

Special Thematic Section on "Rethinking Health and Social Justice Activism in Changing Times"

Building Spaces for Controversial Public Engagement – Exploring and Challenging Democratic Deficits in NHS Marketization

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Abstract

The Brighton Citizen's Health Services Survey (BCHSS) was developed to explore and potentially challenge how knowledge is used and by whom in the production of local health commissioning institutions and relations. Through the creation of an 'animating set of questions', it sought to open up spaces through which to make visible some of the ways of knowing and valuing the NHS and health services that had been minimised through the commensuration practices of post-2012 public engagement. In this way there was a clear agenda to facilitate a form of knowledge democratisation which opened up and validated different 'health publics', in order to explore and broaden participative engagement opportunities. The paper provides an account of the project. It considers the theoretical and methodological underpinnings of this example of 'evidence-based activism', reflects on the impact of the project on local commissioning and considers the range of controversies that arose as a result of the work. It explores the way that research straddling the boundary between academic inquiry and political activism speaks to the many issues that are prevalent in the changing HE sector as well as NHS privatisation, health commissioning and public sector cuts.

Keywords: health, policy, commissioning, public engagement, activism, privatisation

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Introducing a Controversy

In recent years the growth of evidence-based medicine, coupled with the establishment of external standards and national benchmarking audits, has facilitated a shift away from professional autonomy and dominance to external accountability through objective, statistical tools (Speed & Gabe, 2013). The increasing dominance of measures

focussing on external readings of clinical effectiveness can be understood as part of a redistribution of accountability within health care systems, where third parties attempt to gain access to the 'black box' of clinical judgement (Timmermans & Berg, 2003). In this context, how such a shift impacts on how accountability is practiced, and the consequences for the recipients of health and care, is a key focus of our paper.

In recent years, evidence-based activism has been established as a means through which to understand the development of modes of activism that focus on knowledge production and mobilisation in the governance of health issues (Rabeharisoa et al., 2014). Such a term pays attention to the ways in which patients, organisations and activist groups have become key actors in the reflexive work of weighing up, sorting, assessing and reordering heterogeneous sets of data on their health problems, in ways that suit their own interpretation of their context.

This makes possible the development of forms of contestation which shed light on the fragmentary and uncertain nature of biomedical knowledge, and the policy practices through which they are institutionalised (Rabeharisoa et al., 2014). While there have been plentiful studies on how activist groups intervene in health policy monitoring, there have been far fewer that have sought to understand the epistemic activities mobilised to contribute to the issues at stake (Rabeharisoa et al., 2014). Here, knowledge is not a mere resource in which to ground political claims but rather it is a legitimate and fruitful target of social activism.

Such developments take on particular significance when public knowledge controversies become live in a given social space. The Health and Social Care Act (HSCA) (2012) was one such recent public knowledge controversy. This type of controversy resonates with Calon's 'hot situations' and Latour's 'matters of concern' (Whatmore, 2009); the moments of ontological disturbance in which the unexamined parts of the material fabric of everyday lives become molten and make their agential force felt. These controversies produce circumstances where what is at stake is sufficiently important that people want to participate in collectively mapping it into knowledge and hence social ordering. Such knowledge controversies are likely to have multiple and contested identities, indeed so much so that participants in a problem may not only disagree about what is understood about a problem but on whether such a problem even exists (Barry, 2012). Furthermore, Barry (2012) suggests that the analysts of such situations must attend to the relations between claims to knowledge and diverse experts and publics. When such controversies play out, and claims to knowledge become 'molten', there exists the potential to disturb conditions such that everyday reasoning is forced to slow down. According to Whatmore (2009) this creates opportunities to arouse a different awareness of problems and debates as to which experts, non-experts and publics should have a legitimate voice in the knowledge controversy.

Through the HSCA, £80bn of UK health commissioning budget was entrusted to newly formed Clinical Commissioning Groups (CCGs) (Department of Health, 2013). During its passage through the UK parliament and after its successful enactment a number of dimensions of controversy emerged concerning what this legislation meant for the delivery of healthcare nationally and locally. One dimension concerned whether this legislation mandated for the privatisation of the NHS. A second dimension arose around whether or not such privatisation (if indeed this was what was being mandated) was necessarily a 'bad' thing. For example, well-reported issues around lack of affordability, poor efficiency and the wide-scale publication of the care failures of 'Mid-Staffs' (Francis, 2013) appeared to contrast with findings from the Washington based Commonwealth Fund (2017), which had rated the NHS as the most efficient and effective health service in the developed world. Another disagreement emerged over whether the medical establishment supported the legislation. These debates were played out publicly during the legislative process and in particular, the 'listening pause', which emerged during the passing of the bill.

Subsequent research has since suggested that health care professionals, including GPs, say they do not feel that their CCG policies reflect their own views and that they have very little chance to impact CCG's policy decisions (Murphy, 2015). Moreover, there have been suggestions that cost-efficiency appears to be overriding service quality during the CCG tendering process and problems of transparency have been considered to routinely arise due to the institutionalised secrecy through which these contracts are procured, awarded and performed (Deith, 2013).

Reports from across England described 'dysfunctional commissioning', perhaps as a result of confusing and complex accountability frameworks (Checkland et al., 2013). Until 2014 CCGs were under a duty to be financially solvent and were directly accountable to a range of potentially conflicting stakeholders, including the Secretary of State for Health, Healthwatch, the regulator (at the time Monitor), Local Authority Health and Wellbeing boards and the public. While CCGs had a requirement to engage with patients on commissioning, some suggested that the creation of Healthwatch represented a move from a form of patient involvement which sought to influence health and social care services to one which was intended to promote patient choice (Tritter & Koivusalo, 2013). This may be a contributing factor as to why, in terms of commissioning decisions made by CCGs, accountability appears to be focused upward toward the NHS commissioning board rather than to local residents (Tritter & Koivusalo, 2013). Post-2014, the 5 Year Forward View has been endorsed by NHS England but with questionable legislative legitimacy (Madden & Speed, 2017) and the impacts of the developing sustainability and transformations plans on commissioning accountability remain to be seen.

Five years on and we are now afforded an opportunity to construct an analysis of this public knowledge controversy and the emergent and interrelated local controversies. Drawing on a descriptive account of an action research project in the South East of England, this paper describes a case study of a project which attempted to create a provisional space to explore, extend and challenge the knowledge claims and practices mobilised in post-HSCA healthcare public engagement and commissioning. We interrogate the forms of democracy and attendant publics that were produced through HSCA legislation and outline a manifestation of 'statactivism' where a University was mobilised as a claimed space of engagement (Gaventa, 2006) to disturb, slow down, and create opportunities to arouse a different awareness of the tensions around healthcare commissioning and public engagement. First we will consider the post-HSCA engagement spaces of healthcare commissioning and the publics that they produce.

Spaces of Engagement, Consultation and Publics

'Policy spaces' have emerged since the 2012 Health and Social Care Act that allow moments where citizens and policymakers come together. Healthwatch England is a body established under the Health and Social Care Act 2012. It is the national representative body of a series of local Healthwatch organisations in each of the 152 local authority areas in England. Its purpose is to 'understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf' (Healthwatch, 2017). The second public policy space which emerged following the 2012 HASC are regional Health and Wellbeing boards. Here, members of the public can engage with the statutory local authority bodies tasked with improving integration between practitioners in local health care, social care, public health and related public services. In some cases (as in Brighton & Hove) HWB's contained several members of the clinical commissioning group, the organisation whose primary remit is to commission health services for the locality.

There have, however, been suggestions that the engagement and accountability practices that have emerged post-HASC have suffered from many of the previous limitations that have befallen their predecessors (Hudson, 2015; Tritter & Koivusalo, 2013). Many public spaces for citizen engagement in health policy are fraught with difficulties (Fischer, 2009a). Health systems are framed by an increasingly prescriptive and centrally driven set of performance metrics such as waiting times (Currie & Suhomlinova, 2006; Speed & Gabe, 2013). Such institutions tend to exhibit a very specific approach to processes of accountability, centred on notions of operational control based on audit regimes working in combination with central command structures and vertical control (Dommett, MacCarthaigh, & Hardiman, 2016), which may account for the fact that in general there are very few examples where citizen participation has led to tangible improvements in services or changes in policy (Smith, 2006). In terms of the set of social relations between patients and providers (or commissioners), Gulbrandsen (2008) talked about this 'dis-improvement' in terms of how new accountability processes, such as those that have been adopted in post-HASC health commissioning, rather than being seen as new, continue to be seen to operate as 'business as usual' whereby people perceive that the governance model, whilst appearing to be open to new and novel forms of stakeholder participation, in fact works to restrict those self-same opportunities.

In such circumstances the adoption of accountability tools and procedures can be understood as a form of 'organisational hypocrisy' if such tools and procedures are more enabling of practices which enact restrictions on stakeholder voice. Fischer (2009a) and Hudson (2015) suggest that the possibilities and benefits of participation are now seriously limited by social and technological complexity which, through the hierarchical authoritarian relationships found in public administration, enable people only to participate as consumers rather than citizens. Here, an idealistic and utopian theory of deliberative democracy has taken centre stage with many in positions of power unwilling or unable to discuss matters that might adversely impact their own interests (Fischer, 2009b).

Smith (2006) suggests that powerful interests are more than capable of agenda-setting by defining problems in particular ways or avoiding or sidelining or restricting participation to 'safe' issues. Indeed Martin et al. (2015) suggest that that cultures of denial, secrecy, protectionism and fragmentation of knowledge and responsibility are often implicated in these failures in meaningful engagement. In this context the more participation there is, the more the power relations of local communities is masked (Miraftab, 2004). Indeed engagement can become a reified form of pseudo-participation that works idiomatically, and with very little connect to the messy 'real world' of compromise, where the sometimes conflicting demands of different actors need to be acknowledged and addressed if a truly democratic version of participation is to be practiced. Miraftab (2004) suggests that to understand the meaning of advanced liberal governance we must understand not only what possibilities for engagement emerge but also which possibilities are silenced. In this context, it is crucial that we accept the position that creating new institutional arrangements will not necessarily result in greater inclusion. Rather much depends on the nature of the power relations which surround and imbue any new, potentially more democratic, spaces (Gaventa, 2006).

Similarly, while transparency has gained a central significance in debates over matters of governance in recent years (Barry, 2010), greater transparency does not necessarily confer or imply greater openness. Rather, and more straightforwardly, it simply transforms the nature of what is kept secret and what is not (Barry, 2010). Transparency entails a set of processes that don't simply make information public but instead mould institutions into forms that are able to perform certain versions of accountability. Moreover, the audit measurements employed to record transparency and governance initiatives can play a central role in producing specific versions of accountability (Barry, 2010).

Policy spaces reflecting dominant state agendas also have direct implications for those ‘publics’ that engage with them. Hudson (2015) posits that we have seen the development of a consumerist model of post-HASC public engagement in line with the broader marketization in the health sector. This model depends on accountability and measurement practices that position service users (actual or potential) as health consumers. Discourses and practices that position service users as consumers are a hallmark of neoliberal governance. When such accountability metrics are employed to ‘make people up’ (Hacking, 1990) they can perform a powerful productive role by vindicating, limiting, incentivising, legitimating and justifying certain social and political activities (Beer, 2015). They can be, and frequently are, used to facilitate competition, between both institutions and people. Indeed such techniques of notation, computation, examination and assessment can be understood as technologies of governance which impose norms and shape social order through their capacity to translate diverse and complex processes into a single figure with the veneer of political neutrality (Donovan & O’Brien, 2016).

But while Beer suggests that we all consciously (and unconsciously) adapt to the systems of measurement that we live within, it is also the case that under certain circumstances, those accountability metrics can be questioned, sidelined and subverted (Bruno et al., 2014). In the case of a given social system, the central level can exert forms of regulation through a monopoly over the production of statistics (Baudot, 2014), for instance with the recording of crime or employment statistics. Under such public engagement conditions, the figures that do not appear can often be as revealing as the quantitative performance indicators that take centre stage. The analysis of the non-production of information can make visible the social configurations enacted via a given socio-political environment. Indeed public knowledge controversies can make possible the conditions for interrogating such dominant social configurations and the measures (and non-measures) through which they are made possible.

While it could be argued that the implementation of the recent Sustainability and Transformation Partnerships that have emerged in the post-HSCA engagement landscape have been characterised by many of the issues above (Boyle et al., 2017), engagement spaces do still exist currently that offer opportunities, moments and channels where citizens can act to potentially affect local health policies, discourses and decisions and the relationships that affect their lives (Gaventa, 2006).

In terms of turning these problematic engagement practices into more positive social spaces for activism, Bruno, Didier, and Vitale (2014) suggests that there exists ‘margins affording a certain liberty’ when social movements or social actors are able to work across each of the dimensions of space and power (Gaventa, 2006). Despite the dominant consumer model of engagement that has emerged in post-HASC engagement spaces (Hudson, 2015), we would argue that margins and opportunities exist that allow room for manoeuvre toward the construction and implementation of alternative engagement practices.

Statactivism as a Means to Create Alternative Accountability Space

The forms of post-HASC public engagement could be argued to reflect what Arvitzter (2002) calls ‘democratic elitism’. That is, a system of citizen accountability premised on a concern for protecting democracy from *too* much participation by ill-equipped masses, which functions by closing down rather than opening up possibilities for participation. A central problem is that such democratic elitism is premised almost entirely on an instrumental ra-

tionalism where health service planning and commissioning are regarded as technical exercises where health services have only an instrumental value to a consumerist public (Madden & Speed, 2017).

However people do not only have a consumer-oriented relationship to health services. Health services, and hospitals in particular, are important to peoples' ideas about local identity and sense of place (Brown, 2003; Jones, 2016). In the UK, hospitals play an important symbolic role; they are more than just buildings where healthcare is delivered. Jones (2016) suggests they are perceived as the physical incarnation of the NHS and its values within a particular locality. Hospitals are places of suffering, death, life, hopes, fears, anxieties, emotions, relationships and values. Whether by collective imagination or individual experience, hospitals exist at the juncture between life and death and are bound up with our notions of ontological security. And such security is central in mobilising people to protect local health services at risk when such instrumental rationalism is driven to excess by central government ideology (Jones, 2016).

However, during a time of little support for governments' ongoing policy package among health professionals (Murphy, 2015), and where local health care professionals are often in opposition to local and national changes in health policy and commissioning (Murphy, 2015), the importance of local communities is self-evident (Florin & Dixon, 2004). They can play a key role in balancing the rational pragmatics of cost control with forms of protest informed by the lived experiences of health outcomes.

'Statactivism' could be articulated as a way to rebalance the engagement deficits of democratic elitism. Statistics are often contested and have been accused of freezing human relations (Bruno et al., 2014) and providing 'realities' that are mediated by what schemata designed in other worlds can capture (Burton & Gomez, 2015). That said, quantification can also reveal and create feelings of social injustice that can lead to protest. Indeed there are numerous examples of such statactivism where calculation and statistics are used, not as tools for subjection, but as weapons to 'analyse, negotiate and limit dominant players' (Samuel, 2014).

The capacity of a quantitative measure to capture what it is purported to represent can be brought into doubt and attention to the introduction of measures and indicators helps to reveal their creative (rather than 'objective') character (Bruno et al., 2014). This is especially the case during moments of controversy where the ways in which statistics and big data are implicated (and contested) in the articulation of state space become particularly salient (Lury & Gross, 2014).

Here, emerging forms of collective action use numbers, measurements and indicators as means of denunciation and criticism and, as such, make possible a form of re-appropriation of the hegemonic logic of quantification (Bruno et al., 2014). Social critique often relies on statistical arguments and it has been suggested that much can be gained by creating spaces where public debate about remote and previously intangible technocratic processes can happen (Desrosieres, 2014) and where a 'militant use of figures' can be employed to defend the utility and quality of public services (Baudot, 2014). It is through this frame that we should interpret Martin et al.'s (2015) suggestion that the particular benefit to be gained from efforts to gather and manage knowledge is not necessarily clarity but disruption - to create a space for multiple knowledges and marginalised voices. Such a mobilisation of 'knowledge as disruption' (Martin et al., 2015) is the starting point for piece of work that has been established in the South Coast of England in 2016.

The Case Study – The Brighton Citizens Health Services Survey

In response to a perceived need for greater public say in local healthcare commissioning, the first Brighton Citizen's Health Services Survey (BCHSS) was conceived by academics and students at the University of Brighton. The project was initially designed to hold regular 6 monthly public consultations with a substantial number of citizens from Brighton & Hove.

It was informed by Fischer's (2009b) premise that, while citizens may have incomplete understandings of many of the problematic health policy issues, once these issues are re-described in a jargon-free way, most people understand them well. Within the BCHSS the intention was to use survey methods to identify and 'map' moments of commissioning controversy and, through the process of collecting data and reporting the survey results, to provide the basis for a disruption or slowing down of the practices that function to stabilise and legitimise current healthcare commissioning and the limited forms of democracy that they make possible.

The BCHSS was developed as an 'engagement technology' to explore the conditions for developing a form of evidence-based healthcare activism that foregrounded many of the commissioning and budgetary activities that were operating beyond public knowledge and consent (Desrosieres, 2014). In so doing, the project team hoped that the findings could be used to start a local conversation where disparities between commissioning decisions and public needs and values can be made clear and acted upon. In this context, citizen information was used as a legitimate counter point to 'official' information.

Through the creation of an 'animating set of questions' (Espeland & Sauder, 2007), the BCHSS sought to open up a space through which to make visible some of the ways of knowing and valuing the NHS and health services that had been erstwhile minimised through the consumer-oriented commensuration practices of post-2012 public engagement. In this way there was a clear agenda to explore and broaden participative engagement opportunities. In so doing this work sought to heed the OECD call for new ways to include citizens in policy making through citizens actively engaging in defining the process and content of policy making (Gaventa, 2006). Such a venture could be regarded as a replication of the central problem of this paper - that is, idealised forms of pseudo-participation being held up as evidence of democratic engagement. However, in this context the implicit use of reflexive practice and the articulation and presentation of the work clearly signposted the boundaries and intentions of the project team. The job at hand became about working through practices and resources of the university to positively affect policy spaces – aligning or contesting them.

The project developed surveys that were designed to move beyond the post-2012 HASC accountability dominance of recording consumer experience with the health services they used. Rather they sought to capture unmeasured and excluded forms of knowledge representing the voices of the people of Brighton & Hove on important topical health issues like funding cuts, privatisation and the broader tensions between local commissioning and national funding policy directives. These potentially controversial issues were not at the time of data collection any part of the suite of accountability and transparency practices employed across the city.

The project was established using a distinctive approach to survey design and involved developing a public engagement tool aligned to public consultation, participation and deliberation rather than the production of a 'validated instrument'. The methodology that underpinned the project enabled the survey design to evolve as part of a par-

ticipatory, consultative process. In line with a wealth of critical scientific literature, the choice of a co-constructed and value-driven survey can be considered a valid measurement tool. In spite of the criticisms that can be raised, the research process entailed continuous reflexivity (Cohen, Manion, & Morrison, 2007; Thuo, 2013) therefore contributing to the integrity of the findings and analysis (Guba, 1981; Shenton, 2004), and the ethics of the project (Edwards & Mauthner, 2002; Orb, Eisenhauer, & Wynaden, 2001). This process was overseen by the steering group of academics, a member of the University of Brighton's Community University Partnership Project, a member of a local health research charity (The NHS Support Federation) and several students. The coordinating group was made up of a range of people whose relationship to the project was complex. This included those who took part as academics, as academics and activists and as neither. However this group coalesced around a set of values to define the purpose of the survey and ensure that its aims and objectives remained consistent.

The intention of the project was to

- facilitate public education and deliberation on health service commissioning
- promote public engagement on controversial healthcare commissioning topics in order to extend and enrich the public engagement space for health service commissioning
- explore and improve commissioning accountability mechanisms

Initially a survey was designed that focussed on asking the Brighton & Hove public about their

- core values on health commissioning
- current controversial commissioning issues
- future local commissioning intentions

The questions on current commissioning issues were drawn from the minutes of local Health and Wellbeing Board and Clinical Commissioning Group discussions, with a focus on issues of that were or had to potential to be controversial. For instance, the transfer of the contract for patient transport from a statutory to a commercial provider was the subject of considerable debate and press coverage. The list of currently tendered contracts and their end-dates were available on the CCG website. However, since upcoming commissioning intentions were unavailable on the public website, a Freedom of Information request was submitted for a list of services that will be subject to new tendering processes in the forthcoming calendar year. Given the claims that the post-reform English NHS was in the midst of privatisation by stealth programme, this tendering process was (potentially at least) very controversial.

The first survey was a two-page, multiple option questionnaire that took 3–4 minutes to complete. Online and paper versions of the survey were produced. It was disseminated by the survey teams through various forms of social media, including most prominently Twitter and Facebook. The project team sought to sample as broadly as possible and so for this reason the survey was circulated to organisations and groups who might be expected to display a broad political and demographic membership. This included all major local political parties, all resident's associations in the city, all church groups, two universities, and the three local trades unions. Moreover several hundred surveys were complete by a convenience sample of passers-by in Brighton city centre over four consecutive Saturdays. In total, 1,300 completed first surveys were collected and analysed, and 700 of the second survey. Table A.1 in the Appendix shows an abridged quantitative version of the first survey findings.

When the survey was released, the survey team attempted to contact the local CCG, Healthwatch and the Health and Wellbeing Board. Despite numerous attempts at contact, no reply was received from either the CCG or Healthwatch. The lead councillor from the local Health and Wellbeing Board replied by email that they would be interested in viewing the findings.

Once the results had been collected, an initial report was produced ([Brighton Citizens' Health Services Survey team, 2016](#)), and a launch event of the initial report was held at the University of Brighton ([BCHSS, 2016](#)). A press release was issued to all local media outlets, including newspapers, radio stations and online news sites. The launch event drew 40 local stakeholders, including local politicians, academics, NHS staff, and campaign groups. While the CCG did not attend the launch event, their lay representative did although it was not clear whether he was there in a personal capacity or representing the CCG.

The report ([BCHSS team, 2016](#)) presented the findings outlined in [Table A.1](#). It concluded that the public in Brighton & Hove held clear and compelling views on the values that they felt should underpin the ways that they wanted their health services to be commissioned, and it restated Brighton & Hove CCG's statutory remit to ensure that these views were appropriately reflected in their decision making. It stated that, in the city of Brighton & Hove, a vast majority of the public were against the use of private companies in the local health economy and very concerned about some of the recent decisions that had been made to commission private companies to undertake certain services. Finally, there was an acknowledgement that further work was needed on the part of B&H CCG to reflect the public needs and values in their commissioning decisions.

In terms of engaging with the CCG, a deputation to the local council Health and Wellbeing Board was arranged for July 2016. Formally, a deputation consists of a member of the public presenting a statement which is submitted to the board 7 days in advance (selected members of the CCG are also members of the HWB). All board members see the pre-submitted statements and have a prearranged response at the ready. Prior to this there were two points of contact with the CCG. First, an invited meeting with their public engagement officer was used by the engagement officer as an opportunity to show the range of engagement work that they had been doing themselves, almost as a counterpoint to the survey.

Second, the Survey coordinator was asked to ensure that this ongoing CCG work (i.e. not the survey work) was made visible during the deputation, lest local councillors think that the CCG were not carrying out engagement work. There was a discussion as regards the differences between the CCG engagement work and the results of the survey. It was agreed that the CCG's engagement portfolio would be recognised at the meeting.

A few days before the deputation, the CEO of the CCG sought (at short notice) a meeting via third party intermediaries. The CEO visited the office of the survey coordinator and a civil, if tense, discussion covered the exact purpose of the survey and its potential ethical and methodological limitations. Specifically, concerns were raised about whether the survey, due to the orientation of questions, could be held to legitimately represent public opinion and whether the attempts to do so constituted ethical practice. The issues of the ethical and methodological legitimacy of the research were explained in an accessible way to those who sought dialogue with the BCHSS team. There was a discussion on the aims of the survey project. The survey coordinator made the point that it was important for the CCG to be aware of the strength of public opinion and for the public to learn more about the healthcare commissioning system that was (or was not) meeting their needs.

In terms of issues raised by and through the survey methodology, there was a discussion on the respective latitude that the CCG had to avoid the use of private providers in light of the 2012 legislation. The survey coordinator suggested the importance of public knowledge of commissioning changes, potential CCG commissioning flexibility in light of the Monitor guidance and the degree of variability in CCG commissioning across the country (Kings Fund, 2015). There was an agreement that the discussion might be continued at the public deputation.

Two further meetings were had with CCG intermediaries prior to the deputation and a further public talk on the results was scheduled after the deputation. During these informal meetings, it was made clear to the survey leader that the CCG were not happy with the way the results were being presented and that there would be conversations had at a very senior level in the University if the work was to continue to produce problematic results.

At the deputation, the presenter is allowed to briefly reply to the HWB panel response. This board contains 5 members of the local CCG, a Healthwatch representative, a number of local councillors and other local stakeholders. Initially invited as a 15 minute presentation, the survey report was shortened to a two page deposition that required the signature of five local Brighton & Hove residents in support. On the day the results and recommendations of the first report were read out to the Health and Wellbeing Board. Other team members were sitting among the public, as observers. One councillor noted that the results were concerning. Another showed scepticism about the potentially leading nature of the questions. It was reiterated by the deputation presenter (who was the survey coordinator) that the survey was a public engagement tool, scientifically valid under different premises, to record information and citizens' voices, however the limitations of such an approach were acknowledged. From comments made by HWB board members, there appeared to be a general agreement that the findings were in line with the beliefs and values of those who sat on the board. The format did not allow further interrogation of the issues and particularly the examples of where commissioning activity had departed from the wishes of the local people; in the end there were publicly stated commitments of CCG members on the HWB.

A follow-up survey, was released to the public in June 2016. A similar approach was implemented, whereby a Freedom of Information (FOI) request was submitted prior to the drafting of the second survey in order to inform some of the questions in the survey. Initially the FOI request to obtain upcoming contracts for the following year did not prove fruitful in the way that it had with the first survey. Following an invited meeting at the CCG headquarters with the lead researcher and the CCG engagement officer, it became apparent that there was disagreement within the CCG board as to whether to readily provide the information to the lead researcher. Subsequently this information was provided.

The second survey developed the method of the first by seeking greater public involvement in the design of the questions on the survey. The project website was used for a call for members of the public to suggest potential questions of importance to be included in the survey – in terms of a piece of activism, it would prove harder to discount the survey results with the involvement of a wider group of public citizens involved. Hence the second survey was developed from three sources:

- From members of the public who asked the questions on our website.
- From topical and controversial health issues being discussed by councillors at the local Health and Wellbeing Board.
- From a Freedom of Information request on upcoming commissioning plans.

The second survey was widely disseminated through the same routes as the first survey. Less labour time was available to disseminate the survey which possibly contributed to the fact that 700 responses were received.

As the survey project developed over its first two iterations, numerous local media, (such as the local newspaper, 'The Argus', regional radio, BBC Sussex and Juice FM, and regional television, BBC South Today) started to pick up on the findings and use the data collected as a means through which to develop local healthcare stories and to check their information when writing their own stories. For instance, following the second survey, BBC Sussex, on seeing the increased difficulty in seeing a GP across the city and the spate of practice closures, used the data collected from the survey as a means through which to develop a feature on access to general practice across the city.

There were several moments where the stakeholders with the most powerful interests in this context sought to directly challenge the veracity, ethics and appropriateness of the survey project. These included emails and communications in personal and public meetings. The project was challenged by commissioners as potentially unethical, unrepresentative of the local population and methodologically flawed. It was suggested that the survey addressed national policy issues that were beyond local commissioner control. Moreover the local CCG suggested that their own consultations, and the work of Healthwatch were sufficiently substantive to gauge the interests of the Brighton & Hove public although there was acknowledgement that many of the issues articulated in the citizens' surveys were not present in local CCG consultations.

Discussion

The survey project revealed a range of local opinions on healthcare commissioning that resonated with some of the key broader moments of controversy that arose during the development of the HASC. A post-2012 appraisal of public involvement in health care commissioning would appear to speak to some of Fischer's (2009b) concerns about the proliferation of utopian theories and practices of deliberative democracy taking centre stage. In such practices there exists an unwillingness and/or inability to discuss matters that might conflict with or adversely impact the interests of dominant stakeholders. At the inception of the project, one CCG member replied to a member of the public's concern over the use of private companies in healthcare by suggesting that 'it was not within the gift' of local commissioners to discuss potential providers in such terms. As such, this public space was an example where the accountability procedure enacted restrictions on public voices.

There are multiple factors impinging on the capacity for public voices to be foregrounded in healthcare commissioning, not least the way in which CCGs are held as accountable to the legal strictures of the Health and Social Care Act and the legal responsibility to avoid operating in financial deficit. This imperative is further embedded under the STPs approach, where Sustainable Transformation Partnerships which have not had their financial plan approved by NHS England will be prevented from applying for any additional funding to provide healthcare services in their area. However, even within such confines, engagement is possible if well-developed political arrangements can be mobilised that provide people with multiple and varied participatory opportunities (Fischer, 2009b).

Post-HASC public engagement enacts a certain form of singular 'public': that of an 'active' constituent whose deliberations are welcomed if they fit within the areas of concern that board members had pre-agreed to be legit-

imate. Legitimacy was dictated not by topical relevance but by the versions of commissioning that board members felt were both possible and acceptable to voice. It could be argued that current engagement mechanisms articulate a statutory space which enables a very specific version of the public to be made visible and salient (Lury & Gross, 2014). This is a public who consume healthcare services and are measured as such via the engagement practices of Healthwatch and CCG consultations.

We suggest that the survey project allowed for different versions of the public to be made visible; versions that were oriented toward the value and ethics of service provision. Here, a space was eased open to allow the more fluid nature of the way that publics relate to health services to be foregrounded (Bruno et al., 2014). The inception of the survey project, and its broad public dissemination, revealed a range of interesting findings. Not only did it allow for the emergence of multiple and complex ways of publicly engaging with controversial local health commissioning processes (Graber et al., 2018, under review), it also provoked a range of defensive stakeholder practices, perhaps as a result of the controversial and challenging engagement topics that emerged.

To deal with the first point, the concept of health care as caring, loving and nurturing has been argued to largely have been lost in the process of commissioning (Wieringa et al., 2017). The NHS on one hand provides therapy but on the other, board and lodging and tender loving care (Askheim, Sandset, & Engebretsen, 2017). In the UK, hospitals in particular play an important symbolic role; they are more than just buildings where healthcare is delivered. They have been argued to represent for many the physical incarnation of the NHS and its values within a particular locality (Graber et al., 2018, under review; Jones, 2016).

The NHS symbolises the sites of care which were a key part of the post-war welfare state and relate closely to the idea of communality or common citizenship (Brown, 2003). Health services and sites are often more than the sum of their material characteristics; they are the centre of meanings, intentions and felt values, the focus of emotional attachment and significance (Brown, 2003). However post-HASC engagement rubric organises agenda-setting and problem definition in ways which avoid, sideline or restrict participation to Smith's (2006) 'safe' issues and so questions of value, local community and citizenship are lost or minimised.

The BCHSS survey created a space where such issues could re-emerge centre stage. In using quantitative social research to reveal diverse ways of making sense of health commissioning activities and public voice (Samuel, 2014), and to create a space for different ways of relating to NHS commissioning and for the emergence of previously marginalised voices (Martin et al., 2015), it foregrounded local commissioning controversies and mobilised a politics of 'knowledge as disruption' (Martin et al., 2015). As such, the hegemony of local consumer-oriented engagement practices could be challenged through this created space for deliberation that allowed disruption of such hegemonic practices (Gaventa, 2006). The survey project can be understood as a form of 'evidence based activism' which opened space for deliberation where the previously unmeasured could become measurable and where largely private conversations on healthcare commissioning could be brought to public notice.

The survey revealed not only a disjunct between the wishes of the Brighton & Hove public and commissioning activity, but also the problematisation of a singular consumer public whose engagement with health services starts and ends with individual experience of consuming services. The very considerable qualitative feedback highlighted the ways in which local identity, community and sense of place, as well as political and ethical value, are inseparable from the changing health services context (Graber et al., 2018, under review).

The experience of engaging the dominant commissioning stakeholders directly contested what Jones (2016) refers to as the assemblages of knowledge and practice rationalities which typically constitute the objects and subjects of policy and commissioning practice. Martin (2008) suggested that past research shows a tendency of professional staff to question the representativeness of involved members of the public and that this can function as a form of patrolling or controlling of the process of public involvement. Through this frame, public and user involvement can be understood as a technology of legitimation where the selection of appropriate or acquiescent individuals by health professionals might be disrupted via outside parties whose claims to represent the public will hence be contested.

The survey project revealed a series of practices, individual meetings, public meetings and communications where the challenging findings were welcomed, resisted and questioned depending on the stakeholder and the issue. The survey constituted a challenge to the normative engagement practices on health commissioning which are, to a large degree, controlled through the conduct of meetings where professionals and managers are seen to retain control over decision making processes (Martin, 2008). The response of local decision-makers was articulated through an amalgam of settings and practices in which power relations were played out and contests fought in acts that proved far from trivial (Samuel, 2014). Indeed there were several moments where the dominant stakeholders in this context sought to directly challenge the veracity, ethics and appropriateness of the citizens' survey project. This was addressed by the project team through: clearly stating the rationale of the project, and expressing the values driving it; sharing the results of the surveys; and being available for consultation with any stakeholder at any stage of the project.

Concluding Thoughts

This paper provided the socio-economic context in which the BCHSS project started and unfolded, and offered an overview of its quantitative findings. These were discussed through the lens of stactivism and the enactment of democratic processes which sought to bring a degree of meaningful accountability to the commissioning process. The analysis considers potential pitfalls of the survey as an academic tool, and addresses the concerns of the institutions on its reliability by advocating for the co-construction of alternative knowledges that voice communities' unheard positions on policies affecting their everyday lives. It was concluded that BCHSS is a participatory tool that enabled the opening up of a new dialogue between the citizens and the institutions that represent them with the clear aim that top-down decisions will be transparently conveyed, and the bottom-up concerns of citizens' will be taken into account.

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Appendix

Table A.1

Descriptive Findings of Valid Responses From Survey One

When asked who they would prefer to be treated by, almost **88%** of the respondents said the NHS. This compared with **9.1%** who had a preference for a private healthcare company.

When asked whether people believed that “health companies should not make financial profit from people’s health problems”, **92%** strongly agreed or agreed with this statement.

Participants were asked whether, in light of Optum’s international legal difficulties, there should have been a full public consultation on Optum. **93%** said that there should have been.

Over **93%** of people said that they were concerned or very concerned about the award of the Optum contract locally.

The council recently revealed an intention to cut £21.9 million over the next 4 years from the Adult Social Care budget. Over **97%** of people were either very concerned or concerned about these cuts.

97% of people either strongly agreed or agreed with the following statement- ‘The council should be actively resisting these latest cuts by evidencing their impact and sending the messages back to central government’.

In 2016 and 2017 the Brighton & Hove Clinical Commissioning Group are considering inviting health providers to bid to run a primary care mental health service. **93%** of people would be very concerned or concerned if this contract was given to a private provider.

Similarly, regarding the potential contract for NHS 111 service for non-emergencies, **85%** of people would be very concerned or concerned if this contract was given to a private provider.