and on these terms we demonstrate a possible framework able to discriminate important qualitative aspects of SDN functioning at the case level. This is good starting point from which to develop further theory building (Christensen, 2006).

As indicated above, although the investigation reflects findings in a particular organisation, it is legitimate to consider wider inferences from case study research where there are conceptual or systemic linkages (Yin, 2014). CPA case reviews are fora that are able to make and keep promises. This qualifies them as important service entities, systemically embedded in the healthcare system (Freund & Spohrer, 2008). In this investigation, whilst cases were selected from a single organisation, the nature of these cases were that they represented a broad spread of practice within the organisation, and the phenomenon of CPA case management is a systemic feature of many areas of UK mental health and learning disability care, subject to national policy and practice guidance. In that context, the within-organisation variability that we found is mirrored in the wider picture of variation in engagement in CPA case management reported in the literature (Goodwin & Lawton Smith, 2010; Carpenter et al, 2004; Rose, 2003). What distinguishes our findings however, is our more developed conceptualisation of the SDN as capturing that stakeholder perspective, and that we highlight the variation at the between case level rather than the between service level. It would be helpful in further research to corroborate whether in other organisations this same pattern of case level diversity in SDN profile could be found. Nevertheless we argue that our findings do capture something of the difficulty of consistency of practice in CPA case reviews that troubled Flynn & Citerella (2012).

2.9.1. Implications

We have demonstrated the usefulness of the SDN concept as a candidate for studying service context in three ways. First we have grounded the concept in healthcare as a fruitful area of empirical study for informing service research. Second, we have operationalised a particular conceptualisation of the SDN and demonstrated its empirical applicability in generating suggestion for health service improvement. Third, we have been able to develop a practice focused, complex service perspective with claims to have systemic applicability for the wider health and service sector, and we confirm that context functioning is an important source of variation in service practice. These are all features called for in the task to explore context generation in service (Vargo et al, 2017). Continuing to use healthcare as a useful focus, we consider the implications of our findings for service theory, and practice.

2.9.1.1. Implications for Service Theory

As has been highlighted above, variation in patient value co-creation style is an important feature in healthcare that may well influence outcomes (McColl-Kennedy, Hogan, Witell, & Snyder, 2017; McColl- Kennedy et al, 2012; Sweeney, Danaher, & McColl-Kennedy, 2015). As highlighted, the practices observed in these studies could be seen as featuring a patient centric network of participation (contrasting with the collaborative vantage point we have used). This illustrates a potential overlap between what counts as a context generating practice and value co-creation practice. Care is needed when interpreting concepts consistently in the service literature (Grönroos & Gummerus, 2014). Dong & Sivakumar (2017) might argue that both constructs could be simply understood as representing aspects of customer participation. With that qualification, we extend the work of McColl-Kennedy and colleagues by indicating that there can be styles of context generating practices alongside styles of value co-creation practices within the value generating system. Moreover, contribution to variation in style, whether seen as context generation or value co-creation, is rooted in the variation in practices across all participating stakeholders, not just the patient. Further, it might be expected that the within and between interactions of different patient network styles with different clinician or commissioner network styles, and the influences

on those relationships from the other parties, would generate further sources of variation to the quality of the service exchange (Vedel, Geersbro, & Ritter, 2012).

The distinct collaborative, multi-party perspective we present illustrates the step-up in complexity from McColl-Kennedy et al's (2012) simple dyadic exchange view of healthcare, an issue that has been highlighted elsewhere (Baron & Harris, 2008). In later work McColl-Kennedy, Hogan, Witell, & Snyder (2017) do bring in the interplay between clinician and patient practices as a further dimension. Our conceptualisation of SDN quality offers a means for supporting that line of inquiry and it would be interesting to consider further how to integrate our SDN approach with emerging thinking on value co-creation practice styles. For example, similarly to McColl-Kennedy and colleagues, it would be interesting to investigate the relationship between SDN style as a marker of context functioning and co-creation style, service outcomes and other aspects of value generation in future work (Ciasullo, Cosimato, Palumbo, & Storlazzi, 2017). Key themes to explore would include what might be the best context characteristics to achieve the best outcomes in what circumstances. Also, how might optimal SDN styles be achieved, and how might that relate to accessing available network resources?

In our study, we gave visibility to the complex case as a discrete service entity, with distinct shape and form within the healthcare environment. The focus on a service network as a functional unit formed by participant networks in public services has already been studied as a macro level concept (Provan & Milward, 1999), but using the SDN approach fills a gap by foregrounding the service network context at the case level. This addresses a gap in the literature, as we argued earlier. In order to achieve this a significant adaptation has been made to the SDN concept as originally conceived by Tax, McCutcheon, & Wilkinson (2013) to better reflect a more collaborative, multi-party service exchanges environment. Figure 2-5 sets out the distinction between our use of the SDN concept and that proposed by Tax, McCutcheon, & Wilkinson (2013), referencing supporting literature (Zolkiewski & Turnbull, 2002; Gronroos & Gummerus, 2014). There are two key adaptations, first the shift in vantage point, and second the move to multiparty interactions.

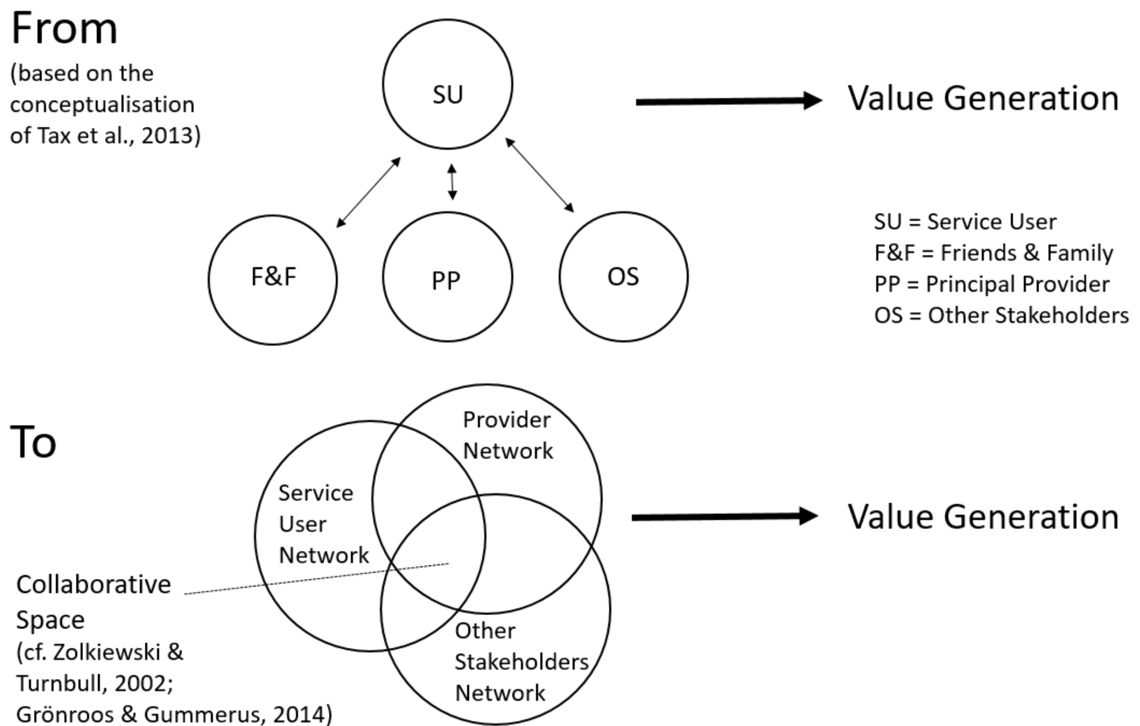

Figure 2-5 Choosing to shift the perspective of the SDN from service user to collaborative space.

Shifting the vantage point from the service user perspective to the collaborative space, we suggest, offers additional insights to service functioning in a complex setting. The collaborative space is a vantage point that has been gaining attention in the literature (e.g. Grönroos & Gummerus, 2014; Ballantyne, Frow, Varey, & Payne, 2011; Törnroos, Halinen, & Medlin, 2016). Meanwhile, a further adaptation has been the shift to a multi-party, collaborative interaction. Whilst, the SDN concept as proposed by Tax, McCutcheon, & Wilkinson (2013) focused on specific dyadic exchanges that are relatively easy to grasp, others argue for the importance of broader, multi-party collaborative perspective (Ballantyne, Frow, Varey, & Payne, 2011; Provan & Lemaire, 2012). Our study indicates that it is possible to capture the collaborative perspective through the interaction and interconnection practices of participants, as suggested by Vedel, Geersbro, & Ritter, (2012). Our adaptation rests on the proposition that the collaborative space, in our example the case management review, functions as an entity capable of making and keeping promises (Freund & Spohrer, 2008). In our worked example, from the CPA policy it is intended that this should be the case for CPA case

reviews (Department of Health, 1990; 2008). However, there would need to be further investigation of how well in fact these entities are embedded in the wider service system in practice.

The approach that we have developed contrasts with the model proposed by Frow, McColl-Kennedy, & Payne (2016) of healthcare context as a generic, institutional arrangement within micro, meso and macro levels of structure. Drawing on the service eco-system view, for Frow, McColl-Kennedy, & Payne (2016), the case (micro) level was simply represented by identified local agents (patient, friends and family, clinicians, nurses and allied professionals, and other patients), but they do not elaborate on how these agents participate. These are seen as embedded in meso, macro and mega levels of organisation, consisting of bodies, agencies, organisations or systems, and the participation practices of agents within wider institutional arrangements are not developed. Our findings suggest that the field of participants at the micro/case level is much more dynamic than the Frow, McColl-Kennedy & Payne (2016) model suggests, with all levels of institutional actors being represented (such as commissioning agents). Meanwhile, although others do adopt a more dynamic, agent focused perspective of public sector networks (Provan & Milward, 2005), in this study we make a contribution by operationalising this at the case level within services. Further, it is interesting to note that neither Frow, McColl-Kennedy & Payne (2016) nor Provan & Milward (2005) take account of features such as the range of different styles of case level context functioning that we describe, and which might be expected to lead to different dynamics within the service system.

Our stance in observing the emerging collaborative space between participating networks rests on how useful this conceptualisation is (Cox & Hassard, 2005). Our approach is consistent with literature that regards the emergent actor-network as a key element of the service eco-system (Lusch & Nambisan, 2015; Vargo & Lusch, 2011). This suggests the need for a critical enquiry into the construction of the service eco-system architecture in practice. Our suggestion is that the vantage point proposed by Frow, McColl-Kennedy, & Payne (2016) may well serve for example for broad generalisations, but when zooming in to specific services and cases (cf. Vargo et al 2017), a more fine-grained, dynamic perspective is needed than recent service eco-system literature suggests (Vargo & Lusch, 2017; Vargo &

Lusch, 2016; Akaka, Vargo, & Lusch, 2013; Vargo & Akaka, 2012). Lusch & Nambisan (2015) suggest, there is more to do to capture the participative architecture in service exchange, for example how co-ordination is designed and implemented. We argue that our adapted SDN approach makes a useful contribution to building this more intricate case level, contextual perspective.

2.9.1.2. Implications for service practice

In this study we have highlighted two dimensions of quality for the SDN supporting CPA case management reviews. The first is the richness of participation of each of the patient, commissioner and clinician networks. The second is the quality of alignment of participation, on the assumption that the more there is co-activation of these networks the better the care process will be supported. By combining these two dimensions a model of SDN quality is therefore proposed to represent this (Figure 2-6). It was encouraging to note the discriminative range to this model in our sample, although further work would be needed to validate it for experimental research. Such a perspective has not previously been proposed for CPA case management, and so this tool is an important contribution for practitioners to be able to reflect on and model variation. There are two important immediate implications. First, this provides a tool for studying the evolution of this important aspect of service experience and, second, it provides a basis for practitioners to be able to capture and share best practice accordingly within the local healthcare community.

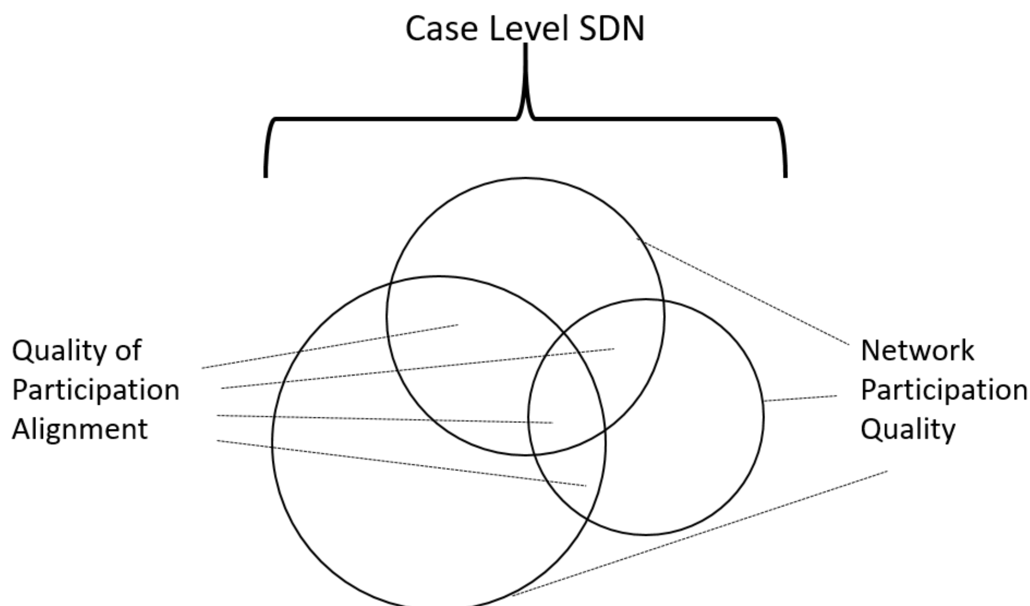

Figure 2-6 Representation of the Configuration of Service Delivery Networks at the Case Management level.

Having identified an issue of consistency across CPA case management reviews, what is of further interest is whether this is a local issue or is a wider feature within healthcare. Our investigation confirms previous findings of variation in CPA patient engagement between services (Goodwin & Lawton Smith, 2010; Carpenter et al, 2004; Rose, 2003). In addition though, our findings extend that to include variation in engagement of other parties also (clinician actors and commissioner actors). They also suggest that such variation is not just between services or healthcare organisations, but also between cases within the same organisation. This raises the possibility that our findings might represent a much deeper and wider systemic difficulty with CPA practice than previously reported, extending through to the micro level of organisations. This echoes the concerns identified in CPA case reviews at Winterbourne View hospital (Flynn & Citarella, 2012), and thus makes an important contribution to the policy agenda for raising CPA case management quality.

CPA case management can be viewed as a good exemplar for study for healthcare case management (Goodwin & Lawton-Smith, 2010). In that spirit we further propose this conceptual tool might prove useful in developing better frameworks to support case management more generally (c.f. Bohmer &

Lawrence, 2008). For example, discussing the application of the SDN concept in practice, Tax, McCutcheon, & Wilkinson (2013) assume that there should be an organising framework offered by the service provider to support participant collaboration. This is mirrored in other comments on the importance of an emergent platform to engage participants in value co-creation in services (Grönroos & Voima, 2013). There is a lack of conceptual support for CPA practice (Simpson, Miller & Bowers, 2003a; 2003b), and we suggest, from the variation across cases in our sample, that a lack of a service framework to more consistently support participant collaboration could explain our findings, consistent with the difficulty that Flynn & Citarella, (2012) identified. Meanwhile, for case management in the wider healthcare setting the Chronic Care Model (CCM) has been suggested as a framework to support service provision, with the activation of patients and other stakeholders featuring prominently in the model (Wagner, Austin, & von Korff, 1996; Wagner et al, 2001). The CCM has not been adapted for use alongside CPA case management. This could now however be explored using our approach to capture the activation of participation that the CCM describes using the SDN concept. Thus, using this more sophisticated representation of context functioning assists with the kind of customised approach to service improvement recently proposed by Swinglehurst et al (2014) in a number of respects, and confirms the useful applicability of the SDN concept to this area or inquiry.

2.10. Conclusions

In conclusion, we have demonstrated that an adapted version of the notion of service delivery network (SDN) was able to capture important aspects of contextual functioning in complex service exchange in healthcare. It was important that we were able to empirically test this approach in CPA case management as this is an area of highly topical interest and represents a good exemplar of case management more generally.

An important contribution from this study is that in exploring concepts and engaging with these case examples we have developed a novel approach to understanding complex service systems. Through our adaptation of the SDN

concept we define a vantage point that bridges the gap between a simple dyadic exchange perspective, and broader inter-service perspectives. This vantage point is ideal for seeing discrete multi-party service projects such as CPA case reviews as being service entities that occupy a central role in the wider service system. We have identified the properties of stakeholder network participation and the degree of co-activation of participation, through our use of the QCA method, as important features of the SDN.

Finally, this study makes a contribution to service theory development by offering a mid-range conceptualisation that bridges the gap between more abstract theoretical perspectives and situated service practice. This is a first investigation of a cross-sectional view in one particular organisation in one sector of health care. Although it is argued that these cases form a good exemplar set, nevertheless further validation work would be needed to confirm the consistency of the approach we propose.

An important dimension to our investigation has been the use of techniques from QCA to structure the data. The use of QCA to methodically structure qualitative data in order to undertake explicit theory testing is a growing area of interest (Fiss, 2011). However, a more sophisticated configurational analysis of service process was beyond the scope of this study. Nevertheless, from a rich descriptive perspective (Rantalla & Hellström, 2010), we have provided a useful exploratory foundation from which we have developed a representation of the nature and quality of context styles. In further research these might be readily operationalised within QCA as constructs for investigating how context generation relates to other aspects of value generating, and to the realisation of service outcomes that matter to people (Ciasullo, Cosimato, Palumbo, & Storlazzi, 2017; Porter, 2014). This helpfully positions our adapted SDN as a candidate mid-range concept to bridge the gap between abstract theory and service practice as has been called for by Vargo et al (2017), and particularly in public services by Hardyman, Daunt, & Kitchener (2014).

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Chapter 3: Paper 2

This paper is a draft that was submitted and accepted for presentation at the 5th Naples Forum on Service, Sorrento, Italy, 6-9 June, 2017.

The paper received a conference award:

Best Paper Award at the 5th Naples Forum on Service, sponsored by *Journal of Service Theory and Practice:*

Spurrell, M., Araujo, L., Proudlove, N., "An Exploration of Valuation Practices in Complex Case Review in Health Care."

As announced,

http://www.naplesforumonservice.it/public/index.php?node=236&nm=JSTP+Award+2017

It is co-authored with my two supervisors. I am first author and wrote the paper and originated the ideas. My co-authors critically reviewed the drafts and helped shape the submission.

The version include in this chapter is the author-accepted draft, but using the hierarchical section-heading structure and table- and figure-numbering system as the rest of this thesis. This version will be finally revised ready for journal submission.

An Exploration of Valuation Practices in Complex Case Reviews in Healthcare

Abstract

Purpose

The purpose of this paper is to explore valuation practices in a complex case setting in healthcare. Value based healthcare is an important theme in contemporary health management, particularly in relation to management of cases with multiple stakeholders. The concept of value co-creation concentrates on value as uniquely (and privately) determined by the beneficiaries. In this context researchers have begun to explore value co-creation styles in relation to health service outcomes. The challenge for value based healthcare, however, is to also capture an accepted valuation of service benefit that has currency for all stakeholders. In the valuation literature this can be viewed as a collaborative performance. Valuation practice styles have not previously received attention in healthcare research. As a result there is a gap in understanding as to how private co-creation of value by individual participants might relate to their collective valuation of service benefit. Beginning to characterise valuation practices in a series of healthcare case reviews is therefore a fruitful investigatory step.

Design/Methodology/Approach

The documentary record of a series of 20 case reviews was obtained with permission for individuals with complex needs from a hospital Learning Disability service. All were subject to a standard case management system entitled The Care Programme Approach (CPA). This process requires regular collaborative case reviews involving patients, family, clinicians and service commissioners. The records were explored using a thematic template analysis. From combining emerging themes and reference to the valuation literature a template of valuation practices was developed for further analysis. Using techniques from Qualitative Comparative Analysis a range of configurations of valuation practice were identified for discussion.

Findings

For this sample case reviews divided between those that were apparently strongly valuation orientated and those that were not. In addition, within that range there were also a number of possible valuation practice configurations identified. These configurations aligned with four styles of practice: To develop an integrative style of a number of modes of valuation practice; A simple style which might form a stem for other practices; A results orientated style; A style characterised by professional learning.

Originality/Value

This study highlights that a range of co-valuation styles are manifest within case review practice. These configurations may well reflect the underpinning value registries in play amongst participants. Thus, variation in valuation practices is an area to consider for healthcare improvement initiatives. This is a novel perspective to the process of gaining collective ownership of outcomes by stakeholders in health. Moreover, we extend service theory by raising the question of how co-valuation relates in counterpoint to value co-creation. We consider that valuation practices might be an extension of value co-creation. Alternatively, we consider whether these are parallel processes in service exchange, with an inter-play between individual value co-creation styles and the collective co-valuation style. Our methodological approach provides a useful starting point for further research.

3.1. Introduction

Value based healthcare is proposed to be important to the task of improving the management of healthcare (Porter, Pabo, & Lee, 2013; Porter, 2010; Porter & Teisberg, 2007). The argument is that it is critical in the way forward to focus on the individual case, and there is much literature that agrees with this stance (Nolte & McKee, 2008; Lillie et al, 2011; Horne, Khan & Corrigan 2013). In this context, for Porter (2010) 'value' is defined as outcomes that matter to patients, relative to service cost. Therefore the clinical project is to organise the delivery of service to those ends. Porter (2010) sets out key areas of benefit they see as arising from this patient orientated perspective. These areas are given a level of stratification

of importance, ranging from 'surviving', to improving in function and avoiding harm to including aspects of the service process such as timeliness. It is argued that these indices provide a spectrum of useful outcome measures from which to gauge and reflect on the usefulness of a service.

Despite the advantages of Value Based Healthcare, there are further issues to be addressed to develop it in practice in healthcare. First, there is more to do to clarify the notion of value and its relationship to theories of value creation. Second, Porter and colleagues have used relatively simple scenarios to develop the concept, and there is more work to understand how it might apply in complex healthcare settings. Third, there is more to do to understand how this approach might lead to the valuation question of in practice being able to weigh 'has the service been worth it', particularly in the complex case setting.

In order to explore this question we will first review contemporary thinking on value and value creation in the service literature as it might be applied to healthcare. Next, we set out some key ideas from contemporary valuation theory. We provide an introduction to case management in English learning disability care. This represents one area where the issue of value from services is particularly topical, and which provides a good exemplar for how in practice valuations might be made in a complex healthcare setting. We then report an empirical exploration of the valuation practices discovered in a series of case management reviews and discuss the implications of our findings.

3.2. Value and Value Creation in Healthcare.

Contemporary service literature is focused on the notion of value co-creation, embedded in some form of service logic. Mostly associated with service dominant logic (SDL), as described by Vargo & Lusch (2004; 2008) value is deemed as experienced uniquely by the customer. In this context, 'value', not unlike Porter's definition, can be defined as that as a result of service the customer perceives they are better off than before (Grönroos, 2008). The process of value co-creation is that knowledge and skills from relevant sources are produced with the customer and integrated for them to be able to create value for themselves. The term value co-creation, introduced by Ramaswamy (2011), at the simplest level

reflects the collaborative nature of this exchange. There are though some further technical considerations as to how the term value co-creation is used in the literature which are beyond the scope of this paper (Grönroos, 2008; Grönroos & Gummerus, 2014). What is important is that there is an increasing emphasis on the applicability of this concept to public sector services (Vargo and Lusch, 2011; Hadjikhani and LaPlaca, 2013), and to healthcare in particular (Alves, 2012; McColl-Kennedy et al. 2012; Radnor and Osbourne, 2013; Hardyman, Daunt, and Kitchener 2014).

In this context there has been work to empirically explore value co-creation in healthcare. McColl-Kennedy et al (2012) studied patient practices in an oncology service and described variations in patient co-creation styles, which they have tentatively linked to some aspects of service outcome. There has been further work to extend the study of co-creation styles to other areas of chronic healthcare such as chronic respiratory or cardiac disorders (Sweeney, Danaher & McColl-Kennedy, 2015). Frow, McColl-Kennedy & Payne (2016) have deepened the theoretical framework for understanding value creation in healthcare. One element to their framework is the embedding of this value co-creation process in the stakeholder network context. The authors also draw on Payne, Storbacka, & Frow (2008) to argue that the enactment of practices in these relationships lead to the realisation of co-created value, and they call for more empirical research.

Frow, McColl-Kennedy & Payne (2016) agree with Baron & Harris who point out that there are particular complexities and constraints in health and public service settings, with the involvement of multiple parties and perhaps differing views as to the outcomes that might be desired (Baron & Harris, 2008). In this context, Korkman, Storbacka & Harald (2010, p. 238) assert that there have been few attempts “to understand the actual practical process of resource integration, and how value stems from integration”. In Payne, Storbacka, & Frow ‘s (2008) model of the management of value co-creation that Frow, McColl-Kennedy & Payne refer to, it is not explicit what value is realised. In fact much of the literature has followed Vargo & Lusch (2008) in seeing value as privately, uniquely determined by the beneficiary. The issue of understanding an agreed sense of collective value of a service that might be negotiated between stakeholders has received less attention. The perspective of Porter and colleagues is to anticipate that

patient value should be externally accessible for wider stakeholders. Healthcare services are embedded in the context of a network of stakeholders (Provan & Milward, 1999; Zolkiewski & Turnbull, 2002). These might be understood as the patient and their supporters, the clinicians and their professional systems and the commissioners and other regulatory bodies (cf. Spurrell, Araujo & Proudlove, 2018). All these stakeholders need to see that their own value needs are met, and that each other's are too. For example, clinicians and commissioners want to know a patient is getting better to justify their continued activities and funding. Patients need to understand that their clinicians and commissioners are happy in order to be sure that they are receiving the right care. Therefore, how such a collective valuation might be enacted, and how it relates to the process of value co-creation is a key element in the development of value based healthcare which is missed in the co-creation literature.

3.2.1. Approaches to Valuation

The classical approach in the valuation literature is to understand collective value as consisting of two aspects. First there is a process of 'valorising', which refers to arranging for value to be created. There does not seem to be any reason not to link this to the process of value co-creation, although the concept was not developed with this in mind. The second aspect is the process of 'evaluation', which is the identification of value as it is created (Vatin, 2013). Although in these terms the focus of the co-creation literature has been on valorising, there has been some attention paid to evaluation. For example after game theory, Spohrer & Maghlio (2008) propose that there should be a process of identification of an outcome scenario following service. This might be one of a series of combinations such as win/win, win/lose, lose/lose etc. that can categorise whether the service need was met or not. Of course this model does not account for multiple stakeholders, as might be found in health. Moreover, it assumes a simple time limited intervention, whereas healthcare is more usually extended and complex.

Payne, Storbacka, & Frow (2008) include a final step of evaluation in terms of customer satisfaction as part of their model of the value co-creation management highlighted above. However, again the approach is rather simplistic for the more

continuous, mulit-layered, multi-stakeholder perspective that more usually applies in healthcare. Moreover, in the Payne and colleagues model the process of evaluation they describe is not a collaborative one. In recent valuation literature, there has been further development of how the process is seen, and there has been recognition of the inextricable interplay between valorising and evaluation. Vatin (2013) argues that an ongoing process of evaluation is integral to the process of making value. Further, in exploring the process of valuation empirically, some argue that in practice the distinction becomes rather blurred (Heuts & Mol, 2013). Therefore there is yet further ground to cover to understand collective value making in healthcare.

The issue of the collective perspective of value in healthcare has been the subject of particular recent attention (Dussauge et al, 2015). In the introduction to a collection of work on the subject, the authors make the point that instead of proceeding from a perspective of trying to define what say valorising and evaluation means, we can draw on the pragmatist insight of rather asking the question as to 'how are values made?' (Ibid, p2). Drawing on Dewey (1913), the argument is in essence that there are two components to how values are made, the making of participant stakeholders and the systems of value (the value registries) that are deployed.

To clarify further, adopting this pragmatic vantage point, Dussauge et al (2015) argue that participants in healthcare are dynamically engaged in a process of stake making, where they can be more or less pulled into fulfilling the role of stakeholders, with investment in the desirable outcome as they see it. Here they blend the classical distinction between the term 'value' as might be articulated by economists, and 'values' as might be associated with sociological discourse. For the authors, value(s) denote and produce the desirable. In adopting the stance of stakeholders, participants will have their particular ways of ordering what they see as desirable, which form their value registries. The enactment of competing desirabilities amongst stakeholders is then how the valuation is performed (p19). In this context the authors propose the notion of valuographic research, which concerns itself with studying the practices involved in such valuation performances.

In further discussion, Dussauge, Helgesson & Lee (2015, p281) develop the potential of valuographic research further. They propose that valuographic studies might usefully capture, describe and compare valuation practices between cases, and from this they envisage a number of potential modes of intervention: Re-balancing, Caring, Interfering and Inspiring. First, from studying and identifying persistent critical issues where valuations are performed there can be opportunities for re-balancing the interactions between participants to improve the valuation performance (Ibid, p282). For the caring mode of intervention there is similarly attention to emerging critical issues in how valuations are performed, but it might be considered that a nurturing of some contribution is required. For example it might be considered whether more emphasis on the patient value registry in the performance would improve the valuation.

For the activist mode of intervention, the authors envisage a more specific project to start from a working position, collectively review the valuation, and then more pro-actively make an alteration, as might be found in an action research project for example. Meanwhile for the inspiring approach, the purpose of eliciting variation in valuation practice across cases would be to activate interest in considering how the world might be otherwise. Therefore, this enables scope for shaping alternatives or focusing choice. It is this mode of valuographic research, with an emphasis on exploring the collective making of value, which we propose to develop in this paper.

3.2.2. Opportunities for Valuation and Valuographic Research in Healthcare

We have argued that value based healthcare is a concept that offers promise, but which depends on being able to arrive at a collective view on value. From the valuation literature we are able to conceptualise that this can be achieved through the performances of valuations. Further, through the adoption of a valuographic methodology, it is possible to study variation in valuation practices across cases in order to gain insight into how to develop this aspect of value based healthcare. The next task is to identify how the broad scope of healthcare practice might be usefully approached to investigate the phenomenon of valuation further. We propose that such a focus can be found through an investigation into case management in healthcare.

Case management refers to a collaborative, integrative approach to evaluating and planning care (Nolte & McKee, 2008; Lorig, 1993). It is often associated with cases of multiple complex needs (Krumholz et al, 2006). Goodwin & Lawton-Smith (2010) distinguish between two forms of case management approach. The first is a hierarchical approach from the vantage point of commissioners, say, overseeing services for patients. The second approach, case co-ordination, is from the vantage point of a structured collaboration of service users and other key stakeholders, patients, families, clinicians and commissioners, "knitting together" care from multiple sources (Goodwin & Lawton-Smith, 2010, p2). A collaborative planning process requires a collaborative evaluation of progress to date, in anticipation of further value creation. Therefore examples of this latter style of case management in particular are likely to be fruitful objects of study for exploring valuation practices. Goodwin & Lawton-Smith single out 'The Care Programme Approach' case management in English mental health care as an area where such a form of case management has been long established approach with the potential to function as an exemplar for healthcare more widely.

The Care Programme Approach case management system (CPA) was introduced in England in 1991. CPA provides for a named care co-ordinator and for a person-centred process for assessing, evaluating, planning and reviewing patients with complex conditions. Periodic case management meetings are regularly held for patients and stakeholders to collaboratively conduct such reviews (Department of Health, 1990; 2008). All English mental health and learning disability service providers are required to deploy CPA in managing complex conditions, and it has general acceptance in clinical use (Kingdon & Amanullah, 2005).

Research into CPA to date has been limited. Where research has been done there is some criticism of the apparent wide variations in practice found (Carpenter et al, 2004; Rose, 2003). There have been examples of a loss of relationship and engagement with the service users, not addressing areas that matter to them and not sufficiently engaging family members (Goodwin & Lawton-Smith, 2010). Simpson, Miller, and Bowers (2003a, 2003b) relate these difficulties to a lack of conceptual underpinning for the CPA process. In a high profile example of service neglect, the failure of the CPA process to evaluate the situation was cited as one factor in the subsequent service review (Flynn & Citarella, 2012). Therefore, whilst

CPA case management may be a good focus for exploring valuation practices in healthcare, there are also important issues of practice at stake, for example in learning disability care, that suggest that such a focus may also contribute to service improvement.

3.2.3. Exploring Valuation Practices in CPA Case Management in and English Learning Disability Service

We have argued that contemporary service literature on value co-creation in healthcare has not gone far enough to support value based healthcare, particularly in relation to the prominent issue of the management of complex cases. In addition to supporting value as benefit uniquely determined by the beneficiary, there is further a necessary dimension of agreeing a collective sense of valuation in order to take stock and further plan the care strategy. The performance of such a valuation is given a particular focus in healthcare case management reviews. In this valuographic study we propose to explore the valuation practices in a series of CPA case reviews in an English learning disability service as a suitable exemplar of this phenomenon. Our hypothesis is that using such a valuographic approach we will be able to usefully capture the making of value within cases. Further by studying the range of valuation practices across cases we will shed light on some of the underlying value registries and their interactions between stakeholders. Thus, posing the question of how it might be otherwise, we hypothesise that the patterns of practice that are discovered will usefully inform service improvement, and usefully further extend value creation theory.

3.3. Methodology

For this investigation we were able to collaborate with a UK learning disability Trust. The Trust provides in-patient mental healthcare to patients with complex needs associated with learning disability and autism. Services are structured into four service areas: care in a medium-secure setting, care in a low-secure setting, a women's service and an enhanced-care (or rehabilitation) service. Patients within the services are all subject to CPA case management review and the Trust operates a protocol describing the process, underpinned by patient-centred values. Within that protocol, CPA case reviews take place at least every six

months. All relevant stakeholders are invited to attend and participate in CPA case review meetings. These meetings therefore provide a useful focus for exploring stakeholder participation in CPA.

In this study we have adopted a multiple embedded case study methodology. Using template analysis (King, 2012) we explored the valuation practices of a systemic cross sectional sample of 20 cases of CPA case reviews in the Trust. Within the case study literature it is legitimate for the focus of investigation to be a defined entity or phenomenon within an organisation (Woodside & Baxter 2011; Yin, 2014). The investigation sits within the theory-building phase of research (George & Bennett, 2005; Christensen, 2006). Approval was obtained from the Trust's Research Committee to undertake the study. No direct patient contact was required for the study and the investigation was structured as a service evaluation project and not a clinical study. All records remained confidential and no information was extracted from which an individual patient would be identifiable.

3.3.1. Sample and Data

The sample selected consisted of the first five cases scheduled from each of the four service areas following research approval. This provided a sample to reflect a broad view of CPA across the organisation. As a service-process study, apart from gender and service area, demographic data on patients were not included. For each CPA review, reports are tabled and the attendance and minutes of the meeting are recorded. The data obtained for study consisted of all documentation filed in the electronic case record for the most recent CPA care review for the selected cases. This documentation comprised the minuted record of the CPA review plus additional reports tabled by professionals and patients. This was a study of documentation as distinct from oral information or direct observation. Atkinson and Coffey (2010, p80) argue that "documentary materials should be considered as evidence in their own right". The construction and conventions associated with documents, in this instance being the official record of the CPA review, are also part of the documentary reality, a version of reality that can be usefully studied. This exploration of the official CPA meeting record with an interpretive approach, supported by the inter-textual consistency across cases, was therefore a valid perspective for investigating the functioning of CPA reviews. The key stakeholders of concern in this analysis are the patient networks, the

commissioner networks and the clinician networks as represented in the case review documentation.

3.3.1.1. The Template

The data obtained from the official CPA documentation was explored using a template analysis (King, 2012). The first step in this methodology is to develop a suitable template, which can be from drawing on relevant literature, by eliciting themes as they emerge in a pilot sample in the data, or from a combination of both. From the literature, Kimbell (2011) describes two principle themes in the quality of value creation processes, which we have drawn on. These are, the extent to which there is collaborative process, and the balance between a problem solving process and more reflective design orientated practices. In this context, from our sample we used a pilot investigation to identify themes as to how progress was presented for stakeholders, and how that was made use of to draw conclusions. Following the template methodology, we confirmed that the resultant themes formed a stable pattern across cases and no new themes emerged, resulting in a final template as set out in Table 3-1.

Template Theme	Template Sub-themes and Nature of Evidence
• Overview of Progress • Progress along care pathway • Progress with patient engagement • Progress with symptoms and function • Progress with social participation • Progress with reducing untoward events	• Whether the status of the patient was established across a broad range of functional areas, and where within those areas there was a more reactive comment or whether there was more methodical, structured detailing of status within that domain • Whether there was a description of trends, either improving or worsening etc. Also, whether trends were reported across a broad range of areas and whether these were structured and methodically reported. • Whether there was learning developed in the review, linking change in status to possible explanations, leading to likely changes in treatment plan. Whether that reflection actively involved the patient. • Whether progress was overall represented as mentions or highlights, or more structured descriptions or supported by a formal measurement tool. • Whether there was a definitive statement to say since the last review that progress had been made, not made or was unchanged overall. • Whether there was inclusion of patient self-report progress, and whether this took the form of narrow unstructured comment, or a structured self-assessment across broad functional areas.

Table 3-1 Mature template for exploring valuation practices in CPA case reviews.

3.4. Analysis

The data for each case was reviewed for accuracy and completeness. The template themes and subthemes were coded using NVivo version 10 (2014). Each set of case documentation was imported into the NVivo project and the data was examined and coded using the template nodes. As an exploratory investigation, data analysis was undertaken using pattern matching of the coded data, consistent with the cross-case synthesis approach advocated by Yin (2014).

A rich picture was developed from the documentary data of the performance of valuations as captured by this template. The range and richness of valuation performances across cases was considered and described.

In order to examine the patterns of network participation in a more structured fashion, we drew on the principles of fuzzy set Qualitative Comparative Analysis (fsQCA) as described by Ragin, (2008; 2006). This analytic technique makes use of set theory to represent qualitative data in a format whereby case level data can be aggregated and interactions and patterns evaluated. This is a quantitative technique that is able to operate with small case samples and avoids some of the difficulties of using statistical techniques in qualitative research (Ragin, 2008; Ragin & Byrne, 2009). The technique relies on assessing the degree of membership of cases to the defined set of interest in a considered process, termed 'casing'. In this study the primary set of interest is the set of rich valuation practices for each of the identified themes in the template. We followed a methodology on casing for investigating social phenomena at the micro level (Basurto & Speer, 2012), with definite set membership defined as 1, definite non set membership was defined as 0 and the transition point of equipoise between in and out was 0.5. We used this technique to classify the richness of valuation practices for each of the themes within these cases, and aggregated these to capture an overall representation of the quality and style of valuation performance for each case. From this vantage point we undertook a qualitative evaluation of valuation performances across CPA case reviews.

3.5. Findings

The first key finding was that a great deal of variation was found across cases as to how valuation practices were manifest. The first question was to consider how much of that variation was due to variation in the quality of the practices that were enacted and how much was due to different approaches and emphases across the different reviews. In this context we identified a set of core practices that were enacted within the case reviews, to a greater or lesser extent. We consider these sets of practices in turn before reporting on how different combinations of these practices were enacted for groups of cases.

3.5.1. Rich Picture of Clinical Status

The most prominent practice was the portrayal of the current status of the patient against the main thematic headings. The current status could be represented by a professional description of say symptoms, function, behaviour and so on at the present time of the review. From the thematic sub-themes we were able to identify a range of quality in this practice. The richer descriptions were able to go into some detail across all the main thematic headings, providing breadth and depth to the portrayal. In addition, in some cases such a report was underpinned by a more structured, systematic methodology. Some cases deployed a structured, reporting tool. For example one commonly used tool was the Recovery Star (MacKeith & Burns, 2008) which provides for a holistic set of headings around symptoms, function and wellbeing against which the service user and key nurse can together rate their current status. However, there were no set formats for deploying structured assessments across cases. There was clear range to the extent to which structured evaluative tools and frameworks were used. Therefore, there was a practice dimension of presenting a rich picture, with the richest pictures including breadth and depth of description and some form of structured assessment. Drawing on fsQCA as outlined above, each case was assessed and assigned a degree of set membership for the quality of the status report we elicited and the quality of structured assessment support that we identified. Figure 3-1 displays the degree of rich set membership for the quality of the status assessment and the structured reporting. A score of 1 is the perfect case, the best cases in our sample reached a threshold of 0.8 for either status report or structured assessment. This was judged a reasonable threshold for good practice, and 9 out of the 20 cases met this criterion. Obversely it can be seen that 3 cases (cases 1, 6 & 14) were found to exhibit a particularly limited rich picture. One case (19) was unusual in presenting a particularly rich picture for a quite narrow area of interest. In subsequent analysis we aggregate these two elements as permitted by fsQCA methodology to form an integrated variand of ‘Providing a Rich Picture’.

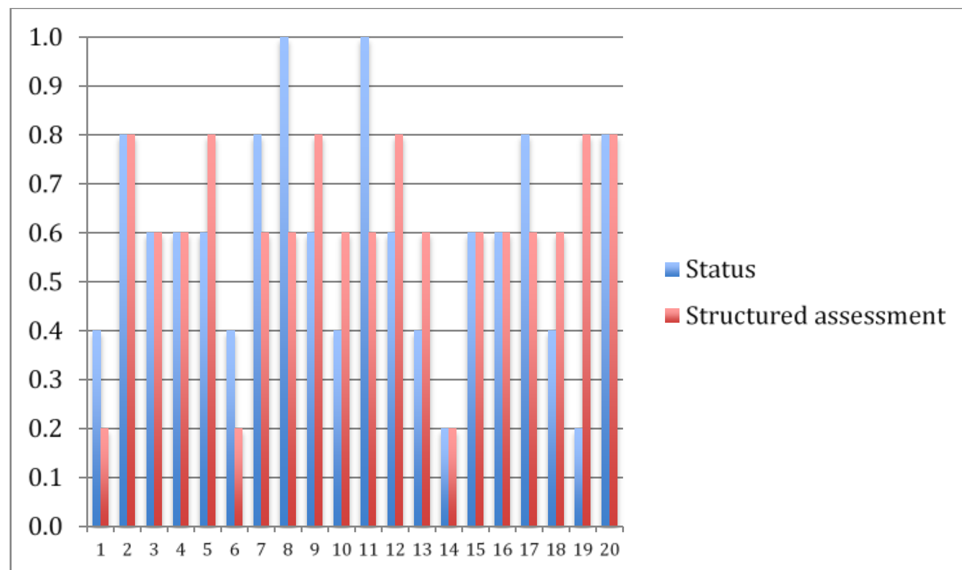

Figure 3-1 Chart of fuzzy set membership for rich practices in representing current status and structured assessment in CPA case reviews

3.5.2. Elicitation of Progress

The next practice we identified was the elicitation of progress since the previous review. Again this was found to vary in quality across cases. Some reviews did not elicit progress at all, others were either limited in breadth or depth. The richest practice demonstrated a systematic elicitation of progress across a wide spread of themes, supported by structured tools and identification of change. Again drawing on fsQCA, as above, we classified cases with a fuzzy set score to reflect set membership of the richest set of elicitation of progress, with 0.8 judged as the threshold for good practice. Figure 3-2 demonstrates that 7 out of the 20 cases reached this threshold. Meanwhile, taking 0.4 as the threshold for absent or rather limited elicitation of progress, 8 out of the 20 cases lay within this category.

3.5.3. Reflection

It was interesting to note (Figure 3-2) that in 7 out of 20 cases we were able to identify a clear practice of attending to the status and progress reports, linking the data to a working theory and reflecting on the findings. For 8 cases there was very limited or no reflection apparent.

3.5.4. Patient Involvement

The practice of involving the patient in the valuation process was a cross cutting theme that also emerged. There were varying levels of eliciting the patient view on status, progress and decision making across the cases. This practice was also cased for reaching the threshold of good practice using fsQCA, as shown in Figure 3-2. Seven cases could be categorised as having a good level of patient involvement in the valuation process, meanwhile 9 out of 20 cases (<0.4) could be categorised as definitely limited in this regard.

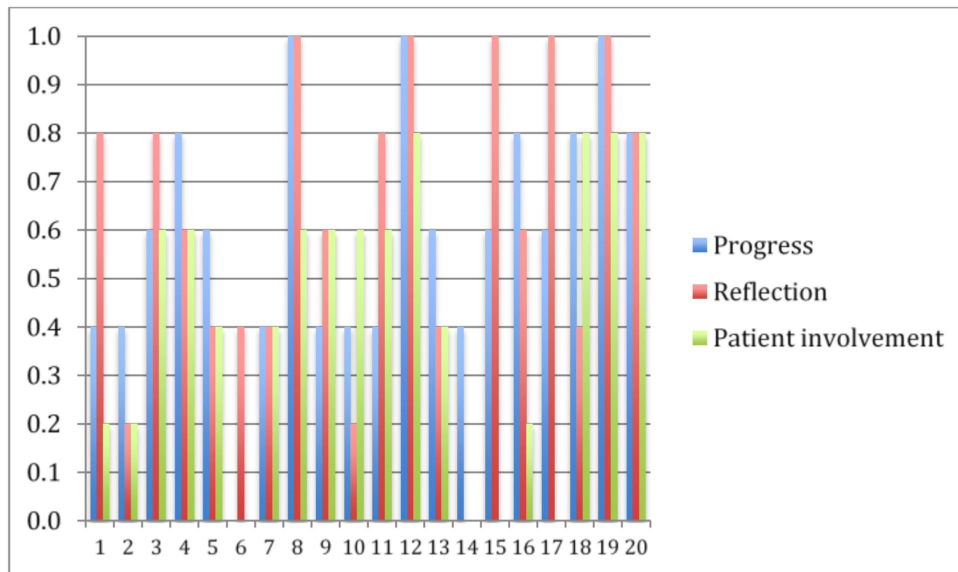

Figure 3-2 Chart of fuzzy set membership for rich practices in representing progress, reflection and patient involvement in CPA case reviews

3.5.5. Reflection Decision Made on Progress or Not

A further additional practice that we identified was the clear formation of the view that either progress had been made or not. In other words, in some cases there was a definite decision taken on this, but in other cases either no consideration was given to this, or a range of more equivocal inferences were made which did not amount to a decision. In Figure 3-3, 7 out of 20 cases provided a strong direction on whether progress was made or not. Meanwhile, 6 out of the 20 cases could be classed as not deciding whether progress had been made or not in the review, with the remaining 7 cases presenting a more ambiguous position on progress.

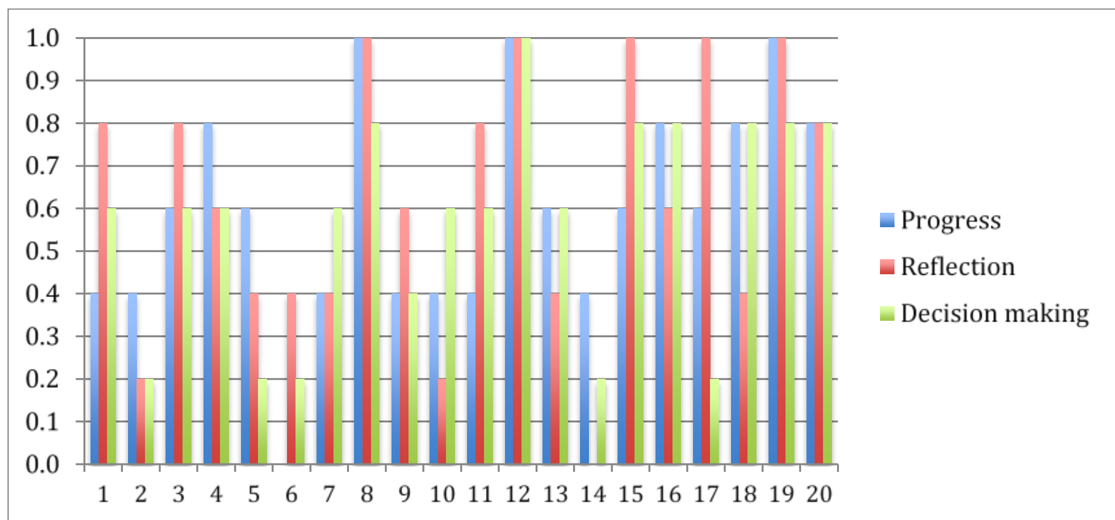

Figure 3-3 Chart of fuzzy set membership for rich practices in representing progress, reflection and decision making in CPA case reviews

3.5.6. Assembling Valuation Practices

We have identified 5 areas of practice which are being performed in case reviews, as evident in the CPA documentation. There is variation to the richness of practice for each of these across the case series. FsQCA is an ideal technique for this small sample size to investigate further how these 5 variations ('Variands') interrelate (Ragin, 2006). By exploring the subset relationships between these variands using QCA techniques it is possible to explore whether there are particular combinations of rich valuation practices found within the sample that are distinct, or whether all these practices are different aspects of a generic valuation process being enacted with greater or lesser quality. In other words are there simply just good quality reviews and limited quality reviews.

3.5.7. Crisp Set Analysis

In order to focus on combinations of rich practices we first converted our table to crisp sets. From our calibration we have determined that a fuzzy set score of greater than 0.8 counts as definitely rich practice. Therefore, instances of 0.8 and 1 in our data set can be represented as 1, below that would be 0. There may be instances where some degree of rich practice is lost by this conversion, but it also

reduces the impact of limited quality reviews. As described by Rantala & Hellström (2001), QCA can help explore the hermeneutic characteristics of data for potential patterns of interest. Using this approach we charted the crisp set data onto a set plot where we could consider whether there were particular clusters of practice. We considered groupings of 3 cases or more as of potential interest, since Fiss (2011) suggests this as a reasonable cut off when looking to more detailed analysis. In the resultant plot we identified clusters of practice that fit our criterion (Figure 3-4).

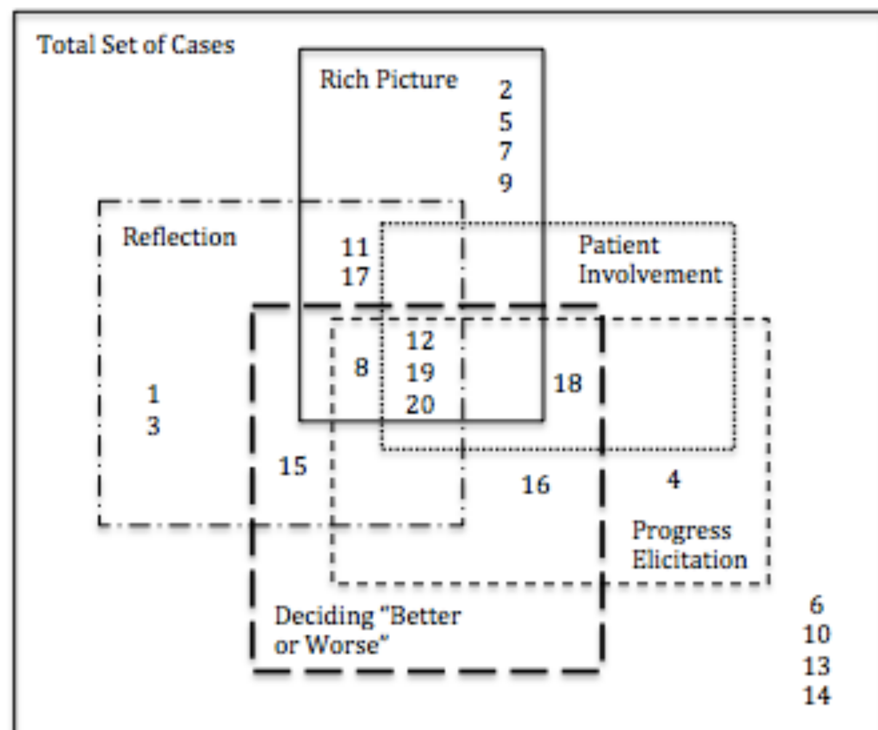

Figure 3-4 Set Plot of Crisp Set Membership of Rich Valuation Practices across the Set of CPA Case Reviews

First there was a clear cluster of 4 cases that lay outside the plot altogether, and these were left out of further analysis as being overall more limited reviews. Therefore, there was a cluster of 16 cases that exhibited a rich level of valuation in a least one practice area.

The next cluster was found where all areas of practice were richly enacted (Cases 12, 19 and 20), and leaving aside patient collaboration a further case can be

included (Case 8). Thus, there can be said to be four cases for which there was a broad integration of several rich practices.

A further cluster was the portrayal of a rich picture of the patient status, with either no interaction with any of the other areas of practice (Cases 2, 5, 7 & 9), or as a combination of rich picture and reflection (including Cases 11 & 17). A rich picture view on status was treated as an aggregation of a broad detailed and methodical status report and the use of structured assessment tools. The calculated fuzzy set coincidence is 0.76. For the cases concerned (2, 5, 7, 9) the fuzzy set scores showed that status report and use of structured tools were closely aligned. Therefore, there does appear to be a cluster of valuation practice (n= 6) that concerns itself simply with presenting a rich picture as an end in itself.

Remaining cases were found to be prominent in some combination of a number of practices. Therefore from this analysis we find that there is an overall set of cases where some level of rich valuation is being enacted (n=16). Within that set there is small set (n=4) where there is clearly rich integration of many practices being enacted, and a set (n=6) where the developing of a rich picture appears to be an end in itself.

3.5.8. Configuration Analysis

In order to investigate further whether more complex combinations of practices could also be meaningfully described we drew on the argument from service design thinking that makes a distinction between problem-solving, in which the desired state of affairs can be known (i.e. “Better or Worse”), and “a process of enquiry during which meaning is constructed with diverse stakeholders” (Kimbell, 2011, p49). We have therefore explored our data first as a problem orientated process leading to a valuation decision (“better or worse”) and secondly as orientated to the elicitation of progress as representing an end in itself for learning purposes. We have also explored our data as not leading to a decision or not leading to the elicitation of progress, as a way of triangulating our analyses.

We investigated these potential combinations with a configuration analysis of fuzzy set membership using fsQCA, as outlined by Fiss (2011). We followed Fiss in using a cut off for at least 3 cases per combination in the truth table analysis. Cases of the outcome are coded at a threshold consistency judged by the

researcher, but usually within the range of 0.75 (Ragin et al, 2008) to 0.95 (Fiss, 2011). Solutions are calculated in two forms, a parsimonious solution and an intermediate solution. As Fiss, indicates the parsimonious solution provides for a more constrained set of inclusion assumptions for the presence or absence of conditions in the underlying set logic used to calculate solutions compared with the intermediate solution. It is not intended that fsQCA makes an absolute determination, rather it provides structured boundaries to what might reasonably be inferred as meaningful combinations. In that spirit a condition that appears in both the parsimonious solution and the intermediate solution is considered to be a core condition. Conditions only appearing in the intermediate are playing a part, but are more peripheral conditions. Conditions that don't appear at all are not likely to be relevant, which is itself informative. A solution consistency of 0.95 is usually taken to be robust (Fiss, 2011).

Table 3-2 reports the result of the configuration analysis where the problem solving outcome is the practice of making a decision on "better or not". In this analysis there was only one solution provided, but the consistency of the outcome was high (Cut off 3, Consistency 0.95, n=16). Taking the intermediate solution, there can be a high level of confidence in the important role for the various valuation practices in combination in the process of deciding "better or not" (Coverage .59, Consistency 0.97). From the parsimonious solution though, it can be seen that it is the involvement of the patient that forms the core practice in arriving at this outcome (Coverage 0.73, Consistency 0.95). Both versions are well within the levels of confidence used by Fiss.

Meanwhile, if eliciting progress is considered as the outcome in its own right, the picture changes to one where there is again only one solution (Cut off 3, Consistency 0.94) but with a configuration of a rich, structured status report along with reflection forming the key practices (Coverage 0.72, Consistency 0.95). Reflection appears potentially as a core condition, although the relatively low consistency might be a challenge. Interestingly, the participation of the patient was not a relevant condition. This configuration might then represent professional reflection and learning.

Configuration	Solution for Reaching a Decision Cut off 3, Consistency 0.95, n=16		Solution for Eliciting Progress Cut off 3, Consistency 0.94, n=16	
	Parsimonious	Intermediate	Parsimonious	Intermediate
Status		•		•
Structure		•		•
Progress		•	N/A	N/A
Reflection		•	●	●
Patient Involvement	●	●		
Raw coverage	0.73	0.59	0.89	0.72
Unique coverage	0.73	0.59	0.89	0.72
Consistency	0.95	0.97	0.82	0.95

Black circles indicate presence of a condition. Large circles indicate a core condition and small circles a peripheral condition. N/A is not applicable. Blank cells indicate not relevant.

Table 3-2 fsQCA Configurations for Making a Decision and Eliciting Progress

It is instructive also to consider whether there are configurations characterised by the absence of outcomes. Table 3-3 repeats the configuration analyses with the absence of making a decision (Cut off 3, Consistency 0.95) and the absence of eliciting progress (Cut off 3, Consistency 0.94) as outcomes. Both analyses provide a single solution. For not making a decision, there is potentially a modest role for all the other conditions, except for an absence of patient involvement (Coverage 0.74, Consistency 0.79). Although the consistency level is low, it supports the importance of patient involvement as a key practice in a decision making configuration. Also, the analyses provide evidence that valuation practices identified are involved in more than just a decision making progress. Although not as robust, the analysis for not eliciting progress reinforces the proposition that a process involving professional reflection, that excludes patient involvement, is in operation (Coverage 0.63, Consistency 0.81).

Configuration	Solution for Not Making a Decision Cut off 3, Consistency 0.95, n=16		Solution for Not Eliciting Progress Cut off 3, Consistency 0.81, n=16	
	Parsimonious	Intermediate	Parsimonious	Intermediate
Status		●		●
Structure		●		●
Progress		●		N/A
Reflection		●	ⓧ	ⓧ
Patient Involvement	ⓧ	ⓧ		ⓧ
Raw coverage	0.94	0.74	0.63	0.63
Unique coverage	0.94	0.74	0.63	0.63
Consistency	0.69	0.79	0.74	0.81

Black circles indicate presence of a condition. Circles with a cross indicate its absence as a condition. Large circles indicate a core condition and small circles a peripheral condition. N/A is not applicable. Blank cells indicate not relevant.

Table 3-3 fsQCA Configurations for Not Making a Decision and Not Eliciting Progress

In summary, a rich picture, consisting of status and structuring of information provides a common stem to a process of decision making on “better or worse” that involves patients, and a process of professional elicitation of progress and reflection without patient involvement.

3.6. Discussion

This study highlights that case management reviews provide an opportunity for making value. In our sample of CPA case management reviews in a UK learning disability care setting it was apparent in 16 out of the 20 cases we explored that there was at some level a rich enactment of valuation practice evident. This provides an opportunity to consider in more depth value creation in healthcare through a valuographic lens. Further, in this discussion we reflect on the

differences we found across cases from this perspective and we develop inferences for healthcare improvement and value creation theory.

3.6.1. The Making of Value

In developing our template we were guided by value based healthcare literature to identify themes that are considered important in healthcare. It is to be expected that this bestows a number of embedded assumptions, and that others might propose competing themes to consider. However, within this particular framework we were interested to know how "what is important" was enacted. To that end we did discover a set of practices that when assembled could be represented as particular styles of making value (Table 3-4). As indicated above, some theorists argue for a two-step process of value creating (valorisation), followed by an evaluation (Vatin, 2013). Dussauge et al (2015) argues rather for the assembling of practices to make value as a more integrative phenomenon. We were able to identify both these patterns within our sample, but with some qualification.

First for the simple style, developing a rich picture, we consider that this sets the stage for the CPA case review itself to be a place where collective value is made. In our sample we found that this first step was a common stem for the other styles of valuation that we found. However, we are left to explain those cases that were represented by the display of a rich picture and no more. One explanation is that this was a study of documentary evidence, so it might have been that the further step of collective evaluation took place in the review, but was not documented. Alternatively, it might be that a simple evocation of the state of play at a point in time for stakeholders to appreciate and evaluate privately can be sufficient. A further possibility was that whilst CPA case reviews are themselves collective value creating opportunities, not all reviews developed that potential.

Contrasting with the simple style, both the results orientated style and the professional learning style appeared to more clearly represent a collective value making process. For the results orientated style the nature of the valuation was whether the patient was "better or worse". From a service eco-system perspective this win/lose outcome proposition would also have currency for the wider service system (Spohrer & Maglio, 2008). There is a lot riding on whether patients are making progress or not in healthcare. For the professional learning style, the

valuation was in terms of the meaning and understanding of what was clinically working or not, which contributes to the further evolution of the clinical care strategy. Interestingly, the results orientated style was notably dependent on patient collaboration (*valuation with*), whilst the professional learning style was *valuation of* the patient, without patient collaboration. This distinction will be discussed further below.

Valuation Style	Description	Approach to Stakemaking (cf. Kimbell, 2011)
Integrative Style	Collaborative and multimodal enactment of all practices	Collaborative problem solving *with* patients, plus possible design for service.
Simple Style	Descriptive practice only	Precursor for any approach
Results Orientated	Sequence of practices leading to “better or not” decision, with patient collaboration as key	Collaborative problem solving *with* patients
Professional Learning	Focus on progress elicitation and reflection, without patient collaboration	Product design *for* patient.

Table 3-4 Description of valuation styles discovered in CPA case reviews, with links to Kimbell’s (2011) framework of design approaches

It might be thought that the evocation of a process of capturing that current state of play and its subsequent evaluation would lend support to the valorisation-evaluation model. Overlaying a linear process is one way of making sense of patterns and configurations in data. QCA and configuration analysis does not necessarily imply a deterministic process within patterns. It is the investigator that brings such assumptions to bear. In the results orientated style and the professional learning style this was a natural assumption to make. With the

integrated style, however, there was a more complex, rich integration of all forms of valuation practice discovered. With a strong emphasis on the patient perspective, reflection and learning, as well as decision making, the making of collective value here closely fits that of a collaborative performance amongst stakeholders, as envisaged more recently in the literature (Ballantyne et al, 2011).

3.6.2. Stakeholders and Underlying Value Registries

From our findings, it would appear therefore that there are a range of ways in which service valuation might be manifest, from simply articulating a rich picture, to a process of valorisation and evaluation and to a collaborative performance. Comparing across these styles enables us to identify the role of underlying value registries in use and relationship with stakeholders as important factors in how value emerges.

Value registries capture “what is desired”. Meanwhile, the process of stakemaking is seen by Dussauge et al (2015) as a key component of valuation practice. The valuographic literature is at an early stage in envisaging frameworks to capture these themes in empirical work. We do see there as being a natural alignment however between how value is made and service design literature. In this context Kimbell (2011) argues that for service design there are two areas of tension to consider. The first is the tension between the desire for problem solving and the desire for understanding and meaning. The second tension Kimbell proposes is between service as (goods-like) providing a product for customers and service as collaborative exchange with customers (cf. SDL: Vargo & Lusch, 2004). This provides some help in being able to structure the underlying value registries and the approach to stakemaking in our data. From this vantage point it can be seen that each style represents a different balance of emphasis between engineering and design, and between passive and active involvement of stakeholders as envisaged by Kimbell (Table 3-4). Thus, the results orientated style is problem-solving orientated, but with emphasis on collaboration. The professional learning style emphasises understanding and design for patients. The integrative style does also emphasise collaborative problem solving, but also includes a component of collaborative understanding. The simple style however is harder to interpret in this way.

Kimbell's (2011) framework also describes "design for service". Here what is desired is a collaborative platform for engaging stakeholders in a shared understanding from which future action can be developed. It would be interesting to investigate further whether the integrative style shared some of these features. It would also be interesting to widen the enquiry to consider whether through interactions in case reviews (beyond the documentary reality) the network of service participants engaged with the simple, rich picture to construct such a design for service platform. This would introduce a helpful way of viewing the process of stakemaking in the value making process, and introduce 'platform making' as a new kind of service outcome to be considered as an important outcome for the case review process.

3.6.3. How it might be otherwise

In this valuographic exploration we have highlighted a number of themes for further consideration. It is important to note that in activating these themes we have applied a number of different views to the sample data. There may well be themes that we have not highlighted that could also be interesting. Moreover, the styles of valuation that we describe are not necessarily exclusive, there could well be elements of overlap within cases. The purpose of this inquiry in surfacing key valuation styles and comparing across cases has been to pose the question as to how it might be otherwise. Dussauge, Helgesson & Lee (2015) argue for a range of responses to cross case comparison findings.

It was striking to note the degree of variation across cases and between cases within a sample from a single health provider organisation. The healthcare management implications are considered further below. However, it is clear that there is scope to consider ways of further cultivating valuation practices. On the one hand, there were four cases where there was not strong evidence for collective value making in the care process at all at the review. On the other hand, there were 3 cases that notably engaged in a particularly broad, rich valuation process. Therefore in the first instance, drawing inspiration from these rich cases poses the question as to how it might be otherwise for those other cases where collective value making was less evident (Dussauge, Helgesson & Lee, 2015).

Further, by eliciting a range of co-valuation styles we open the question as to whether different styles have different advantages. It was beyond the scope of this paper to determine whether empirically different styles have particular advantages in terms of objective measures of health outcome at this stage. It may be in fact that different styles might have applicability at different times. For example, the cases with less emphasis on patient collaboration may be a function of their level of wellness at the time of review, in which case the professional learning style would be appropriate. Nevertheless, it is also important to consider whether in some cases there might be an opportunity to further nurture patient participation, or to rebalance the emphasis to better incorporate the perspective of patients and other stakeholders in some cases. These strategies further mirror those suggested by Dussauge, Helgesson & Lee (2015) as arising from valuographic study insight.

With regard to rebalancing in particular, this study is based on the documentary reality of CPA case reviews. It can be imagined that additional interactions occurred in the review discussions, and outside the review, that were not recorded, but which might also be relevant. However, as far as these reviews were concerned, the variation to the quality of collaborative input from patients poses questions specifically about rebalancing of “stakemaking”, as Dussauge, Helgesson & Lee (2015) would envisage it. It might be further noted that others who were not evidently such active contributors, such as family and commissioners might also be viewed as important stakeholders. The constellation of stakeholders close to the service process, patients, family, clinical professionals, commissioners and so on, can be thought of as a unique service delivery network (SDN) for each case (Spurrell, Araujo & Proudlove, 2018). Network context is a key aspect of value creation in the literature (Edvardsson, Tronvoll & Gruber, 2010). Therefore, a further dimension to interact with the collective making of value would be to consider the role played by the particular SDN context. An exploration of the interaction between valuation style and SDN in the optimisation of making value would be important further investigation.

3.6.4. Patterns of Practice Inform Healthcare and Extend Value Creation Theory

The advantage of exploring healthcare is that at its best it exemplifies how a combination of service practices can support the flourishing of an individual service user. It is a natural series of experiments, rooted in a long tradition of practice and thought. On the other hand, where outcomes are not as hoped for, conceptual frameworks from contemporary service thinking are increasingly proving valuable routes to improved understanding. From this study we can both inform healthcare practice improvement, and critique the application of value co-creation as it has been previously been conceptualised.

For healthcare, our finding of marked variation between cases on practice performance in CPA case reviews adds to concerns already expressed in the literature on the functioning of CPA in England (Simpson, Miller & Bowers, 2003a; Simpson, Miller & Bowers, 2003b). A similar marked variation was found for service delivery network functioning in CPA case reviews in an earlier, related study (Spurrell, Araujo & Proudlove, 2018). First, this suggests that our sample's variation represents a common phenomenon in CPA case review practice, and quite possibly in case management review more generally, accepting CPA as a good exemplar of case management (Goodwin & Lawton-Smith, 2010). Second, we agree with others that there is a need for the development of concepts and frameworks to better capture and explain case management functioning in healthcare (Goodwin & Lawton-Smith, 2010).

A particular contribution we make in this investigation is that variation is not just a function of quality of the review process, but also a function of adopting different valuation styles within the stakeholder context. The present dominant focus of healthcare improvement is to look for standardisation across healthcare practices. Whilst this is no doubt important, Swinglehurst et al (2014) have argued that a degree of customisation of practice to particular cases is also required. Therefore it is important to recognise and classify styles of interactions as a part of the health improvement agenda with a view to better understanding how to optimise outcomes. We would see our 'co-valuation styles' as a similar feature to the co-creation styles that were elicited by McColl-Kennedy et al's (2012) study of a different aspect of service functioning. As indicated above there may well be good

reason for it to take time to build up the confidence of patients and other stakeholders to be able to collaborate as fully as might be liked, therefore there may be a process of maturation of style to be supported as care progresses.

For value creation theory, we have argued that the trend to limit conceptualisation to value co-creation misses out an important further step in being able to frame healthcare, and other complex service environments. The emergence in our study of styles of collective value making (‘co-valuation’), echoing earlier work on styles of value co-creation (ibid), highlights the need to span the individual-collective boundaries in capturing service exchange. There appear to be two possible routes to link this insight with the literature. First it might be that what is being captured is simply a further step in a linear process of value creation, providing a richer view of the follow-up phase of the service encounter experiences described in Payne, Storbacka & Frow’s (2008) process model of value creation management. Alternatively, there are reasons for seeing value co-creation and co-valuation as continuous related, but parallel processes. This would rather match the value network perspective (Norman & Ramirez, 1993), and perhaps provide some structuring to how the making of value might be enacted across the micro-macro levels in the service eco-system model that is currently gaining prominence (Frow, McColl-Kennedy & Payne, 2016; Akaka, Vargo & Lusch, 2013).

3.7. Conclusion

In this study we have taken steps to bridge the gap between the proposed importance of value based healthcare, and how the making of healthcare value might be enacted in practice in a Learning Disability care setting. From this valuographic perspective we have highlighted that case management reviews in healthcare can be opportunities for service valuations. From this vantage point a collective assessment of value can be made available for service adjustment and service management purposes. In this context, we have extended other work that shows that there is a notable degree variation in case management practice in mental health and learning disability care in England. However, we have demonstrated that at the case level there are different co-valuation practice styles

being enacted, which need taking account of when considering practice variation. We would argue that different styles of co-valuation may reflect different stages of care evolution and the different valuographic perspectives prevailing amongst service participants. The relationship between co-valuation style, the service network interactions and the emergence of optimal valued outcomes are important themes for future research.

In adopting this valuographic perspective we have raised important questions for contemporary value creation theory as it has been applied in healthcare. We argue that whilst there has been attention paid to value creation as uniquely determined by the beneficiary, theoretical models need to also take more account of how collective value is made. From our findings there might be merit in seeing a final step of 'evaluation' as part of a value generating process. Alternatively, private value creation and collective valuation might be separate but interactive processes to be modelled together more holistically within the service network context. This is an important distinction that can usefully inform further service research and service design. It has very practical implications for making case level service experience more accessible for healthcare management and improvement.

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Chapter 4: Paper 3

This paper is a draft. The abstract was submitted and accepted for presentation at the Frontiers in Service Conference, Austin, Texas, USA, September 2018.

It is co-authored with my two supervisors. I am first author and wrote the paper and originated the ideas. My co-authors critically reviewed drafts and helped shape the version.

The version included in this chapter is intended to be for further revision with a view to a formal journal submission.

The Complex Case Management Framework: Structuring the Relationship Between Stakeholder Activation and Value Realisation in Complex Healthcare.

Abstract

A challenge for supporters of value based healthcare, is the need to develop a framework that supports and optimises practice where there are multiple participants and complex needs. The widely respected Chronic Care Model (CCM) does not fill the brief. The aim of this paper is to develop the conceptual groundwork from relevant service literature to better refocus the chronic care model (CCM) for framing complex case management. A provisional complex case management framework (Complex CMF) was proposed, which was tested in an exploration of a series of complex case management reviews in a learning disability hospital setting. The exploration highlighted a complex relationship between stakeholder activation and the process of value realisation in case reviews, which are key ingredients to be integrated for valued outcomes. Referencing further service literature, additional ingredients were highlighted which related to the structuring of the service process, and the proposed Complex CMF was revised accordingly. This revised framework sets the stage for local service care platform co-development to meet individual case requirements. This is associated with offering a more sophisticated perspective on assembling valued outcomes in local service practice. These contributions are a focus for further research.

4.1. Introduction

There are calls for the appropriation from the service literature of better service platforms or frameworks to support complex healthcare and its case management (Bohmer & Lawrence, 2008; Batalden et al, 2016; Nolte & McKee, 2008). In this context, there has been movement to adopt the making of value as a powerful organising idea in healthcare (Ciasullo et al, 2017; Porter, Pabo & Lee, 2013). The term 'Value Based Healthcare' (VBH) is most prominently used, associated with Porter and colleagues (Porter, Pabo & Lee, 2013; Porter, 2010; Porter & Teisberg, 2007), and can be underpinned by a 'service dominant logic' (Vargo & Lusch, 2004; 2008; 2016; Ciasullo et al, 2017). There is further work that proposes the importance of the collaborative space as a focus for value generating interactions (Spurrell, Araujo & Proudlove, 2018; Grönroos & Gummerus, 2014), and that a study of valuation practices from a valuographic stance might be helpful (Spurrell, Araujo & Proudlove, 2017, Dussauge et al, 2015; Dussauge, Helgesen & Lee, 2015). This appropriation of service thinking potentially transcends public-private sector considerations (Vargo & Lusch, 2011; Hardyman, Daunt & Kitchener, 2014), and holds out promise of engendering more sophisticated relationships with service users and their carers (McColl-Kennedy et al, 2017; Frow, McColl-Kennedy & Payne, 2016; Hardyman, Daunt & Kitchener, 2014; McColl-Kennedy et al, 2012). The rhetoric sounds good. The question this work seeks to explore is how to develop this 'value based healthcare' approach in practice into a service framework that works for particularly complex healthcare service settings.

The Chronic Care Model (CCM; Wagner, 1998; Wagner et al, 2001) provides a useful starting point as the most widely used framework for supporting case management currently (Nolte & McKee, 2008). The CCM is core to the influential concept of 'The Medical Home' which is seen as paving the way to better, more personalised care (American College of Physicians, 2005). The CCM takes important steps in refocusing care away from acute procedures provided for patients to collaborative practices with patients over longer courses of illness. The CCM adopts the stance that the quality of activation of participants in the service process leads to service outcomes (Wagner et al, 2001). This is in keeping with contemporary thinking both in the health and the service literatures (Ciasullo et al,

2017; Frow et al, 2015; Storbacka et al, 2016). However, the focus of the CCM is not on case level practice, and it is on chronic care management, not complex case management (De Bruin et al, 2012; Nolte & McKee, 2008). The distinction is that the former simply refers to the care for single medical conditions managed over long periods. Complex cases are also longer term, but they include features such as multiple conditions, interplay with social and institutional factors and varying levels of engagement as additional dimensions to be managed (Osborne & Strokosch, 2013). Insofar as it goes, the CCM provides a useful, broad framework that dovetails well with the spirit of value based healthcare. However, zooming in to the specific complex case, there is loss of traction for being able to conceptualise and support the specific patterns of practice that are necessary for the realisation of value.

In this context, Batalden et al (2016) reviewed the model from the perspective of service value co-creation thinking (Vargo & Lusch, 2004; 2008). However, we argue that their work does not go far enough in its conceptual work, or with its applicability for the individual complex case. Taking note of Batalden et al (2016), the aim of this paper is to undertake a fresh revision with a view to proposing a revised complex case management framework (Complex CMF). Following the principle established by Wagner and colleagues (Wagner, 1998; Wagner et al, 2001), we investigate the applicability of the Complex CMF by exploring how well it structures the relationship between activated stakeholders and valued realisation in a series of complex case reviews. We subsequently revise the framework and develop a programme of further work.

There are three important elements setting the scene for this study. The first is to define our approach to value and value realisation. There is an issue with the consistency of terminology surrounding ‘value’ (Grönroos & Gummerus, 2014). The most useful approach for the purposes of this study is that ‘value’ is taken to mean that, after the receipt of a service, the service user perceives that they are better off (Grönroos, 2008; Grönroos & Voima, 2012). What is then of concern is to understand the process of ‘Value Generation’, which encompasses the whole system that allows value to be created (Grönroos & Gummerus, 2014). In this context, we have defined ‘value realisation’ to refer to how value is made explicit in

this service process, and ‘valued outcome’ is the representation of realised value that can be seen as having wide currency amongst stakeholders, and others.

The second is to define our approach to the empirical focus of interest when there is not a settled definition of what a complex case consists of. However, within the field of healthcare case management, there is reason to think that the Care Programme Approach (CPA), a case management system operated in English mental healthcare and learning disability services (Department of Health, 1998; 2008), offers a relevant focus of study (Goodwin & Lawton-Smith, 2010). Goodwin & Lawton-Smith also draw attention to this being a troubled area of practice in which the consistency of approach needs attention and for which more research is needed. From this field, the phenomenon of practices within CPA case management review in a specialist learning disability service provides a suitable empirical focus for this study. We follow Spurrell, Araujo & Proudlove (2018) in defining the case level perspective as the service space formed by the intersection of patient, clinician and commissioner stakeholder networks. From this vantage point, this population of cases definitely passes the threshold as being complex, whilst at the same time serving as a meta-theoretic sample from which inferences can be drawn more widely.

The third element is to outline the pragmatic stance that structures this inquiry. A pragmatic mode of inquiry is of increasing interest in healthcare (Pedersen, 2018; Hauge, 2017; Dussauge et al, 2015), and we argue that it is an ideal stance for exploring the development of service frameworks for complex care. Adopting a pragmatic stance, knowledge is constructed in a collaborative, experimental context, as judged by contribution to distinct, practical opportunities (Miller, Fins & Bacchetta, 1996). In the absence of a previously well-developed theory, a pragmatic inquiry is ideal for bringing multiple conceptual resources into play whilst attending to the actual clinical situation (Pedersen, 2018, p.18). The pragmatic inquiry is achieved through two kinds of operations, one dealing with conceptual matters, the other with observations (Hauge, 2017, p.13). Through the fruitful interplay between these domains, the investigator looks to develop a fresh synthesis that offers more adaptive conceptualisations, distinct practical advantages, and which direct attention to further programmes of work (James, 1907, in Thayer, 1982; Dewey, 1938, in Thayer, 1982, p.332). Adopting this angle

within a pragmatic stance is a legitimate option for a case based exploration (Cox & Hassard, 2005).

From the outlined stance, in this study we bring together service literature and healthcare literatures in the context of an empirical study of how value is realised in complex case management. This paper is structured as follows: Following this first section, the second section explores service literature relating to the conceptualisation of value realisation, as it might apply to the complex service setting. The section also explores healthcare literature relating to the CCM in more detail, along with Batalden et al's (2016) revision. This literature also includes relevant parts of the case management literature. From the tensions and possibilities that emerge between these literatures, we propose a possible complex case management framework (Complex CMF). The key features of the proposed framework are that complex healthcare is a multi-party service exchange, with patient, clinician and commissioner networks all having important agency as stakeholders. In each case of complex care, there is therefore a particular stakeholder activation profile that structures the richness of participation in the care process, and that this ought to relate via a process of value realisation to the development of improved valued outcomes.

In the third section of this paper, we zoom in on the service focus of interest, CPA case management review practices. We further refine the focus and introduce the selection of the exemplar case series of complex cases from a particular service specialising in complex learning disability care in hospital. A multiple case based exploration is outlined in which we seek to explore the applicability of the revised complex CMF. We do this by testing the relationship between activated stakeholders and value realisation. Drawing on the proposed framework conceptualisation, we capture stakeholder network activation within the case level service delivery network (Tax, McCutcheon & Wilkinson, 2013; Spurrell, Araujo & Proudlove, 2018). We adopt a valuographic approach to capture value realisation practices in the documentation of case reviews (Spurrell, Araujo & Proudlove, 2017). We then explore the relationship between these constructs within case reviews.

In the fourth section of this paper, with the support of tools from Qualitative Comparative Analysis (QCA), we report a striking level of variation of practice,

both for stakeholder activation and value realisation across the series of cases. There is indeed some inter-relationship between stakeholder activation and value realisation, but we identify that stakeholder activation is not always a sufficient ingredient. There may be a more complex relationship to be understood than suggested by the proposed Complex CMF. We highlight some additional ingredients to consider.

In the final section of this paper we discuss our findings, with the emergent additional ingredients in mind. In particular, through an interplay with emerging conceptualisation on service micro-foundations (Storbacka et al, 2016), we highlight the evolution of the nature of the service exchange over time, and the variety of styles of collaboration and value realisation that are in play, and the different ways these might be integrated from case review to case review over the course of case management process. We highlight that further attention needs to be paid to how participants are structured to interact, reflect and learn, and we consider that the aggregation of these ingredients can be thought of as a service platform within a complex case management framework. We revise our proposed complex case management framework accordingly and set the stage for a further programme of research. This is the first effort to adapt the thinking behind the CCM to mental health and learning disability care. The study makes a contribution in progressing a service framework specifically aimed at supporting complex case management. We make three distinct contributions with this revised framework. We offer fresh avenues for exploring service improvement. We contribute a conceptual framework for developing local complex case focused care platforms for services. Our approach provides a basis for a programme of research to optimise the realisation of valued outcomes for case orientated services.

4.2. Value Realisation in Healthcare Landscape

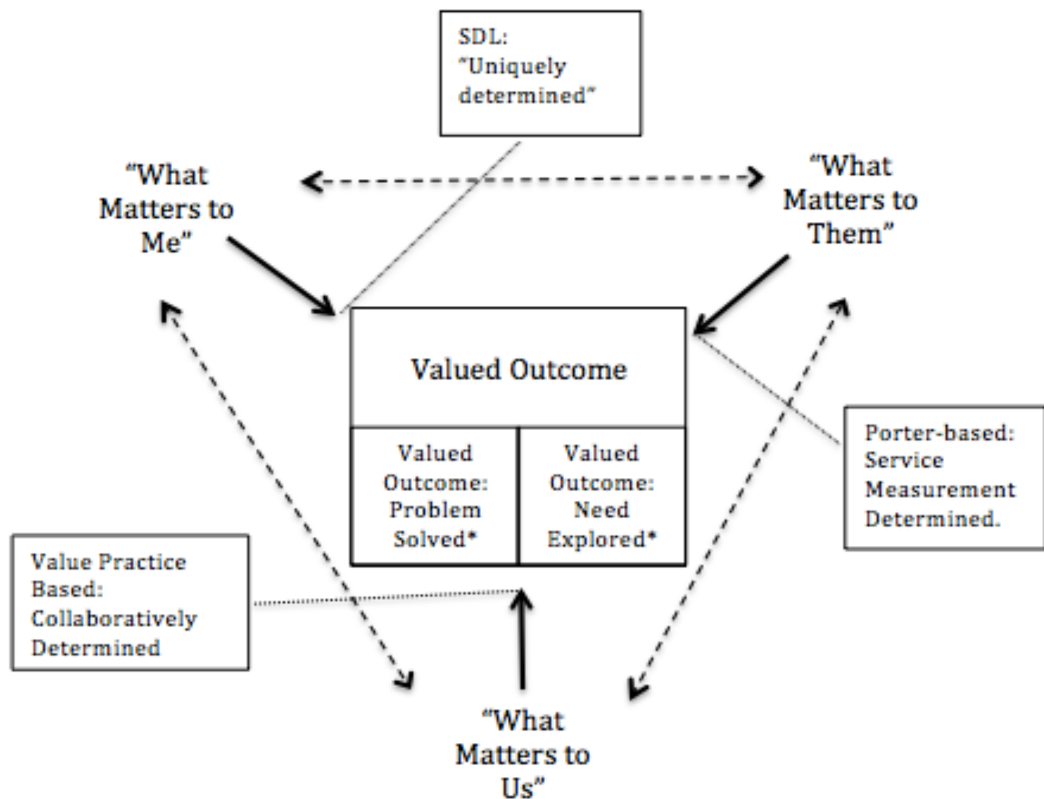
There is a growing interest in adapting contemporary service thinking to support public sector services such as healthcare (Osborne, Radnor & Nasi, 2012; Radnor & Osborne, 2013; Osbourne & Strokosch, 2013;). Although for healthcare this interest has tended not to focus on the micro-level of service, and has been largely conducted conceptually (Hardyman, Daunt & Kitchener, 2014), more recent

empirical work on value co-creation in healthcare has emerged (McColl-Kennedy et al, 2017; Sweeney, Danaher & McColl-Kennedy, 2015; McColl-Kennedy et al, 2012). However, there is yet more work to do. There continues to be conceptual uncertainty regarding the notion of value and value creation (Grönroos & Voima, 2012), and there are concerns as to how the particular care setting studied by for example, McColl-Kennedy et al (2012) might be representative of complex cases in the public health sector (Spurrell Araujo & Proudlove, 2017; Hardyman, Daunt & Kitchener, 2014). Further, along with others (Hardyman, Daunt & Kitchener, 2014; Osborne & Strokosch, 2013; Radnor & Osborne, 2013), the move by Osborne, Radnor & Nash (2012) towards revising the theoretical support for public sector management draws on two particular bodies of work, that of Service Dominant Logic (SDL), associated with Vargo & Lusch (2004; 2008; 2016), and Value Based Healthcare (VBH), associated with Porter and colleagues (Porter, 2010, Porter & Teisberg, 2007; Porter, Pabo & Lee, 2013). These are distinct, contrasting vantage points that capture, respectively, value as uniquely determined by the beneficiary (Vargo & Lusch, 2004; 2008; 2016) and value as measuring the outcomes of treatment that patients most care about (Porter & Teisberg, 2007). Therefore, value associated with SDL has currency for the individual beneficiary, and for VBH value has currency for the wider health care system. Each approach merits further empirical exploration, both in themselves, and when being brought together as Hardyman, Daunt & Kitchener (2014) and others propose (Ciasullo et al, 2017).

From another perspective, the determination of valued outcomes is an exercise in valuation, a valuographic view that is freshly emerging in healthcare (Hauge, 2017; Spurrell, Araujo & Proudlove, 2017, Dussauge et al, 2015; Dussauge, Helgesen & Lee, 2015). By framing value realisation in these terms there is an emphasis on the performative nature of value realisation (Dussauge et al, 2015; Dussauge, Helgesen & Lee, 2015). What counts as valued outcome involves a pragmatic focus on the whole process of making and discovering what matters together. Participants have both a private view of what matters to them, but also through the valuation process represent a public view of what matters to the stakeholder group collectively. We therefore argue that there is an additional, pragmatic perspective in discovering ‘what matters to us,’ ‘us’ being all the direct participants in the care

project in focus. There is evidence that this valuation practice perspective might prove helpful in understanding case level value generation (Spurrell, Araujo & Proudlove, 2017; Hauge, 2017; Dussauge et al, 2015; Dussauge, Helgesen & Lee, 2015).

Amidst these differing perspectives on the notion of value in healthcare, value realisation might be thought of as having two aspects: the value generating system, which different approaches may conceptualise differently, and valued outcome, which is how value realisation is embodied to have currency amongst stakeholders. Figure 4-1 sets out to illustrate this landscape with a view to orientating this exploration.



*In design terms, the realisation of valued outcome can be represented as problem solving or an exploratory enquiry (Kimbell, 2011, p 45)

Figure 4-1 Valued Outcome Realisation in Healthcare

Figure 4-1 represents a particular care project in principle, for which the participant context has yet to be defined. Porter, Pabo & Lee (2013) argue that care is based on a project that encompasses all the relevant participants and is not constrained to a conventional view of health service structure. Porter anchors the concept of value in the phrase "what matters to patients" (Porter 2010, p2477). We therefore have used the phrase "what matters" to help frame the process of value realisation from other vantage points. Three vantage points are described: what matters to the individual service user, what matters to the wider service system, and what matters to the participants in the particular care project ("Us"). Each of these represents a position that gives rise to a distinct valuographic outcome, with different purposes and meanings. As argued by Kimbell (2011) from a design tradition, there is a tension between what matters as solving problems, and what matters as exploring meaning and understandings. Therefore, this represents a further dimension of quality to the value realisation process for each vantage point. Each vantage point will likely interact with and influence others, for example what is meaningful to the individual would be influential in what is seen as important in the wider health system. In this landscape, there are three routes to valued outcome that are represented in the literature, involving what is taken to be value, and how it is constructed.

"What matters to them" aligns with the VBH approach associated with Porter and colleagues (Porter, 2010; Porter & Teisberg, 2006; Porter, Pabo & Lee, 2013). From this vantage point, what matters are health outcomes that can be objectively measured so that they can have currency in the wider health system. A normative framework of what matters to patients is proposed (Porter, 2010, Porter & Teisberg, 2006), and valuation is the process of determining the benefit to the patient relative to cost, in which the patient remains passive (Porter 2010, Porter & Teisberg, 2006).

By contrast, within SDL value co-creation is concerned with a subjective and idiosyncratic vantage point of view (Hardyman, Daunt & Kitchener, 2014). Here "what matters to me" is uniquely and privately determined by the service beneficiary (Hardyman, Daunt & Kitchener, 2014, Vargo & Lusch, 2008, McColl-Kenedy et al, 2012). Other stakeholders are passive in this determination, and there is not a direct link with how this valuation might have wider currency. This

perspective is the remit of the individual case study. Indirectly, wider inferences might be drawn where subjective experience and sense making can be usefully interpreted (Helkkula, Kelleher & Philström, 2012; Jaakola, Helkkula & Aarikka-Stenroos, 2015). Alternatively, wider inferences about value might become accessible through aspects of the service user value creation practices that can be observed (cf. McColl-Kennedy et al, 2012), or through obtaining feedback obtained in the context of a proposed value co-creation model (cf. Payne Storbacka & Frow, 2008).

There is also a collective perspective, which in complex healthcare is the case as a multi-party collaborative project (Spurrell, Araujo & Proudlove, 2018). In principle, this is recognised by Porter and colleagues (Porter, 2010; Porter, 2010; Porter & Teisberg, 2006). It has conceptual support in the services marketing literature (Ballantyne et al, 2011), and as 'a joint sphere' in the value co-creation literature (Grönroos & Gummerus, 2014). Furthermore, in healthcare, particularly in chronic and complex cases, the collaborative space exists as an extended reality for service users and others, where the continuity of care and benefit and response are tightly interwoven constants for all. Therefore "what matters to us" is a necessary consideration as a route to determining valued outcomes, which has so far received little attention in the literature (Spurrell, Araujo & Proudlove, 2017; Spurrell, Araujo & Proudlove, 2018). However, Spurrell and colleagues have argued that such a multiparty service project can be defined as service entity (Freund & Spohrer, 2008), and that a study of valuation practices within such a project offers a means of capturing how the collaborative perspective on value might be realised. It is this collaborative perspective on value realisation that is adopted in the remainder of this paper.

4.2.1. The Chronic Care Model

The Chronic Care Model (CCM) was developed by Wagner and colleagues (Wagner, 1998; Wagner et al, 2001) to address the gap in support for the management of a relatively narrow range of ambulatory, long term conditions in healthcare. There has not been a substantial effort to address the needs of patients with complex multiple conditions (De Bruin et al, 2012), notwithstanding recent exceptions (Sendall, Mccosker & Crossley, 2016). However, Wagner and colleagues (Wagner, 1998, Wagner et al, 2001) were early advocates of the view

that how care was organised was a critical factor for good outcomes. The CCM was developed to reflect that care had to be provided with patients rather than to patients, and that for this to happen there needed to be a system change: “patients must be the pilot” (Coleman et al 2001, p66). On this basis, the CCM proposed that in the context of a supportive framework, productive interactions between activated patients and informed pro-active clinicians would lead to improved health outcomes (Figure 4-2). This framework therefore has much in common with contemporary service literature such as SDL, as outlined above, which seeks to promote a collaborative perspective to the creation of value in public services (Hardyman, Daunt & Kitchener, 2014; Radnor & Osborne, 2014; Osborne, Radnor & Nasi, 2012). Batalden et al (2016) adopt the view that as service concepts have developed, the CCM does not take sufficient explicit account of service as a process of co-production. However, co-production in the service process is only a preliminary step (Grönroos & Gummerus, 2014; Grönroos, 2011). More importantly Batalden et al’s review is not itself orientated to an understanding of the process of value creation, a key axiom for SDL (Vargo & Lusch, 2004; 2008; 2016), and critical to supporting the generation of valued outcomes in healthcare (Spurrell, Araujo & Proudlove, 2017; Frow, McColl-Kennedy & Payne, 2016; Hardyman, Daunt & Kitchener, 2014; Payne, Storbacka & Frow, 2008).

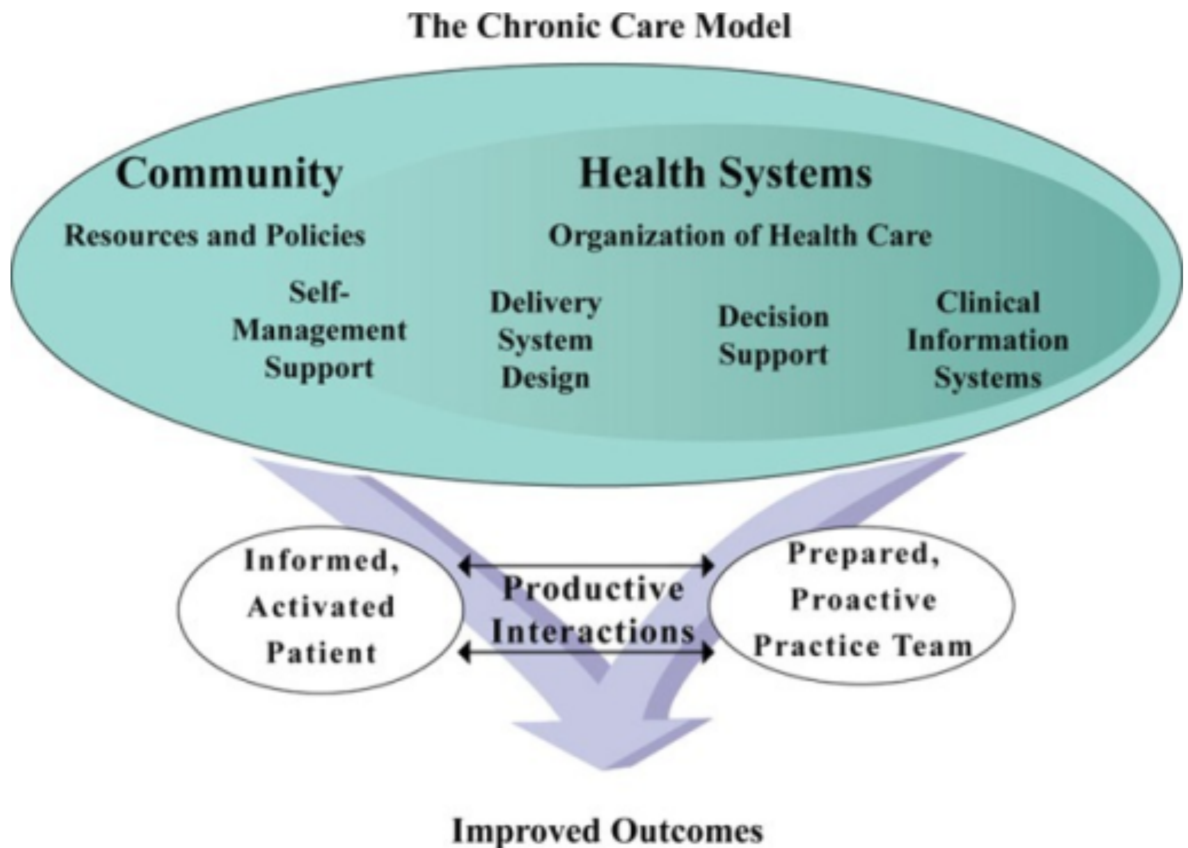


Figure 4-2 The Chronic Care Model (CCM)

Chronic Care Model, developed by The MacColl Institute, © ACP-ASIM Journals and Books, reprinted with permission from ACP-ASIM Journals and Books. First published in: Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Eff Clin Pract 1998; 1:2–4. Sourced https://openi.nlm.nih.gov/imgs/512/41/4941163/PMC4941163_bmjqs-2015-004315f02.png?keywords=chronic+illness,chronic+diseases.

Meanwhile, the CCM also goes on to propose that the service process takes place within the context of a number of additional elements of contextual support. These could be enhanced and optimised to support the service process. Broadly, these contextual elements are grouped as aspects of health system organisation, and aspects of the wider community resource and policy context. These are developed in more detail in subsequent literature (Wagner et al, 2001; Stellefson, Dipnarine & Stopka, 2013). It can be seen, however, that this service context consists of different kinds of elements. On the one hand, there is an engagement with a wider network of other parties concerned to support the service process. On the other hand, there are sets of organisational resources that might be usefully mobilised and used by parties involved in the service process. Interestingly, this mixing of different types of elements to describe context occurs with other

frameworks that are also sometimes used in healthcare, such as 'The House of Care' (Coulter, Roberts & Dixon, 2013). Batalden et al (2016) in their critique of the CCM conceptualise the service context as being at the intersection of patients, clinicians and the wider health system. However, they too carry forward the House of Care view and amalgamate responsive commissioning with organisational processes as a source of agency in the service process. As Grönroos & Gummerus (2014, p218) point out: "Only direct interactions enable co-creation between the actors, such as a service provider and a customer, and form a platform for value co-creation." Thus, whilst non-human interactions can be a resource (Vargo & Lusch; 2004; 2008; Storbacka et al, 2016), it is argued that interactions between actors and interactions between actors and non-human resources should be kept distinct (Grönroos & Gummerus, 2014; Grönroos & Voima, 2013). On this basis, Spurrell, Araujo & Proudlove (2018) propose that for the complex healthcare project, the service context is better defined in terms of the particular participant actors. In line with other work, Spurrell et al suggest that local agency derives from the patient and their network of supporters, the clinician network and a network of other interested parties, which can practically be thought of as the service delivery network (Tax, McCutcheon & Wilkinson, 2015). From this vantage point, the service context could be reframed therefore as the intersection of patient, clinician and commissioner networks (Spurrell, Araujo & Proudlove, 2018).

In practical terms, examination of whether implementing the CCM improves outcomes has led to mixed findings (De Bruin et al, 2012), and may relate to the influence of key motivated individuals (Holm & Severinsson, 2014). In a systematic review its application in US Diabetes management, Stellefson, Dipnarine & Stopka (2013) found that even implementing some elements of the CCM framework was associated with positive clinical outcomes. However, they found that there was far less emphasis on what the right processes should be. It is clear, as it turns out, that the CCM is explicitly concerned with the contextual organisational elements, rather than serving as an operational model for the service process in its own right. In other words, it is "a synthesis of system changes to guide quality improvement" (Wagner et al, 2001, p76). It does not directly support care practice, and expects for there to be practice variation from

organisation to organisation as the local circumstances might determine (Coleman et al, 2009, p81). Its limitation for small scale application has also been noted (Coleman et al, 2009). Again, this particular nature to the CCM is not taken into account by Batalden et al (2016) in their attempt to improve its practical applicability. A fresh perspective that focuses rather on the process of productive interaction between participants to produce case level outcomes, with an understanding of context, would be helpful if care practice is to be more directly supported.

In summary, the CCM makes an important first step in shifting the focus towards health conditions as commonly enduring, and towards more collaborative approaches in healthcare. The core proposition that productive interactions between activated patients and informed pro-active clinicians would lead to improved health outcomes is powerful. However, the core proposition of the CCM is not sufficiently informed by service theory. Moreover, in practice the focus of the CCM has been on the development of organisational resources, rather than operationalising the service process for the assistance of participants engaged in value creation. Despite subsequent attempts to revise the CCM (Batalden et al, 2016), further work is needed to shift the focus to a framework supporting the individual complex case, and the process of value realisation.

4.2.2. Complex Case Management

As stated by De Bruin et al (2012) and Nolte & McKee (2008), only limited attention has been paid to supporting the management of the complex case with multiple conditions and more diverse support needs, as distinct from simply the single long term condition. Another area of literature that pertains to the issue of complex case management, though, is the case management literature. Case management refers to a collaborative, integrative approach to evaluating and planning care (Nolte & McKee, 2008; Lorig, 1993). Although the CCM does feature in the case management literature as one of the modes of structuring care that have been drawn on (Nolte & McKee, 2008), the case management literature represents a much broader purview, and where attention is paid to cases of multiple complex needs (Krumholz et al, 2006). Goodwin & Lawton-Smith (2010) distinguish between two forms of case management approach. The first is a supervisory approach from the vantage point of care commissioners, say, suitable

for more deterministic programmes of care. For more complex, uncertain care, case management takes the form of care co-ordination. These authors see this as a structured collaboration with service users and key stakeholders, (families, clinicians and commissioners), “knitting together” care from multiple sources (Goodwin & Lawton-Smith, 2010, p2). Therefore, service frameworks that support this kind of collaborative care are likely to be of interest in this area. Goodwin & Lawton-Smith (2010) single out ‘The Care Programme Approach’ (CPA), case management in English mental health care, as an area where such a form of case management has been a long established approach with the potential to function as an exemplar for healthcare more widely.

The Care Programme Approach case management system (CPA) was introduced in England in 1991 (Department of Health, 1990; 2008), and it is widely accepted in clinical use (Kingdon & Amanullah, 2005). CPA provides for a named care co-ordinator and for a person-centred process for assessing, evaluating, planning and reviewing patients with complex conditions. Regular case management reviews are held for patients and stakeholders to collaboratively conduct such reviews. All English mental health and learning disability service providers are required to deploy CPA in managing complex conditions. However, CPA has been criticised for a lack of conceptual underpinning (Simpson, Miller & Bowers, 2003a; 2003b), which might explain something of the variation to its implementation in practice. (Carpenter et al, 2004; Rose, 2003; Goodwin & Lawton-Smith, 2010; Simpson, Miller & Bowers, 2003a; 2003b). Therefore, whilst CPA describes the rudiments of a structured process of assembling stakeholders from CPA review to CPA review, it does not provide a framework for capturing how that collaboration should be organised in practice such that it links to value realisation. Taking the impetus provided by the CCM development, there would be an advantage in bringing such a structured framework to bear on CPA case management in English mental healthcare. Meanwhile, this field would also be suitable for exploring the capabilities of such a framework in supporting complex case management more generally.

4.3. Refocussing the CCM: The Complex Case Management Framework

The proposal therefore is to draw on the CCM, the structuring found within CPA case management review process and contemporary service literature to formulate a complex case management framework (Complex CMF) to support case level service practice. In previous work on this theme, Batalden et al (2016) made a helpful contribution in re-framing the service space for care as between patients, clinicians and the wider service system. However as discussed above, the authors do not go far enough with their conceptual development in order to capture the case level vantage point. Furthermore, service is not just about collaboration and coproduction but is also a process of value generation, which Batalden et al (2016) do not develop in their model. We consider the value perspective, before re-examining the collaborative vantage point at the case level. But first we consider framing the complex case as within the case management process.

Taking UK mental health CPA case management as a helpful exemplar (Goodwin & Lawton-Smith, 2010), a key dynamic of CPA case management is the process of assembling stakeholders and undertaking case reviews. Therefore, this generates a convenient recurring focus on the productive interactions between participants, which constitute the essence of the CCM concept (Wagner, 1998; Wagner et al, 2001). The case management review is therefore an accessible window onto the value generating practices that might generate valued outcomes. We argue that a refocused complex case management framework needs to incorporate this iterative review process as key structuring element. Therefore, we propose that the case review to case review process should form the central structure of the proposed framework.

Meanwhile, as outlined above, understanding the generation of valued outcomes needs to be set against the conceptual landscape, as illustrated in Figure 4-1. In various terms, there is convergence on the notion that, in context, value for a service user is seeing themselves as better off than before (Grönroos & Voima, 2012), or framed as delivering what matters to them (Porter, 2014). However, there are different perspectives to how value realisation might be modelled: objective, subjective and pragmatic. There are merits in each perspective. For a

more objective perspective, value based healthcare (VBH) proposes developing normative standards for a condition led population perspective (Porter, 2010; Ciasullo et al, 2017; see also www.ichom.org, N.D.). This brings the advantages of a more objective perspective to determining valued outcomes. However, this perspective does not directly relate to the case level value generating processes. It is reliant on the development of condition specific measures, as yet a work in progress, and does not pay attention to the multi-stakeholder perspective in the process. On the other hand, the subjective perspective can be seen in a series of investigations of value co-creation in health (McColl-Kennedy et al, 2017; Sweeney et al, 2015; and McColl-Kennedy et al, 2012). However, in these studies the realisation of value itself remains a private, subjective concern. Some attempt is made to link behaviours and objective service outcomes (McColl-Kennedy et al, 2012), but this is recognised as a complex relationship to understand (McColl-Kennedy et al, 2017). Further, whilst the authors attend to the co-creation practices of patients, those of other participants are not considered (Spurrell, Araujo & Proudlove, 2017; Spurrell, Araujo & Proudlove, 2018; Hardyman, Daunt & Kitchener, 2014). There is therefore a gap in understanding the collaborative perspective in this approach.

The alternative, pragmatic approach, as indicated in Figure 4-1, draws on valuographic literature (Dussauge et al, 2015; Dussauge, Helgesson & Lee, 2015), and is led by a study of valuation practices found in the complex care setting (Spurrell, Araujo & Proudlove, 2017). Spurrell et al argue that the valuation is the collective performance that combines an understanding amongst parties of both the richness and the style given to the value realisation process, that is particular to the case, but which has the potential to be understood and have currency more widely. The authors draw on design ideas from Kimbell (2011) to structure how styles of value realisation might be captured. Thus, valued outcomes can be represented as a range of co-valuation style and richness of value making practice that can serve a number of stakeholder needs (Spurrell, Araujo & Proudlove, 2017). It is this collaborative focus on value within case reviews that has been incorporated into the proposed complex case management framework.

Finally, to understand the service context as proposed by Batalden et al (2016), the collaborative context to the CCM might be better interpreted as the productive

interactions between patients, clinicians and the wider health care system. As discussed above, there is a problem with blurring the distinction between organisational processes and actor configurations in framing context. We therefore follow Grönroos & Gummerus (2014) in focusing on actor configurations as generating context. Building on other service literature and network literature (Zolkiewski & Turnbull, 2002; Provan & Milward, 1999), Spurrell, Araujo & Proudlove (2018) argue that the service space might usefully be represented as the interface between the patient network (patient, carer, advocates etc.), the clinician network (multi-disciplinary team and other related clinicians) and the commissioner network (the service commissioner and their representatives). This pragmatic assemblage of the relevant constituents is also seen as a key feature for value based healthcare (Ciasullo et al, 2017). In this conceptualisation, other important but more abstract concerns, such as regulatory or organisational matters, are all mediated through the intentionality of the people participating in the care process, acting as agents for these concerns. Therefore, each case review is associated with a particular service delivery network, formed from the participating contribution from each of these stakeholder networks (Spurrell, Araujo & Proudlove, 2018). Meanwhile, in collaborative service exchange, all participants are seen as actors (Vargo & Lusch, 2011). Thus, productive interactions, or collaborative planning, are dependent on all stakeholders being activated in the process. As such, this suggests that the semantic distinction between 'informed and activated patients' and 'prepared and pro-active clinicians' described in the CCM becomes less significant. We argue that what is pertinent is to consider how all stakeholders are activated in the round. In other words, in multi-party exchange such as complex healthcare it is for all stakeholders to be activated participants. Thus, the reformulated complex case management framework is set out in Figure 4-3.

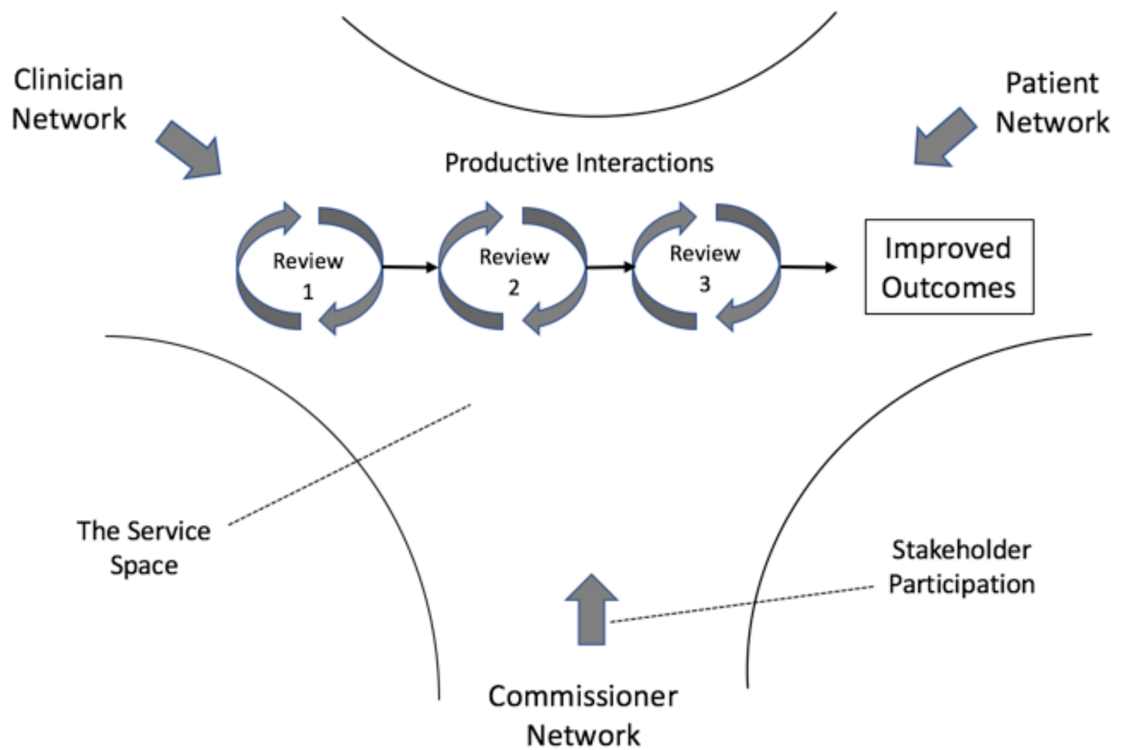


Figure 4-3 Proposed Complex Case Management Framework (Complex CMF)

In summary (Figure 4-3), for complex case management the framework consists of a process of productive interactions from case review to case review. Each review incorporates a process of collaborative value realisation, and over a series of value reviews improved service outcomes might expect to be seen. The service space is defined at the intersection of three key stakeholder networks: patient, clinician and commissioner. It is expected that other important concerns, say of regulations or custom and best practice, are relayed through people within these participating networks. Re-expressing the core idea behind the CCM, it is the participation of activated stakeholder networks, as uniquely expressed in each review, which, through the process of value realisation, leads to the generation of improved outcomes.

4.4. Testing the Complex Case Management Framework

The aim of the complex CMF is to better underpin value based healthcare for the complex case, for example for CPA case management. The framework outlined integrates the process of iterative case review from CPA case management with the concept from Wagner and colleagues (Wagner 1998, Wagner et al, 2001), that there is over time a process of value realisation as a function of stakeholder activation and engagement in the process, which the case reviews reveal. This raises the following questions:

- How well does the framework relate to the empirical experience of complex case management, as exemplified by CPA case review?
- What is the relationship between stakeholder activation and value realisation that is found in this focus of interest?
- From an exploration of these questions, what further elements need to be considered to structure complex case management support?

In this endeavour, there are two particular angles of interest. The first is to understand how to progress from case review to case review, in order, over time, to generate valued outcomes that have wider currency. The second is to understand more about the micro-level value generating processes within the individual case review. These questions scope out a broad programme of research.

This paper undertakes a first pragmatic exploration, aiming to establish an initial level of confidence in this direction of travel and to elucidate some of the important empirical themes to develop further. In the absence of an existing, suitable theoretical framework a pragmatic stance is an appropriate approach to take (Pedersen, 2018; Ansell & Geyer, 2003). We undertake a qualitative exploration of a series of CPA case reviews in a complex learning disability service setting. We adopt the angle that a directed exploration of the relationship between stakeholder activation and value realisation, within CPA case management reviews in a particular service, provides a useful probe for testing the applicability of the complex CMF approach, and for directing attention to better approaches for within case value realisation. The justification for this inquiry, within the pragmatic stance, is that it will generate insight into the applicability of the framework, it will

suggest practical links with other relevant conceptual resources and it will offer distinct practical suggestions for service improvement. Meanwhile, as a result of this process, an outline for a broader programme of research will be proposed.

As a first step, this will be a cross sectional study of the case review phenomenon. We envisage that the longitudinal relationship within the case review to case review process would be a subject of future study, once the framework's applicability in principle had been better understood. In the following section we further set out the methodology and how the concepts of stakeholder activation and value realisation might be captured and compared. We then present our findings for further discussion.

4.5. Methodology

For this investigation, we were able to collaborate with a UK learning disability Healthcare Trust. The Trust provides in-patient mental healthcare to patients with complex needs associated with learning disability and autism. Services are structured into four service areas: care in a medium-secure setting, care in a low-secure setting, a women's service and an enhanced-care (or rehabilitation) service. Patients within the services all have CPA case management reviews at least every six months. All relevant stakeholders are invited to attend and participate in CPA case review meetings. These meetings therefore provide a useful focus for exploring stakeholder activation and value realisation in CPA.

In this study, we have adopted a multiple embedded case study methodology. Using template analysis (King, 2012) we explored the participation practices and the value realisation practices of a systemic, cross sectional sample of 20 cases of CPA case reviews. It is accepted that the focus of investigation can be a defined entity or phenomenon within an organisation (Woodside & Baxter 2011; Yin, 2014). The investigation sits within the theory-building phase of research (George & Bennett, 2005; Christensen, 2006). Approval was obtained from the Trust Research Committee to undertake the study. No direct patient contact was required for the study and the investigation was structured as a service evaluation project and not a clinical study. All records remained confidential and no information was extracted from which an individual patient would be identifiable.

4.5.1. Sample and Data

The sample selected consisted of the first five cases scheduled from each of the four service areas following research approval. This provided a sample to reflect a broad view of CPA across the organisation. As a service-process study, apart from gender and service area, demographic data on patients were not included. For each CPA review, reports are tabled and the attendance and minutes of the meeting are recorded. The data obtained for study consisted of all documentation filed in the electronic case record for the most recent CPA care review for the selected cases. This documentation comprised the minute record of the CPA review plus additional reports tabled by professionals and patients. This was a study of documentation as distinct from oral information or direct observation. Atkinson and Coffey (2010, p.80) argue that, "documentary materials should be considered as evidence in their own right". The construction and conventions associated with documents, in this instance being the official record of the CPA review, are also part of the documentary reality, a version of reality that can be usefully studied. This exploration of the official CPA meeting record with an interpretive approach, supported by the inter-textual consistency across cases, was therefore a valid perspective for investigating the functioning of CPA reviews. The key stakeholders of concern in this analysis are the patient networks, the commissioner networks and the clinician networks as represented in the case review documentation.

4.5.2. The Template

The data obtained from the official CPA documentation was explored using a template analysis (King, 2012). The first step in this methodology is to develop a suitable template, which can be from drawing on relevant literature, by eliciting themes as they emerge in a pilot sample in the data, or from a combination of both. We developed two templates. The first was to explore participation practices as a marker of stakeholder activation, the second was to explore value realisation.

4.5.3. Stakeholder Activation as Participation Practices

In the complex case management framework that we propose, we have adopted the vantage point that the dominant sources of agency in the service process as being the patient, commissioner and clinician networks, in line with Spurrell, Araujo & Proudlove (2018). The patient network included family members, advocates, legal representatives and local primary clinicians (such as social worker or community nurse). The commissioner network included service commissioners, or agents acting for the commissioners. The clinician networks were members of the specialist multi-disciplinary team responsible for the case. We viewed activation in terms of participation practices, represented by evidence of participation in reviews, the structuring of space to encourage participation and evidence of pro-active contributions in the CPA review documentation. Therefore, stakeholder activation as participation practice is the combination of membership of stakeholder network and quality of representation, structuring and pro-active contribution in the review.

Stakeholder Network	Participation practices
Patient • Patient, family, advocate, legal representative, community nurse or social worker from home team Commissioner • Commissioner of agent of commissioner. (Sometimes a social worker also acted on behalf of the commissioner) Clinician • Responsible clinician, other medical staff, nurses, psychologist, occupational therapist • Other specialists such as Speech & Language Therapist	Representation • Level of attendance at CPA review from network members Structuring • Structured documentary space within agenda and minutes to allow for contribution from each stakeholder network Contribution • Views reactively elicited in discussion • Pro-active expression of views in minutes and co-production of reports to inform the review process

Table 4-1 Mature template for exploring participation practices as a marker of stakeholder activation in CPA case reviews.

4.5.4. Valuation Practices as Value Realisation

As previously outlined (Spurrell, Araujo & Proudlove, 2017), from a combination of the value based healthcare literature (Porter, 2010; Porter & Teisberg, 2007) and a pilot investigation (Spurrell & Proudlove, 2014) we identified a range of themes that captured how progress was presented, assessed, collaborated on and determined across key functional areas that represent valued outcomes for patients. We noted varying qualities of collaboration, reflection and problem solving in the reviews. In this context, we discovered emergent themes for the template analysis that formed a stable pattern across cases, as set out in Table 2. These practices might be described as both building value (valorising) and evaluating benefit. The combining of the valuation practices of valorising and evaluating as a representation of value realisation is accepted within the valuographic literature (Dussauge et al, 2015), and together capture “what matters to us”, as outlined above (Spurrell, Araujo & Proudlove, 2017).

Thus, in this study we were interested to capture the richness and breadth of how current status and progress was represented, along with quality of attention to evaluation, collaboration and decision making. The construct of value realisation was built from weighing and aggregating these valuation practice elements across the key valued outcome themes to produce our assessment of value realisation, as summarised in Table 4-2.

Template Theme	Template Sub-themes and Nature of Evidence
Valued Outcomes • Overview of Progress • Progress along care pathway • Progress with patient engagement • Progress with symptoms and function • Progress with social participation • Progress with reducing untoward events Cross cutting themes • Breadth of assessment • Use of structured assessment or scale • Collaboration • Reflection • Decisiveness	• Whether the status of the patient was established across a broad range of functional areas, and where within those areas there was a more reactive comment or whether there was more methodical, structured detailing of status within that domain • Whether there was a description of trends, either improving or worsening etc. Also, whether trends were reported across a broad range of areas and whether these were structured and methodically reported. • Whether there was learning developed in the review, linking change in status to possible explanations, leading to likely changes in treatment plan. Whether that reflection actively involved the patient. • Whether progress was overall represented as mentions or highlights, or more structured descriptions or supported by a formal measurement tool. • Whether there was a definitive statement to say since the last review that progress had been made, not made or was unchanged overall. • Whether there was evidence of collaboration, such as inclusion of patient self-report progress, and whether this took the form of narrow unstructured comment, or a structured self-assessment across broad functional areas.

Table 4-2 Mature template for exploring valuation practices in CPA case reviews.

4.6. Analysis

The data for each case was reviewed for accuracy and completeness. The template themes and subthemes were coded using NVivo version 10 (2014). Each set of case documentation was imported into the NVivo project and the data was examined and coded using the template nodes. As an exploratory investigation, data analysis was undertaken using pattern matching of the coded data, consistent with the cross-case synthesis approach advocated by Yin (2014). A rich picture was developed from the documentary data as captured by each template for participation practices and valuation practices respectively. The range and richness of participation practice and valuation practice performances across cases was considered and described.

In order to examine the range and richness of patterns of participation practice and valuation practice in a more structured fashion, we drew on the principles of fuzzy set Qualitative Comparative Analysis (fsQCA) as described by Ragin, (2008; 2006). This analytic technique makes use of set theory to represent qualitative data in a format whereby case level data can be aggregated and interactions and patterns evaluated. This is a quantitative technique that is able to operate with small case samples and avoids some of the difficulties of using statistical techniques in qualitative research (Ragin, 2008; Ragin & Byrne, 2009). The technique relies on assessing the degree of membership of cases to the defined set of interest in a considered process, termed ‘casing’.

In this study, the primary set of interest is the set of rich participation practices and the set of rich valuation practices for each of the identified themes in the respective template. We followed a methodology on casing for investigating social phenomena at the micro level (Basurto & Speer, 2012). The casing process allows us to systematically consider the span of practice within the sample from the least richest set to the richest set. Definite rich set membership defined as 1, definite non-set membership was defined as 0 and the transition point of equipoise between in and out was 0.5. This technique therefore allows us to classify the richness of participation and valuation practice for the respective sub-themes within each of these cases. Within the QCA technique, by aggregating these we were then able to assemble an overall representation of the quality of stakeholder activation as participation practice, and of value realisation as valuation practice

for each case. We report the findings across cases for each of these two dimensions of quality and we present a set based qualitative analysis of the interrelationship between them.

4.7. Findings

Our findings are presented in three sections. First, we describe the range to the nature and quality of respective network participation practices, as representing stakeholder activation. Second, we similarly describe the picture for valuation practices, as representing value realisation. In the third section, we explore the relationship between network participation practices and valuation practices within the sample.

4.7.1. Participation Practices as Stakeholder Activation

The range to the quality of participation practices across cases in our sample represented a complex picture. A more detailed treatment of these findings can be found elsewhere (Spurrell, Araujo & Proudlove, 2018). However, in essence we found that there was overall a considerable degree of variation in participation practice quality from stakeholder networks across cases, from rich to somewhat limited. The nature of the variation was not just about the functioning of each stakeholder network in isolation, but includes a dimension of 'co-activation'. In other words, in the richest cases there was also a rich level of participation practice associated with more than one of the stakeholder networks.

This representation of varying stakeholder activation profile is shown in Figure 4-4. In our analysis, we have defined a threshold of 0.8 as representing reaching a definite rich level of participation from respective networks, and 0.4 represented a definite lack of participation. The intervening cases can be seen as having some interim level of participation quality. We identified that in 7 out of 20 cases the overall quality of participation did not reach the threshold of definitely good for any stakeholder network, and 13 that did. However, in only one case (case 6) was participation from all the stakeholders definitely limited. Meanwhile, in only 3 cases was there definite co-activation, with rich participation from at least two stakeholder networks (patient and clinician networks, cases 4 & 18; commissioner and clinician networks, case 13). Therefore, we have elicited a continuum of

stakeholder activation quality as a function of richness of participation practice from individual networks and the degree of matching rich participation from co-activated others.

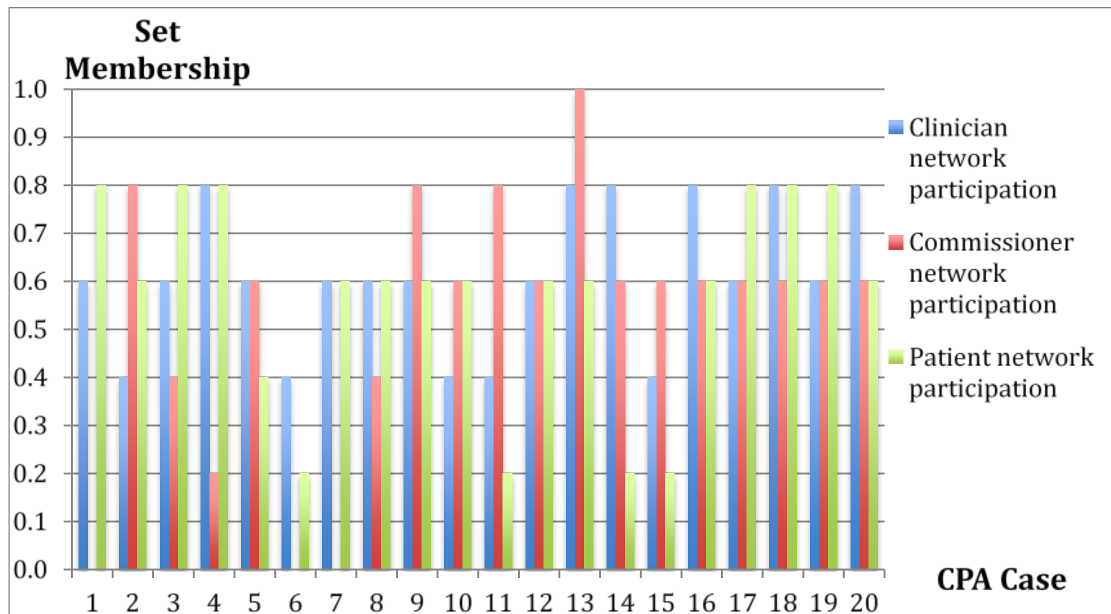


Figure 4-4 Chart of fuzzy set membership of rich network participation for each patient, commissioner and clinician networks for a sample of CPA case reviews (Source: Spurrell, Araujo & Proudlove, 2018, as in Section 2.3.4)

4.7.2. Valuation Practices as Value Realisation

The range of value making practices that we elicited also represented a complex picture, as outlined in more detail elsewhere (Spurrell, Araujo & Proudlove, 2017, see Chapter 3). In essence, whilst we found a wide variation in valuation practices from case to case, we found that there were two orders of variation. First there was variation to the richness of the enactment of valuation practices, and secondly there was variation to the kind or combinations of kinds of valuation practice that we found. This led to the discovery of a range of clusters of collaborative valuation performance styles as set out in Table 4-3.

Styles of Valuation Practice	Number of cases of definitely rich cases (>0.8)	Number of cases of definitely not rich practice (<0.4)
Rich Picture	10	3
Progress Elicitation	7	8
Results Orientated “better or worse”	7	6
Reflection on what might be learnt	7	8
Patient Involvement	7	9

Table 4-3 Table of the distribution of cases across styles of valuation practice, as either definitely a rich exemplar case or definitely not a rich exemplar case (n=20)

We have described in more detail elsewhere, how the different valuation styles were arrived at (Spurrell, Araujo & Proudlove, 2017, see Chapter 3). In brief however, we identified a core practice of developing a rich picture, which was found to be a combination of sub themes we had identified in the template: broad structured status reporting, and use of structured assessment scales (e.g. The Recovery Star: MacKeith & Burns, 2008). Four further sub-themes from the template were also looked at as pivotal to the value making process. These were progress elicitation, reflection and learning, a results orientated “better or worse” decision and patient involvement. Again, using a threshold of 0.8 to characterise definitely rich practice, and a threshold of below 0.4 as definitely not rich practice, we were able to explore the different valuation practice themes that we found and how, in themselves or in combination, they represented different styles of value realisation across cases.

By converting our scores to provide a crisp set plot (Rantala & Hellström, 2001), we studied the combinations of practices that might be found hermeneutically. We considered groupings of 3 cases or more as of potential interest (Fiss, 2011). From the set plot (Figure 4-5), there was a clear cluster of 4 cases that lay outside the plot altogether as being overall more limited case reviews (‘no valuation’). Therefore, from the 16 cases that exhibited a rich level of valuation in a least one practice area, there was a cluster of four cases where all (Case 12, 19 and 20), or nearly all (Case 8), of the possible valuation practices were richly enacted, forming

an Integrated style of valuation. There was also a standalone rich picture cluster, where no further value making practice was richly identified (Cases 2, 5, 7 & 9).

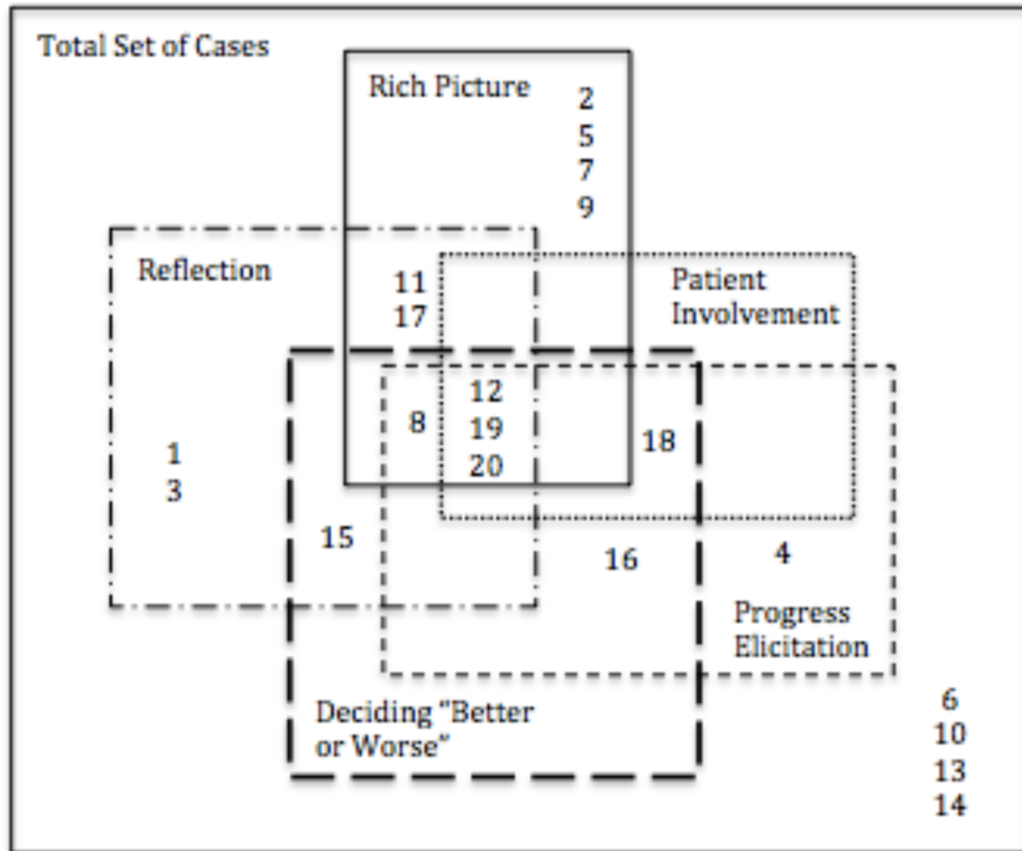


Figure 4-5 Set Plot of Crisp Set Membership of Rich Valuation Practices across the Set of CPA Case Reviews

As outlined above, an orientation to value making can be seen as that of a problem-solving process, or as a process of enquiry or exploration, or a combination of both (Kimbell, 2011, p49). In order to investigate whether other more complex combinations of practice were present we used fsQCA to undertake a configurational analysis based on these alternate principles. We took the results orientated practice of determining "better or worse" as indicative of problem solving and the practice of progress elicitation as indicative of exploration. We investigated these potential configurations of practices associated with problem solving or exploration based on the fuzzy set scores, as outlined by Fiss (2011).

Following Fiss (2011), we used a cut off at least 3 cases per combination in the truth table analysis. Cases of the outcome are coded at a threshold consistency

judged by the researcher, but usually within the range of 0.75 (Ragin et al, 2008) to 0.95 (Fiss, 2011). Solutions are calculated in two forms, a parsimonious solution and an intermediate solution. As Fiss indicates, the parsimonious solution provides for a more constrained set of inclusion assumptions for the presence or absence of conditions in the underling set logic used to calculate solutions compared with the intermediate solution. It is not intended that fsQCA makes an absolute determination, rather it provides structured boundaries to what might reasonably be inferred as meaningful combinations. In that spirit, a condition that appears in both the parsimonious solution and the intermediate solution is considered to be a core condition. Conditions only appearing in the intermediate are playing a part, but are more peripheral conditions. Conditions that don't appear at all are not likely to be relevant, which is itself informative. A solution consistency of 0.95 is usually taken to be robust (Fiss, 2011).

Table 4-4 reports the result of the configuration analysis. In this analysis, 'rich picture' was entered as its constituent practices of a status report and use of structured assessments. For results orientation, there was only one solution provided, but the consistency of the outcome was high (Cut off 3, Consistency 0.95, N=16). Taking the intermediate solution, there can be a high level of confidence in the important role for the various valuation practices in combination in the process of deciding "better or not" (Coverage .59, Consistency 0.97). From the parsimonious solution though, it can be seen that it is the involvement of the patient that forms the core practice in arriving at this outcome (Coverage 0.73, Consistency 0.95). Both versions are well within the levels of confidence used by Fiss (2011). Therefore, there is a results focused practice style within the data, underpinned by patient involvement.

Configuration	Solution for Results Orientation Cut off 3, Consistency 0.95, N=16		Solution for Eliciting Progress Cut off 3, Consistency 0.94, N=16	
	Parsimonious	Intermediate	Parsimonious	Intermediate
Status		•		•
Structure		•		•
Progress		•	N/A	N/A
Reflection		•	●	●
Patient Involvement	●	●		
Raw coverage	0.73	0.59	0.89	0.72
Unique coverage	0.73	0.59	0.89	0.72
Consistency	0.95	0.97	0.82	0.95

Black circles indicate presence of a condition. Large circles indicate a core condition and small circles a peripheral condition. N/A is not applicable. Blank cells indicate not relevant.

Table 4-4 fsQCA Configurations for Making a Decision and Eliciting Progress

Meanwhile, if Eliciting Progress is considered as the outcome in its own right, the picture changes to one where there is again only one solution (Cut off 3, Consistency 0.94) but with a configuration of a rich, structured status report along with reflection forming the key practices (Coverage 0.72, Consistency 0.95). Reflection appears potentially as a core condition, although the relatively low consistency might be a challenge. Interestingly, the participation of the patient was not a relevant condition. This configuration might then represent a practice of “professional reflection and learning”.

In summary, across this series of cases, 5 practice styles for value realisation have been described: No valuation (N), Rich Picture production (RP), Integrated valuation practice (I), Results Orientated (OR) and Professional Reflection (P). We have summarised these case groupings in Table Q. We did note 2 cases that might be categorised as more than one style, but using QCA and configuration analysis does not at all imply a single, deterministic process within patterns. It is just what was found.

4.7.3. The Relationship between Stakeholder Network Activation and Value Realisation.

Through our constructs of participation practice and valuation practice, we explored the relationship between stakeholder network activation and value realisation. We used a series of set plots that combine these constructs (Rantala & Hellström, 2001). Three set plots (Figure 4-6, Figure 4-7 and Figure 4-8) have been used to capture different thresholds to the quality of stakeholder activation: rich participation, not rich participation and intermediate level of participation. The degree of co-activation of stakeholder networks was represented by the set overlaps. From the analysis above, cases were classed according to their respective style of value realisation. As per Fiss (2011), we were interested in clusters of 3 or more cases as a minimum in QCA.

We discovered that there was a complex relationship between stakeholder activation and value realisation. First, we discovered that it was possible to see a rich value making process in the absence of one activated stakeholder network or another, as seen in Figure 4-8. This was most marked for the commissioner network where there were 5 cases of rich value realisation (of one style or another), but no activation of commissioners. Perhaps more surprisingly, there was rich value realisation despite a lack of clinician and/or patient network activation in 4 cases. Interestingly, of these, 2 cases with apparently neither patient nor clinician network activation (Cases 11 & 15) did have some modest commissioner network activation instead (Figure 4-7). In only 1 case though was there a correspondence between no activation at all and a lack of value making in the review process (Cases 6). Conversely there was only one case (Case 13) where there was definitely some rich stakeholder activation, but where a process of value making was not seen. Therefore, whilst stakeholder activation does not necessarily link with rich value realisation, generally value realisation is associated with some level of stakeholder activation from one source or another. However, it appears to be fluid as to where that source of activation comes from across the three stakeholder networks.

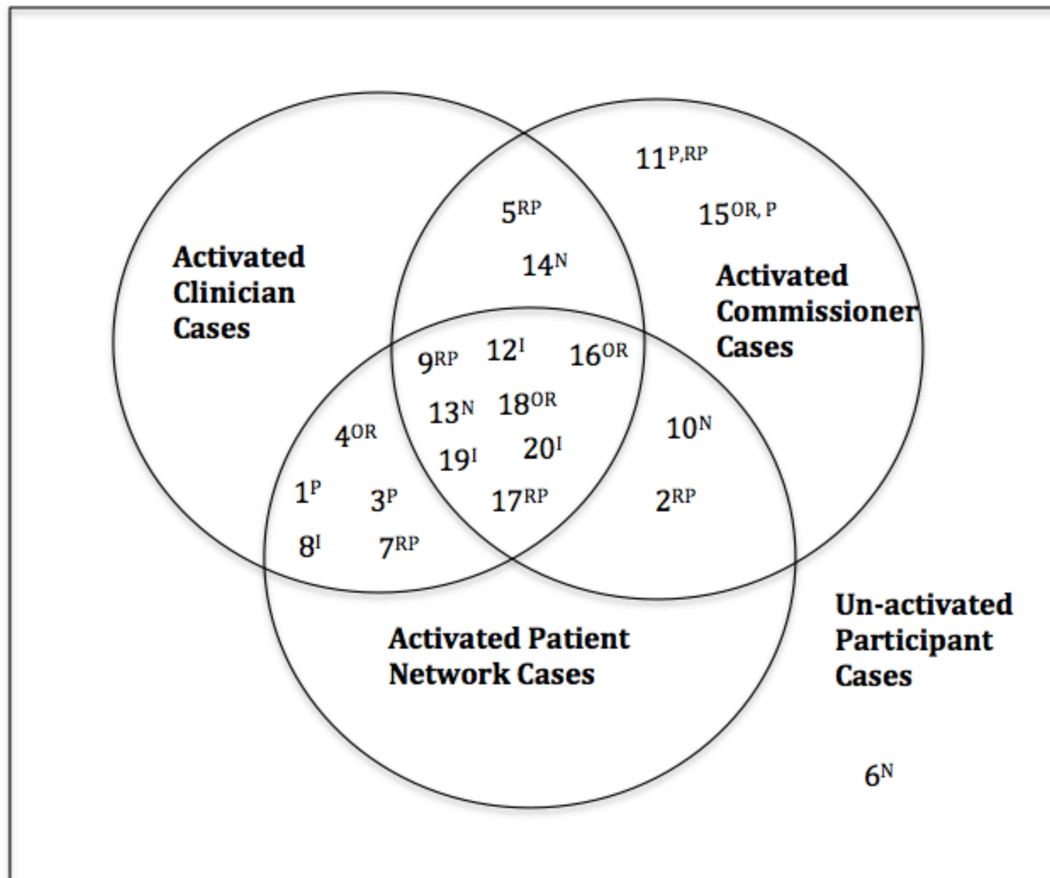


Figure 4-6 A Set Plot of network activation, using a threshold of 0.6 to create a crisp set of richly activated cases by style of value realisation.

With regard to particular value making styles, it can be seen from Figure 4-7 that the integrated style (I) of value realisation was most associated with the modest co-activation of all participant networks for 3 cases (12, 19, 20), and for patient and clinician activation for a fourth (Case 8). However, this association was not present if the threshold for activation were raised (Figure 4-6). Therefore, there is a suggestion that rich integrated styles of value making are linked with multiple stakeholder network activation, but this cannot be definitely confirmed from our data.

A rich picture (RP) style cluster was found with an apparent modest level of activation, either of clinician and patient networks, or of clinician and commissioner networks (Figure 4-7). Interestingly, the rich picture style was particularly associated with commissioner activation at the higher threshold of definition (Cases 2, 11 & 9), although the suggestion of other network co-activation was not found at this level.

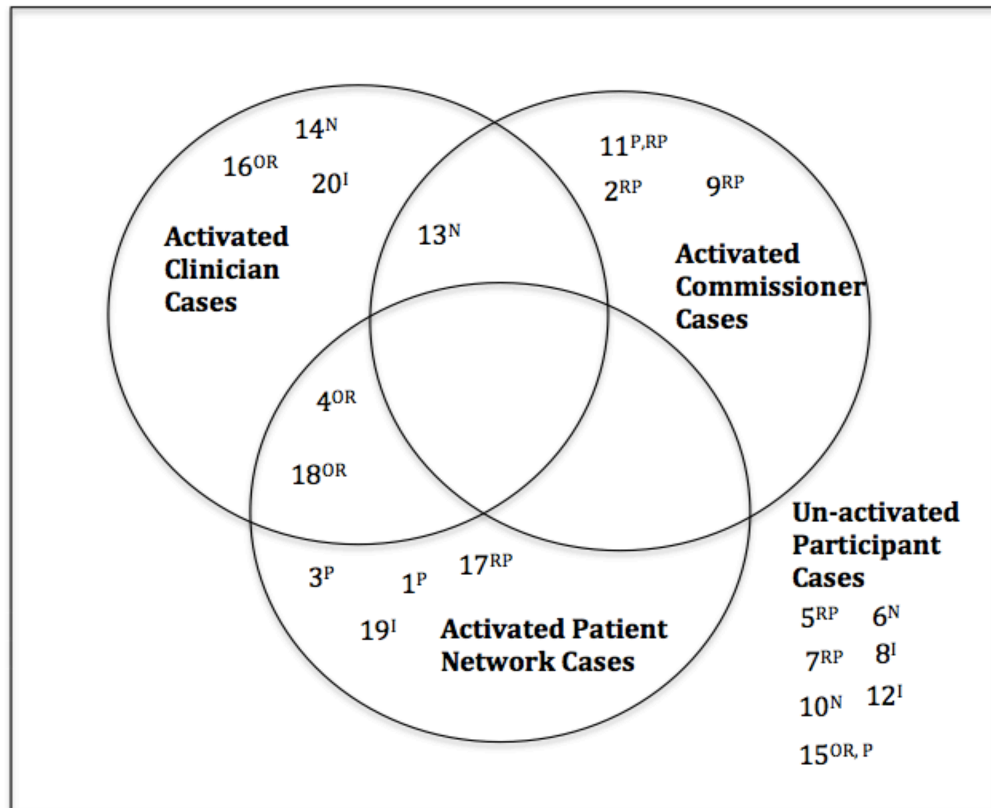


Figure 4-7 A Set Plot of network activation, using a threshold of 0.8 to create a crisp set of richly activated cases by style of value realisation.

A results focused (OR) style cluster was found in Figure 4-6 to be associated with a rich activation of the clinician network (Cases 4, 16 & 18). In two of these cases there was also co-activation with the patient network (Cases 4 & 18). These cases were the only clear example of activated clinician and patient networks being associated with rich value realisation. Conversely, from Figure 4-8, clinician and patient network activation was not necessary in all cases for there to be rich value realisation in this style (Case 15), as commented on above.

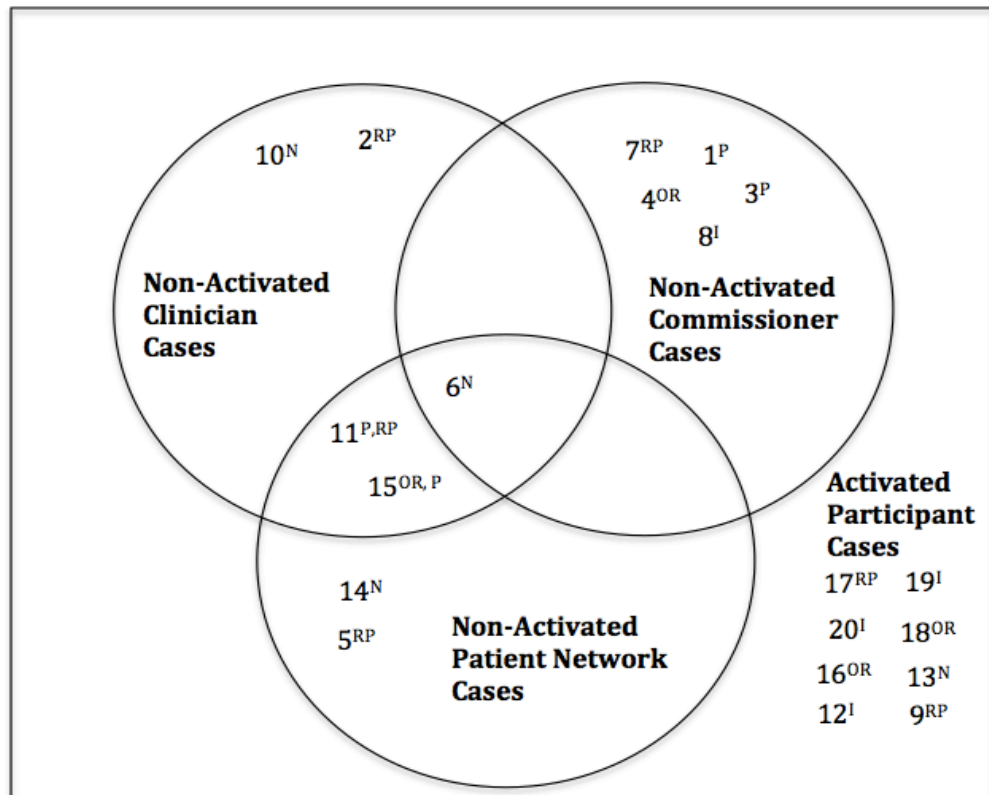


Figure 4-8 A Set Plot of network non-activation, using a threshold of 0.4 to create a crisp set of definitely not activated cases by style of value realisation.

For the professional reflection (P) style of co-valuation there was no specific clustering identified to suggest either a positive or a negative association with a particular profile of network activation. Nonetheless, no cases lay outside the overall activated network space either (Figure 4-8). This was taken as suggesting that this practice style is present but more diffusely associated with the various stakeholders.

As summarised in Table 4-5 therefore, within the overall positive association between stakeholder network activation and value realisation in this crisp set analysis, there are an intricate set of interactions between the stakeholder network activation profile and different styles of co-valuation in reviews that need to be further explored. There was no additional benefit from repeating the analysis with fuzzy set data.

Styles of Valuation Practice	Description of value making style	Cases[1]	Comment on associated stakeholder network activation
Overall	Any value making from across the different Styles	All, except cases 6, 10, 13, 14 (see the no value making style)	Activation at some level, originating fluidly across the three stakeholder networks.
Integrated	A rich combination of all identified elements of value making practice were seen	8, 12, 19, 20	There was a suggestion that this style was most likely to correspond with activation of all stakeholders
Rich Picture	Simply a broad and detailed account of the current status of the patient was made, often supported with structured assessment tools. No notable further development of value making evident.	2, 5, 7, 9, 11	Possible correspondence with either Patient & Clinician Activation, or Commissioner & Clinician Activation. Definitely corresponds with commissioner activation alone
Results Orientated Style	A set of practices where a level of Rich Picture is elicited and followed by a focus on deciding whether progress is being made or not. May involve other value making practices, but to a modest and varying extent, but definitely with a rich focus on patient involvement	4, 15, 16, 18	Most associated with clinician activation and possibly patient and clinician co-activation
Professional Reflection	A set of practices where a level of Rich Picture is elicited and followed by a focus on reflecting (for example on diagnosis and formulation).	3, 11, 15	Diffusely associated with stakeholder activation. No particular profile implicated.

	Definitely without patient involvement		
No Value Making	The evidence for value making practices within the review was limited	6, 10, 13, 14	Definitely some stakeholder activation can be found, despite not giving rise to value making.

[1]Cases can be assigned to more than one Value Making Style as multiple combinations can be considered relevant

Table 4-5 Summary of the styles of valuation practice, with associated comments on relationship with the respective stakeholder network activation profile.

4.8. Discussion

The aim of this investigation was to test the applicability of a proposed complex case management framework (complex CMF) in a suitable service setting. Our angle has been that, adopting a pragmatic stance, assessing the relationship between stakeholder activation and value realisation would test the applicability of the complex CMF, and would lead to suggestions for further refinement. Our key findings were that we were successful in eliciting evidence of diversity of both stakeholder network activation profiles and styles of value realisation within reviews. However, whilst overall there was some confirmation of a positive relationship, it was qualified. First, it was not a completely consistent finding, second the nature of the relationship was more fluid than expected and third there were intricacies to the interaction between different stakeholder activation profiles and styles of value realisation that our findings suggest need more exploring. In further discussion, there is consideration of how well the investigation process has represented the empirical focus of the investigation. Next, the implications of these findings are discussed with reference to the literature. This includes reflecting further on what additional features a service framework needs to capture, and how that might influence service platform design. A fresh synthesis is then proposed, which offers distinct practical advantages, and which directs attention to a further programme of work.

4.8.1. Methodological considerations

In this case based study, we have followed others in focusing on participant practices as a means of exploring health (McColl-Kennedy, 2012; Arnould, Price, and Malshe, 2006; Payne, Storbacka, and Frow, 2008). Further we have adopted a particular network vantage point, as distinct from studying the more usual dyadic perspective (Spurrell, Araujo & Proudlove, 2018). In this context, Baker (2011) argues that more diverse work involving structured qualitative case studies would be a helpful addition to health improvement research, complementing other approaches. This investigation therefore makes a contribution in this regard. There are however a number of limitations to bear in mind.

4.8.1.1. Triangulation

This was a study of CPA case review documentation, within a much broader flow of case management. There were many parallel interactions between participants taking place outside of the review, or that might not have been captured in the documentation, that might also have been relevant. There are other ways of viewing and potentially measuring stakeholder participation and the realisation of valued outcomes. It would be an advantage therefore, in future, to be able to triangulate findings against these other perspectives. However, as emphasised above, case reviews are critical elements of the case management process (Flynn & Citerella, 2012). If such exchanges are to be better structured and supported, then the documentary reality on which this investigation is based, with its cross-case comparison, is entirely pertinent to that. Thus, this investigation represents one approach as a first step towards better structuring that case review process. Meanwhile, from the pragmatic standpoint, practical insights gained through this investigation can be a source of meta triangulation with other theoretical standpoints (Lewis & Grimes, 1999). The pattern of these findings can therefore provide a focus for testing against, for example, the emerging micro-foundational work on value co-creation within the service eco-system perspective (Storbacka et al, 2016). This is discussed further below.

4.8.1.2. The Longitudinal Perspective

This was a cross-sectional exploration of practices within a discrete set of reviews at a point in time. The reviews were systemically selected to represent the broad sweep of service across the organisation. However, these cases would have been quite possibly at different stages of their different care pathways through the service. This might have been one factor that contributed to the highlighted variation between cases that was found in both areas of practice. Further, as highlighted above, it is likely that different cases might evolve different practices over time. Alternatively, the kinds of practices seen might need to fluctuate as participants experience changes, which might include fluctuating confidence to engage, or competing other pressures such as demands on their time. However as has been argued (Spurrell, Araujo & Proudlove, 2018; Spurrell, Araujo & Proudlove, 2017), further work is needed to distinguish the appropriate dynamic of evolving, fluctuating case practices from other sources of variability. A larger longitudinal study would therefore be an important further next step.

4.8.1.3. Qualitative Comparative Analysis (QCA)

For an exploratory investigation, discovering patterns within the data more methodically better enables the theory building process, to which in due course more objective theory testing methodology can be applied (George & Bennett, 2005; Christensen, 2006). The advantage of employing QCA in this study has been its ability to combine a qualitative perspective with a sophisticated structuring of the exploration, in terms of set classification, working with the judgment of the investigator. This aligns well with the structured but creative qualities of the pragmatic stance. There has been criticism of QCA both in terms of its degree of subjectivity, and in terms of how this affects the underlying set logic (cf. Bennett & Elman, 2006). However, it is becoming increasingly accepted as a way of coping more methodically with complex public sector service questions (Rihoux, Rezsöhazy & Bol, 2011). The difficulty encountered in our study was that, whilst a number of rich patterns became evident, the numbers of possible combinations within our cases meant that with this sample size we could not always be confident that there were not further important positive or negative associations to be found. In further investigation, it would be helpful to model our constructs of stakeholder activation and value realisation for a larger sample population, and to triangulate

those findings with statistical modelling techniques. However, we have set the stage in terms of further developing the use of our constructs and to being able to refresh our previous formulation of the complex case management framework.

4.8.2. The Complex CMF and Further Necessary Ingredients

Although the complex CMF functioned as expected to a point, it was surprising to find that stakeholder network activation was not always sufficient for value realisation to be found. This relationship is an expected feature for Wagner and colleagues (Wagner, 1998; Wagner et al, 2001). It is also a key dynamic in the service literature (Storbacka et al, 2016). This was a small study, and its limitations are discussed below. Nevertheless, our findings raise some important questions for how to support case level value based health care, features of the value making process at the case level, and the design of the complex case management framework.

4.8.2.1. The Role of Case Management

As outlined above, case management as exemplified by CPA is a troubled area of practice (Simpson, Miller & Bowers, 2003a; 2003b). One possible explanation of our findings might be that the relationship between activated stakeholders and value realisation may not in all cases be transacted in case management reviews. This is consistent with reported literature for CPA, that for some services it appears to be side-lined, notwithstanding its perceived value for patients (Rose, 2003). However, our investigation was of practice within one organisation, where it is clear that in many cases reviews are indeed a rich forum of value making. On the other hand, with the lack of conceptual support for structuring CPA case management as argued by some (Simpson, Miller & Bowers, 2003a; 2003b), it may represent the effects of lacking a coherent care platform as envisaged by Bohmer & Lawrence (2008). This may explain a drift in focus even within the same organisation. Investigating this further involves understanding how, in a complex service, the relationships between stakeholder activation and value realisation are structured and mediated within case level service platforms. These findings, we argue, underline the importance of designing case level value orientated service platforms into complex healthcare practice.

4.8.3. Service Platforms

The emerging importance of the structuring of the care process as a factor in realising valued outcomes leads to further consideration of the nature of care platforms for healthcare. Bohmer & Lawrence (2008) appropriate the concept of care platforms for healthcare from the wider business sector, envisaging an organising framework for anchoring the key ingredients of the service process. This 'infrastructuring' of service activities, as some might put it (Ehn, 2010), falls within the scope of developing service platforms. Service platform design is a key focus for service research (Ostrom et al, 2015) and transformational design (Sangiorgi, 2010). However, Storbacka et al (2016) point out that the service platform concept can be associated with a diverse set of meanings and contextual perspectives. The focus in this paper is to understand case level service platforms in terms of the intermediary features that structure and support the relationship between stakeholder activation and value realisations. We would hypothesise that 'making service platforms' might be done more or less well, and that different styles of interaction platforms might well influence the quality of service outcomes. This view is in keeping with others, both in general service literature (Kimbell, 2011; Luotola et al, 2017; Storbacka et al, 2016), and in healthcare (McColl-Kennedy et al, 2012; McColl-Kennedy et al, 2017; Spurrell, Araujo & Proudlove, 2017).

4.8.4. Features of Case Level Service Platforms

The making of case level service platforms draws attention to how, in a complex service, the relationships between stakeholder activation and value realisation are structured and mediated. Helpfully, Storbacka et al (2016) have conducted a review of micro-foundational service processes that offer prompts for some suitable mediating themes to consider. These suggestions have been appropriated to structure the discussion further.

The first theme relates to the fluidity of stakeholder activation, meaning how the nature and scope of stakeholder participation engages with the service process. The second theme relates to how the different dispositions, intentions and agency functions are structured into the service process. The third theme captures how various patterns of integration might be enacted within the service process, and

how these might evolve over time. We argue that understanding more about these themes can inform care service platform design.

4.8.4.1. Fluidity of Stakeholder Activation

For the complex service, the first ingredient is the challenge of structuring the integration of varying and diverse stakeholder networks. For Storbacka et al (2016), the shift to a multi-party perspective in micro-level exchange is seen as important. This incorporates a perspective on the number of actors and their diverse interactions. Further, Storbacka et al ascribe importance to micro combinations of actors as having agency in micro-exchange. Similarly, in this investigation the reformulated complex case management framework proposed above (Section 4.3) represents a shift to a micro-level, multi-party perspective. Further, building on the approach to the service delivery network (SDN) proposed by Spurrell, Araujo & Proudlove (2018), agency is also ascribed to this collaboration focused on the case review. Thus, how fluctuations in both shape and agency for stakeholder networks are likely to be captured and channelled are important aspects for service platform development.

Our findings confirmed that the nature of the multi-stakeholder profile was itself an important dimension. For this ingredient, we found a more distinct fluidity to the role and source of stakeholder activation within case level SDNs than might have been expected. Thus, we found cases where it was the activation of prominent commissioner representation that appeared to be related to realising value. More usually, either patient prominent or clinician prominent SDNs would be expected to be more closely linked. Further, there were apparent advantages to the rich co-activation of more than one set of stakeholder participants, which could include commissioners. In this context, these more dynamic forms of stakeholder activation tended to produce richer and more sophisticated forms of value realisation, such as the integrated style. That dynamics within patient networks in healthcare can assist the process of participation in value co-creation has previously been shown (McColl-Kennedy et al 2012; McColl-Kennedy et al, 2017). Our findings extend that to suggest that wider interactions within and between the networks of all the participants can also be a source of assistance, they can lead to more diverse valued outcomes and they represent a key capability for care platforms to support.

4.8.4.2. Intention, Disposition and Agency

There is agreement with Storbacka et al (2016) in recognising that the intentionality and disposition of participant actors are important elements to be captured by the service structure. However, there is an important distinction between our network theory informed view of agency associated with stakeholder activation, and the service eco-system stance of Storbacka et al (2016). In line with Grönroos & Gummerus (2014), it was an important feature of our stance not to mix actor and non-actor elements as having agency within service models. Nevertheless, for either perspective, how people engage with service frameworks in healthcare is key. That the disposition of patients to engage was a limitation for both the CCM (Wagner, 1998; Wagner et al, 2001) and Batalden et al (2016) was highlighted above (Section 4.2.1).

In this context, our findings illustrate the potential importance of collaborative agency as a further capability to be supported. Our findings suggested that for instances where there was less evidence of patient network activation, it was still possible to see a helpful realisation of value associated with the rich activation of other networks. This potential for cross agency between stakeholder networks in contributing to the value realisation process is an interesting possibility. For example, the nature of healthcare, and other public services, is that there can often be constraints of one kind or another on service user participation, perhaps with patients being particularly vulnerable to this (Osborne & Strokosch, 2013). In the event of limited engagement, say due to illness, it can be useful at times if others are able to carry the value generating process forward with "the common good" in mind (Bryson, 2004). Such agency would have to be carefully and intricately structured within the service framework to maintain a collaborative service process, and thus represents a further dimension to the capabilities of stakeholder SDNs to explore.

4.8.4.3. Patterns of Integration and Purpose

For Storbacka et al (2016), the case level as a micro environment within a service eco-system perspective sees a diversity of ingredients of actors and engagement properties, with the service platforms as patterning their integration in a process of value co-creation. In this study, within a pragmatic stance, there are similarities with this view. However, within our pragmatic, valuographic approach, we have in

contrast focussed on a collaborative value perspective. From this stance, collaborative value as “what matters to us” can and should also change as different perspectives become reconciled in the process of making value (Heuts & Mol, 2013). Different kinds of valued outcome might result from different kinds of patterning of the service process (Spurrell, Araujo & Proudlove, 2017). Different kinds of valued outcomes might for example reflect unique aspects of a case and its complexity. It might reflect the evolution of the care project over time, or reflect wider more intricate interactions with stakeholders, who might be responding to particular regulatory or social factors for example. Thus, CPA reviews might well represent distinctly different kinds of projects from case to case, bearing different kinds of fruit within and between cases over time. This is a more intricate view of the value generating process than Storbacka et al envisage. This complexity of value realisation is an important aspect of calls for more customised and design led approaches to structuring healthcare (Swinglehurst et al, 2014). There is a growing interest in bringing the design perspective to bear on service micro-foundations (Luotola et al, 2017; Storbacka et al, 2016).

In this context, if the starting point for service design is its purpose, in line with Kimbell (2011), in this study we found that there was an important distinction between case reviews focussed on problem solving, and those focussed on exploration and developing of understanding. Luotola et al (2017) associate the latter more open design stance with addressing more complex situations. We found some cases with blends of both these purposes. Thus, we found that there were different intentions to case reviews going on within CPA case management, not explained by stakeholder activation profiles. Clearly different purposes might suit different case reviews at different times. Difference in purpose, therefore, forms a further key theme to draw on for understanding the patterning of service. Thus, there is work to do to see how such diversity of purpose is built into the structuring of service care platforms.

4.8.4.4. Summary

In summary, the mediation between activated participants and value realisation does need unpacking in terms of how that is structured within the case level service exchange. The capabilities of that structuring are therefore a further influence on the generating of valued outcomes. Some useful themes have been

highlighted as suggestions for incorporating into service care platform designs, including the fluidity of the SDN and the more intricate structuring of agency, along with an accommodation of different kinds of care projects to suit different cases and different stages of evolution for cases within care project.

4.8.5. Reconceptualising a Framework for Case Level Service Platforms

Having zoomed into the empirical experience of how participation activation relates to value realisation, we are in a position to reconsider and revise the proposed complex CMF. The important principles that have emerged include a re-confirmation of the importance of the service space as co-constructed between stakeholder networks and the importance of the case management process as being structured from review to review, each capturing a fresh collaborative valuation. Based on this investigation, the additional features we would wish to capture within a revised framework would be the evolution of care over time, and a more intricate view of the capturing and aggregating of valued outcomes (Figure 4-9).

4.8.5.1. The Evolution of Care

As captured by the SDN concept, the functioning of the activated stakeholders that generate the context for the case management process is much more fluid and dynamic than previously accounted for, either within other work in healthcare (Spurrell, Araujo & Proudlove, 2018; McColl-Kennedy et al 2012; McColl-Kennedy et al, 2017; Frow, McColl-Kennedy & Payne, 2016), or in the emerging micro foundational work (Storbacka et al, 2016). Reflecting on the work of Storbacka et al (2016), we suggest that there is a dimension of collaborative agency to be understood, which enables more engaged participant networks to support the participation of others within a formed SDN. In that context, we would suggest that this interplay within the SDN, and its direction of purpose are features that would reasonably evolve as care progresses, for example as trust, and engagement develop. This evolving sophistication of cohesion and purpose within service networks has also been picked up on as important in the wider service literature (Vedel, Geersbro & Ritter, 2012). Meanwhile, the interplay with value realisation allows for a process of learning and reflection from case review to case review, such that valued outcomes are aggregated as a complex learning process.

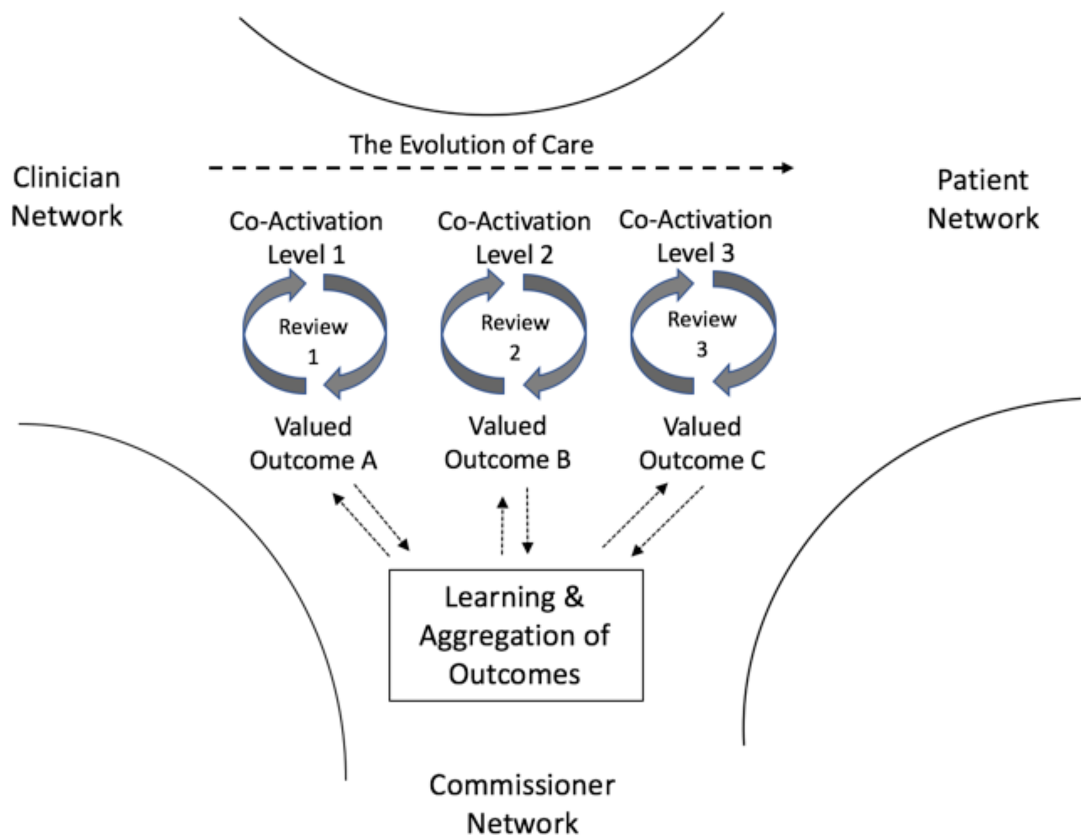


Figure 4-9 The revised complex case management framework (Complex CMF)

4.8.5.2. Structuring Learning and Aggregation of Outcomes

Having introduced the dimension of evolution within the care process, the second area of revision refers to structuring and mediating the interplay between the diversity of stakeholder activation profile, as seen within SDNs, and the different styles of co-valuation leading to different kinds of outcome. Thus, each case review is a unique performance with a particular kind of valued outcome. There is an important function therefore to capture, make sense of and assemble these distinct case review outcomes over time. It is this learning and aggregating of outcomes over time that forms the heart of the service care platform. This analysis chimes with the observation by McColl-Kennedy and colleagues that different styles of co-creation are important (McColl-Kennedy et al, 2012; McColl-Kennedy et al, 2017). Investigating further the style of this integrating function itself would

be an important next step. Drawing on Storbacka et al (2016), and building on the discussion above (4.8.4.3), this deeper understanding takes steps towards developing practical, but more intricate, value based service platforms to assist complex case management.

4.8.5.3. Summary

The revised complex CMF has incorporated the importance of evolutionary momentum in the care process, and adopted a more intricate learning process for aggregating valued outcomes. Further, the assembling of more distinctive, individualised pieces of the value realisation jig-saw produce a rather more qualitative notion of valued outcome, which fits with further analysis within a set theoretic methodology. Therefore this framework is well placed to support the development of particular local service platforms in complex healthcare settings. We argue that this certainly responds to the challenge to better develop care platforms in healthcare (Bohmer & Lawrence, 2008). We also argue that it goes further in giving practical shape to what "knitting together care" might mean for Goodwin & Lawton-Smith (2010). We further propose that this revised framework takes helpful steps towards supplying the conceptual underpinning for collaborative case management that has been called for (Simpson, Miller & Bowers, 2003a; 2003b).

4.9. Conclusion

In this paper, we have responded to the gap in support for complex case management practice leading to valued outcomes in healthcare. This has been manifest as both an absence of a suitable practice framework or suitable care platform, as suggested by Bohmer & Lawrence (2008), as well as a gap in conceptual support from the service theory landscape. Adopting a pragmatic approach, we have pieced together from available conceptual resources a first complex case management framework for consideration. Within the pragmatic stance we tested the capabilities of the framework by exploring the predicted relationship between stakeholder activation and value realisation within a series of CPA complex case reviews in a learning disability service. As a result, we have been able to make further helpful revisions to the proposed framework. This is the

first service orientated, practice based framework to be directly focused on complex case level service in healthcare. It is the first to be directly concerned with supporting collaborative value realisation for patients and other stakeholders, contextualised in a process of case management. In this context, this work makes three distinct contributions.

First, it enables practitioners to map distinctly important features of how value is made at the case level in their services. These can be mapped against generating the service context, the service platform features and the realisation of valued outcomes. Further work is needed to refine these domains of interest, but we can nevertheless draw attention to important, fresh avenues for service improvement. Since this case series represented exemplars of complex case management more widely, significance can also be drawn from these themes for other areas of complex practice across both mental healthcare and other specialties, and across the UK and other healthcare systems. Further work in other settings is needed to confirm wider applicability, however with the complex CMF conceptualisation we contribute a fresh set of tools to assist with health improvement work.

Second, this investigation sits at the cross roads between domains of theory; the healthcare domain and the service domain. This reflects the further conceptual work needed to support practitioners in healthcare. However, it is interesting to notice the areas of synergy and dissonance across these conceptual resources and tools, through the touch points of this study process. Pragmatically, bringing these diverse perspectives together in an empirical setting makes a distinct contribution to theory building. Thus, in this work we have been able to show the importance of a more developed view on value for the healthcare world, and how that might be structured. We have enabled abstract theoretical constructs from service to interact with what happens in healthcare practice. Meanwhile, zooming in to compare emerging micro-foundational thinking with case level healthcare practice for example, it was striking how distinct and diverse languages for important elements such as engagement and service platforms might hinder or misdirect the development of principles to satisfy health, service and practitioner constituencies. This study was focused on a meta-theoretical sample, which was intended to enable lessons to be drawn for complex healthcare and case management in health more generally. In similar terms, there is work to do to

influence theorising on complex service exchange more generally amongst the burgeoning schools of thought for which this is of increasing interest.

Third, it provides the foundation for scoping a further programme of research. Progress has been made in an initial testing of how well the framework relates to empirical experience, and what further elements need to be incorporated. We have made a helpful contribution in enriching insight into the relationship between stakeholder activation and value realisation with a view to valued outcomes. From this work, for practitioners, we propose that the outline of the further research would entail a programme of direct structured interaction between practitioners and the themes within the complex CMF. This would involve structuring a research collaboration with practitioners to map practices using the themes suggested by the complex CMF. It is envisaged that the constituency of practitioners would span representatives from patient, clinician and commissioner networks. The research questions would focus on participant experience of the framework, its accessibility, how well it mapped practice experience and how useful it was found to be.

For service managers and researchers, the emphasis of future research would be in employing the framework in collaboration with other theoretical stances to further model the relationship between stakeholder activation service platform elements and valued outcomes. The research questions would focus on re-confirming and extending understanding of how value is made in complex services, and the relationships between important elements in the process on a longer term basis. Grounded in further empirical work, the question would address the conceptual interplay and commensurability of diverse theoretical stances. This would include comparing set orientated QCA based analysis and variable orientated statistical modelling. In that context, the future research programme could include deriving techniques for practically modelling and optimising value based health care in service systems.

4.10. References

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Chapter 5: Discussion and Conclusions

The aim of this thesis is to progress the development of support for service users, practitioners and others involved with value realisation in complex case management in healthcare, using conceptual resources from service literature. The focus of concern is to improve, from the case level perspective, the configuration of service context, to better understand and represent the value generating system, and to progress the development of a suitable case level service framework. These aspects were considered in the form of key research questions (RQ1, RQ 2, RQ 3, Section 1.6), addressed through a pragmatic focus on CPA case management in a UK complex learning disability service as a suitable exemplar. The three papers address each of these three foci of concern, each making a distinct contribution. In this concluding section, the main contributions of these investigations are summarised first. Next, considering the set of papers together, a series of broader principles are outlined. An integration of these principles takes steps towards a generic platform to meet the needs not just of this local sector issue, but also to make a contribution to complex case management more broadly (RQ 4, Section 1.6). Furthermore, taken together, insights from addressing the research questions have implications for service theory itself (RQ 5, Section 1.6), as well as generating the potential for service improvement within the host organisation, and the wider service sector (RQ 6, Section 1.6).

The conclusion summarises the implications of this project for reframing complex case management for the local service, for developing value based healthcare and expanding on the service and methodological literatures involved. The outline of a future research programme concludes the chapter.

5.1. Overview of Individual Paper Contributions

5.1.1. Introduction

The three papers adopt distinct but inter-related perspectives on a common empirical focus, a series of CPA case management reviews. Before summarising the main contributions from each perspective, there are some general points to make. In each of these investigations there is an inherent variation to the

richness of practice seen across cases for each of the foci of concern. The previous literature has highlighted that CPA practice has been inconsistent (Section1.2.3), but this is the first time that links have been made directly with particular elements of case level practice. With regards to variation in practice, this is seen as an important dynamic within healthcare improvement (Wagner, Austin & Von Korff, 1996; Berwick, 2008). However, across these papers, the point is made that the aim of studying variation may be to ensure consistency of practice, or as opportunity for refining and customising service configuration (Swinglehurst et al, 2014). The papers make a contribution in determining that both these dynamics are important, and in pointing out opportunities for improvement on both fronts. Furthermore, the principal themes explored in these papers, engaging with participants in context, value making practices and framing the value generating process, all represent features common to all case management scenarios in healthcare. Therefore, a useful contribution is made both to CPA case management more widely in UK mental healthcare, and, indeed, to case management systems more generally.

It might be argued that there is more work to do to deepen this work by direct observations, continuing the exploration into other care settings, and by triangulating with other forms of data. For example, new approaches are being developed to systematically include health related quality of life outcomes for patients (Tulsky, Carlozzi & Cella, 2011), and for patient reported outcome measures (Thornicroft & Slade, 2014). Further evaluative resources are specifically being developed in relation to the broad agenda of value based healthcare by the International Consortium for Health Outcome Measures (ICHOM, N.D., www.ichom.org). In keeping with Figure 4-1 in paper 2 (Section 4.2, Chapter 4), it is important to allow for the distinct contributions from all these different evaluative standpoints. The investigation of empirical data from the pragmatic standpoint adopted in this thesis is a novel contribution to this wider endeavour, but which others are also starting to explore (Devers et al, 2013).

5.1.2. Understanding the Service Context (RQ 1)

Paper 1 (Spurrell, Araujo & Proudlove, 2018 – see Chapter 2) aims to tackle the issue of how the complex case might be best contextualised within the service environment (RQ 1, Section 1.6). The approach taken was to represent the complex case in healthcare as a project that sits at the intersection of key stakeholder networks. Further, the case review becomes a service focus for which a service delivery network (SDN) can be defined and operationalised. In this paper, the position taken was that the SDN was a function of the quality of participation from the three main stakeholder networks (patient, clinician, commissioner), as well as the degree of co-activation and alignment of those participatory contributions. Thus, through the lens of the case review process, the SDN for each complex case project demonstrated a distinct SDN participation profile.

It was a limitation of this paper that the investigation elicited just one particular aspect of context generation for the case review process. There would have been other ways in which the contributions of participant stakeholders were mediated, within reviews, and throughout the wider service process. Further, the emphasis was on the three main stakeholder networks. It should be acknowledged that there are further perspectives (eg regulatory) that are important, though more complex to represent. Thus, there is more to be done to confirm the findings, and to further explore the function of the SDN longitudinally and across other healthcare settings. Nevertheless, the argument is made that, for the complex case in healthcare, a shift is needed towards a bespoke framing of cases from a multi-party perspective. The concept of the case level SDN introduced provides one way of structuring that component for the generation of valued outcomes in complex healthcare.

5.1.3. Understanding the Value Generating System (RQ 2)

The aim of Paper 2 (Spurrell, Araujo & Proudlove, 2017 –see Chapter 3) is to explore what approach to the realisation of valued outcomes best captured the reality of this case series of complex, multi-party service exchanges in healthcare (RQ 2, Section 1.6). The approach taken was to investigate valuation practices within complex case reviews as a means of better understanding how to bridge the

gap between uniquely (and privately) determined value for beneficiaries and the development of collaborative value that has currency for all stakeholders. The key insights were that many case reviews (but not all) could be viewed as functioning as a collaborative valuation. In this context, a range of styles of co-valuation were elicited from case review practice, along with a range to the quality of how different styles of valuation were enacted across cases.

The limitations were that this was a first investigation of this dimension of service functioning within case reviews in healthcare. Thus, further work to confirm these findings more broadly, and in other service areas would be important. A limitation to address would also be the need to triangulate the range of findings described in this exploration with other assessments of value generation, both for stakeholders individually and as recognised by the wider service system. Nevertheless, the paper expands the perspective on value generation in this case series. A new focus for how value is collaboratively generated in healthcare was introduced, that needs accommodating by the service improvement and service theory literature.

5.1.4. The Complex Case Management Framework (RQ 3)

Building on insights developed in Papers 1 & 2, Paper 3 (Chapter 4) explored the relationship between the case level SDN and the collaborative realisation of valued outcomes. The aim was to deepen understanding into how that relationship might best be structured. Further, it was important to establish a strong link with contemporary practice so as to progress suitable frameworks to support case level value based healthcare. In the paper, drawing on literature and insights from papers 1&2, the leading care framework, the chronic care model (CCM), is revised. The functioning of the SDN and value realisation relationship are tested using the revised framework, leading to a further refinement and proposal of a novel complex case management framework (Complex CMF).

The paper provides a first exploration of the revised framework for supporting complex case management. The study adopted a cross sectional vantage point on a particular case series, using a particular operationalisation of SDN and value realisation. Therefore it would be advisable to replicate the investigation for a wider case series over time, moving into other sectors of healthcare. Further, in future investigation, it would be important to triangulate the emerging picture

against other conceptualisations of context and valued outcome (such as standardised outcome measures, and patient self-evaluation). Nevertheless, the paper's contribution is a considered and further revised complex case management framework. The complex CMF offers a number of novel features for structuring the optimal integration of participants and assembling valued outcomes over time. This provides a more nuanced perspective to how in practice case level service platforms might usefully be designed, which will be discussed further below.

5.1.5. In Summary

As per the thesis plan (Section 1.6), each of these three investigations has focused on a shared meta-theoretical study population. Each has problematized a different aspect to the challenge of complex case management practice to generate valued outcomes. Thus, distinct contributions are made across these three papers with regard to capturing and optimising the service context, the process of value realisation and the structuring of practices within a suitable case level service framework (cf. Section 1.6). The stage is therefore set for drawing some wider implications for supporting CPA case management in particular, and for framing value based healthcare for the complex case more generally.

5.2. The Broader contribution: Developing an Integrated Case Level Service Platform (RQ 4)

This project is not just about reading the three papers in sequence, but also reading across the three papers. This provides a vantage point to address the further research questions that have been posed in the introduction (Section 1.6). This next section draws together the themes generated across these three papers and, in the context of relevant service literature, develops 5 proposed practical principles to support the broader agenda of value based healthcare at the case level. The integration of these principles forms the basis for proposing an integrated generic platform for supporting complex service practice (RQ 4). The contention is that these principles are relevant to practitioners and service managers, as well as having broad applicability across a variety of healthcare settings concerned with complex case management. Within a pragmatic stance, it

is the demonstration of how these principles can be enacted in practice that gives them currency. Thus, whilst it is envisaged that these principles together provide a generic framework for practitioners and service managers to draw on, it would be a within-service matter to co-develop the specific service platforms to meet local requirements as envisaged by (Bohmer & Lawrence, 2008). In this context, Bohmer & Lawrence's notion of a 'care platform' is seen as interchangeable with that of 'the service platform', as discussed above (Section 4.8.5.3).

5.2.1. Principle 1: The Individual Case is the Unit of Analysis

The first principle from across the three papers is the adoption of the case level vantage point. Each case is a unique project. That is to say, the patient as the primary service recipient is contextualised within an emergent service system which itself becomes a focus of interest. From the service eco-system perspective this (micro) system is intricately bound up in a dynamic relationship with higher levels of the system, as articulated by Akaka et al (2013) and others (Vargo & Lusch, 2016; Vargo et al, 2017). What is distinctive across these three papers is to show how the phenomenon of the complex case review, as a service entity (Freund & Spohrer, 2008), performs as one means by which the case perspective is given substance. Drawing on the findings and discussion across the three papers, the case is therefore manifest as a function of the multiplicity of parties involved, the inherent complexities of the case, the differing styles of participation and co-valuation being deployed, and the evolution of the project over time (cf. Ford & Håkansson, 2006).

The relevance of this insight can be found by reference to both healthcare and service marketing literature. The contention is not just that it is desirable and helpful to adopt the case level vantage point, but also that it is practicable and necessary for optimising value generation. As indicated previously, some commentators highlight that more attention is needed on adopting the case level perspective (Hardyman, Daunt & Kitchener, 2014; Baker, 2011), and of putting this perspective into practice (Edwards, 2011). The build-up of individual variability in the complex health and the service exchange literature has already been highlighted in these papers (e.g. McColl-Kennedy et al, 2017; Vedel, Geersbro & Ritter, 2012). In addition, from the network literature, the capturing of the network of participant actors, along with aspects of their interactions and valued outcome

generation is consistent with seeing such entities as "the foundational unit of analysis" (Dicken et al, 2001: cited in Törnroos, Halinen & Medlin, 2016, p1).

It is important within a pragmatic approach that the developing conceptualisation of the case level project has practical applicability. As reported across the three papers, McColl-Kennedy and colleagues have clearly made a start in capturing the case level view of patient value co-creation style for people with chronic conditions (McColl-Kennedy et al, 2012; Sweeney, Danaher & McColl-Kennedy, 2015; McColl-Kennedy et al, 2017), and this theme is continued in this thesis. The thesis makes a further contribution by expanding the scope of the case level perspective to better capture the more complex cases, with a broader consideration of the multi-party view and of how the value generating system functions at the case level.

In this thesis, the distinction between a focus on defined, predictable clusters of patients (cf. Porter, Pabo & Lee, 2013), and a focus on the case as an individualised project has been brought into sharper focus. The distinction is a qualitative one, and not just a matter of gradation. In other words, some cases are managed as definitely having a collaborative quality, with fluidity of context and a focus on "what matters to us" (Spurrell, Araujo & Proudlove, 2017). In other instances, this position is not adopted. Thus, adopting the case level vantage point sets the stage for exploring more fully what might constitute "knitting together of care" for case management in practice (Goodwin & Lawton-Smith, 2010).

Meanwhile, for value based healthcare, there is an important challenge to the assumption that complex cases can be adequately captured by simply more refined clustering and segmentation of objectivist criteria, as proposed by Porter and colleagues (Porter, 2008; Porter, 2010; Porter & Teisberg, 2007, Porter, Pabo & Lee, 2013). What emerges from this thesis is that each case is potentially a project co-constructed between participants. This contributes to emerging service literature that argues for positioning service exchange more firmly in the interactive space between participants (Törnroos, Halinen & Medlin, 2016). This betokens a fluidity that counters the apparent fixity of contextual space seen in the more institutionalised arrangement, for example as proposed by Frow, McColl-Kennedy & Payne (2016), discussed in Paper 1 (Chapter 2). It challenges the contemporary emphasis on the complex cases as sitting within a provider's

organisational space. This sharpening of the distinction and reframing of the complex case is an important contribution to the theory development process. The following further principles build on this insight to explore how in practice the case as an individualised project might function in the generation of value.

5.2.2. Principle 2: Optimising the Service Delivery Network (SDN)

The second principle is discovering how to optimise the capabilities of the service delivery network. Whilst the idea of rich representation at case reviews from diverse parties is not new, what is new to healthcare is reconceptualising this as a service network, with properties by virtue of its structure that can confer benefit. As illustrated in Figure 5-1, in the approach explored in Paper 1, each case review SDN can be optimised by drawing on wider framing networks of stakeholder agents (patients and carers, commissioners, clinicians), and by fostering their co-activation to produce a quality of alignment to that participation (Section 2.9.1.) The argument is not that this is the only way to operationalise SDN quality, but that this particular version was shown to confer benefit. As discussed in Paper 1 (Chapter 2), typically in the literature there is awareness of the patient having an engaged supporting network (e.g. McColl-Kennedy et al, 2012), but there is less focus on applying this to clinician and commissioner networks. Therefore, a proposed 360 degree assessment of where the network contribution ought to come from and the quality of that contribution (Figure 5-1) is an important principle. Further, Paper 3 (Chapter 4), for example, reports evidence of rich stakeholder network participation within the SDN appearing to compensate for less rich contribution from elsewhere in the value generating process. Therefore, a suitably activated and structured SDN can have potential to work around difficulties where say the patient is not able to participate as fully and freely as might be hoped for, at least until the care project has sufficiently developed to resolve that (Section 4.8.4.2).

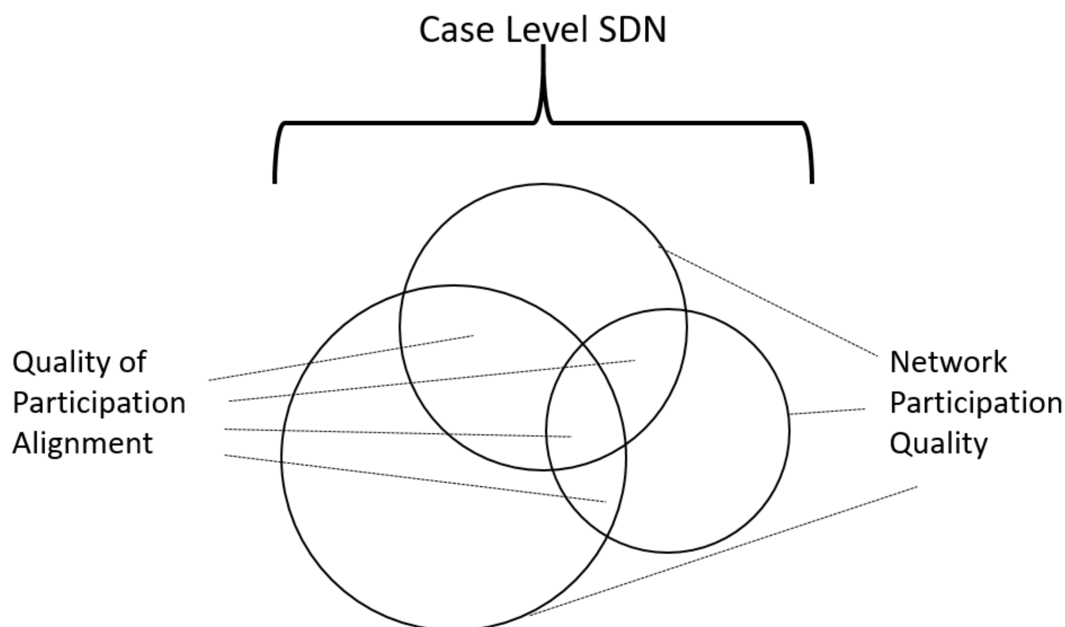

Figure 5-1 Representation of the Configuration of Service Delivery Networks at the Case Management level (taken from Paper 1, Section 2.9)

This principle is relevant because there is growing recognition that the optimal configuration of participants in healthcare is an important contribution to outcomes, as indicated in Paper 1 (Chapter 2). Interestingly, this principle has been further emphasised in recent work examining the transformative role of service design in healthcare (Anderson, Nasr & Rayburn, 2018). These authors draw attention to the fact that it may be that engaging and collaborating with service users is "critical to the success of complex long term service experience" (ibid, p.106), but that work is needed to structure how that might be designed in. Their argument was not supported by empirical work to elucidate how that might be achieved. Therefore the exploratory work undertaken in this project is quite relevant. By demonstrating in a healthcare example one approach to structuring a view of participation and collaboration, a useful theoretical contribution has been made (cf. Gallan et al 2013).

What is interesting about the practicality brought to bear through the adapted SDN concept developed in Paper 1 is the identification of emerging constructs of network participation quality and the quality of participation alignment. These, in their own terms and in combination, lay the groundwork for developing more objective assessment of participation within the SDN concept (Figure 5-1). This practicality is further developed in Paper 3 (Chapter 4) through the interaction

between the case level SDNs and the value realisation process, in effect giving a series of snapshots for comparison of ‘what works’ looks like.

The introduction of the adapted SDN as a fresh dimension to the service context landscape makes a contribution to theory building, as discussed in Paper 1 (Section 2.9.1.1). In contrast to the contemporary literature (Anderson, Nasr & Rayburn, 2018; Patrício et al, 2011; Section 1.4), this principle brings to life the complex case as a more fluid, co-constructed entity with levels of sophistication to how a diverse configuration of participants might contribute. In this context, this conceptualisation helps to capture how this organisational form might be viewed. It also provides a framework for considering how to compare and evaluate the effectiveness of different ways of empowering the SDN as a means of service improvement and as a key ingredient for service platform design.

5.2.3. Principle 3: Collaborative Value Realisation

The third principle is to develop a pragmatic realisation of collaborative value that arises from the particular valuation process, in context. Thus, from Paper 2 (Chapter 3), the case management review can be seen as a valuation exercise, where multiple orders of value are considered and reconciled within a co-valuation process (Section 3.6). Paper 2 sets out a range of valuation practice styles that were elicited (Section 3.6.1), and in Paper 3 (Chapter 4) the possibility is raised that different kinds of value might be realised at different times and in different cases (4.8.4.3). Paper 3 further emphasises the complexity of the relationship between SDN profile and the making of value. Therefore, valued outcomes from case reviews are a qualitative composite of the character of the SDN, the co-valuation practices and the particular stage in the evolution of care. In other words, as Spohrer & Maglio (2008) might put it, for the participants in the project, ‘are we winning or not’? How do we arrive at that view, and what reflection on how to develop the care project does that give rise to?

This collaborative view of value as “what matters to us” in the care project is a relevant and important perspective that is distinct to the subjective world of the beneficiary creating value for themselves, or that of deployed external measures of service experience or outcome (Paper 3, Section 4.2). ‘What we think’ at a case review at a point in time in a care project is a vital ingredient in the care planning

process in practice because it has the potential not only to reflect the view of all participants, but to address some of the inherent complexities of commensuration of different orders of value being expressed. This might be by empowering the voices of more vulnerable contributors in the process and sharing decision making as highlighted above (Section 4.8.4.2; Gallan et al, 2013). This might be by supporting a process of commensuration of contrasting orders of value amongst participants, capturing the shift from the dyadic to the many-to-many perspective (Patricio, Gustafsson & Fisk, 2018). Further what also emerges (Section 4.8.4.3), is that there is tension within case review performances, reflected in the range of co-valuation styles that emerged (Paper 2). This might well align with blending an approach between design and problem solving, as envisaged by Kimbell (2011). This is relevant in the context of recent emphasis on the role of service design in transforming healthcare (Anderson et al, 2013; Anderson, Nasr & Rayburn, 2018; Ostrom et al, 2015).

In practical terms, Figure 5-2 provides an illustration of pathways to collaborative value that our case series revealed. The diagram illustrates the case review embedded within its participant stakeholder networks. Within that context the paths to valued outcomes highlighted in Paper 2 (Section 3.6.1) are modelled. This sets the stage for further investigating how what matters to the participants is given currency within case reviews, and how that is supported or otherwise within the wider healthcare system (Akaka, Vargo & Lusch, 2013).

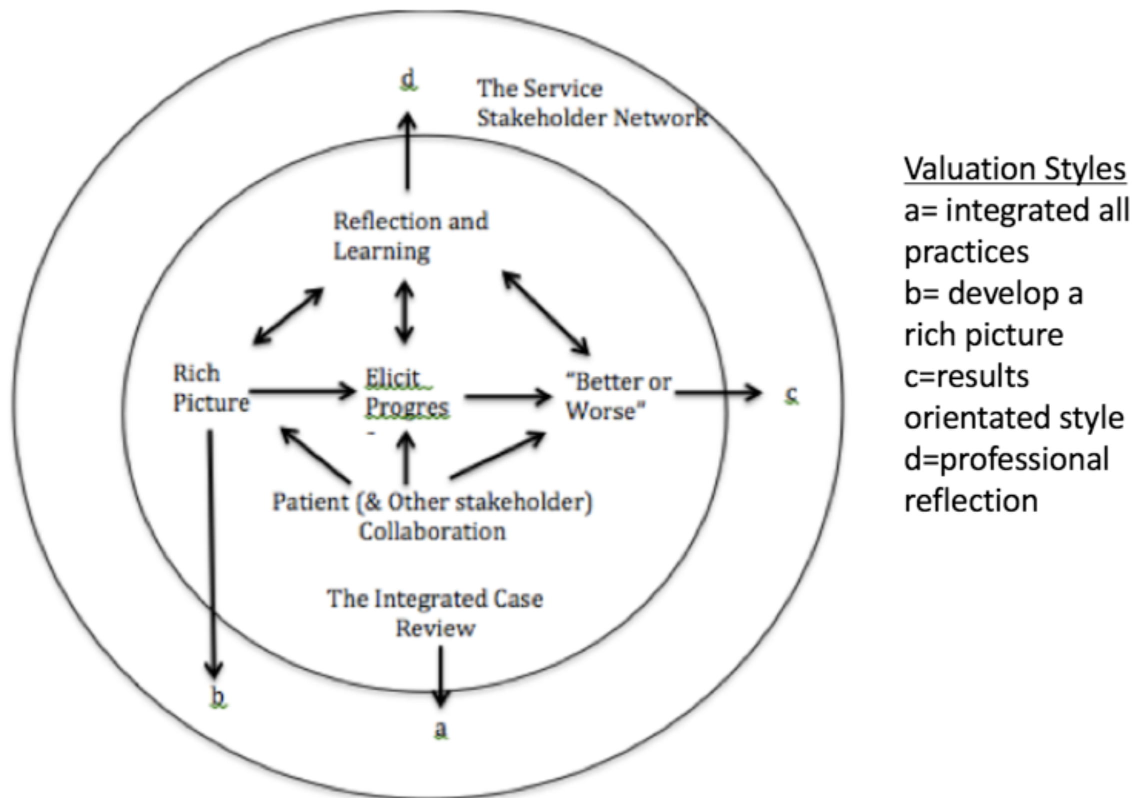

Figure 5-2 Pathways to making different kinds of value in CPA case management reviews. (Based on Table 3-4, Paper 2)

Reflecting further on this principle, the realisation of "what matters to us" as illustrated in Figure 5-2 is framebreaking. There is a tension between how we reconcile both the principle of patients at the centre of healthcare, and "designing service experiences in whole" for all participants in the system (Anderson, Nasr & Rayburn, 2018, p.109). By offering a potential framework for structuring a collaborative view that is both individualised and encompassing multiple views on value, this project offers one way of reconciling the tension. This is a perspective that can be seen as previously reflected in a shift to value networks (Patrício et al, 2011), but which is only just beginning to be explored in healthcare (e.g Pinho, Beirão & Patrício, 2014). The conceptualisation in Figure 5-2 provides a basis for further investigation and reflection of value making practice in healthcare and other complex service settings from this novel perspective. Further work is needed however to render the process of value realisation in terms of valued outcomes that might have wider currency.

In summary, for Principle 3, a distinct but complementary process to reflect collaborative value realisation is a necessary feature for framing value based healthcare for the complex case. This is not to lose the importance of the patient subjective view within the personalisation of healthcare agenda. Instead, the collaborative view would reflect an individualising agenda as seen in Principle 1 (Section 5.2.1), where the emphasis is on the case as a co-constructed care project. It might be suggested that 'personalisation' is reserved for the subjective standpoint, whilst "individualisation" might better suit the collaborative standpoint. This more intricate distinction is not currently made in the literature. Thus, this project advances a useful starting point toward structuring and operationalising how the realisation of collaborative value might be captured in service systems, complementing other vantage points.

5.2.4. Principle 4: Aggregation of Valued Outcomes

Case management reviews form an iterative process, building up understanding over time within the case management process. Building on Principle 3 above (Section 5.2.3), each case review offers the opportunity for a collaborative valuation. Principle 4 is concerned with how each collaborative review generates a valued outcome that has currency and can be aggregated both within the case management process, and for wider service management purposes.

In this project, whilst each case reflected value realisation at a point in time as outlined above, the case study series featured in the three papers did not include a longitudinal perspective. Nevertheless, collectively the cases did represent a range of stages in care across a case management process over time, and in Paper 3 how cases thus evolve within services over time is discussed (4.8.5.1). For Principle 4 therefore, the proposal is that the structuring of the service process from case review to case review is a key dynamic to the case management process. Each case review weighs progress in terms of valued outcomes, consisting of a collaborative valuation (Principle 3). In these terms, with each case review a touchpoint in the service journey, there is the potential to develop an aggregated view of progress over time (Patrício, Gustafsson & Fisk, 2018). This would not just be meaningful to the direct service participants, but expressed as

the aggregated collaborative judgment of a sequence of reviews, it could also have currency for wider stakeholders. Therefore, what process of aggregation might best apply across case management reviews as service touchpoints, and how might the uniqueness of each outcome be reconciled within a process of aggregation are key questions. A further question is how that process of aggregation fits within a wider context of service process.

5.2.4.1. The Process of Aggregating Collaborative Outcomes

There are two aspects to the purpose of aggregation of service outcomes. One is to track progress over time for a single case. The other is to track progress across different cases within a service of interest. Each depend on working with the nature of the outcome from each review. In terms of the process of aggregation, for some the process is conducted through the tracking of proxy measures, such as measures of satisfaction or outcome (See Chapter 1, Section 1.5.1). Others, adopting a value network perspective, have tended to rely on building qualitative descriptions of service experience (e.g. Pinho, Beirão & Patrício, 2014). In this project the nature of the case review outcome is presented as a unique, collaborative piece, involving collective practices, judgments and style of representing progress. This involves both a qualitative dimension, and a categorical element. Each piece is important as a categorical contribution to a larger jigsaw to be assembled over time. Meanwhile the nature of each piece, how it contributes to the wider service picture, and the quality of how that piece has been realised remains of key interest to the stakeholders. The composite of the qualities of the piece and its contribution to the care project over time might be termed progress. The aggregation of collaborative outcomes therefore offers a novel approach to capturing service progress, which merits a further elucidation of how the process might work.

Two sources of assistance with progress emerge from this project. First, each case review performance is capable of assigning a judgment on progress: indeed, that is integral to the valuation process as per Principle 3. Thus, within the care project over time participants are able to evaluate and reflect on what is working and what is not working and how it might be otherwise in terms that make sense to them collectively. As highlighted in Papers 2 and 3 (Paper 2, Section 3.6; Paper 3,

Section 4.8.5.2), this can be viewed as sitting within a valuographic process of enquiry as described by Dussauge et al (2015).

Second, it has been demonstrated through the worked case examples in this project that, within a pragmatic stance, a set theoretic approach is capable of structuring and capturing qualitative judgments such that systematic analysis can be undertaken using techniques from QCA (Ragin 2006; Ragin 2008). Within the range of co-valuation styles the assignment of progress does emerge as an important theme above (Paper 2, 3.5.2; Paper 3, 4.7.2). In other words, from a pragmatic stance within a community of practice (cf. Section 1.7.1.2), for whichever value making style is being enacted, there is an opportunity to cultivate a judgment from the case review as to whether progress has been made or not in terms of 'what matters to us'. Although they adopt the terms 'win' and 'lose' rather than 'progress', Spohrer & Maglio (2008) argue that such categorical approaches are the appropriate perspectives to take on outcomes in service systems. Such outcomes would certainly be amenable to quantitative treatment for example using QCA (Ragin, 2006). Meanwhile, this judgement making within a community of practice resonates with Dewey's notion of a democratic inquiry process as a valid basis for discovering knowledge (Section 1.7.1.3).

A further investigation of the feasibility of cultivating judgments on progress as serviceable outputs from case reviews in practice is needed. However, in principle it can be structured for the participants within case reviews to arrive at an agreed story of progress between them within reviews over time, whilst allowing a determination of 'making progress or not' to be generated for wider stakeholders. The agreed story remains meaningful to the participants over the course of care, whilst categorical assurances of progress (or otherwise) that are grounded in the collaborative experience are available for aggregation. This offers a practical basis for how the aggregation of case review outcomes can be taken forward for service management purposes.

The relevance of developing such an approach to aggregation within healthcare is its useful role in maintaining focus for participants from case review to case review to pro-actively reflect on progress, as well as serving as a focus for capturing real time value making. This provides both a source of information for service coordination and assurance (Tax, McCutcheon & Wilkinson, 2013), and a means

of integrating the service design perspective into the process, as envisaged by Anderson, Nasr & Rayburn (2018). This fits well with value based healthcare where the drive towards outcomes that matter is strongly featured. Moreover, as it is currently portrayed (Section 1.5), it potentially enriches the value based healthcare landscape by adding the dimension of "what matters to us" as a further mode of tracking progress. The approach complements other work in healthcare that emphasises the importance within value networks of the collaborative process in the evolution of outcomes over time (Pinho, Beirão & Patrício, 2014). Furthermore, some see the ability to aggregate individual case experiences as the root to transformation in healthcare service design (Patrício, Gustafsson & Fisk, 2018).

5.2.4.2. Aggregating Valued Outcomes and the Wider Service Process

In terms of how the flow of case management reviews over time relates to the service process more broadly, the work across Papers 2 and 3 (Chapter 3; Chapter 4) suggests two key aspects to consider. One approach is to simply see a stage of co-valuation as an extension of co-production and co-creation that have been previously described as stages in the service process (Grönroos, 2011). This format can be seen reflected in Payne, Storbacka & Frow's (2008) model of value co-creation in healthcare. In terms of that model, after engaging participants, assembling resources and beneficiaries creating value for themselves, a further stage of exchange can be added to reflect the interaction amongst parties to recognise and reflect what each other are saying about their experience of service. Thus, the aggregation of feedback data from participants in this staged approach is one methodology that could be considered, if such a linear service process can be justified. For some purposes the simplest case suggested by Payne, Storbacka & Frow's model might be sufficient. However, as it stands, the approach does not do justice to the more complex service situation, such as healthcare, where there are networks of multiple stakeholders (Pinho, Beirão & Patrício, 2014), and a continuous process of value realisation of perhaps several different styles. Meanwhile, from the valuographic insights discussed in Paper 2 it can be argued that what is creating value and what is evaluation of the service cannot be simply distinguished (3.2.1).

The other approach is to conceptualise a process of participant value realisation and collaborative value realisation as distinct, but interacting parallel processes. Figure 5-3 illustrates these two distinct approaches to aggregating value. In the alternative approach, the linked parallel process of public collaborative value and private, individually determined value offers a more sophisticated approach, and it aligns in principle with how in the literature the service eco-system structure is seen as being built up (Vargo et al, 2017). In other words, what is proposed is that just as Vargo & Lusch (2004, 2008) emphasis a cycle of value co-creation focused on the individual beneficiary, there is similarly within the service ecosystem a linked but distinct cycle of collaborative value realisation that mirrors it. This perspective extends the pragmatic stance to include the institutional positioning of case reviews in healthcare, as envisaged by Sabel (2012). This latter proposal shifts the ground in that it leads to theorising a boundary mechanism to explain how understanding of value at the micro and meso levels can be commensurated in complex service systems. As pointed out in Paper 1 (Section 2.9.1.1), the likelihood of such more fluid institutional arrangements would be a suitable focus for pragmatic inquiry. It would be interesting to compare such a perspective against alternative contemporary conceptualisations such as multi-level service design (Patrício et al, 2011).

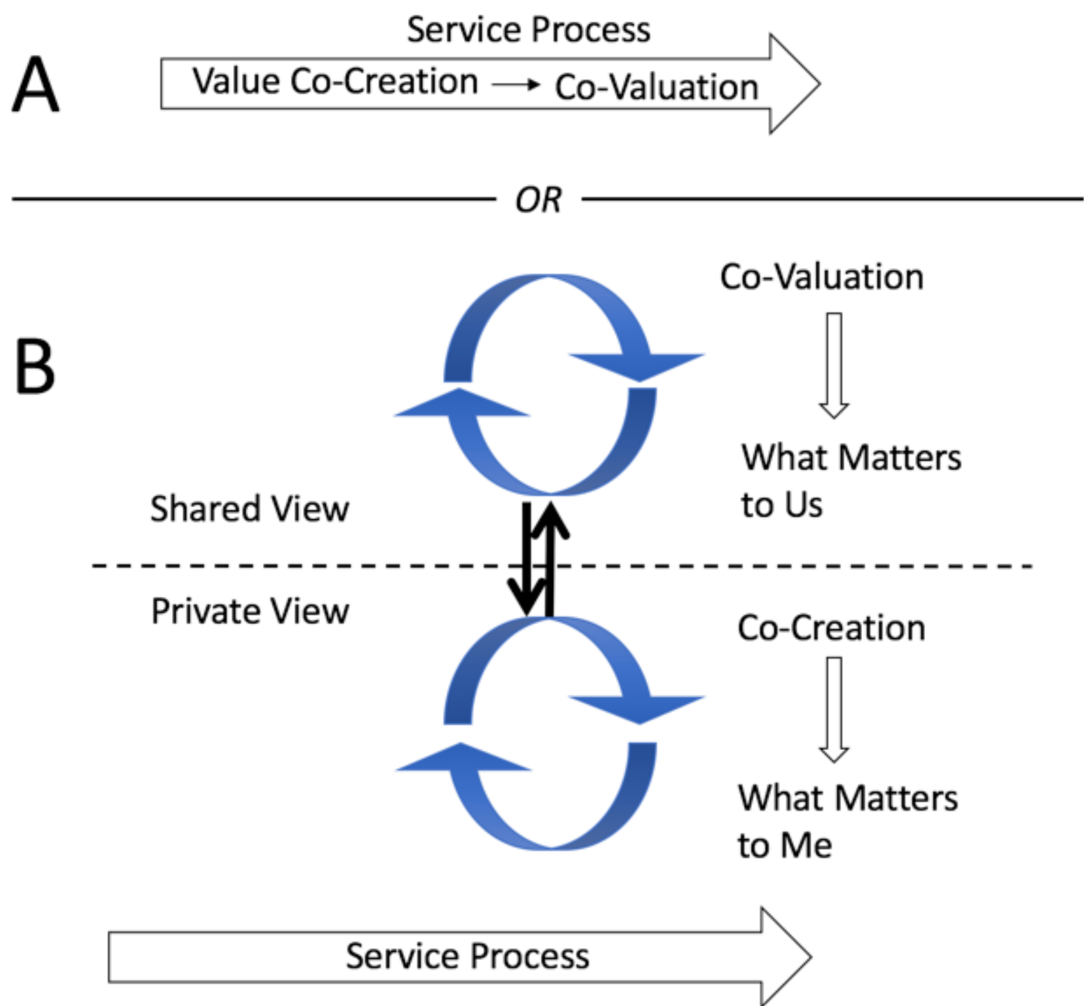

Figure 5-3 Contrasting models (A & B) of value aggregation

In summary, Principle 4 introduces and underlines the importance of the longitudinal perspective to case management reviews, with the aggregation of value over time. In this context, valued outcomes from case review series form complex pieces to be assembled over time. This process serves both to form a meaningful picture over time for stakeholders to respond to, whilst also providing a basis for seeing that progress is being made for wider service purposes. There are further questions to resolve about how to pragmatically accommodate such an interplay between the case level and wider service system perspectives within available service conceptualisations.

5.2.5. Principle 5: Service Platform Co-design

The fifth principle is that the healthcare service provider requires a service platform that can support complex case management to best effect. There are diverse perspectives on the concept of a service platform in the literature (Storbacka et al, 2016). For this thesis, a service platform can be thought of as an archetype: an organisational form that provides a template for structuring the service process, including the role of participants, their interactions, and the service process (Greenwood & Hinings, 1996; Myhren et al 2018). Service platforms are seen as a means of enhancing service exchange, and opening up opportunities for innovation (Lusch & Nambisan, 2015). It is the responsibility of the service provider to lead on the development and co-ordination of the service platform (Tax, McCutcheon & Wilkinson, 2013; Grönroos, 2011). This work addresses the fact that explicit service platforms are not a prominent feature in healthcare (Bohmer & Lawrence, 2008).

To develop this principle an important distinction is made between a service framework and a service platform. Following Ostrom (2011, p8), a framework consists of the most general form of theoretical analysis. They identify the general elements and their relationships to be able to organise further inquiry. They provide a meta-theoretical language for comparing theoretical perspectives. Like Ostrom's concept of a model (ibid), service platforms are intended to represent more specific and more precise representations. As such the position adopted here is that specific local service platforms sit within a wider, meta-theoretical service framework. Meanwhile, the term 'care platform' as used by Bohmer & Lawrence's (2008) is taken to be equivalent to the term 'service platform' in the literature. In the light of the four principles outlined above, this section considers the service framework perspective first, before considering the development of specific, local case level service platforms.

A key contribution of Paper 3 was the development of a proposed complex case management framework (Complex CMF). Figure 5-4 reproduces the framework from Paper 3 (Section 4.8.5). Consistent with the above principles, building on previous work (Wagner, 1998; Wagner et al, 2001; Batalden et al, 2016), the framework proposed is intended to re-focus attention on the case level as the unit of analysis, that each case is a distinct project within a unique SDN, and that there

is a process of co-valuation which allows distinct and individualised collaborative outcomes to be aggregated over time to best effect.

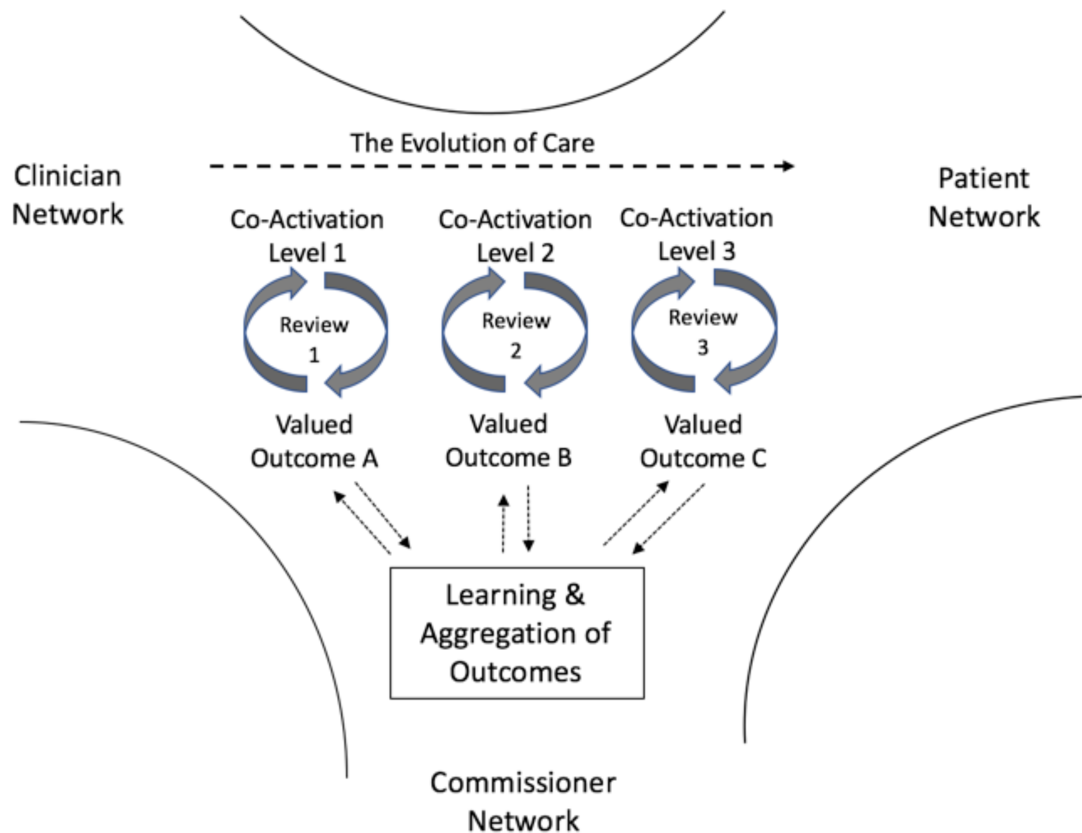

Figure 5-4 The revised complex case management framework (Complex CMF): Taken from Paper 3 (Figure 4-9)

In order to develop a service platform a further step is needed. The task would be to develop a structure within this framework that operationalises these principles for the particular participants in each complex case management project, in its specific service context.

5.2.5.1. Discovering Service Platforms in Existing Practice

A specific exploration of what structuring or archetype the service provider deployed to support these CPA case management reviews was not within the scope of this investigation. However, within a pragmatic inquiry, it is important to pay attention to the actual clinical situation (Pedersen, 2018). In that spirit, it is

possible to reflect that within the series, some cases benefitted from a rich and detailed structuring to the service process, and some did not. For those that did show more structuring, as has been pointed out, there were different styles of co-participation and co-valuation evident as in play for example. Therefore, it is proposed that, within the manifestation of these practices, there is an implicit service platform to be discovered for each case. Meanwhile, in Paper 3 (Section 4.8.3) the nature of this structuring is hypothesised as contributing to the relationship between participant context functioning and the realisation of valued outcomes.

In approaching the design of a service platform, either the service provider determines the configuration *for* the other service participants, or the service provider develops the configuration *with* the participants (Kimbell, 2011). Since it is the collaborative approach that is increasingly emphasised in healthcare (Horne, Khan & Corrigan, 2013), it is the collaborative approach that is appropriate to support complex case management reviews. This means that it is for the local service to operationalise the service platform in collaboration with local stakeholders. Beginning with recognising the service platform dynamic already in place, the insights developed in this thesis function as a set of tools to assist in developing the service platforming process further.

5.2.5.2. Service Platform Development Tool

From the perspective of co-developing service platforms to support case reviews within services, as highlighted, some structuring is already happening. Therefore, the key first step is to consider what practices are in place already and then how might these be otherwise. Figure 5-5 is a tool that aims to reflect the distinct insights developed within this thesis about what is important for case level value generation in complex case management, drawing on the themes drawn from value based healthcare (Paper 2, Chapter 3), and woven through these three papers and built into the Complex CMF (Figure 5-4). Thus, it integrates three dimensions: the circle of support that is framing the case; the value generating themes that are being enacted; and the progress from case review to case review, as makes sense locally. The questions for each element are what practices are in place already? Then, how might they be improved and what additional practices could be considered? Bearing in mind that different approaches to collaboration

and purpose can be used to achieve different levels of sophistication (cf. Kimbell, 2011), it is envisaged that this approach offers a means of effecting care platform co-design that can be intricately developed within the local setting.

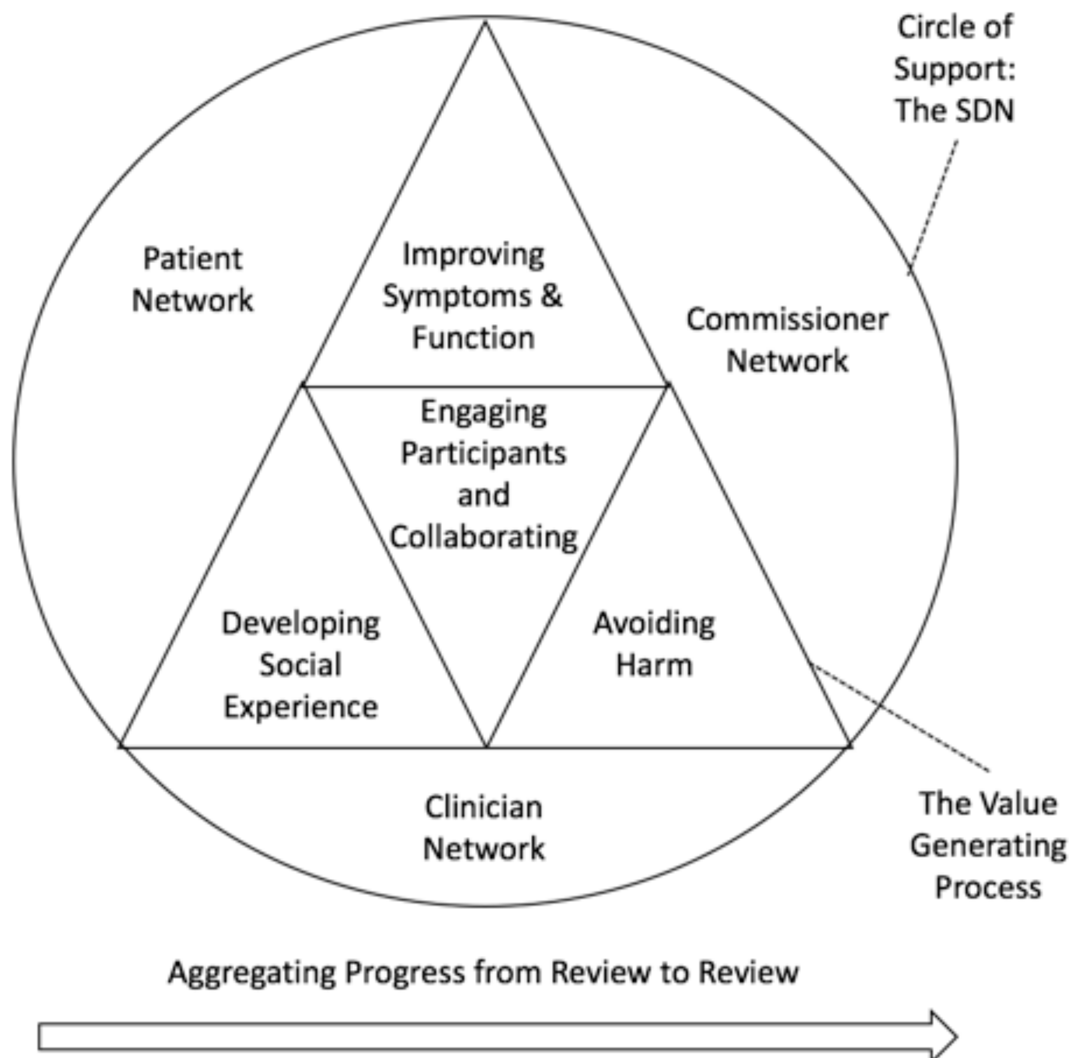

Figure 5-5 Service Platform Development Tool

Interestingly, Kimbell (2011) positions such an approach as ‘a platform for service’, where its nature is to embrace the input of the local participants in customising the structuring of the service to best collaborative effect. Thus, it is envisaged that this tool can support the service provider in developing consistent care approaches

across cases within services in consultation with service users and others. However, the tool also assists with developing a means of bringing all the case level participants onto a common ground for a much more individualised, within case co-design process. Section 5.4.3 below expands on how this tool has been used in the host organisation within this DBA project.

A perspective on context, value realisation and a practice framework in support of complex case level care management has been developed across these five principles outlined, as proposed in the introduction. The culmination in a tool for co-designing and putting into practice a collaborative service platform to effect these principles makes a highly relevant contribution. First, establishing a case level service platform is seen as relevant in the healthcare literature (Bohmer & Lawrence, 2008). Meanwhile, as outlined in the introduction, the gap in organising and structuring of case management is a key concern in the case management literature (Section 1.3.2). Further, this platform tool presents within the healthcare landscape an archetype that is able to draw attention to the collaborative complex case level view, in contradistinction to the more mainstream, single condition or clustered, care pathway views.

The relevance of emergent service platforms for complex service settings with many to many interactions is also highlighted more generally in contemporary service innovation and design literature (Patrício, Gustafsson and Fisk, 2018; Lusch & Nambusan, 2015). Further, Sangiorgi includes the designing of infrastructures and enabling platforms as a key ingredient in transformative service co-design for the public sector (Sangiorgi, 2011). Citing Ehn (2008), Sangiorgi argues for the importance of developing the capability of ‘design in use’ for such services, in which the service platforms play a pivotal role. Ehn argues that through such a process of “infrastructuring” (Sangiorgi, 2011, p36), customisation and continuous use design becomes possible. Putting these elements together pragmatically, the service platform development tool (Figure 5-5) supports the structuring of the collaborative review and design of care practices in play within case reviews. Meanwhile, the emerging CPA review to CPA review staging principle supports the realisation of a platform for supporting continuous use design and customisation.

One implication of the principle of case level service platform co-design is that it provides the space to build consistency of practice within cases and from case to case. At the same time, it supports an individualised structuring of the service within a platform template style that best suits (cf. Myhren et al, 2018). This goes some way to addressing the tension within healthcare between using ad hoc structuring of the service experience, drawing on the local clinicians proceeding as they think best, and introducing proscribed protocols for care processes to ensure standardisation of practice and care experience (Swinglehurst et al, 2014). It starts to make sense of the introduction of variation in co-creation styles in healthcare introduced by McColl-Kennedy et al (2012).

In order to shift the ground in healthcare however, progress is needed in putting principles into practice (Edwards, 2011). Thus, the advantage of this project is that within the pragmatic stance the practical reality of complex case management and its diversity of practice has been harnessed in this exploratory process. As a result, an approach to service platform co-design has been described, with the expectation that it could have applicability not just for complex healthcare, but also for services more widely. This takes the idea of people-powered health to a fresh level (Horne, Khan & Corrigan, 2013), and sets the stage for a research programme to investigate the further applicability of service platform co-design in other, wider healthcare settings, and in complex services more generally.

5.3. Reflection on Contributing to Theory (RQ 5)

This section provides a reflection on the fact that the various conceptual and theoretical resources drawn upon for this project have been adapted, revised and shifted in response to the challenges of these investigations. Some transformational implications for wider service theory are highlighted in the respective papers (e.g. Section 2.9.1.1; Section 3.6.4; Section 4.8.5). The aim of this section is to focus on the broader interplay between conceptual resource and investigation within the overarching thesis project.

As set out in the introduction (Section 1.7.1), this thesis is developed within a pragmatic stance, and does not adopt an a priori, strong theoretical position. In fact, a range of conceptual tools have been appropriated from different, relevant

bodies of theoretical literature to support this exploration. In making these appropriations, this project has been able to advance issues in capturing context, realising collaborative value, and identifying the principles and features necessary for framing case level value based healthcare. Each of these adaptations or refreshed conceptualisations potentially makes a fresh contribution to the literature as discussed over the course of this thesis. Key instances of these contributions are revisited in the further research section below as they relate to advancing value based healthcare (Section 5.5.4). To the extent that there is practical usefulness and fruitful research, confirmation of these theoretical insights would be an important source of validation (Section 1.7.1.5). Meanwhile to the extent to which these fresh conceptual insights do prove helpful and fruitful, there are a number of further points in relation to theory that emerge for consideration.

5.3.1. A Source of Empirical Example.

It is a recurring motif in the diverse literature quoted in this thesis that there is a lack of empirical application and testing of theoretical concepts in practice. This can be seen both in service literature and healthcare literature (for example, Section 1.2.3; Nolte & McKee, 2008; McColl-Kennedy et al, 2012; Ford & Mouzas, 2013; Hardyman, Daunt & Kitchener, 2014; Vargo & Lusch, 2016). Meanwhile, such empirical applications that have been reported were based on different kinds of foci of interest. For example, the investigation of the ego-centric perspective was more usual in the service literature (e.g. McColl-Kennedy et al, 2012). Meanwhile, the focus for healthcare literature was rather on service user populations (e.g. Section 4.2.1) Therefore, there is an important contribution to be recognised in bringing conceptual tools into play with case level empirical data and testing their applicability. Thus, in this project a contribution was made for example in empirically exploring Tax, McCutcheon & Wilkinson's (2013) concept of service delivery networks for multi-party collaborative exchange (Paper 1, Chapter 2). Again, empirical work within a valuographic framework (Paper 2, Chapter 3) is also a useful contribution (Vatin, 2013; Dussauge, Helgesson & Lee, 2015).

5.3.2. Bringing the Case Level into Focus

In a related point, a further feature of the theoretical resources that feature in the literature, as discussed above (Section 1.4.3; Section 1.5) was the general need to

further develop conceptualisations for application to the case level, rather than just in general service terms. For example, the Chronic Care Model (CCM) was focused on broader service co-ordination issues rather than co-ordination of the individual case, for which there was limited empirical exploration (Paper 3, Chapter 4). Thus, a key contribution in this project has been the reformulation of the CCM (and also the reworking of the CCM by Batalden et al's 2016), to be able to focus attention in on the individual complex case. This differing perspective on zooming into the case level service experience is a key concern in the literature (Baker, 2011; Ford & Mouzas, 2013; Hardyman, Daunt & Kitchener, 2014; Vargo & Lusch, 2016; Storbacka at el, 2016). This project's empirical findings show, for example, the shift in the nature of valued outcome from a simple measure or a subjective report conceptualisation at the service level, to a complex, interactive piece of a larger jigsaw that has rich implications when focused in on the individual case (Paper 2, Section 3.6.1; Paper 3, Section 4.8.5.2). Thus, this project has made a further contribution in demonstrating empirically the additional complexity that the case level perspective brings when zooming in.

5.3.3. The Meta-Theoretical Exchange of Ideas.

This project has adopted a vantage point at the intersection of a range of theoretical fields and approaches (see Section 1.7.1.5). The introduction outlines some of these as being the case management landscape (Section 1.4.3), the context generating landscape (Section 1.5) and the value landscape (Section 1.5.1). These are all conceptual spaces, which represent tensions between contrasting theoretical perspectives. As indicated, throughout the process of this project fresh adaptations have been realised which address some of these tensions. In addition, the adopted pragmatic case level focus provides a common ground that bridges the exchange of ideas between different conceptual domains. Thus, provided it proves helpful, the collaborative framing of value based healthcare that has been developed reflects a meta-theoretical synthesis from these diverse sources. It is instructive then to notice that, with a continuing focus on this meta-theoretical sample, it has been the case that further theoretical perspectives have come into view. As developed in this discussion above (Section 5.2), there are further themes in the literature from service design and service innovation that can be appropriated as aligning with the challenge to

optimise services at the case level within complex (often public) service systems. There is gathering momentum to synthesise multi-disciplinary contributions and multiple perspectives to achieve transformative service research (PatrÍcio, Gustafsson & Fisk, 2018). It can be argued that, with its grounding in empirical, meta-theoretical sample, and the pragmatic exchange of ideas demonstrated within this methodology, this thesis makes a good contribution to that gathering momentum.

It is important to bear in mind the risks of combining diverse conceptual resources. The mis-appropriation of ideas for circumstances that they were not intended to address is a recognised source of error (Möller, 2013). There is an important tension across this project in relation to complexity and the multi-level, multiparty view of exchange, which is a key focus for contribution in this thesis. The service ecosystem view that underpins a range of conceptualisations used in this investigation provides one approach to this perspective. However, there are key points of divergence, which are instructive. For example, pragmatically, this project focuses on a discovered case level context. There are similarities and differences with this and the micro-level perspective seen in work drawing on the service eco-system perspective. This issue and its implications are highlighted at different points across in Papers 1 and 3, for example (Section 2.3; Section 4.8.4.3). It can also be seen in the discussion of Principles 4 & 5 (Section 5.2.4; Section 5.2.5). The nature of complex, multi-level service proposed by Patrício et al (2011), for example, is not the same as the emergent complex case level conceptualisation developed in this section. First, a pragmatic position of found definitely complex cases has been adopted in this project (Section 1.2.1). Second, this project did not adopt an a priori position on non-case level service context, it was just an emergent practical reality. Meanwhile, for Patrício et al, a multi-level position has quite ordered and specific connotations. Meanwhile, the term is also used differently by others (eg Frow, McColl-Kennedy & Payne, 2016). Therefore, it can be argued that further groundwork to review and revise the conceptual landscape is a necessary task for gathering further momentum behind transformative service research.

5.3.4. The Interplay Between Service Research and Healthcare

The exchange of ideas between healthcare and bodies of service theory is not new. The issue of appropriating ideas from service theory to healthcare has been recognised. For example, the appropriation of the concept of “lean” for healthcare has attracted much attention (Radnor & Osborne, 2013). By the same token, it is also important to notice that ideas from healthcare have long influenced conceptualisations in service theory. This can be seen where the idealised notion of the patient-doctor interaction has been appropriated, for example to model service encounters (Stabell & Fjelstad, 1998; Tax, McCutcheon & Wilkinson, 2013). The flow of ideas between bodies of thought is therefore an important dynamic. It is therefore perhaps timely to for this project to update the idealised patient doctor encounter with a fresh, more typically complex, multi-party exchange for use in service thinking.

Further as discussed in the introduction (Section 1.7.1.1), the pragmatic stance adopted within this thesis does provide a framework for integrating different types of knowledge together. As noted previously, some argue for dispensing with a distinction between clinical and organisational domains (1.7.1.4). Through the process of pragmatic inquiry and engagement with empirical work, ultimately it is the development of distinct practical opportunities that matters. What has been proposed from this work is a generic organising framework that captures diverse elements to represent complex service exchange, without underestimating the difficulties and complexities of relying on seemingly more all-encompassing theories would present (Kohli, 2011; Möller, 2013). It also represents an opportunity for practitioners in different settings to mobilise other conceptual resources and map them onto a framework that supports their particular service focus and circumstance to the realisation of collaborative outcomes that are valued by them.

5.3.5. Summary

In summary therefore, the pragmatic stance is of course itself a conceptual resource that merits further reflection. Its value has been as an enabling framework for integrating a multi-theoretical landscape and linking that with what might be found in empirical practice. As highlighted in the introduction, it ought to

have more prominence in healthcare improvement (1.7.1.4). It has been helpful in this project to deploy existing tools such as set theoretic methods and QCA that work well within a pragmatic stance. This project also makes a further contribution by developing further approaches and tools that might assist others with local service improvement efforts, and investigating complex service exchange. However, this approach should complement other investigatory stances (Cox & Hassard, 2008). Further, in this thesis an exploration of a common, meta-theoretical sample was undertaken. This should be complemented by other perspectives, where different samples are explored in parallel, and over time for example (Lewis & Grimes, 1999). Meanwhile, it is essential to the validity of this approach that it not only suggests something distinctly, conceptually or practically, but that such suggestions can be seen being coherent over time (Section 1.7.1.5). Thus, the establishment of a relevant programme for further work is key. Whilst suggestions for further research have been highlighted at different stages of this investigatory process, some key broad themes for further work are selected and presented below (Section 5.5.4.1).

5.4. Reflection on Project Impact for Host Organisation (RQ 6)

As a DBA project, the implications of this work for the host organisation are critical. As set out above, work has been done to suggest approaches to healthcare improvement more generally. In this section, what is under consideration is the specific impact on the host organisation, a hospital providing specialist learning disability care for complex patients. A DBA project is not the final thesis, so much as the interplay between the organisation and ideas generated as the project unfolds. In this context, a number of distinct contributions have been made. First, there has been a process of presenting service evaluation data within relevant forums within the organisation's specialist learning disability service. This led to a mobilisation of fresh concepts and tools with which to grasp contemporary service management issues. Second, there has been the mapping of care practices in relation to generating valued outcomes using conceptual tools developed within this project. Third, going beyond this project, there has been an appropriation of the concept of framing valued based healthcare for the complex case to develop a fresh service delivery framework for supporting complex case management, which

is being piloted with a view to wider roll out within the specialist learning disability division.

5.4.1. In House Service Evaluation.

Papers 1 & 2 (Chapters 2 & 3) were highly relevant explorations of diversity of CPA practice within the host organisation. The data from each was presented at a range of service improvement and educational meetings for clinicians and service managers. It was helpful to have a sense check that the findings were judged to be consistent with the experience of others in the organisation. It was instructive for the organisation to draw attention to how case reviews were structured and organised as a source of variation not previously considered. At this stage, these presentations did not feed through to an overhaul of the CPA case review process as might have been expected as a number of significant organisational changes overtook the process. However, it is the case that this project lends further weight to the need to refresh thinking on how to do CPA within the service sector (Section 1.2), and how to strengthen systems from the kind of service failure that was unfortunately reported at Winterbourne View hospital (Flynn & Citarella, 2012; Section 1.2.4).

5.4.2. Introduction of Novel Concepts.

At the clinical team level, rather than the organisation management level, there was interest in learning more about what makes for case level value. Interestingly this had not previously been a prominent area of reflection amongst practitioners. In this context, a road show of workshops was undertaken across the specialist learning disability division. The workshops consisted of an exploration with clinical teams of what the themes were that captured value for patients, referencing value based healthcare as represented in Paper 2 (Chapter 3). The workshops adopted a particular case open to the team as a focus for discussion. The discussions focused on the value themes that emerged through this project. There was an exploration with clinicians of what practices were being employed that could be mapped against value themes, and what further practices might be useful to improve the generation of value for the patients. It was helpful to confirm a consistent recognition of the key themes that emerged in Paper 2 as being relevant and comprehensive. Benefit was realised in the workshops by expanding

understanding within the teams into the broader ways that value might be generated in the service, including areas that might have previously been overlooked or received less emphasis. Meanwhile, the exercise served as a useful focus for the team to generate fresh further practices that might be introduced to advance value for patients. Thus, the care of a number of individual patients was enriched following such discussions.

5.4.3. Framing Value Based Healthcare for the Complex Case.

At the organisational level, a development project was commenced within the organisation that sought to reconfigure the care experience for the complex case on value based health care principles. Stemming from the findings of the papers in this project and the emergent principles outlined above, a novel framework was developed, the Complex Case and Recovery Management Framework ("The CCaRM"). The purpose of the framework was explicitly to provide a platform for design for teams to work with as envisaged above (Section 5.2.5), and which would be readily meaningful, particularly for service users. Therefore, appropriating the service platform tool structure featured in Figure 5.5 (Section 5.2.5.2), the CCaRM is similarly structured (Figure 5-6). The principle themes are reframed as developing the circle of support, building a shared understanding, collaborative planning for progressing problem areas, managing risk and keeping people safe and promoting social participation and recovery. A final element is understanding whether progress is being made from review to review (cf. Section 3.3.1.1)

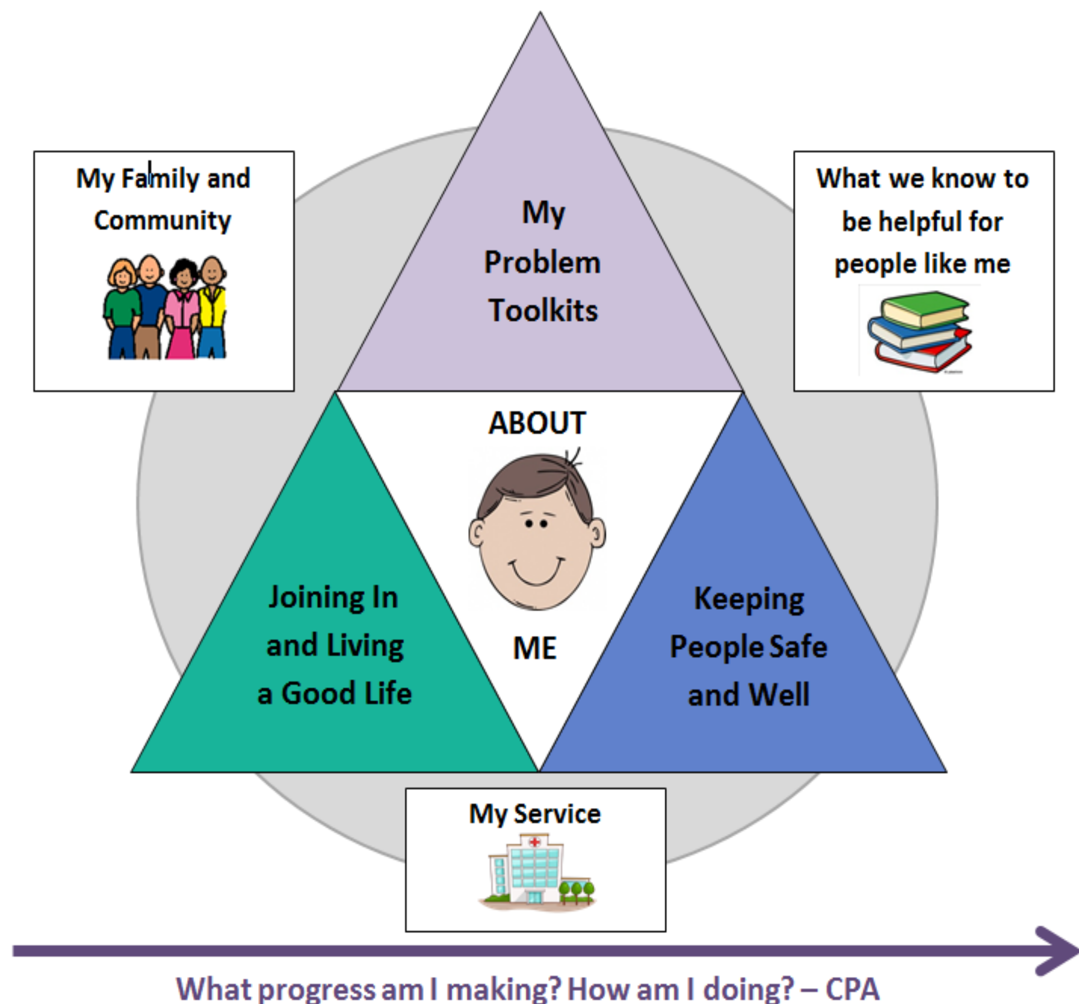

Figure 5-6 The Complex Case and Recovery Framework ("The CCaRM"): Easy Read Version

Figure 5-6 was developed with patients and colleagues within the host organisation, and serves as an illustration of the influence of this thesis.

This co-developed architecture serves to orientate the care participants (professionals, commissioners and service users) as to what are the areas that matter for each case, and how best to direct support and resource consistently, drawing on best practice. Figure 5-6 presents the easy read version as one illustration of a range of tools that have emerged from The CCaRM project. All facets of care are captured by the framework and individualised to suit the particular case. This framework, along with a range of other linked individualised collaborative support tools, are assembled for use through a process of collaborative platform making.

A detailed description of the CCaRM and how it is used is beyond the scope of this project. However, it serves to illustrate how the five principles outlined above (Section 5.2) have been taken and applied in the host organisation. In this context, using the CCaRM has therefore in practice been of service within the organisation for supporting care practice and designing interventions, and for building into business cases for new service development for example. The CCaRM has been presented in a number of fora within the local service sector (e.g. Spurrell et al, 2017), and is currently undergoing further evaluation within the specialist learning disability division within the organisation.

5.5. Conclusions

It is one thing to propose that a focus on value should be the central driver for healthcare and healthcare transformation, it is quite another to understand how that principle might be put into practice. This issue becomes more pronounced when considering the pressing need for practice support with the management of the complex healthcare case. The focus of this thesis has been to explore this question, with the aim of further developing an understanding of how in principle to frame value based complex case management. As a DBA project there is a particular, practical remit to link the work with the service realities of the host organisation and its service sector, this being the troubled area of CPA case management. In this regard, this thesis makes three broad contributions. First, a fresh conceptualisation is developed for how to view the service predicament of the complex case. Second, a set of principles are developed that link that synthesis with a project for participants to co-develop service platforms for themselves. Within a framework, such a service platform is therefore individualised by the participants to support practices to realise collaboratively valued outcomes in complex case management systems such as CPA. Third, the appropriation of ideas is a two-way street. Just as the appropriation and synthesis of ideas from the wider service sector might benefit healthcare, so might the development of the principles for complex case management in this healthcare focused project be useful for the wider service sector. This thesis represents just a start on this work. Whilst particular contributions have been highlighted across the course of this thesis, the focus of this section is to capture the broad overarching contribution

made by this project. Meanwhile, for each of these areas, an additional contribution is the identification of further key questions to be answered and the outlining of further suitable research programmes accordingly.

5.5.1. Reconceptualising the Complex Case

The findings of this project are that a much more dynamic and nuanced view is needed for understanding service context and the process of value realisation in healthcare. Thus, in contrast to the work of McColl-Kennedy et al (2012) and McColl-Kennedy et al (2017), it is the performance style of *all* the participants, not just the service user, that determines the framing context for value creation. This is important because it is through the configuration and disposition of these diverse agents that the resources are made available for the service process. In contrast to the view represented by some authors (e.g. Storbacka et al, 2016; Coulter, Roberts & Dixon, 2013), it was not thought necessary or correct to separate human and non-human agency as the principal source of resource. Further, in contrast to Frow, McColl-Kennedy & Payne (2016), complex cases are not seen as rigidly held within hierarchical institutional structures, they are emergent within their own network spaces (cf. Törnroos, Halinen & Medlin, 2016), with complex interactions with the wider service eco-system. This is important because it adds a further dimension to calls for people, particularly patients and carers, to be more empowered in the case level context (Horne, Khan & Corrigan, 2013).

Meanwhile, for the realisation of value, this project has revealed this to be a more complex performance than suggested by for example Porter and colleagues (cf. Porter, 2008; Porter & Teisberg, 2007; Porter, 2010; Porter, Pabo & Lee, 2013). Valued outcomes are not passive phenomena, they are realised through a performance that captures and aggregates progress in terms of what matters to the participants from case review to case review. Valued outcomes are realised through including a collaborative process amongst participants to work out and shape what that valued outcome consists in at that point in time. This is important because it is the making of value and the assembling of these qualitative elements of progress over time for each case, and across cases within a service, that give weight to how a service might be judged as delivering value based healthcare (cf. Dussauge et al, 2015).

With a more intricate, dynamic view of context and contingent resource on the one hand, and a more complex value practice based view on the other, a fresh perspective emerges from this project on how to frame value based healthcare for the complex case. This includes new perspectives on how to optimise each of these context and value making process themes, both separately and as interacting features within the complex case project. This matters because these are novel avenues for service improvement initiatives. These themes in particular represent opportunities for addressing shortcomings identified for CPA case management within the host organisation, and the wider healthcare sector (Section 1.2). In principle, the same also applies to wider case management. Meanwhile as set out above (Section 7.2), this work has set the scene for the proposed principles that might be used for developing a service platform tool to support practitioners with the challenges of complex case management (Bohmer & Lawrence, 2008).

5.5.2. The Co-Development of Service Platforms

In this thesis, a unique perspective has been developed for responding to the call for care platforms to support complex case management in healthcare (cf. Bohmer & Lawrence, 2008). What has emerged is that the focus of service is the individual case (Section 5.2.1), not the population of cases, or the service segment, or the institutional service pathways. Meanwhile in keeping with Kimbell (2011), what has been envisaged has been the development of a platform for service. In other words, a framework that can be consistently applied from case to case, but which at the case level can be collaboratively customised by the participants to shape a particular service platform that best serves the particular case, anchored by the aim of progress towards valued outcomes. Thus, using the principles outlined (Section 5.2), this thesis paves the way for clinicians and service managers to lead the platforming of care practices within services in a way that does justice to individualisation of care, whilst maintaining an overarching consistency of practice.

As illustrated above (Section 5.4.3), through the interplay between this DBA project and the host organisation, a specific contribution has been made in developing the Complex Case and Recovery Management Framework (The CCaRM) as a platform support tool within the local service. This is important as it demonstrates an early bridging from research into practice, which is a key issue

for enabling healthcare to benefit from service theory insights (Proudlove, Moxham & Boaden, 2008). Further, the initiative is organised to be woven into the CPA case management process. Therefore, this approach lends itself to structuring not just CPA case management more widely, but case management in other complex healthcare settings too (Goodwin & Lawton Smith, 2010). This general conceptualisation of framing value based healthcare for the complex case fruitfully complements more established service level approaches to structuring outcome delivery such as the CCM (Wagner, 1998; Wagner et al, 2001). Taking this a step further though, this project has made a further contribution to the practice sector through its re-conceptualisation of the CCM (The Complex CMF, Section 4.8.5). Building on work commenced by others, (Batalden et al, 2016), this takes forward the initiative to better align healthcare models and frameworks with contemporary service theory.

5.5.3. Lessons for Service Theory

As highlighted above (Section 5.4.2), the experience of service in healthcare has previously been an important resource for developing service theory. The reality of complex case management in healthcare is that it can attract the attention of a diverse range of service theory perspectives, some quite distinct and some conceptually overlapping. Ultimately, such service projects are about best configuring diverse, polymorphic service entities, each with multiple stakeholders, and optimising them as value generating systems. However, as Möller (2013) argued, there is no single, best theory to represent the service landscape, and this project demonstrates quite how intricate the adaptation of available service constructs needs to be. Nevertheless, this thesis demonstrates how such a multi-theoretical landscape can be engaged to useful effect by a pragmatic case study focus. In this context, a number of distinct conceptual features have been developed.

First, by recognising CPA case reviews as service entities within the service system, this encourages the opening up of this more complex agency perspective as an important focus of study for service system research more generally. Meanwhile, as highlighted above (Paper 2, Chapter 3), a pragmatic, valuographic perspective to the making of value has been developed. From this, a number of distinct insights and contributions have emerged. Second, it has been helpful to

make an empirically based contribution to the expanding body of work in this area. Third, from a practice based standpoint, understanding how value is made shifts the ground so a currency for service realisation is a collaborative performance. Thus, this project illustrates how such more complex, composite valued outcomes can be realised and aggregated. At the same time, it opens up the study of micro-level service functioning to a much richer range of questions. This includes how to reconcile value co-creation and co-valuation within service exchange. A further question that it generates is how to understand and manage the transition between what is valued within the case level collaborative exchange, and what is valued across the wider service system. Further, with the complex case management framework (Complex CMF), by reconceptualising the capturing of context and the process of value making, a fresh paradigm for modelling the value generating system has been proposed as a basis for further research (Section 5.2.5).

5.5.4. Limitations and Further Research.

The approach taken within this thesis has been to focus on the phenomenon of CPA case reviews for a series of complex cases in a learning disability service. The case series has been positioned as a meta-theoretical sample for exploring and adapting a range of conceptual resources to gain a better understanding of how in practice to frame a process of value generation for the complex case in healthcare. From this also, lessons might be drawn more widely for instances of complex service provision. This project represents a first step in this process. There are two key limitations, from which a further research programme can be defined. The first arises from the need to explore other settings to see whether the features discovered in these three investigations are more generally applicable. Therefore, as discussed within the papers, there is more work to do to replicate the findings in other areas of healthcare, and to explore further the many different other collections of participant practices that can be found within such service exchanges to further corroborate the principles that have been proposed.

The second area of limitation stems from the pragmatic stance adopted within this thesis. It is the extent to which the work of this thesis has progressed understanding in distinct, practical and useful ways, and how a programme of inquiry would be continued that represents the limitation of this work (1.7.1.5).

Therefore, there is a task to investigate how well the ideas developed within this thesis serve in practice. Set out below is a proposed programme for further research.

5.5.4.1. Directions for Further Research

The task of framing value based healthcare for the complex case has led to a more dynamic and more intricate view of the case level service exchange. In this context three particular themes emerge as needing further investigation. First, there is the question as to whether the principles of platforming the complex service developed in this project can be shown to be useful in practice. Second, there are further questions as to the relationship between the development of case level context and the realisation of valued outcomes, and how that might be modelled. Third, within the intricacies of the collaborative case level process, how might a collaborative perspective on value be more systematically captured and related to other approaches to value. These three research programmes are summarised as follows:

1. *How to take forward the idea of service platform co-development and make it work in practice?*
   Within the principles developed in this thesis, represented by the complex case management framework (Complex CMF), the proposition is that case level value based care platforms can be co-developed by the participants within local services. These would achieve two aims, the improved individualisation of care to achieve valued outcomes, and an assurance of consistency and coherence of service across cases. The research question involves exploring and demonstrating how this can be realised in practice. This proposition lends itself to adopting an action research or participative design methodology for developing the local realisation of a local service platform co-development system. Subsequently, it is envisaged that further investigation would assess whether in fact, the aims of better care individualisation together with improved, effective care consistency could be demonstrated.
   As indicated above (Section 5.4.3), a start has been made on this question within the host organisation. Thus, from the interplay with this project, the Complex CMF has been re-interpreted for local use as the Complex Case

and Recovery Management Framework (CCaRM). This represents a platform for design (Kimbell, 2011), serving to help teams within the host organisation to collaborate with case level participants in the realisation of relevant value based care platform to support practice. In this context, an in-house project is underway to evaluate the CCaRM framework further accordingly.

2. *How does modelling the relationship between Service Delivery Network (SDN) arrangements and style of value realisation impact on service outcomes?*

   This project has shifted the ground in terms of operationalising the functioning of service at the case level as a function of SDN profile and style of value realisation. Paper 3 (Chapter 4) explored this relationship and gave an indication that other co-factors might also be involved, and the investigation stands as a useful pilot project. Taken together with the wider principles developed in the thesis, the stage is set to propose a more substantive empirical research programme. The proposition would be that, using the tools developed in this project, different SDN profiles, different styles of value realisation and different combinations of these can be linked to different material service outcomes. The proposition would be further, that optimising the case level service platform would make a further contribution to service outcomes. Such service outcomes that might be important in the healthcare economy could include for example speed of recovery, sustainability of recovery, levels of resource usage.

   It is envisaged that establishing the credibility of case level platforming depends on demonstrating an impact on wider service concerns, such as those suggested. Such a research programme would need to be case focused, and expanded to model sample cases on a longitudinal basis in a range of settings. The view developed in this thesis of valued outcome as potentially a composite of both qualitative and quantitative features brings an additional richness to the research programme. In that context, it would be interesting to explore service outcome modelling using QCA and variable orientated modelling associated with structured statistical modelling techniques. From the work in this thesis, SDN profiles, styles of value

realisation and case level platform co-development are amenable to practice refinement. Therefore this proposed research programme would further provide a helpful focus for service improvement work.

3. *Can case reviews function as a tool for the valuation of "what matters to us"?*

   As discussed above (Section 1.5; Paper 3, Chapter 4), shedding light on the intricacies of case level, or micro level, value generation is an important focus in contemporary service literature. It is proposed within this thesis (Principle 3, Section 5.2.3) that a suitably structured case review can function as a means of determining and representing collaborative valued outcomes, as 'a service valuation'. However, in this thesis attention was principally focused on the process of realising valued outcomes. There is more to do to be able to represent collaborative, valued outcomes as having currency within the healthcare system. There is more to do to relate collaborative valued outcomes with other forms of valued outcomes (Section 5.2.3). This is the focus for the third proposed research programme. The research questions would be: how to structure case reviews as service valuation episodes and how to capture that output as having currency within the service? Meanwhile, how would that emergent collaborative outcome relate to and triangulate with other measures of subjective and objective outcome?

   Within the pragmatic stance, this thesis contributes a valuographic perspective to this work. From this stance, it can be argued that it is through what Dewey might view as a democratic process that a collaborative valuation is determined (Section 1.7.1.3). This offers a means of distinguishing collaborative valuations as 'democratic outcomes'. It is envisaged therefore that the research programme would involve exploring ways of supporting a discourse within case reviews to reach democratic agreement on valued outcomes. To this end, some groundwork has already commenced within the host organisation. Once this process had been developed and stabilised as a consistent and reliable capability, one means of representing collaborative value becomes available for further research. This would include a systematic evaluation of democratic outcomes against

more established measures of service outcome. This would be important in supporting the justification for bringing this fresh, collaborative perspective on value as key to value based healthcare, as has been argued in this thesis.

Two of these three research programmes (Programmes 1 & 3) are already proving of interest within the host organisation. Meanwhile, Paper 1 (Chapter 2) has already been accepted for publication in a peer review journal, Paper 2 (Chapter 3) has been the basis for a well-received presentation at an international conference and submission for publication is planned. Paper 3 (Chapter 4) is an advanced draft with a view to publication. These are helpful steps in setting the stage for progressing research programme 2, and for supporting all these further lines of research more generally. As previously stated (Section 1.7.1.5), this realisation of avenues for further research is important to the justification of the pragmatic stance that frames this thesis.

5.5.4.2. Final Note

This thesis itself reflects an evolving body of thought. There is a process of conceptual revision and adjustment embedded in the thesis to reflect this fluidity. It is expected that this will continue through the formal publication process, and from further experience in bringing ideas into practice.

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Appendix

This appendix draws on material from case 12 (referred to here as case X) for illustration purposes.

6.1. Introduction

The purpose of this appendix is to furnish exemplar case details to illustrate the transition from the raw documentary data to the data used within the series of investigations at the heart of this thesis. The focus of this thesis has been documentary data relating to a series of vulnerable individuals in a healthcare setting. It has been necessary therefore to manage this data carefully. It is appropriate therefore to include in this appendix an account of how care has been taken whilst presenting this illustration.

As noted by Hayes & Devaney (2004), case records are a particularly rich source of insight into contemporary practice. There are, however, certain challenges to overcome when using them in research involving vulnerable subjects in sensitive areas of practice (Hayes & Devaney, 2004). First Hayes & Devaney point out that any data pertaining to healthcare, or offending behaviour would be deemed as sensitive. To this one might add organisational sensitivities for example from caring for people with a history of offences that might be high profile in the general public domain. Second, there are challenges in consistently engaging and interacting across a set of vulnerable subjects who may be anxious and experience intrusion (including when eliciting meaningful consent). Third, there is a balance to be struck. On the one hand there are legal and ethical duties towards research subjects, paying attention to duty of confidentiality and being mindful of their interests. On the other hand, in theirs and the public interest, there is the importance of achieving much needed insight into "*the needs and views of the marginalised in society*" (Hayes & Devaney, 2004, p329). In considering this issue in relation to using social work case records, for Hayes & Devaney (2004, p321) the way forward is that the research is framed as a service improvement project, and that there are stringent safeguards to ensure anonymity, including only reporting data in an anonymised and aggregated format. The author's reference the relevant Medical Research Council guidelines (2000), indicating that the number of people accessing the data before it is coded should be kept to a

minimum and that coding the data should commence as soon as possible in the process. Meanwhile, data should only be handled by staff who have a duty of confidentiality.

For this thesis, the project similarly has status as a service improvement project, and I have legitimate privileged access to the data as clinician working in service improvement in the organisation. As suggested by Hayes & Devaney (2004), the investigations that form the heart of this thesis have deployed anonymised aggregated data. Nevertheless it is helpful to provide this worked case example as a necessary part of demonstrating the research process. Hayes & Devaney (2004, p324) point out that whilst the principle is that there should be no means of identifying the individual directly or indirectly from the data, there is no system for agreeing what constitutes an anonymous record. The responsibility for this lies with the researcher. In conducting case based research, Buchanan (2012) recommends that the first is to develop a case description, which then forms the basis for subsequent analysis. In line with the Medical Research Council guidelines cited above, this is consistent with commencing the coding of data as soon as possible. Therefore, the stance taken for this exemplar has been to present a version of the original data that has been transformed into a research account of the detailed elements that were found, with judicious non identifiable quotes and extracts as necessary. In developing this case description, those aspects that impinged on issues of confidentiality or sensitivity were abridged, and there were some further amendments made to improve the presentation of the material.

In this context, the layout of the appendix commences with a note and description of the documentation that attached to the case. Next, some exemplar snippets are introduced that were tagged against the different template themes used in the investigation. The casing guideline for developing degree of respective fuzzy set membership is introduced. From an overview of the data, a tabulated commentary is presented first in relation to stakeholder network participation and then in relation to the value making progress. The tables include degrees of fuzzy set membership of sets of rich practice relative to the spread of cases for each subsidiary theme, and for the main themes explored within the papers that form the core of this thesis.

6.2. Documentation

6.2.1. Introduction to Documentation

There were six documents comprising the case record for case X. These consisted of:

- Care Programme Approach (CPA) Meeting Minutes
- Occupational Therapy Report
- Recovery Star Report
- Nursing Report (including self-report version of Recovery Star review and HoNOS highlight)
- Clients Treatment and Care Plan Review
- The Main Areas of Importance to Me – My Easy Read Care Plan

Recovery Star is a structured, patient centred assessment tool (MacKeith & Burns, 2008). The Health of the Nation Outcome Scale (HoNOS) refers to a structured, multi-dimension clinician assessment tool. The HoNOS, or variants of it, derive from work undertaken originally by Wing et al (1998).

6.2.1.1. The Care Programme Approach (CPA) Meeting Minutes

This Care Programme Approach (CPA) Meeting Minutes records those present as:
Present:
Acting Ward Manager
Consultant Psychiatrist
Clinical Nurse Specialist
Parents
Client (Patient)
Occupational Therapist
Social Worker

Apologies:
Case Manager

Minute taker:
Senior Secretary.

The body of the document is structured as below.

1.Introductions & Apologies
This section notes that introductions were made and apologies given by those who could not attend. It was also noted that documents relating to the meeting had previously been circulated and those present confirmed they had received these.

2.Review of Previous Minutes
It is noted that the minutes of the CPA meeting were agreed to be a correct record.

3.Service Task Actions/Outcomes from the Previous Minutes
This is a typical series of update on actions ordered at the previous review, such as the arranging of various appointments and confirmation of commencement of a therapy programme.

4.Assessment & Outcomes
This section serves to capture the highlights from the various professional reports that were tabled.
Nursing
The highlights of the nursing report were confirmation of being placed on the waiting list to progress to the next unit at a lesser level of security. There was also a comment on some limited incidents between the subject and others.
Occupational Therapy (OT)
The highlights of the OT report were to note the subject's good attendance and engagement. His motivation and enthusiasm were noted, but some disruptiveness has also been seen. After discussion about not jeopardising progress, this was noted to have settled.
Psychiatric
The highlights from the Consultant Psychiatrist's verbal (not written) report were to note that suitable permission had been granted to support the proposed move on to a less secure unit. It was noted that key therapeutic programmes had commenced. Despite occasional unsettled interactions, it was noted that incidents of concern had reduced, and that there would be an expectation in future of the patient taking more responsibility. There was confirmation that behaviour had been appropriate in key risk areas, and that engagement needed to continue. A positive reduction in weight was also noted. A home circumstance report was requested. The patient was congratulated on their progress and wished good luck for when transfer came through.
Psychological Therapy Service
An oral update (no written report) was provided by a clinical nurse specialist attached to the psychological therapy service. The current stage on the treatment plan was noted. Comment was made on the slowness of the start, but that progress could now be seen. There was acknowledgement of some of the difficulties being faced, but that the patient themselves were pleased with their progress. There was encouragement to keep up the good work.

5.Patient's Perspective & Treatment & Care Plan Development
This space was for the patient and family to express views. This was oral, with no written report. The comment from the patient was that they were glad to be getting off the unit (to the transfer unit). The comment from the parents was that they thought he was doing well, and that they were pleased his glasses were sorted out.
6.Information from External Professionals (no written reports tabled)
The Social worker commented that he was pleased with the progress made in the previous year. He commented that he would continue to visit and monitor progress on the move on unit.
7.Any Other Business
None
8.Service Tasks/Action Plan
This section listed a series of brief planned service tasks to maintain the care plan.

6.2.1.2. Occupational Therapy Care Programme Approach Report

This report had been developed by the OT, but in collaboration with the patient. The author was also present at the review meeting. The account is structured against key themes of interest as follows:

Introduction

The report notes the full involvement of the patient in the planning and decision making around his OT programme and goal setting. It notes that he participated in completing an Interest Checklist and an Initial Assessment which have enabled him to work with OT to identify activities that are purposeful and meaningful to him and to set a number of goals. This information had been used to formulate his Shared Activity Planner to meet his needs and interests and help to develop the skills he requires to meet his goals. It was noted that he required further OT assessment to fully identify his functional ability and how he manages this in daily living. This would help OT to continue to develop his intervention plan which in turn will enable him to work towards his personal goals. It was noted that when he moved on there would be liaison with the OT for that unit to ensure a smooth transition.

Volition (motivation, values and interests)

It was noted that the patient on the whole had a good attendance to OT sessions and presented as motivated and enthusiastic. Several incidents were noted where he has presented with a lack of motivation and it had been difficult to engage in the activity. It was noted that he was able to demonstrate insight into how his behaviour could negatively affect his progression and that he does not want to jeopardise moving on to. The patient was reported as having a positive attitude to his progress and planned move on. He was also noted to value his relationship with his parents and his role as a son. A wide range of interests were noted that had been included into his activity programme.

Habituation (roles, habits, routines)

In this section, the outline of the weekly activity programme was recorded. It was then noted that the patient had demonstrated commitment and taking responsibility for the programme by completing an interest checklist and being involved in the production of a varied and balanced timetable. A good structure to the patient's day was noted as being important to him. His positive contribution to a speak up group was noted, and he was reported as identifying with his role as a son and a service user in hospital.

Performance (physical, psychological, communication & interaction)

In this section, there is further comment on the patient's overall engagement and motivation, but with some more variable engagement and disruptive behaviour at times. The patient was reported this as being in reaction to being provoked by another service user, or feeling angry at something said to him. It was noted that there was a need for further assessment of aspects of occupational performance. On the whole though he had demonstrated no physical problems, he displayed effective use of both fine and gross motor skills, but he presented with some difficulty with his fitness in sports sessions which had led to an increase in frustration. Concentration skills within sessions was reported as variable, but this appeared to be improving particularly in numeracy sessions where he demonstrated the ability to adapt well to learning new complex tasks. It was noted that the patient had demonstrated being able to plan, sequence, problem solve and make decisions independently. He had attended Living Skills sessions and engaged well, but had shown some difficulty in being able to identify a healthy diet. He was noted as able to communicate verbally and makes eye contact, but some issues of invading personal space and using inappropriate language and behaviour towards staff were noted. This was reported as having improved over the course of sessions. With regard to communications and interactions with staff and peers, this was noted to vary. An example was given of demonstrating appropriate social interactions and shared a role with another peer, and the patient often interacted appropriately in sessions. On the other hand, it was noted that there had also been regular incidents disruptive behaviour.

Environment (physical, social and cultural)

In this section, it was noted that the patient's environmental needs were being met as far as possible, which he was accepting of. It was noted that the environment did enable him to access opportunities for meaningful occupation and to allow individual decision making relating to his treatment and care. It was noted that the patient has community leave to access shops and local activities. An example was given of the patient doing a presentation in a local forum which had helped boost his self-esteem. It was noted that the patient sees himself as having some friends, but he doesn't get on with some others. However, he gets on with staff and is reported feeling that his cultural needs are met.

OT Recommendations
The report concludes by setting out some key recommendations to continue the programme of work, followed by a setting out of the service user goals:

Service-user Goals

With support the service user has set the following goals:
- To continue engaging in OT sessions to help with his move on
- To continue attending the treatment programme
- To be a car mechanic
- To return to living in the community.

Short term Goals
1. Continue attending OT sessions
2. Demonstrate appropriate behaviour during OT sessions
3. Continue attending sports sessions
4. To engage in work on healthy eating
5. To engage in further OT assessment

Medium Term Goals
1. To learn skills required to be a car mechanic e.g. access a college course

Long Term Goals
1. To live in the community
2. To learn to be a car mechanic
3. To gain employment as a car mechanic

Service-user Feedback
In the final part of the report there is a statement recorded that the patient has agreed with the information in his OT CPA report and that he did not have any further comments to make. There is then space for both an OT signature and a service user signature on the report.

6.2.1.3. Recovery Star Report

This report is based on the Recovery Star (MacKeith & Burns, 2008). This tool has been developed in mental health care to offer a more holistic framework for working with patients to discuss and evaluate their progress. The framework can be used to record the clinician's assessment of progress, or the patient's view of progress. This particular document refers to an assessment completed by the patient's case manager against the respective headings. Against each heading a

judgement score for that sub-theme on a scale from 1 to 10 (10 is best) is included. The previous score is also noted in brackets. There is commentary from the case manager to highlight the key features of the patient presentation against that theme since the previous review. This account is slightly abridged for presentational and sensitivity purposes, but is otherwise the original text.

1. Managing mental health
Score 6
X has recently had a spell of unsettled mood and there have been a number of disruptive and abusive notes entered onto care notes, I believe that this may be linked to the possible move from medium to low secure and X has anxiety around this, although he denies this. I have had discussions with him around his behaviour and he is always remorseful afterwards and will apologise. Extra support and reassurance is needed for this time of transition and throughout the transition period. (Previous score 7).

2. Physical health and self-care
Score 6
X is self-motivated to attend to his personal hygiene needs without the need for prompts from staff. He takes time to attend to his skin condition by the use of topical creams and will prompt staff when he needs these. X recognises that physical exercise is a good mood booster and will help him to lose weight which will improve his self-esteem as well as his general health. X has a full session planner including sports sessions. He sees the dietician in order to learn how to eat more healthily and is trying to lose weight. X is very overweight and did well in losing 4 Kg initially. He continues to lose weight in small amounts and is praised for this. He is a smoker but currently not interested in quitting. X enjoys his walks and will ask to go for a walk if staffing permits as he enjoys the time away from the flat and allows him to relax. (Previous score 5)

3. Living skills
Score 7
Due to his current placement X is limited on the scoring in this area. He recognises that he is not able to live independently at present, he relied heavily on his dad previously and would struggle to be independent if he was living in the community. He has been engaging in sessions such as Budgeting skills and he feels like he has improved in this area. X also sees improvement in his reading and writing skills and Is keen to engage with any therapy and help that can be provided. He has a full OT programme and is aware that staff can help him with the areas he has needs in. (Previous score 7)

4. Social networks
Score 6
X is able to make and maintain friendships and has been settled on the flat however recently there has been numerous entries on care notes regarding him being disruptive and abusive towards both peers and staff, he understands that this can affect how he maintains friendships and will quickly apologise for his actions and behaviour, he has recently had a visit from the ward manager of the move on unit and so there may be some anxiety's around transition which in turn are resulting in his unsettled behaviour. (Previous score 6).

5. Work
Score 7
X has never had a long term job and can't imagine the idea of this. He has said that he would struggle with application forms due to his poor reading / writing skills however he is getting better at this. X has stated that he would like to be a mechanic and realises he would need some training,

possibly college. He used to enjoy attending a farm project. X is concentrating on therapy at the moment as he sees this as priority for moving on.
(Previous score 7).

6. Relationships
Score 7
X is concentrating on his relationship with his parents at the moment. He likes their input and can't imagine a relationship with anybody else at the moment. He has stated that he would like another relationship in the future.
(Previous score 7).

7. Addictive behaviour
Score 9
X has previously had a problem with alcohol and drugs and those they were a major factor in his offending. He admits that when he was drunk he could be violent. He currently has no access to alcohol and states that he has no interest in returning to drinking when he leaves.
(Previous score 9)

8. Responsibilities
Score 9
X knows the rules and will try to behave himself on the MSU however he is easily led and can become involved in verbally abusive threats towards other peers. He will apologise quickly, he understands how his behaviour can affect him moving on.
(Previous score 9).

9. Identity and self-esteem
Score 7
X states that he is sorry for his actions and is glad that he is attending therapy. He benefits from having staff 1 – 1 to talk through issues. X now has ground leave and has had trips out, he states that he is happy and looks forward to trips out. X still continues to lose small amounts of weight and this contributes to a positive self-esteem and encourages him to lose more weight and exercise more.
(Previous score 7)

10. Trust and hope
Score 8
X continues to build therapeutic relationships with both staff and therapists, he is developing trust and will talk about his feelings with people that he has good relationships with, he can sometimes find it difficult to trust certain people and will find it difficult to talk about any concerns he has to people he " doesn't get on with". X is currently awaiting an assessment to move on and he has hope that in the future he will live in the community and have his own flat somewhere closer to his dad's house.
(Previous score 8).

Goals before next Star reading
To continue to attend living skills sessions and work on my money skills, this will help me to manage my own monies in the future.
To actively engage in my sessions with OT
To have more access into local community
Case manager to arrange more walks for me.

6.2.1.4. Nursing Report

The nursing report for the CPA was prepared by the patient's case manager. The case manager would usually also attend the CPA case review meeting themselves but on this occasion the report was presented by a colleague. As with the Occupational Therapy report, the report is structured against a number of headings, as seen below. This is an abridged commentary on the original report.

Review of care.
The report notes that the patient continues to reside in a flat area of the unit with a small group of other service users, and that there is nursing input from both male and female staff. A comment is made about enjoying spending time on the flat playing cards, socialising and joining in with other flat activities, that he has a good sense of humour and can have a good rapport with both staff and peers. It was noted that he enjoys walks in the grounds which he accesses daily when he can, in an attempt to lose some weight. The report confirms his full schedule of OT activities, and notes that this has allowed him to develop his social skills which has been reflected in the Recovery Star section, and the Honos secure rating scale results (see below). It is noted that the patient responds well to the structured environment in which he now lives, which provides him clear expectations and positive role models.

Psychological Therapy Service.
Attention is drawn to a separate therapy report, but in the event this consisted of a verbal update noted in the minutes, not a written report as such. Otherwise, it is noted that the patient had started group therapy and had been keen to attend. His nervousness about going at times was noted, and that once there he was more settled. He was reported to discuss this with his case manager and his progress with therapy sessions on a regular basis.

Incidents since Last CPA meeting.
It was noted that there had been one incident recorded since the last CPA

Behaviour
It was noted that there had been numerous entries onto the case record in the previous few weeks regarding the patient's attitude towards his peers and staff, and that these seemed to coincide with his visit from the ward manager regarding a possible move on. Examples of 7 particular incidents are then briefly described.

Family Contact.
It was noted that the patient was visited every fortnight by his parents and that he had regular phone contact with them three nights per week. Also, he had been recently granted ground leave with his family that was going well. It was noted that the patient liked to meet up with his family outside the conservatory for a brew and a chat.

Physical Health issues.
It was noted that the patient had been identified as high risk in regards to his weight, and that he attended appointments to the dietician to be weighed. He had also been supported by the nursing team to lose weight, although had been very reluctant at times. Easy read information had been given regarding obesity and how to eat healthily although it was noted that he continued to choose less healthy options and refuses to accept nursing advice. It was noted that he was a smoker with no interest in quitting.

Mental Health Issues.

It was noted that there were no current mental health issues, although there was concern that there may be some anxiety issues related to a move to low secure. It was reported that this had been discussed with the patient, but he had denied this.

Self Care/Social Skills.
The patient was noted to be capable of engaging socially with staff and peers and had a wide variety of social and domestic skills, which he was capable of completing without assistance. He was noted to be active in seeking help and advice if he needed it.

Outings/Leisure/Community Skills.
The patient was noted as having leave within the grounds on a 1:1 basis with either male or female escort, and local are leave also on a 1:1 basis. Further outings were reported as requiring a 2:1 staffing ratio. There were no reported issues during outings.

Compliance with Care.
The patient was reported as having found it easy to form a therapeutic relationship with the case manager (the author). It was reported that he had been encouraged with healthy eating, having apparently wanted support. However he was reported as having found it difficult in practice, and had become difficult with staff attempting to support him. It was noted that the patient had since requested to attend drop in sessions with the dietician and had attended 2 sessions, he had lost weight and had said that he would continue to attend the weekly sessions and that he wished to try and lose weight.
It was reported that the patient complied with his medication, (creams for skin condition). However he had recently refused the medication. Otherwise he was reported as generally pro-active in seeking staff support to discuss issues of concern to him although, although it was noted he could be easily led by others if the flat dynamics were unsettled. It was noted that he admitted preferring hospital to prison and had stated that he wanted to learn and progress quickly and wanted help in order to be able to live life back in the community, initially with his family. It was reported that he recognised that he needed help and support in order to progress and not relapse in to his old offending lifestyle.
The patient's general presentation was reported as having been relatively settled with few concerns over his general demeanour occurring when he was easily led by others on the ward. It was noted that his recent entries onto care note's regarding disruptive and abusive behaviour could be linked to his move to low secure, and anxiety's around this. It was commented that there have been few significant areas of concern with most issues being around non-compliance with requests or becoming verbally abusive towards others. It was stated that the patient had been engaged in behaviours such as grouping with other peers and calling people names. It was commented that becoming involved in being verbally abusive to others seemed to have occurred on being easily led. It was commented that there was a long history of aggression towards others by the patient, but that to date there had only been a few occasions whereby he had become verbally aggressive to peers. It was noted though that, as he has settled into his new environment there had been a gradual increase in non-compliance and him becoming verbally abusive. These had been relatively easy to manage it was noted, and he had usually become remorseful after the event. He was noted to have some basic coping strategies for managing his anger such as going to his room and playing on his PlayStation, and had benefited from engaging in therapy to help him develop his anger management skills further. It was noted that the patient appeared to benefit from talking to staff about how he was feeling and for staff to remind him of his progression and future goals.

Supervision/Escorts Level.
The current levels of supervision and escort within the unit and when out of the unit were recorded.

Interpersonal relationships.
The patient was reported to be generally settled and enjoying a wide range of activities including gym work which he reported to enjoy. He was reported to appear happy in his dealings with peers enjoying group activities such as games of cards and jigsaw solving. He was also noted to like

football and that he would actively engage in this session which in turn helped to increase his fitness levels and encouraged weight loss.

Nursing assessments.
The report continues with reference to completing the Recovery Star assessment and with providing an update on the HoNOS scale rating. The Recovery Star has two versions, one completed from the point of view of the case manager, and one completed from the point of view of the patient (but with assistance of the case manager). The case manager version is presented as a separate document, and the patient self report version in embedded in the nursing report. For presentational purposes, the update summary on the HoNOS review is included next, and the more detailed Recovery Star report (patient version) can be found at the end of this representation of the nursing report.

With regard to the HoNOS scale review, it was reported that the patient scores had remained stable within this assessment period, despite a slight improvement in score around aggression. It was commented that this was reflected in the fact of (only) 2 incidents of note recorded in the case record since the previous review. It was noted that the patient himself had admitted that he likes structure and felt that he had this on the unit. It was noted that the patient's risk and management guidelines were continuing to be reviewed monthly to support him towards his future care pathway.

Client's Perspective.
The nursing report included a section to report on the patient's perspective. In this report it was noted that on the whole the patient was happy with his stay on the unit and had no concerns about the treatment he is receiving. It was noted that he had a copy of his Treatment and Care plan and was happy to comply with them. It was reported that the patient stated that he had no issues or areas of concern whilst remaining detained. He was reported as having been granted ground leave on a 1-1 basis (either male or female) and had had numerous trip to the local community, and that now he was now looking forward to future ground leave.

Nursing Recommendations.
This section simply notes three areas to continue to focus on for further support. These were stated as:
To continue to support the patient on his Current Treatment and Care plan and to develop new (care plans) as and when necessary.
To continue to support the patient around his healthy eating and weight loss.
To provide the patient with support around face to face meetings when he requires them.

Legal issues.
This last section notes the current legal status relating to the order detaining the patient to hospital, and that his legal rights had been discussed with him, noting his capacity to understand his rights.

Nursing Report discussed
A statement to say that this report had been discussed with the patient concludes the report.

"Recovery Star Self Report Version" (with assistance of case manager)

This patient self-report version of the Recovery Star, completed with the assistance of the case manager, has been lifted from the body of the nursing report to better present it. It is not clear why this patient version had been embedded in the nursing report, but the clinician report version is a separate document in the care record. Nevertheless, as for the clinician version it consists

of a self-assessment completed by the patient (assisted by the case manager) giving their view of progress against the respective headings within the Recovery Star (MacKeith & Burns, 2008). Against each heading a judgement score for that sub-theme on a scale from 1 to 10 (10 is best) is included. The previous score is also noted in brackets. The document makes discursive comments from the patient point of view on progress against that theme since the previous review. This report is slightly abridged for presentational and sensitivity purposes, but is otherwise the original text.

1. Managing mental health
Score 7
I recognise that I have a problem with my mental health particularly my low moods around my guilt stemming from my index offence. I'm not on any medication for this and don't want any, preferring to talk through my issues with staff and therapists. I have completed my anger management sessions and feel that this has helped me. I have learnt how to deal with stress by thinking about my family and memories of them. I also like to look at photos of my family when I am feeling down. (Previous score 6).

2. Physical health and self-care
Score 5
"I want to take responsibility for looking after myself well".
I am self motivated to attend to my personal hygiene needs without the need for prompts from staff. I take time to attend to my skin condition by the use of topical creams and will prompt staff when I need these. I recognise that physical exercise is a good mood booster and will help me to lose weight which will improve my self esteem as well as my general health. I have a full session planner including sports sessions. I see the dietician in order to learn how to eat more healthily I am trying to lose weight. I am very overweight and did well in losing 4 Kg initially. Unfortunately I have put it all back on recently. I am a smoker but currently not interested in quitting. I do ask to go for a walk if staffing permits and enjoy the time away from the flat as it allows me to relax.
(Previous score 6)

3. Living skills
Score 7
"I want to be able to live independently – and I believe I can do it".
Due to my current placement I am limited on the scoring in this area. I recognise that I am not able to live independently at present and, given the chance, would struggle to function as I relied heavily on my dad previously. I have been engaging in sessions such as Budgeting skills and I feel like I have improved in this area I also see improvement in my reading and writing skills and I am keen to engage with any therapy that can be provided. I have a full OT programme and they can help me with the areas I have needs in.
(Previous score 5)

4. Social networks
Score 6
"I believe I can be part of a community and have a role".
Although I have settled in well with both staff and peers I would eventually like my own flat again. I am friendly and polite for the majority of the time but I know that I am struggling with wider networks due to being on the MSU. I have recently been granted ground leave on a 1-1 basis which I am happy about, as I have been able to access the local community and have a walk around. I

enjoy getting off the flat spending time with the people I live with and I value the social aspect of life within the hospital.
(Previous score 5).

5. Work
Score 7
"I believe that it is possible for me to have a job."
I have never had a long term job and can't imagine the idea of this. I would struggle with application forms due to my reading / writing skills but I am getting better at this. I would like to be a mechanic and realise I would need some training, possibly college. I used to enjoy it at the farms project. I am concentrating on my therapy at the moment this is my priority at the moment.
(Previous score 5).

6. Relationships
Score 8 & 7
"I have some of the closeness I want." (Family), "I believe it is possible for me to have the closeness I want." (Girlfriend).
I am concentrating on my relationship with my parents at the moment. I like their input and can't imagine a relationship with anybody else at the moment. I would like another relationship in the future, I feel like I am over the guilt of what I did. I just want to move forward with my life.
(Previous score 5).

7. Addictive behaviour
"I see I need to make changes myself to tackle my addictive behaviour."
I know that I have previously had a problem with alcohol and drugs and that they were a major factor in my offending. I admit that when I was drunk I could be violent. I currently have no access to alcohol and I have no interest in returning to drinking when I leave. I have said that if therapy around substance abuse was offered I would do it. (Previous score 5)

8. Responsibilities
Score 9
"I want to live within the rules."
I know the rules and try to behave myself on the MSU. I have learnt that I am best not to kick off; I just want to get out of here. I am fully aware of what is expected of me and will remind staff of what I need to do to progress. I will continue with my sessions and actively engage in my planned sessions. . I have moved flats to a quieter one and I think this will help me in future.
(Previous score 6).

9. Identity and self-esteem
Score 7
"I can see that there is a me beyond my mental health."
I am sorry for my actions and am glad of my therapy and staff 1 – 1 time to talk through issues. I can see a future for myself but I feel it is a long way off. I accept that this is something that will take time and I recognise that I will need help and support to achieve my goals. I feel confident and I am happy that I now have ground leave this will help me to gain some identity within the community.
(Previous score 5)

10. Trust and hope
Score 7
"I feel hope for the future."
I know I have done wrong in the past with my offending behaviour and I want to engage in the help offered to me for my rehabilitation. I can see a life outside hospital and I want to re-join my family. I know that this will take time to achieve. I'm not too sure as to when I will be ready and I realise it

as a long term goal rather than a short "fix". I trust my parents and I am developing trust with staff and therapists.
(Previous score 5).

6.2.1.5. Client's Treatment and Care Plan

The treatment and care plans refer to a suite of documents, which are intended to be individualised to each patient. In principle, there is a care plan for each identified area of need for the patient. Care plans are structured to state the area of need and a 'treatment plan', which serves as an overview of the therapeutic aim, with an inclusion of the patient perspective. Then there is a section to set out what the specific care plan is, followed by treatment review date, proposed treatment outcome and the proposed care outcome (intending to capture a broader perspective on outcome. The style of the document is typically in the form of bullet points and brief statements, rather than more explanatory prose. Stylistically, the text tends to be presented in a first-person format "as if reported by the patient". However, some statements are more clearly verbatim attributable to the patient at the time of the review. There is no particular ordering to the discrete treatment and care plans, and some are more comprehensively represented than others. Indeed, it can be noted that an unknown 'Area of Need 3' is missing from the record. This is an abridged commentary on the document, but with a scattering of directly reported comments.

Area of Need 1 was referred to as "Legal", followed by the statement "*I am here under section*". The broad treatment plan was presented as the statement: "*I understand that I have to live on the unit, however I have now been granted ground leave on a 1-1 basis*". This was supplemented by comments more clearly attributed to the patient that "*I know that I am here for treatment and that I have to have permission to be granted leave. I have had trips to local area*", and "*If I go along with therapy and treatment and don't kick off I will help myself to get out.*" The care plan consisted of a series of statements to say that the staff will assist the patient in accessing a solicitor when needed, they will help with explaining and discussing legal rights regularly, which would include providing easy read information. Staff will be aware of issues around leave and leaving and will support the patient with that, as well as talking through meetings and reports that they are writing about the patient. The treatment review date was stated as a plan to review the care plan each month at ward round. The treatment and care outcomes were framed as the same objective of being able to continue with ground leave with a view to hopefully accessing places further away in the future.

Area of Need 2 was referred to as "Offending Behaviour", followed by the statement that "*I am here because I have committed several offences in the past"*. The broad treatment plan was for the patient to understand why they had done what they had done and to be able to change in the future. It was also for the patient to continue to attend the treatment programme and utilize coping strategies, including use of a diary. This was supplemented by a comment attributable to the patient that: *I am enjoying therapy, I am beginning to understand what I did was wrong; talking to support*

staff helps me to talk about my feelings". The care plan consisted of a statement to say that the staff would support the patient in attending therapy sessions, that the case manager would continue to support them on their flat, and that there would be 1:1 sessions to talk things through when needed. It was also stated that staff would remind the patient of his coping strategies when he was feeling low or angry. The treatment review date was stated as a plan to review the care plan every 4 weeks during ward round, or if there were inappropriate behaviour. The proposed treatment and care outcomes were both framed as keeping the patient from committing further offences and to keep themselves and others safe from harm.

Area of Need 3 was not found in the documentation

Area of Need 4 was referred to as "Physical Health". There was no reported comment from the patient. The broad treatment plan was to be under the dietician and to have a plan in place to teach healthy eating. It was stated that if staff were concerned about the patient's weight they would support him in eating less. Further, the doctor would review the patient's physical health every month, and there would be an annual physical with blood tests. The patients view was reported as being "*To try and maintain a healthy diet*". The care plan consisted of a series of statements that the patient would see the dietician every week; the staff would support the patient by escorting him to any medical appointments; having provided information on how to stop smoking, there would support if the patient chose to give up (the patient being reported as not currently interested in quitting); finally staff would help the patient to complete health action plans and to use the patients diary to see that he was aware of appointments. A series of comments attributed to the patient were that "*I sometimes need reminding to look after myself*", and "*I don't mind it when staff help me to look after myself"*. It was stated that the team would review the care plan every 4 weeks during ward round or if the patient became unwell. The proposed treatment or care outcome was to maintain a healthy lifestyle with staff support and to make sure of attendance at all medical appointments, which would help the patient to stay healthy.

Area of Need 5 was referred to as "Learning Disability". The IQ of the patient was stated. The broad treatment plan was for there to be ongoing treatment to help to the patient understand areas that the patient needed help in so that he can live in the community when he leaves. It was for the patient to be actively engaging in budgeting skills, English and math's sessions and living skills sessions, recognising that these sessions would help the patient to learn new skills and help them to live more independently in the future. The patient's view was reported as "*I want to know more about how I can live outside and need help to be able to do this*". The proposed care plan consisted of a series of statements, which were presented in a first-person style most likely to promote a feeling of person centredness to the language in the document. The statements were: "*I have 24 hr support*;" "*I'm given the chance for 1:1 support when I need it*;" "*I have staff support to help me in daily living*;" "*I'm encouraged to look after myself every day and go to sessions*;" "*Staff will talk to me about meetings coming up and tell me how I'm doing with my therapy*;" and "*I will continue to attend sessions and develop my skills*". There proposed treatment outcome was stated to be the same as the treatment plan, and it was stated that the doctor and nursing team would review the care plan every 4 weeks during ward round.

6.2.1.6. The Main Areas of Importance to Me

The care plan review document was supplement by a further section, the "*My Easy To Read Treatment And Care Plan*", which aimed to present a simpler version, expressed in the first person, that is expected to be more accessible for the patient to understand. Set out below, this section of the document has not been amended, paraphrased or abridged for this appendix.

Improving My Health:
The dietician is helping me to lose weight and staff are encouraging me to eat less.
I get weighed weekly by the dietician
The Dietician will help me to management my weight
Staff to support me to eat healthy and remind me of what foods are better for me.

Treatment
I have finished my Anger management therapy.
I have started therapy.
To continue to attend and utilize strategies I learn.

Living Environment/
Flat Issues:
I have now settled on unit.
Staff to support Me

Areas of Importance
(Issues Discussed)
I have been granted ground leave.
I have been to the local area, no issues.
I have also been granted leave to go further afield however this has yet to be arranged.
To continue to monitor trips

Day Services:
I have a new schedule with O.T. and attend the gym. I enjoy playing cricket and have started to play football also.

Meetings:
I am happy to attend my ward round meetings. Also happy to attend my CPA meetings.
Case manager to discuss meetings and reports with me before I attend so that I know how I am progressing.
Family:
Have contact with parents, they visit fortnightly, I ring them three times a week.

Escort Status /
Escort:
2.1 further afield.
1:1 local and within the grounds

Rehabilitation:
I am currently happy with my therapy sessions.
I ask for help from staff when I need to discuss my problems.

Any Other Areas:
i.e. Legal Issues
No.

6.3. A Worked Example of Applying Casing Templates

The section above, containing direct material, paraphrased material and elements of commentary, provides a substantive picture of the case material used in this

thesis. The next step is to provide some illustration of how the thematic template was applied in the investigations. There were two particular foci of concern. The first was to explore the themes relating to the participation of the diverse parties involved from different stakeholder networks, and the second was to explore the making of value within the review process. In this next section, there is first a consideration of participation context revealed by the evidence, and subsequently a consideration of the value making practices.

As described in the thesis introduction (see section1.7.2), after consolidating the case documentation there followed a process of exploring the various themes and sub themes of interest across the case series. This was supported by a process of casing (Basurto & Speer, 2012), which prepared the data for being assimilated for fuzzy set qualitative comparative analysis (see section 1.7.2.6). Therefore, in this exemplar, the guide frameworks that supported each of the themes of interest in these investigations are presented, along with an illustration of tabulated highlights from the data for this exemplar case. There is also a correspondence with the development of the final fuzzy set membership assignment (fsQCA) illustrated, which were used in the analyses for the investigations reported in this thesis.

6.3.1. Exploring Participatory Context

With regard to exploring the participatory context to CPA case reviews, three stakeholder networks were identified. These were the commissioner network, the patient network and the clinician network. Set out below are the key features of the casing process for each of these perspectives for this exemplar case. This leads on to Table Table 6-1Table 6-1A 4 which highlights the assembling of the overarching view of participation in this exemplar review by each stakeholder network.

6.3.1.1. Commissioner Network Profile

For this exemplar case, there was consideration within the documentation of the importance of the perspective of commissioning and related wider societal interests in terms of the legal position of the patient, and the appropriate positioning and resourcing on the care pathway. The agency for these issues was with the patient's social worker for example, rather than directly from commissioner representation. In this context, Table 6-1 sets out the framework for

the casing commissioner network participation profile. It can be seen that three sub themes have been identified as the presence of agent(s) at the review, the structuring of space within the meeting format to enable participation for this stakeholder network, and the degree of active taking part in the data. The threshold criteria for assigning the case to a degree of set membership, consulting with the best practice seen within the case series, is shown (i.e "casing").

Aspect of participation	Measure (Each item 1,0 0r partial)	Comment	Threshold
Presence at Review	Commissioner present Other professionals representing the commissioner perspective	The commissioner of the service might attend, a representative might attend, or another professional can be acting on their behalf, usually the social worker	0= No Representation .6 = Another professional is acting on their behalf .8 = A clear deputy for the commissioner attends 1.0 = The commissioner attends
Structured space in the review agenda, discussion and reports	Agenda heading for commissioner view Minute heading for commissioner view or outside professionals Heading for care pathway progress	The emphasis is on space for commissioner interest in having space for active care pathway discussion	0 = No commissioner discussion space .4 = Clear space for care pathway discussion or similar focus, but not evidently used 0.6 = Commissioner agenda space evident within a more general heading such as 'external professionals' 0.8 = Active space for commissioner agenda 1.0 = Active space for a broad and detailed commissioner agenda
Active taking part	Reactive contribution to minuted discussion Pro-active contribution to discussion In minutes Report or update on commissioning progress. Degree of collaborative interaction, use of coproduced reports etc.	The emphasis is on the commissioner interest in progressing care pathways. However, there are also broader active interests such as suitability of placement and perspectives on public interest. In addition, the commissioners range in how proactive they wish to represent these perspectives	0 = No commissioner activity .2= Superficial indirect representation by other professionals .4 = Indirect representation by other professional .6 =Direct but relatively passive representation from commissioner or substitute (eg social worker) passive interest from commissioner or agent for commissioner .8 = More focused pro-active participation from commissioner or agent substitute 1.0 = pro-active and broad commissioner participation

Table 6-1: Framework for Casing Commissioner Network Profile

6.3.1.2. Patient Network Profile

Similarly to above, there was consideration of participation from the perspective of the patient and their supporters. For example, the presence and contribution of the family was noted as a feature in this exemplar case, as was the degree of collaborative contribution indirectly through professional reports. Table 6-2 sets out the framework to reflect the approach to casing used, similar to above. It is worth noting the diversity of potential attendees who might be considered as associated with supporting the patient perspective.

Aspect of participation	Measures (each item 0,1 or partial)	
Presence at Review	No Presence	0
	Patient only present, or patient not present but others present on patient behalf.	.2
	Patient and advocate, but no other support present	.4
	Other, wider members of patient network present:	
	One of family member, solicitor, home team member	.6
	Two others present	.8
	Several others present	1
Structured space in the review agenda, discussion and reports	No structured space	0
	Agenda heading only	.2
	Structured into review minutes only	.4
	Some space for patient view in professional reports	.6
	Diverse opportunities for structuring patient view, including self-reports	.8
	Above, plus dedicated patient self-report and family member reporting	1
Active taking part	No active participation	0
	Indirect contribution through professional reports or other documents, reactive to professional prompts.	.2
	Reactive response from patient or network member in discussions in addition	.4

	Active taking part by patient or representative, or evidence of collaborative working in reports Diverse active contribution from several supporters, and level of collaboration more marked. Patient and supporters leading the review	.6 .8 1

Table 6-2: Framework for Casing Patient Network Profile.

6.3.1.3. Clinician Network Profile

For the clinician network profile, the issue of structuring the space for participation was set aside as it is this stakeholder group who themselves control the structuring of CPA case reviews within the local system. Therefore the pertinent features that were explored consisted of the breadth of representation of clinicians at the review, and the degree of active contribution. Table 6-3 sets out the framework for casing the clinician network profile.

Aspect of participation	Measure (Each item 1,0 0r partial)	Comment	Thresholds
Presence at Review	Responsible clinician present Case manager present Unit manager present Ward doctor, occupational therapist or psychologist or other therapist present	In order to reflect the richest possible range of knowledge and skills being brought to the review, emphasis is given to the diversity of types of professionals involved, eg medical, nursing, unit manager, occupational therapist, psychologist, other kinds of therapists or specialist nurses.	0 = No clinical representation- a theoretical rather than practical set point 0.4 = Bare minimum medical and nursing representation only. 0.6 = Satisfactory representation would be medical, nursing or unit manager and occupational therapy 0.8 = Good representation would be numbers of additional clinicians beyond the minimum. 1 = Marked diversity of representation
Active taking part	Reactive interactions in minutes Degree of contribution of diverse reports and proactive discussion in minutes from	In order to reflect how pro-active the clinical contribution was the emphasis is given to the diversity of available professional reports, and whether within those	0 = No active clinical representation- a theoretical rather than practical set point 0.2 = No reports tabled 0.4 =Tabled reports and

	network members. Degree of collaborative interaction, use of co-produced reports etc.	reports additional effort has been invested in making them collaborative.	meeting minutes lack breadth and evidence of collaboration. 0.6 = Available reports are more comprehensive, with some evidence of collaborative focus with patients and others. 0.8 = More detailed reports are available, with a clear collaborative focus with patients and others 1 = Marked diversity of reporting and evidence of co-produced reports with patients and others

Table 6-3: Framework for Casing Clinician Network Profile.

6.3.1.4. Assembling the profile of stakeholder participation for each case:

Table 6-4 collates the highlight features of each of the participant networks (patient, clinician and commissioner) into an overview. The aggregated view of the overall participation profile for the case is captured by the final fsQCA casing.

Participant Network	In Attendance (fsQCA)	Not in attendance and comment	Structured Space (fsQCA)	Active Participants (fsQCA)	Comment	fsQCA Casing
Patient	Patient Parents (.6)	No apologies from advocate or solicitor	Patient view structured into care plan discussion (.6)	Patient (partial) Family (.6)	The patient's views were represented in collaborative professional reports. There was some proactive direction of care evident in the reports. The direct contribution in the meeting was limited, but there was an elicitation of the family view in the review.	.6
Clinician	Consultant Unit Manager Clinical Nurse Specialist Occupational Therapist (.6)	Apologies from Case Manager No Psychological Treatment	Standard Agenda Meeting Minutes Occupational Therapy Report	Satisfactory representation, with some collaborative progress reporting. Degree of	Unit manger acted for the case manager. Would have been strengthened	.6

		Specialist (PTS)	Recovery Star Nursing Report Health of the Nation Outcome Scale Treatment and Care Plan Review	detail in discussions was light. (.6)	by presence of case manager and PTS representation and evidence of more detailed discussion in case review.	
Commissioner	Social Worker Represented the Commissioner View (.6)		Structured space for external professionals available, and some structuring of commissioner issues into professional reports (0.6)	Some considered discussion with Social Worker representing commissioner perspective, though not specifically structured the into review agenda. (.6)	There is a consistent but relatively passive awareness of the wider commissioner perspective evident. There was no direct representation or direct focus in discussion.	.6

Table 6-4: Table Summarising the Overall Participant Network for Case X

6.3.2. Exploring the Making of Value

Building a picture of the qualitative range in value making practices within case reviews was more intricate as there were two dimensions to consider. One dimension consisted of the range of valued themes developed within the template. As shown in column one of Table 6-5, these were:

- An overview and progress along the care pathway
- Progress with patient engagement
- Progress with symptoms and function
- Progress with social participation
- Progress with reducing untoward events.

For each of these themes a further set of cross cutting value making practice themes were used that consisted of a view of the breadth and richness to how each of these themes were captured in the documentation (status), the extent to which progress was elicited and whether use of structured reporting or measuring had been used to strengthen the evaluation. Of further consideration was the extent to which there was reflection and learning evident and whether a clear evaluative judgement had been made to say that there had been improvement in that value theme or not. The final element was the extent to which the patient view on progress had been explicitly incorporated across these elements. A casing

framework similar to those outlined above was developed for each of these cross cutting themes, as it applied to each of the valued themes. Table 6-5 presents the findings for the exemplar case, where the range of quality of value making practices are set against each of the valued themes. This provides insight to the rich picture behind the final process of developing an overview of the range of valuation practices that emerged for this exemplar case. The assignment to fsQCA set membership for this case have been inserted in brackets for the respective practice themes.

Valued theme	Status (fsQCA)	Progress Trend (fsQCA)	Use of structured assessment or scale (fsQCA)	Reflection and Learning (fsQCA)	Decisive (fsQCA)	Patient View (fsQCA)	Overall (fsQCA)
Care Pathway progress	Point of transition to LSU noted, with some factors to address	Confirmation of present setting. In reviewing outstanding factors for progress the positive trend is highlighted	Descriptive mention	Reflection on the effect of anxiety on making the transition to LSU	Judged to be making progress	Not specifically elicited for this theme	Overall developed sense of making progress
Engagement	General commentary across reports	Trend to improvement noted	Descriptive capture	Positive reflection with X on the role of engagement in progress	Judged to be making progress	Patient view expressed	Definite improvement
Symptoms and function	Structured report against functional headings in documents	Trend not specifically considered, but patient sense of improve noted	Descriptive capture	Joint reflection with patient evident	Judged to be making progress	Patient did report their view of trends for improve	Patient led reflection and definite improvement
Social participation	Broad, structured reporting supported by functional headings and STAR	Structured reflection of progress against headings (eg STAR)	More structured description but no change in score work	Reflections evident, linking to ongoing initiatives and care planning	Judged to be making progress	Patient engaged in progress report and engaged with a patient self-report version of the STAR	Rich evaluation and definite progress
Unwanted effects	Note of number incidents and some physical health concerns	Framed as progress since last review. Fluctuations commented upon	Structured description and change score on STAR. No change score for physical health	Reflection on underlying factors leading to improvement and source of ongoing fluctuations	Judged to be making progress	Patient view indirectly in reports	Structured evaluation, with some use of score, but more passive approach to physical health. Definite improvement
Overall breadth of assessments	Structured, systematic report,	Highlight of progress enhanced by	Mostly structured description,	Clear process of learning and	Judged to be making progress	Patient actively contributing	Captured details of status and

	supported by a reporting frameworks and STAR etc	integrating collaborative patient view	but some change score usage and staging	linking change to strategy	across a broad range of themes	to structured progress report process to a greater or lesser extent Family views also sought	progress across the span of sub themes. Evidence of collaboration with family and patient in forming the picture
Overview	General broad, detailed narrative commentary. (.6)	Systematic, collaborative update on progress on valued themes to a greater or lesser extent, drawing on reflections from HONOS, STAR, reports and family input. (1)	Staged on recovery pathway plus structured description supported by HONOS and STAR (.8)	Clear efforts to reflect on underlying factors from clinicians, and supported by some efforts also from the patient (1)	Consistently decisive in viewing there to be progress (1)	A strong theme of collaborative view being expressed, mainly indirectly through tabled reports (.8)	Sophisticate assessment and confirmation of good progress (.8)

Table 6-5: Table Summarising the Overall Patterns of Value Making Practice for Case X

6.4. References

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