

**TRAJECTORIES OF VALUE:
AN EXPLORATION OF VALUE CO-CREATION AND DESTRUCTION IN
CANCER SERVICES**

BY

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For Mark, Isabelle and Thomas

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SUMMARY

This is the first study to apply an analytical framework based on service-dominant logic (S-D logic) to a UK specialist health care context. The primary aim is to investigate how value, when framed as value that is perceived and determined on the basis of use (i.e. 'value-in-use', Vargo and Lusch 2004a) is conceptualised by service users (patients) and service providers (health care staff) in a specialist cancer service setting. Factors influencing the trajectories of 'value' (creation and destruction) in micro-level health service encounters are also analysed.

This work is transdisciplinary in nature and combines scholarship from fields including services marketing and public management regarding value, value co-creation and patient and public participation in public services (specifically patient engagement in direct health care). In doing so, this work focuses on the S-D logic framework and the recent application of this approach in public management research (Osborne et al 2013). This study adopts an interpretive approach (using semi-structured interviews and observational data) to the investigation of these focal study phenomena. This study responds to calls for research regarding the empirical application of S-D logic (Ostrom et al 2015).

Study findings reveal that 'value' is a temporal concept, which varies over time and is experienced 'in context'. The S-D logic framework usefully focuses attention on the service user and interactions between patients and health care staff during service encounters. S-D logic does not, however, neatly map into a health care context. The findings show that value can be created and destroyed both within single encounters, and across multiple health service encounters. Four main themes are identified which contribute to the creation and destruction of value in the UK specialist cancer care context: access to resources (includes specialist knowledge and skills and physical resources); the quality of interactions; resource use and organisational factors.

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ABBREVIATIONS

FP(s)	Foundational premise(s)
NHS	National Health Service
NPM	New Public Management
PLG	Patient Liaison Group
S-D logic	Service-dominant logic
SE	Service encounters
UK	United Kingdom
US	United States
VCC	Value co-creation
VCD	Value co-destruction

INTRODUCTION

This study is the first to apply an analytical framework based on service-dominant logic (S-D logic) to a UK specialist health care context. The primary aim is to investigate how value, when framed as value that is perceived and determined on the basis of use ('value-in-use', Vargo and Lusch 2004a) is conceptualised by service users (patients or patients/family members) and service providers (health care staff) in a specialist cancer service setting¹. Factors influencing the trajectories of 'value' (creation and destruction) in micro-level health service encounters are also analysed. This work adopts a transdisciplinary approach and brings together scholarship from disciplines including services marketing and public management regarding value, value-co-creation and patient and public participation in public services (specifically patient engagement in direct health care). In doing so, this work focuses on the S-D logic framework and the recent application of this approach in public management research (Osborne et al 2013).

This study contributes empirically to services marketing and public management literature by eliciting 'user-defined' articulations of value, an under-researched area in both fields of literature. Conceptually, this study illustrates how key assumptions in S-D logic, regarding the processes underlying value co-creation, require further elaboration in a health care context. The capacity to access, exchange, utilise and integrate resources, are shown to be central factors in value formation (positive and negative) in this service context.

1. Background

Given rising global health care expenditures and ageing populations, it is unsurprising that increasing emphasis is placed upon attaining 'value' in health care systems. The

¹ The terms patient and service user are used interchangeably throughout this thesis to describe people using health services. In a similar vein, the terms service providers and health care staff are used interchangeably to describe people working in the health service and providing a service. This thesis also introduces the term 'customer' in the context of discussing literature in services marketing. The arguments presented throughout this thesis do not, however, propose that the term 'patient' is synonymous with that of 'customer' or enter into debates regarding such within this study.

ensuing use of concepts such as ‘patient centred care’, ‘patient activation’ and ‘patient engagement’, reflect attempts to capture ‘patient value’ in health care (Joiner and Lusch, 2016). Although these three concepts are often used interchangeably, they are not identical (Carman et al 2013).

Patient centred care is a broad term used to articulate a vision of healthcare as a partnership, where patient values and preferences guide clinical decisions and patients have the required education and support to enable them to make decisions and participate in their own care (Institute of Medicine 2001, p.3; Carman et al 2013, p.223- 224; Montgomery 2013, p.15). Patient activation, refers to the extent that the individual understands their requirement to have an active role in the management of their own health and health care and specifically concerns their knowledge, skill, and confidence to undertake this self-management role. This is viewed as distinct from compliance, where the emphasis concerns getting patients to adhere to medical advice (Hibbard and Mahoney 2010; Hibbard and Greene 2013).

Patient engagement has been variously defined, with this term typically articulated as a wider concept which includes activation; the interventions designed to increase activation and patients’ resulting behaviour (Hibbard and Greene 2013, p.207). An alternative view of patient engagement forwarded by Carman and colleagues (2013, p.224) concerns patients (including their families and/or representatives) and health professionals working in active partnership at various levels across the health care system (direct care, organisational design and governance, or policy making) to improve health (individuals and/or populations) and health care. Whilst recognising the inter-relatedness of the concepts of patient centred care, patient activation and patient engagement, the focus of this study is upon patient engagement within direct care at the micro-level (i.e. individual health care encounters involving patients and health care professionals).

Patient engagement (often referred to as ‘involvement’ or ‘participation’) in health care is increasingly viewed as a vehicle for improving the responsiveness, effectiveness and efficiency of health care systems. This is partly driven by a desire to reduce costs as well as representing a shift from viewing patients as passive

recipients of care, to active participants and partners in the promotion and management of their health (Laurance et al 2014; Coulter 2011). Empowering the users of health care services is viewed as a means of increasing consumer agency (i.e. freedom of choice and ability to exert that choice) and also well-being i.e. health (Anderson et al 2016). In doing so, it is argued that there has been a movement towards the “responsibilization of health” (a shifting of functions from providers to consumers) as a means of improving health outcomes and a co-opting of “vocabularies of co-production” (Anderson et al 2016, p.262-263).

Within the public management literature, the terms ‘co-production’ and ‘co-creation’ are used interchangeably (Voorberg et al 2015). These terms are often broadly used to signify levels of involvement and participation of end users of services (i.e. patients) in the planning, design, delivery and audit of services (Realpe and Wallace 2010; Voorberg et al 2015). Additionally, the terms co-production and co-creation can denote a shifting of responsibility from health care providers to patients in terms of managing their own health (Fotaki 2011; Anderson et al 2015). This is particularly pertinent in initiatives designed to integrate self-management of long term health conditions (i.e. diabetes, depression) into routine care (Heath Foundation 2012).

Whilst co-production and/or co-creation (when framed as above) can lead to the empowerment of users, consequences can also be negative, particularly, if these shifts in responsibility are accompanied by a decline in available services (Fotaki 2011; Bendapudi and Leone 2003). Asymmetry in expertise between providers and users of health care services, particularly in highly specialised service contexts such as cancer care, further complicates this situation (Anderson et al 2016). When faced with a complex service system, limited time, a situation characterised by uncertainty (particularly pertinent in a cancer service context), a range of stakeholder discourses and information overload, service users can experience stress and anxiety (Berry and Bendapudi 2007). An additional issue of concern, therefore, is whether all patients have the prerequisite skills, knowledge and indeed desire or motivation to ‘actively’ engage and be involved.

A developing critique of patient involvement initiatives argues that efforts to ensure patient participation in healthcare have been viewed as similar to those of manufacturers in engaging consumers in designing and marketing products (Batalden et al 2016; Joiner and Lusch 2016). This mindset (referred to as goods-dominant logic), views one party as the creator of goods (i.e. products or services) and the other as a passive recipient of the value the goods produce. Whilst this logic prevails, it is argued these initiatives will be conceptualised in terms of customising goods and treatments as they are delivered to patients (Joiner and Lusch 2016, p.26). This in turn, frames the relationship between the provider and the patient as one where the provider is experienced, knowledgeable and the creator of value, and the patient as inexperienced, passive or dull who consumes or uses up value (Joiner and Lusch 2016, p.26).

A potential solution to this situation is to draw upon 'service-dominant logic' (S-D logic); an evolving framework within the services marketing literature, which emphasises a "logic of togetherness where actors² use their applied knowledge and skills to provide benefit to another and themselves" (Joiner and Lusch 2016, p.26). Through such processes, 'value' is seen to be co-created, rather than delivered by one party and consumed and destroyed by another. From an S-D logic perspective, value is always co-created but individually perceived and determined (mainly by the service beneficiary) on the basis of use (Vargo and Lusch 2004a, 2008, 2016a; Lusch and Vargo 2006). The emphasis in S-D logic is on the co-creation of 'value' (defined as benefit or increase in well-being), rather than the co-creation of a service or health outcomes (Vargo and Lusch 2012, p.5).

Similar arguments, concerning the 'logic' underpinning services such as health, have been raised by Osborne and colleagues in public management literature and research. These authors argue that 'public goods' should be conceived of as 'public

² Actors are defined in S-D logic as "entities that have agency, the ability to act purposefully" (Lusch and Vargo 2014, p.56). In this study, this term is used to refer to people involved in interactive value formation processes i.e. customers, service providers, patients, their families and health care staff. Interactive value formation is value that is co-created during the interaction between the customer and the provider. This is differentiated from non-interactive value formation, where value is produced by the provider and used up by the consumer (Echeverri and p.351-352).

services' (this includes health care) rather than 'public products'. This approach advocates that public management should be underpinned by service management approaches (including the work of Lusch and Vargo 2006), rather than business management theories. Instead, it is proposed that a 'public service-dominant approach' should be applied to the delivery and analysis of public services (Osborne 2010; Osborne et al 2013). This body of work additionally argues that there is a lack of conceptual clarity regarding the term co-production and proposes an alternative typology of co-production. This typology incorporates public administration and service management theories and has recently been extended to also consider value co-creation (Osborne and Strokosch 2013; Osborne et al 2016).

It is argued that achieving a productive and sustainable health system, which is responsive to the needs of health care consumers, requires partnership approaches which extend the 'user' role to one of co-participant and co-creator of health services and system sustainability (Bovaird 2007; Dunstan et al 2009; Batalden et al 2015; Janamian 2016). This entails widening the notion of 'inclusion' beyond viewing patients as active participants in managing their own health, to also include the potential for involvement in innovation and value co-creation (Janamian 2016; Batalden et al 2015; Nambisan and Nambisan 2009). Although value co-creation is not a new concept within business management literatures, its application in health care remains underdeveloped (Janamian 2016; Joiner and Lusch 2016).

In the Spring of 2017, there are no published empirical studies which consider value co-creation or the application of S-D logic within a UK health care context. Although value co-creation has been studied empirically within a specialist cancer service context in an Australian privately funded health care setting, it has not been investigated directly within a UK specialist cancer service setting (McColl-Kennedy et al 2012). Additionally, there is a lack of research exploring how 'value' is perceived from a service user perspective (Coulter 2012; The Health Foundation 2012; Medberg 2016). Given these research gaps, this study draws on S-D logic (which emphasises customer-centric services and the co-creation of value), as a means of furthering understandings of patient engagement in micro-level cancer service encounters.

Whilst value co-creation, as outlined from a service-dominant logic perspective may lead to the creation of value for more than one party (i.e. for patients and health care providers), the main focus in this study is on 'patients', as the main beneficiaries of service in health care (Vargo and Lusch 2016a).

A brief introduction to the S-D logic framework and key concepts are outlined below before outlining the aims, objectives, structure, and key contributions of this study.

Overview of service-dominant logic

Service-dominant logic emerges from the services marketing literature and is defined as: "a lens, a perspective for seeing the economic and social world differently from traditional microeconomic and related marketing-management view; what we have called 'goods-dominant logic'" (Vargo 2011, p 4). It is a framework which challenges distinctions between 'goods' and 'services', and instead advocates that academics and practitioners should focus on the commonalities (Vargo and Lusch 2004b).

The S-D logic approach has undergone multiple revisions since its inception, (these will be discussed in the subsequent chapter) and continues to evolve. It is underpinned by 11 foundational premises (FPs). Five of these foundational premises have recently been assigned axiom status, as they are viewed as capturing the essence of S-D logic. These are summarised in Table 1 and will be discussed in more detail in the subsequent chapter.

At the heart of S-D logic is the notion that 'service', (the application of resources for the benefit of another or oneself) forms the fundamental basis for all economic exchange, whereby 'service' is viewed as a core feature of both goods and products (Vargo and Lusch 2004a, 2014, 2016b; Brodie et al 2011; Edvardsson et al 2011; Lusch and Vargo 2014). Resources are viewed as anything that an 'actor' (e.g. customer or provider) can draw on for support. In S-D logic, these are classified as either 'operand' resources (which require other resources to act on them in order to provide benefit, which are often static and tangible i.e. medical equipment) or 'operant' resources (capable of acting on other resources to create benefit, often intangible and dynamic

e.g. human skills and capabilities). As these two types of resources are often inter-linked, it is proposed that for operand resources to create benefit, an actor needs to know how to act on them (i.e. a radiotherapist having the skills and knowledge to use specialist radiotherapy machines to administer treatment). In short, from an S-D logic perspective, “the application of operant to operand resources is what creates benefit” (Lusch and Vargo 2014, p.57).

Table 1: Eleven foundational premises of S-D logic (adapted from Lusch and Vargo 2014; Vargo and Lusch 2008, 2016a)

Number	Foundational premise
FP1.	Service is the fundamental basis of exchange
FP2.	Indirect exchange masks the fundamental basis of exchange
FP3.	Goods are distribution mechanisms for service provision
FP4.	Operant resources are the fundamental source of strategic benefit
FP5.	All economies are service economies
FP6.	*Value is cocreated by multiple actors always including the service beneficiary.
FP7.	Actors cannot deliver value but can participate in the creation and offering of value propositions. ³
FP8.	A service-centered view is inherently beneficiary oriented and relational
FP9.	All social and economic actors are resource integrators
FP10.	Value is always uniquely and phenomenologically determined by the beneficiary
FP11.	*Value cocreation is coordinated through actor-generated institutions and institutional arrangements
FP1 assigned axiom status also referred to as Axiom 1 FP6 assigned axiom status also referred to as Axiom 2 FP9 assigned axiom status also referred to as Axiom 3 FP10 assigned axiom status also referred to as Axiom 4 FP11 assigned axiom status also referred to as Axiom 5 (this axiom was only added in 2016)	

* The terms ‘cocreated’ and cocreation are not hyphenated in Vargo and Lusch 2016a

S-D logic proposes that value (benefit, or an increase in well-being) is co-created (value co-creation) through the interactions and activities of ‘actors’ (e.g. customers and service providers) during which resources (i.e. operand resources such as knowledge and skills) are exchanged and subsequently integrated and utilised by the beneficiary (Vargo and Lusch 2004a, 2006, 2008, 2012; Edvardsson et al 2011; Lusch and Vargo 2014). These resources may extend beyond those of the service provider and ‘customer’ (or patient in this study) to also include private sources (e.g. family and friends) and customer self-generated activities (e.g. positive thinking and sense

³ A value proposition under S-D logic is “how an ‘actor’ co-proposes to positively affect another ‘actor’ ”(Lusch and Vargo 2014, p.72).

making). This implies that multiple actors can be involved in value co-creation (Vargo and Lusch 2011; McColl-Kennedy et al 2012).

According to the S-D logic framework, 'value' is only realised through the use of a service (value-in-use), as opposed to "value being embedded in tangible goods at the factory gate" and subsequently exchanged, i.e. 'value-in-exchange' (MacDonald et al 2011, p.671). In other words, value is viewed as co-created through the interactions of customers, providers and other market actors rather than provided by firms and subsequently delivered to customers (Karpen et al 2012). Value co-creation is a collaborative activity (between two or more economic actors) with "the purpose of creating value beyond what each actor can achieve independently" (Neghina et al 2015, p.223).

Although early applications of the S-D logic framework concentrated on the positive aspects of service exchange, a developing body of work suggests that interactive value formation processes can also be negative, and lead to value co-destruction (Plé and Chumpitaz Cáceres 2010; Echeverri and Skålén 2011; Smith 2013; Laamanen and Skålén 2015). There has been some recent recognition of the potential for negative as well as positive consequences of service use in public services (Robertson et al 2014; Williams et al 2016; Osborne et al 2016).

An essential principle underlying the notion of 'value-in-use' is that value is individually and contextually perceived and determined by the beneficiary, on the basis of their use experience of service (Vargo and Lusch 2008; Grönroos 2011; Medberg 2016). This implies that 'customers' are the "arbiters of value" in service provision (Tronvoll 2012, p.288). This is an important consideration in this study, as adopting this perspective directs attention towards patients' preferences, experiences, and their conceptualisations of 'value'.

2. Study approach, research question, aim and objectives

This study adopts an interpretive approach and qualitative research design (i.e. semi-structured interviews and observational data) to investigate the research question, aim and objectives of this thesis.

The overall research question this study seeks to address is:

What does 'value' mean in a specialist cancer service setting, and to what extent can S-D logic enhance understandings of 'value' in this health care context?

Aim

The primary aim of this study is to investigate how value, when framed as value that is perceived and determined on the basis of use (i.e. 'value-in-use', Vargo and Lusch 2004a) is conceptualised by service users (patients or patients/family members) and service providers (health care staff) in a UK specialist cancer service setting.

Objectives

1. To investigate trajectories of value in a UK specialist cancer setting by exploring how service users (patients or patients/family members) and service providers (health care staff) conceptualise value when framed from an S-D logic perspective i.e. (value-in-use or benefit) (Axiom 4/FP10).
2. To identify potential barriers, facilitators and supports for value co-creation by exploring conceptualisations of value and service user and service provider accounts of service experiences (Axiom 1/FP1; Axiom 2/ FP6; Axiom 3/ FP9).
3. To explore how the following selected axioms/ foundational premises underpinning service-dominant logic: Axiom 1/FP1; Axiom 2/ FP6 and FP7; Axiom 3/FP9 and Axiom 4/ FP10, relate to and/or have relevance to the selected study context (Refer to Table 1). This leads to a series of five secondary objectives.

A. To investigate the nature of the service exchange in cancer service encounters by exploring how service users and providers describe the processes of knowledge/skills exchange and involvement in treatment and care processes (Axiom 1/FP1).

B. To explore how is value co-created within a cancer service context and who are the 'actors' involved, by examining service user and provider conceptualisations of 'value'. (Axiom 2/FP6).

C. To investigate the nature of 'value propositions' offered by service providers (how they define the service they are offering) and how these relate to patient expectations and conceptualisations of value (FP7).

D. To investigate the nature of the resource integration process in a cancer service setting through exploring (a) the types of resources which service users draw upon, (b) the range of resources offered by the specialist centre and (c) how previous experiences of treatment and care relate to current experiences of service use (Axiom 3/FP9).

E. To investigate how value is conceptualised by service users and service providers within the study context (Axiom 4/FP10) - see objective 1.

In applying the S-D logic framework to a specialist service context, it is necessary to tap into the assumptions underlying this framework. The analysis undertaken in this study, as indicated in the study objectives, explores the relevance of four of the five axioms of S-D logic and an additional foundational premise to the selected study context. These specific foundational premises have been selected for a number of reasons. First, as outlined earlier, the central tenet of the S-D logic framework is the assumption that 'reciprocal service', is the "fundamental basis of economic exchange" (Gummesson et al, 2010, p.10). It has been argued that all foundational premises are based on this underlying assumption (Kryvinska et al 2013). The nature of the service exchange during cancer service encounters is therefore an important area of consideration within this study. Second, FP1, FP6, FP9, FP10 are assigned

axiom status in the S-D logic framework and are the key premises from which six other foundational premises are additionally derived (Lusch and Vargo 2014). Third, the selected foundational premises are those which Vargo and Lusch (2012) have previously suggested most directly concern 'value' (FP6, FP7, FP10) or underpin the process of value co-creation (FP9).

As noted in Table 1, the S-D logic framework was extended in 2016 to incorporate an additional axiom/foundational premise (Axiom 5/FP11) which concerns institutions and institutional arrangements (Vargo and Lusch 2016a). Although this axiom is also viewed as influential in understanding value co-creation, this is not explored within the context of this study. This is because, that latest axiom (FP11) differs in orientation to the other selected axioms and warrants a meso or macro level of analysis. In contrast, the emphasis in this study is on micro-level service encounters (i.e. interactions between patients and health care staff during individual service encounters). The rationale for adopting a micro-level approach to the analysis is outlined below.

Micro-level focus

The focus in this study on 'micro-level' health encounters responds to a concern that earlier patient and public engagement initiatives in the UK NHS have tended to focus on securing involvement within commissioning and service reviews (some of which are large scale and sophisticated). In contrast, this study focusses on the everyday interactions and the face-to-face contact between individual patients (Coulter 2012). In failing to pay attention to this 'micro-level' of analysis, it is argued that "[...] the NHS has put the cart before the horse..." (Coulter 2012, p.7).

Moreover, it has also been suggested that the majority of studies of value co-creation have focused on meso- or macro- perspectives, rather than the micro-level of service interactions. Research concerning how 'customers' and 'providers' engage in value co-creation at the basic level of direct interactions is limited (Neghina et al 2015). This somewhat surprising given that it has been argued that analysis of value co-creation at the micro-level can provide the building blocks for greater understanding

of value co-creation in more complex settings (i.e. where larger numbers of 'actors' are involved, interactions are repetitive or longitudinal, or there are differing dependencies between interacting 'actors') and at higher levels of analysis such as meso and macro levels (Neghina et al 2015, p.222; Vargo 2011).

Relevance

This study links to the innovative work of Osborne and colleagues in the field of Public Management who argue that a 'public service-dominant' logic should underpin public service delivery and analysis (Osborne 2010; Osborne et al 2013, Osborne et al 2016). This developing body of work draws upon services marketing literature (which includes the work of Lusch and Vargo 2006) and argues that such literature has largely been absent in public management theory (Osborne 2010, Osborne et al 2013). This study partly responds to the call by Osborne and colleagues for empirical research to test the insights and limitations of the public service-dominant approach and to consider conceptualisations of value in public services (Osborne et al 2013; Osborne et al 2016). Although this study does not directly examine a 'public service-dominant' approach, it does apply S-D logic (Vargo and Lusch 2004a, 2006, 2008, 2016a) to analyse a public service context i.e. specialist health care context. In doing so, this work has the potential to contribute to the body of work in public management, through the exploration of conceptualisations and trajectories of value arising through micro-level health service encounters.

This study also responds to the recent call by Ostrom et al (2015) to direct Service Research towards three priority areas; understanding value creation, enhancing the service experience and improving well-being through transformative service. Calls for the use of qualitative and ethnographic research methods in relation to empirical applications of the S-D logic framework have increasingly been made by a number of services marketing scholars, as a means of unpacking and understanding the 'black box' of value co-creation (Grönroos 2011; Leroy et al 2013; Nordgren and Åhgren 2013; Chandler and Lusch 2015; Ostrom et al 2015). Additionally, this study also addresses at least two research priorities stated in a special edition of the Journal of Service Research: (a) understanding and facilitating patient experience, and (b) the

transformative potential of health services (Danaher and Gallan 2016, p.435). By undertaking this study within a specialist cancer service context, where there is a prolonged period of engagement with the service, the nature of the patient experience and perceptions of 'value' can be explored at a micro-level over the service journey. Investigation of the customer experience as it develops over time is identified as an important future research area by McColl-Kennedy and colleagues (2015), and one which is currently lacking in extant research.

3. Contributions of the study

This study offers conceptual, empirical, methodological and policy contributions to scholarship in the fields of public management, services marketing, and health services research.

First, the conceptual contribution of this study arises from the identification and exploration of trajectories of value (positive and negative) as a consequence of service use. This phenomenon has not previously been conceptualised in this way in the services marketing and public management literature. In doing so this study reveals that value is a temporal concept, which varies over time and also in the context of individuals lived experiences. This study is the first to consider how value accumulates and/or dissipates at an individual service user/customer level within and across single or multiple micro-level service encounters, in single or multiple organisations. Given the multiplicity of health care providers in a cancer service context, this study extends extant knowledge regarding value co-creation as this study focuses on multiple rather than discrete service encounters. These findings have relevance for other 'professional' or 'customer-facing' service sectors where engagement with the service may be prolonged and ongoing rather than a single encounter.

Second, this study forwards two empirical contributions. First, this study explores perceptions of 'value' from the perspectives of service users and service providers, an area that is currently under researched in both services marketing and public management literatures. By gaining insight into how value is perceived, further

understanding is gleaned into factors facilitating or restricting the creation of value in a specialised cancer service context. Second, this study furthers understandings of the processes underlying value co-creation (service exchange and resource integration), which have previously been viewed as an unexplored black-box (Pfisterer and Roth 2015). In doing so, this study answers calls for research regarding the extension of knowledge in relation to value co-creation processes (Grönroos 2011; Leroy et al 2013; Nordgren and Åhgren 2013; Chandler and Lusch 2015; Danaher and Gallan 2016; Ostrom et al 2015).

Third, the methodological contribution of this study concerns the development of a framework to classify and analyse negative value trajectories. In doing so, this study offers an early typology for classifying such phenomenon which could be used to further insight into factors facilitating value co-creation, and also adapted to other service contexts. Potential applications of this framework could concern work adopting similar qualitative research methods than those undertaken in this study. Alternatively, the framework could be incorporated within surveys of broader collections of organisations.

Fourth, this study contributes at a policy level through reinforcing the importance of focusing on processes of care and not just health care outcomes. Specific attention is drawn to the quality and nature of interactions in health care encounters. This is an important consideration given recent service failings such as those outlined in the Francis Report (2013). These findings could be used to inform training and development programmes for staff working within a health care context. This study also extends extant knowledge regarding 'patient value', a developing area of interest for a number of health care programmes in the UK (i.e. Prudent health care, Wales; Realistic Medicine, Scotland).

4. Chapter structure

Chapter one reviews the focal literatures informing this study and articulates the relevance of the key concepts of 'value-in-use' and 'value co-creation' to enhancing understandings of patient engagement in health care (direct engagement in own

health, care and treatment) within individual, micro-level service encounters. In doing so, this chapter draws together perspectives from multiple literatures concerning value, service-dominant logic, patient engagement in health care and public service-dominant logic to outline and justify the key research questions addressed within this study.

Chapter two outlines the systematic research methodology used to conduct this study and the rationale for adopting an interpretive approach to the investigation of the focal phenomena. Features of case study and qualitative research are discussed before detailing the triangulated data collection used in this study. The processes of negotiating access to the study site; study participants and conducting the interviews and observations are additionally relayed and a brief summary provided of the nature of the data collected. Ethical considerations are paid attention to throughout this section. Methods of data analysis are then outlined before reflecting on the research process and how issues such as credibility, transferability and reactivity were managed within this study.

Chapter three introduces the main findings arising from this study. These are arranged into two main sections. The first section investigates service user and service provider conceptualisations of 'value' within the context of a UK specialist cancer service setting. The second section presents an analysis of the nature and extent of value co-destruction within the context of a cancer service setting. This section also considers how 'value' (positive and negative) accrues or diminishes across individual and multiple service encounters and the potential for value to be recovered within and across organisational sites. This concludes with a summary of the key findings.

Chapter four outlines the main contributions of this study, limitations of the research study and highlights areas for future research.

CHAPTER ONE: THE DYNAMICS OF VALUE IN HEALTH CARE

“One of the most enduring and controversial topics in medicine is the concept of what constitutes value in health care” (Ramsey and Schickedanz 2010, p.1).

Introduction

In light of increasingly limited health care resources and rising health expenditure, it is not surprising that health care ‘value’ is typically conceived of in economic terms, with emphasis placed on the costs and outcomes of service interventions (Porter and Teisberg 2006; Porter 2010; Ramsey and Schickedanz 2010; Right Care 2011; National Voice 2015). Recently, however, it has been argued that economic articulations of ‘value’ reflect a ‘payer’ centred perspective that may not appropriately capture the perceptions of health service users regarding what is of most value to them (Tilburt et al 2011; National Voice 2015). These are important considerations in relation to conceptions and metrics of ‘value’, as the perspectives of those using, providing and funding health care may not necessarily be shared.

Given these concerns, framing value from a perspective in the services marketing literature known as service-dominant logic (S-D logic) may afford additional insights into how value is perceived by users of health care services (Akaka and Vargo 2015; Lusch and Vargo 2014). The S-D logic framework proposes that ‘value’ is a subjective, experiential and phenomenologically determined concept. According to S-D logic, value (benefit or increase in well-being) is only realised in use, ‘value-in-use,’ and is always unique to a particular context (Chandler and Vargo 2011; Vargo and Lusch 2012; Rihova et al 2013; Lusch and Vargo 2014, p.57). Whilst value is co-created through the interactions and activities of various ‘actors’ (e.g. customer or service provider), during which resources are exchanged and subsequently utilised and integrated, value is ultimately determined by the beneficiary of service on the basis of their service experience (Vargo and Lusch 2012; Rihova et al 2013).

The S-D logic framework emerges from efforts to extend and integrate previous research regarding ‘service’ as the basis of exchange (Akaka and Vargo 2015). An

important aspect of S-D logic is that the term ‘service’ (the application of knowledge and skills for the benefit of another) is distinguished from the plural term ‘services’ (units of output), with the latter associated with goods-dominant logic⁵ (Kryvinska et al 2013; Lusch and Vargo 2014, p.12). As discussed in the introductory chapter, the basic tenet of S-D logic is that “service is exchanged for service” for the benefit of another actor or oneself (Lusch and Vargo 2014, p.15). Actors are not, however, able to deliver value to another actor. Instead, they can offer potential value through value propositions i.e. a promise of service to be delivered (Lusch and Vargo 2014, p.72). The primary focus in S-D logic, is on operant resources, with the beneficial application and integration of such resources resulting in ‘value’ (Vargo and Lusch 2004a, p.7; Brodie et al 2011). In adopting this alternative logic of exchange, it is proposed that attention be directed towards the “experiential” and “phenomenological” aspects of value (Akaka and Vargo 2015, p.460).

This interpretation of value, and value co-creation, sits in stark contrast to perspectives which have regarded value as “a ratio between service quality and cost” (Sandström et al 2008, p.112). In framing value from an S-D logic perspective as ‘value-in-use’, it is proposed that users of the service have a dual role as both judges, and co-creators, of the value of a service (Sandström et al 2008). There is, however, limited empirical research which explores how ‘customers’ themselves perceive value-in-use (Medberg 2016). The relationship between perceptions of ‘value’ and ‘value co-creation’ is also understudied. One outcome is that limited attention has been given to the relationship between customer service experiences and their co-creation practices (Gummerus 2013; Helkkula and Kelleher 2010; Helkkula et al 2012).

Focus of the chapter

The purpose of this chapter is to explore the relevance of the concepts of ‘value-in-use’ and ‘value co-creation’ to enhancing understandings of patient engagement in

⁵ This logic frames exchange in terms of units of output (goods), with the production and exchange of goods forming the central components of business and economics (Lusch and Vargo 2014, p.4).

health care (direct engagement in own health, care and treatment) within individual, micro-level service encounters⁶. In doing so, this chapter moves to the foreground, two developing areas of research ('value' and 'value co-creation'), and explicates the relevance and potential application of these concepts to the sphere of health care. The analytical themes introduced in this chapter draw on emerging literatures in the fields of services marketing (i.e. service-dominant logic) and public management (i.e. public service-dominant logic) to draw attention to the importance of examining 'value-in-use' and 'value co-creation' within a health care context (Vargo and Lusch 2004a, 2004b, 2006 2008, 2011, 2012, 2016a; Osborne 2010; Osborne et al 2013; Osborne et al 2015; Osborne et al 2016).

In undertaking this work, this chapter brings together multiple streams of literature and research to frame this case for the first empirical investigation of these concepts and the S-D logic framework within a UK specialist cancer service setting. Exploration of these literatures also assists with the formulation of the specific objectives of this study. These objectives concern the exploration of conceptualisations and trajectories of 'value' within a cancer service context, and the identification of potential barriers, facilitators and supports to value co-creation. Further elaboration of the research questions addressed in this study are provided later in this chapter.

The emphasis in this study, as outlined in the introductory section, is on patients' engagement in direct care (micro-level service encounters) rather than involvement in organisational design and governance or policy making. The focus on 'micro-level' encounters is in response to concerns that this level of analysis has been neglected in UK NHS policy and practice (Coulter 2012). This level of analysis is also under-researched in studies exploring value co-creation (Neghina et al 2015).

Additionally, it should be noted that although value co-creation (as outlined from a S-D logic perspective) may lead to the creation of value for more than one party (i.e. for patients and health care providers), the main focus in this study is on 'patients',

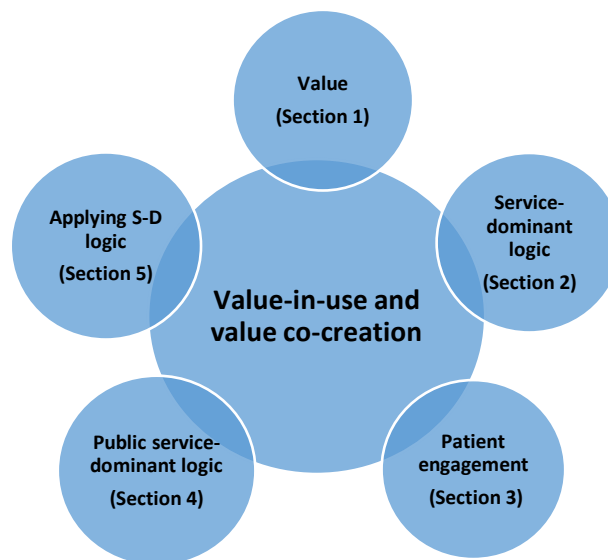
⁶ Service encounter is a period of time during which a customer directly interacts with a service (Shostack 1985; Bitner 1990).

as the main beneficiaries of service in health care (Vargo and Lusch 2016a).

Chapter structure

In moving towards an understanding of the contribution of the concepts of ‘value-in-use’ and ‘value co-creation’, it is necessary to locate these concepts within the wider literatures discussed within this chapter. This is represented diagrammatically in Figure 1. This work is undertaken in five main sections (illustrated in Figure 1) before concluding the chapter with a summary of these various literatures and discussions.

Figure 1: The location of value-in-use and value co-creation in relevant literatures



Section one of this chapter considers the various definitions of value in the marketing, public management and health care literature. This section incorporates discussions concerning the shift in mainstream marketing literature from viewing ‘value’ as a property intrinsic to goods/objects and thus a commodity that can be exchanged (value-in-exchange), to one which views ‘value’ as an experiential concept and related to ‘use value’ (Ng and Smith 2012; Vargo and Lusch 2004a, 2006). Attention is also drawn here to conceptualisations of ‘value co-creation’ within the marketing literature and differing ways of framing ‘value’, i.e. ‘value-in exchange’ versus ‘value-in-use.’ A range of perspectives on the process of value co-creation are additionally explored (Vargo and Lusch 2011; McColl-Kennedy et al 2012; Grönroos

2006, 2008, 2011). The potential for value co-destruction, as an outcome of service use is also raised. The inter-relatedness of the concepts of quality and value is then briefly introduced before moving to summarise alternative perspectives on 'value' in the public management literature concerning 'public value' and co-production (i.e. Moore 1995, 2012, 2013, 2014; Bryson 2004; Bryson et al 2017; Bovaird et al 2015; Loeffler and Bovaird 2016). This section concludes with a discussion regarding ways of framing value in the context of health care.

Section two discusses the development of S-D logic and central aspects of this framework. Critiques of S-D logic are explored before discussing research in the services marketing literature which has explored the application of S-D logic to a health care context.

Section three draws on literature in public management concerning patient engagement and involvement in health care. Although the focus of this study is on patient engagement in direct care, it is necessary to locate initiatives at this level in the context of the wider patient and public participation literature. This section discusses how exploring 'value-in-use' and 'value co-creation' in a health care context could enhance engagement initiatives.

Section four addresses the application of services marketing literature to public management focusing on a body of work undertaken by Osborne and colleagues. This stream of scholarship advocates that public management should be underpinned by service management approaches (i.e. service-dominant logic) rather than business management theories. This section discusses the emphasis within this stream of work on service user perspectives and recent propositions regarding enhanced typologies of co-production. Attention is also drawn briefly here to differing interpretations of 'co-production' within public management and services marketing literatures. Differences between the work of Osborne and colleagues and the approach adopted in this study are outlined.

Section five discusses the potential implications of applying the S-D logic approach to a UK specialist health care context and outlines areas which require further consideration.

Finally this chapter summarises the contributions of these literatures and identifies research gaps where the empirical work undertaken in this study could contribute to extant knowledge. The main research questions identified in this study are then outlined in relation to the empirical application of the S-D logic framework to a UK specialist cancer service context.

Section 1: Value-in-use, value co-creation and service-dominant logic

1.1 The thorny issue of value

“Value is perhaps a chimera in the managerial and social sciences, but it has proved to be a compelling one” (Arnould 2014, p.129).

The notoriously elusive concept of value is one which has been discussed for over 2000 years (Ramsey and Schickedanz 2010; Ng and Smith 2012, Karababa and Kjeldgaard 2014). Indeed, Graeber (2001) has argued that the very ambiguity of the term appears to make it attractive. It is perhaps not surprising that the literature pertaining to ‘value’ is vast, with definitions of value spanning disciplines including: economics, philosophy, sociology, anthropology, psychology, management and marketing (Ramsey and Schickedanz 2010; Ng and Smith 2012). A common feature in all definitions, regardless of discipline, is that value is recognised as a multidimensional concept. Attributes frequently mentioned to define value include utility, social significance, emotional and spiritual meaning and monetary expenditure. The importance of specific attributes may, however, vary in importance depending on the perspective of the individual or organisation (Boztepe 2007; Ramsey and Schickedanz 2010).

Graeber (2001, p.2) identifies three broad streams of thought in relation to value: sociological, economic, and semiotic. The first (sociological), concerns ‘values’ that people hold as “conceptions of what is ultimately good, proper, or desirable in

human life". The second (economic), concerns: "the degree to which objects are desired, particularly, as measured by how much others are willing to give up to get them". The third (semiotic), concerns value in the linguistic sense and is characterised most simply as "meaningful difference". A review of literature on value (management, marketing, philosophy and economics literature) undertaken by Ng and Smith (2012, p.207) categorises the existing value literature into the six themes of "value understanding: utility, economic worth, perceived satisfaction, net benefit, means end and phenomenological experience". Whilst acknowledging this range of perspectives, it is outside the remit of this study to cover all of these various value 'streams'. Instead the first focus here is on 'value' in the economic sense, where this is viewed as exchange or use value, as these perspectives have dominated schools of thought in both marketing and health care (Ng and Smith 2012; Ramsey and Schickedanz 2010). Attention is then drawn to alternative phenomenological perspectives on 'value.'

1.2 Exchange-value, use-value and a third way?

Debates concerning value centre on two main issues. The first of these concerns whether objects have extrinsic or intrinsic value. This relates to whether value is subjectively assigned by the user and independent of the products physical qualities, or if value is viewed as embedded within the object (Plato 1930; Ng and Smith 2012). The second debate concerns the 'goodness' in an offerings use or experience, (commonly known as 'use-value') in contrast to that of 'exchange value' (which is characterised by an offering's worth in exchange). Although both approaches describe the "goodness of something", the former is viewed as concerning the "goodness of use", and the latter "the goodness of exchange for something else" (Ng and Smith 2012, p.212).

The emphasis within economics, and within the marketing literature, has traditionally been on value-in-exchange (implying goodness is embedded within the product and is characterised by an offering's worth in exchange). Recently, however, within services marketing there has been a shift to 'value-in-use' (Ng and Smith 2012). The concept of value-in-use is not a new concept. This has origins in the works

of classical philosophers such as Aristotle and Plato and is also noted in the early work of Adam Smith (Vargo et al 2008; Ng and Smith 2012; Lusch and Vargo 2014; Medberg 2016). Lusch and Vargo (2014, p.7) argue that although the “father of economics”, Adam Smith, acknowledged value-in-use as “real value”, this perspective on value essentially shifted ‘backstage’ in the early part of the Industrial Revolution. Emphasis was instead placed on the production and export of goods as these were viewed by Smith as the key source of national wealth. Exchange-value was subsequently used as a surrogate for ‘value-in-use’ by Smith. The exchange perspective on ‘value’ was thought to be easier to understand and offered a systematic, or uniform measurement of wealth (Lusch and Vargo 2014).

Not everyone agreed with the classifications offered by Smith and the emphasis on ‘productive activities’ (activities focussed on the manufacturing and distribution of tangible goods). Ng and Smith (2012, p.213) propose that other economic scholars (such as Mill 1848 and Say 1821); “recognised that all activities that contributed to well-being were productive (had value-in-use)”. Despite these differing viewpoints, the emphasis largely remained on Smith’s model of exchange-value. According to Lusch and Vargo (2014, p.8) the movement in economic thought from philosophy to science around this time (i.e. 1800’s), further amplified and institutionalised the meaning of exchange-value. The advance of Newtonian Mechanics, which viewed matter as embodied with properties, translated easily to the “concept of a product, or ‘good’, embedded with ‘utilities’ (exchange-value)”. By the middle of the 19th century, the concept of ‘utility’ as more of, an “embedded property of matter”, than a measure of usefulness took hold as the primary unit of analysis in economic science (Lusch and Vargo 2014, p.36). It is suggested that such an emphasis became the focus of neoclassical economics and “paved the ground” for marginal utility theory (Ng and Smith 2012, Lusch and Vargo 2014, p.8). This viewpoint is reflected in the following extract from Vargo and colleagues (2008, p.147).

“The ‘product’ (good) embedded with ‘utilities’ (exchange-value) became the focus of neoclassical economics grounded in marginal utility theory (Marshall, 1927; Walras, 1954). And so, economic science became grounded on a foundation of goods-dominant logic and nominal exchange value”.

The notion of 'utility' is one which Ng and Smith (2012, p.208) suggest continues to underpin contemporary business thought across a range of disciplines. It is a concept, which they argue has been used as a proxy for 'use-value' within exchange-transactions. This, they suggest, has had a profound impact on the original conceptualisation of utility as this decontextualises and deindividualises value, "into the notion that that a product has its own essence, often without reference to the perceiver or the context" (Ng and Smith 2012, p.214). In doing so, an implicit assumption is made, in that use-value is viewed as utility and thus immediately obtained at exchange. Such interpretations potentially have implications in the arena of health care, given the emphasis on 'utility measurement' in economic evaluations of health care interventions (National Institute for Health and Clinical Excellence 2014).

A challenge to the interpretations of 'use-value' and 'utility' outlined above is offered through, what Ng and Smith (2012) identify in the literature as a third, alternative, approach to value. According to this third approach, value is viewed as residing in the phenomenological experience of the customer rather than in an object, product or possession (Ng and Smith 2012, p.224). This more recent perspective is attributed to the work of Holbrook (1996, 2006, p.715) who defines value as an "interactive, relativistic preference experience". In other words, "experience defines what is valuable to a customer and not the purchase" (Pinho et al 2014, p.472). Holbrook's typology of customer value is based on three dimensions (extrinsic vs intrinsic, self- vs other oriented, and active vs reactive). The various combinations of these dimensions results in eight distinct types of value: efficiency, excellence, play, aesthetics, status, esteem, ethics and spirituality (Holbrook 1996, Pinho et al 2014, p.472).

According to this phenomenological approach to value, the customer is an active participant in the creation of value rather than a passive evaluator (Ng and Smith 2012). This is a view, which Ng and Smith suggest is adopted in S-D logic in terms of discussions concerning philosophical, economic and management foundations of value. This position is supported by Akaka and Vargo (2015, p.460) who advocate that

the S-D logic perspective on value falls “[...] in line with Holbrook’s (2006) view of value as an evaluation of an experience”. In adopting this perspective on value, Ng and Smith (2012) additionally propose that S-D logic has recaptured Adam Smith’s early notion of ‘value-in-use’ through:

“[...] repositing that value goes beyond simply the utility of an offering to value as a co-created phenomenological experience and derived with the participation of, and determined by, the beneficiary...” (Ng and Smith 2012, p.225).

The framing of ‘value in-use’ from a more phenomenological perspective, as noted above is not unique to the authors of S-D logic. Indeed, Sandström and colleagues (2008) advocate ‘value-in-use’ is the cognitive evaluation of the service experience. A more holistic emphasis on value co-creation, which embeds value in personalised experiences is also noted in the work of Prahalad and Ramaswamy (2000), Prahalad (2004), and Payne and colleagues (2008). Grönroos and Voima (2013, p.136), elaborate further on the nature of value-in-use and define this as the extent to which a customer feels better off (positive value) or worse off (negative value) than before using the service. An emphasis on negative value is not, however, currently reflected explicitly within the S-D logic framework.

MacDonald and colleagues (2011, p.671) suggest that the S-D logic literature, whilst highlighting the importance of “customer perceived value-in-use” has not clearly defined or proposed how value-in-use can be assessed. An alternative definition of value-in-use is offered by this group of authors, whereby value-in-use is defined as: “a customer's outcome, purpose or objective that is achieved through service” (Macdonald et al 2011, p.671). Such a perspective on ‘value’ links with Payne and colleagues’ (2008, p.86) view on the value creation process as one which occurs when the customer performs a series of activities to achieve a desired outcome. It can be seen from such assertions that the framing of ‘value’ is also viewed as linked to the manner in which value co-creation is defined. This issue is addressed in section 1.3.

1.3 Value and value co-creation

Despite the centrality of the concepts of value and value co-creation in marketing, it is argued that “value is perhaps the most ill-defined and elusive concept in service marketing and management” (Grönroos and Voima 2013, p.134). Value co-creation has also been variously defined in the literature, with differing conceptualisations broadly divided into those which are predominantly either firm focused or customer focused. Variation is also apparent in terms of respective theoretical roots, with those articles focusing on the ‘firm’ mainly stemming from strategic management, strategy and industrial marketing (McColl-Kennedy et al 2012). The conceptualisations which focus on the firm typically view the ‘customer’ as an “input into firm processes” whereby customers become temporary members of the firm (McColl-Kennedy et al 2012, p.371). This contrasts with Vargo and Lusch (2004a, 2011) who advocate that value co-creation may reach beyond the boundaries of the firm. According to McColl-Kennedy and colleagues (2012), a key area of intellectual debate arising from these differing conceptual roots concerns the framing of value as ‘value-in-use’ versus ‘value-in-exchange’ (Vargo and Lusch 2011; McColl-Kennedy et al 2012). As noted above, it is the former perspective on value which is drawn upon in S-D logic.

1.3.1 Differing approaches to value co-creation

Value co-creation has also sparked debate amongst scholars in terms of how value is created, with relatively little known about how customers engage in co-creation (Payne et al 2008, p.83; Chandler and Vargo 2011). Heinonen and colleagues (2010, 2013) suggest that co-creation requires a reverse perspective, with service providers focusing on becoming involved in customers’ lives rather than on how to engage customers in co-creation with the firm. They argue that value-in-use emerges as a function of both customer logic and experiences. This group of authors view goods and service-dominant logic as provider-dominant, rather than customer-centric and advocate a customer-dominant logic of service.

Saarijärvi and colleagues (2013) suggest that approaches to value co-creation fall broadly into four main camps: the service logic approach to value co-creation (which distinguishes between customer service logic and provider service logic); the S-D logic approach to value co-creation; a service science approach to value co-creation (concerned with how participants, processes and resources interact to create value in service systems, Vargo et al 2008) and other approaches to value co-creation (i.e. many-to-many marketing which focuses on multiple networks and multitudes of actors in value co-creation). The section below discusses the first of these approaches, service-logic, as this perspective on value and value co-creation is the most critical of S-D logic (Grönroos 2006, 2008, 2011; Grönroos and Gummerus 2014; Grönroos and Ravald 2011; Grönroos and Voima 2013).

The main divergence in the approaches of S-D logic and service logic relates to the specification and roles of 'actors' involved in value co-creation. Grönroos and colleagues argue that S-D logic is a systematic, abstract and metaphorical approach to value co-creation, which does not clearly discuss the nature and locus of value, the roles of the actors involved in the process, or the part 'actors' play in 'co-creating' value (Grönroos and Voima 2013; Grönroos and Gummerus 2014). Service logic, whilst sharing the same fundamental view that goods and services are resources which are designed to provide service to customers, differs to S-D logic. The service logic approach argues that the role of customers and providers in value creation has not been analytically specified and requires further theoretical elaboration (Grönroos and Voima 2013; Medberg 2016).

Service logic proposes three dynamic spheres (joint, customer, and provider) within which the firm's (i.e. the provider's) and the customer's actions can be categorised. In contrast to S-D logic, which advocates that all value is co-created, service logic argues that value is only co-created in select instances i.e. when there is direct, personal interaction between the provider and the beneficiary (in the joint sphere). Without direct interactions value co-creation is not possible, and the role of the firm is then only one of facilitator, with the customer the sole creator of value (Grönroos and Voima 2013; Medberg 2016; Vargo and Lusch 2016a). Additionally, the service

logic perspective acknowledges that there is potential for the service provider to negatively influence the customer's value creation (Grönroos and Voima 2013).

The service logic perspective on value has been challenged by Vargo and Lusch (2016a, p.11), who argue that the conceptual difference between co- and facilitate is essentially incomprehensible and does not inform academics or practitioners in any useful or actionable way. The view of customers as independent creators of value is also not shared in S-D logic. Whilst S-D logic recognises that an actor can uniquely assess or evaluate value, this framework argues that actors cannot create value on their own (Vargo and Lusch 2011). The work of Grönroos and Voima (2013) is, however, useful in terms of considering (a) spheres within which value co-creation (as defined within S-D logic) can be investigated empirically and (b) the potential for value creation processes to be negative (i.e. value co-destruction) as well as positive (see end of section 1.2).

It can be seen that there are a number of approaches and interpretations of both 'value' and 'value co-creation'. Saarijärvi and colleagues (2013) suggest that analysis of the differences, rather than similarities, among value co-creation approaches, is a useful means of identifying sources of friction in value co-creation approaches. This team of authors posit that diversity in approaches to value co-creation relates to differing interpretations regarding what constitutes the 'value', the 'co-' and the 'creation' within it and advocate dismantling value co-creation into its constituent parts (Saarijärvi et al 2013, pp. 10-11). In order to clarify the nature of the value co-creation concept and enhance understanding of value co-creation they advocate that analysis should focus on three main areas:

- (i) clarifying what kind of value for whom (i.e. what is the customer /firm benefit and how is value creation supported?);
- (ii) clarifying by what kind of resources (i.e. what firm/customer resources are integrated into the customer's/firm's value-creating processes?) and
- (iii) clarifying through what kind of mechanism (i.e. what is the mechanism through which firm/customer resources are integrated into customer's/firm's processes?).

The analytical frame proposed by Saarijärvi and colleagues (2013), whilst useful for comparing and contrasting approaches to value co-creation, also has relevance for exploring value co-destruction. This latter concept is discussed further in the subsequent section.

1.3.2 Negative outcomes of interactive value formation processes

Although there is recognition within the services marketing literature that value co-destruction is also a potential outcome of interactive value formation processes, the body of literature and empirical studies focussing on value co-destruction is currently very limited (Plé and Chumpitaz Cáceres 2010; Echeverri and Skålén 2011; Smith 2013; Robertson et al 2014; Kashif and Zarkada 2015; Prior and Marcos-Cuevas 2016). Value co-destruction was first proposed as concept in a theoretical paper by Plé and Chumpitaz Cáceres (2010, p.431) and is defined as:

“[...] an interactional process between service systems⁷ that results in a decline in at least one of the systems’ well-being (which, given the nature of a service system, can be individual or organisational)”.

Laamanen and Skålén (2015) posit that studies of value co-creation have tended to consider interactions between ‘actors’ as harmonious and of mutual benefit. It is argued, however, that value co-destruction is a significant feature of the interaction between a service provider and customer, in that the application of operant resources (i.e. knowledge and skills) not only co-creates value but also co-destroys value (Plé and Chumpitaz Cáceres 2010). Value co-destruction predominantly arises through the accidental or intentional misuse of resources (its own or those of another system) by a system acting in an inappropriate or unexpected manner (Plé and Chumpitaz Cáceres 2010; Smith 2013, Carù and Cova 2015). Resource misuse occurs when one service system (i.e. customer or service provider) fails:

“[...] to integrate and apply the available and operant resources of at least one of the service systems (the firm and the customer) in

⁷ A service system is defined as “configurations of resources (including people, information, and technology) connected to other systems by value propositions” (Vargo et al. 2008, p.145).

an ‘appropriate’ or ‘expected’ manner from the other system’s perspective (the firm)” (Plé and Chumpitaz Cáceres 2010, p.432).

Whilst value in service settings is collaboratively realised through service provider and customer interactions, value co-destruction can arise if service users and providers draw on “incongruent elements” of value practices (Echeverri and Skålén 2011, p.368). It is argued, therefore, that value co-destruction can arise through the misuse or misalignment of resources and/or practices (Prior and Marcos-Cuevas 2016). The emphasis on value co-destruction as a collaborative process, as implied by the term ‘co’ should, however, be carefully considered. Prior and Marcos-Cuevas (2016) argue that such an emphasis implies that each actor plays an important role in value co-destruction processes, when not all actors participate equally. There may be limitations on ‘actors’ in terms of time, information, and resource availability. This is an important consideration within a health care context, given the asymmetry in information and expertise which can exist between patients and medical staff in terms of knowledge of a disease and health care treatment and processes (Anderson et al 2016).

Disparity is also apparent in the services marketing literature in relation to the conceptualisation of service failure⁸ and value co-destruction. Skourtis and colleagues (2016, p.565) argue that, despite the emerging school of thought in marketing literature in relation to S-D logic, service failure and subsequent service recoveries⁹ are conceptualised under the goods-dominant logic paradigm. Instead, they suggest that service failures should be reconceptualised as ‘value co-destruction moments’. This premise rests on the notion that when service failure occurs some forms of value are co-destroyed (i.e. functional, social, emotional, epistemic and conditional) in a similar way to that created during the value co-creation process.

⁸ A breakdown in the delivery of service or service that does not meet customer expectations (Hoffman and Bateson 2010, p.439).

⁹ The actions a service provider takes in response to service failure (Grönroos 1988)

1.4 Service quality and value

Gummesson (2008), commenting in the marketing literature, argues that the concept of 'value' brings together two other concepts of quality and customer satisfaction. The boundaries between these three concepts are, however, "blurred and partly overlapping" (Gummesson 2008, p.144). Value is viewed as a wider and more subjective measure than service quality, with service quality seen as a sub-dimension of value. However, no clear consensus exists in the services marketing literature regarding the relationship between value and service quality (Medberg 2016). The concept of service quality in the marketing literature has been defined as the gap between expected and perceived service (Parasuraman et al 1985). Although 'gap theory' is commonly applied in marketing, it has been subject to criticism, with the measurement of expectations seen as adding limited information beyond that gained from measuring service perceptions alone (Babakus and Boller 1992; Dagger et al 2007). Despite disagreements over how to measure service quality in the services literature, this is a concept that is increasingly seen as multi-dimensional and consisting of interpersonal quality, technical quality, environment quality, and administrative quality (Dagger et al 2007; Greer et al 2014).

Although all four dimensions of service quality are important in assessing quality in a health care context, Dagger and colleagues (2007) argue that only two relate to the evaluation of one to one health care encounters; interpersonal quality (an evaluation of the interaction between 'actors' i.e. service user and service provider) and technical quality (i.e. an evaluation of the expertise, professionalism and competency of the service provider). In practice, the technical quality of the service delivery is often hard to separate from the interpersonal quality (Dagger et al 2007). Commenting in the services literature, Berry and Benadpudi (2007) suggest that technical quality whilst clearly vital to patients is more difficult to evaluate. Similar to other technical services such as repair or appraisal services, customers have a considerable knowledge disadvantage when using health care services, with clinical quality often difficult for the patient to judge even after the service is performed. They additionally highlight the relationship between technical and interpersonal

quality in a health care context and posit that patients need health care staff to be behaviourally as well as technically competent.

In considering a high emotion service such as cancer care, Berry and colleagues (2016, p.3) argue that “The more patients have at stake, the more sensitive they are to the quality of the service performance”. Berry and colleagues (2016, p.407) additionally posit that patients’ experiences (positive and negative) accumulate based on clues (the signals patients perceive in using a service) embedded within the service experience. Three types of clues are identified (functional, mechanic and humanic) which relate to perceptions of medical competence, first impressions of the service and interactions between patients and staff (Berry et al 2006; Berry et al 2016). In order for patients to have positive experiences. Berry and colleagues (2016, p. 410) argue that these clues need to be well managed, because poor management may exacerbate negative emotions such as stress, anxiety and fear.

Whilst recognising that conceptual distinctions between ‘service quality’ and ‘value’ are made in the services marketing literature, it is unclear whether service users discriminate between these various elements in practice. Indeed, the recent work of Medberg (2016) found overlaps between conceptualisations of value-in-use and perceived service quality in terms of the dimensions identified (i.e. functional, technical and economic quality). Medberg (2016, p.104) argues, however, that service quality is not a sub-dimension of ‘value-in-use’ but the way in which customers operationalise ‘value in use’ in service episodes.

1.5 Quality and value-based health care

The concept of quality in health care policy and literature is also problematic. Porter (2010) argues that its usefulness has been lost given the many meanings it can have. Porter illustrates this by pointing to the often cited Institute of Medicine (2001) definition of goals for the health care delivery system, from which he derives six disparate elements: safety, effectiveness, patient centeredness, timeliness, efficiency and equity. He argues that the focus should instead centre on an overarching concept such as ‘value’. Failure to measure value is viewed by Porter as

one of the main reasons that health care reform has been so difficult in comparison with other fields (Porter 2010). Porter forwards an alternative view, increasingly referred to as value-based health care. This body of work is influential in the US but has also recently been discussed within the UK health care arena (Porter and Teisberg 2006; Porter 2010; Right Care 2011, p.19; Conrad et al 2013).

Value, according to Porter, is defined as health outcomes achieved per unit of currency spent, with outcomes relative to cost (Porter 2010). He argues that this should always be defined around the customer and, in a well-functioning health care system, value creation for patients has the potential to shape rewards for “all other actors in the system” (Porter 2010, p.2477). In other words, if value improves, patients, payers, providers and suppliers can all benefit. Within Porter’s (2010) framework, value is created for the patient by providers’ combined efforts over the full care cycle. The unit of measurement for ‘value’, according to Porter “should encompass all services or activities that jointly determine success in meeting a set of patient needs” (Porter 2010, p.2478).

Porter’s work is heavily premised on the measurement of health outcomes rather than process measures. This has Porter viewing the latter as useful for internal strategies, but no replacement for outcome measures. He advocates the measurement of health outcomes, as a means of providing a feedback loop which may facilitate innovation and states that by not doing so “any complex system attempting to control behaviour without measuring results will limit progress to incremental improvement” (Porter 2010, p.2478). A potential concern, when focusing solely on health outcome measures, is the extent to which they encompass dimensions and issues of importance to the patient in their service experience. Indeed, recent work undertaken in a US cancer service context indicates that patients do not define ‘value’ in economic terms when considering their cancer experiences. Instead, they place more emphasis on existential, practical or relational benefit (Longacre et al 2015). Although Porter’s work usefully directs attention to ‘value’, it is limited in that it represents a ‘payer’ rather than a patient centred perspective on ‘value’ (Tilburt et al 2011).

Whilst a value-based approach has been implemented at a local level in a UK Health Board, the extent to which Porter's framework (Porter 2010) will be implemented more widely in the UK is currently unclear (The Economist Intelligence Unit 2016a, 2016b). Value, is however, an area of emphasis in a number of health care programmes in the UK i.e. Prudent Health Care in Wales; Realistic Medicine in Scotland and Right Care in England (Right Care 2011; Bradley and Willson 2014; Scottish government 2016; The Economist Intelligence Unit 2016b).

1.6 Public management, public value and co-production

The creation of value in public services, has also been addressed in the public management literature regarding public value theory and co-production. Although the perspective on value offered in these respective literatures, differs to that of S-D logic, it is useful to briefly summarise the approaches to 'value' adopted in these respective fields.

The concept of public value was first introduced by Mark Moore in his text *Creating Public Value* (1995). This idea has been further developed in later work which proposes both tools and strategies (i.e. public value account; public value cycle, public value scorecard) for recognising and measuring public value, and key philosophical assumptions which should underpin public value accounting (Moore 2012, 2013, 2014; de Jong et al 2017). Central to this stream of work, is the idea that public managers, in a similar vein to private managers producing private value (i.e. monetary gains using private assets), should "use their imagination and skills to produce public value for citizens using the public assets held by democratic governments" (Moore 2014, p.465). This conception of 'public value', should however, extend beyond narrow monetary outcomes to also include those which benefit and are valued by the citizenry more generally (Williams and Shearer 2011, p.1367).

Key philosophical claims underpinning Moore's work on public value' are that citizens (as a collective), rather than 'individuals', are viewed as the appropriate arbiters of value in a democratic society "when the collectively owned assets of government are

being deployed” (Moore 1995, Moore 2014, p. 465). These collectively owned assets include the authority of the state as well as government money, with the normative framework for assessing the value of government production relying “on both utilitarian and deontological philosophical frameworks” (Moore 2014, p.465).

The concept of public value, according to Moore (1995, p.73), “focuses managerial attention *outward*, to the value of the organization’s production, *upward*, toward the political definition of value, and *downward* and *inward* to the organization’s current performance”. In developing a strategy for public sector organisations, Moore (1995, p.75) posits that three broad tests need to be met: (1) the strategy must be substantively valuable (i.e. the organisation produces things of value to overseers, clients and beneficiaries); (2) it must be legitimate and politically sustainable and (3) it must be operationally and administratively feasible. These tests are important as they identify the conditions needed for the production of value in the public sector, with managers encouraged to rethink ‘basic strategy’ until there is alignment between the three aspects of this ‘strategic triangle’ (Moore 1995, p.71).

Bryson and colleagues (2017) argue that the strategic framework requires adaptation from one based on the model of a single public sector manager creating value for an organisation, to more complex contexts where: (i) more strategic actors, organisational contexts and perceptions of public value are at play, and (ii) where public value entrepreneurship may involve co-production and inter-organisational collaboration within or across sectors. Indeed, Bryson (2004, p.25) argues that “success for public organisations” is dependent on “satisfying key stakeholders according to their definition of what is valuable”.

In considering the concept of ‘public value’, Bryson and colleagues (2017, p.648) suggest that an area warranting attention is how ‘co-production’ processes can contribute to the creation of public value. According to Bovaird and colleagues (2015), user and community co-production was first raised as an important topic in both the public and private sector in the 1970’s (i.e. Ostrom and Ostrom 1977). In a recent paper considering the facets of co-production, Alford (2014, p 299) suggests:

“The original idea was foundational, but relatively simple: that not only the consumption but also the production of public services can require the participation of citizens”.

In recent years, the concept of co-production has regained traction. This is potentially due to (i) recognition that the achievement of public service outcomes increasingly relies on multiple stakeholders (i.e. service users and the communities in which they live) and (ii) fiscal pressures facing governments (Bovaird et al 2015, p. 1). Variation is, however, found in the public management literature with regards to the types of co-production that are identified i.e. individual or collective co-production, as well as the respective dimensions of co-production i.e. co-commissioning; co-design; co-delivery (Bovaird et al 2015). The unit of analysis of co-production may also differ i.e. public service; public service organisation or user (Loeffler and Bovaird 2016).

Loeffler and Bovaird (2016, p.1006) outline two distinct sets of criteria in the public management literature to categorise ‘individual’ and ‘collective’ co-production: whether the outputs are individually or collectively enjoyed, and whether the inputs are individually or collectively supplied (Bovaird et al 2015; Loeffler and Bovaird 2016). It is argued that different conceptions of co-production emerge from using these criteria: (i) individually provided co-production can be for either the benefit of those directly involved or can be enjoyed by a wider group of people; (ii) collectively co-provided co-production can be for the benefit of the private individuals directly concerned or a wider group (Loeffler and Bovaird 2016, p.1010). In practice, however, there are likely to be hybrid categories with co-production activities provided both by individuals and collectives, and the benefits of such activities reaped by those directly involved as well as wider groups (Bovaird et al 2015, p.3; Loeffler and Bovaird 2016, p.1010). On this basis, it can be argued that co-production activities may result in differing types of value, both public and private or some form of group value in between. This is in contrast to the original formulation of co-production by Ostrom and colleagues, whereby “co-production resulted only in public value” (Alford 2014, p. 301).

As outlined earlier (see page 18), this study advocates a micro-level approach to the exploration of value and value co-creation. In contrast to the approaches outlined in this sub-section, the focus in this study is on value creation within the context of individual's (i.e. patient's) cancer-related service experiences rather than (i) the creation of value at a societal level (i.e. public value) or (ii) whether value is individually or collectively produced and reaped.

1.7 Towards a phenomenological perspective of value

Patient-reported outcome measures are one way of attempting to integrate patient perspectives into the 'value equation' (Savitz and Luther 2015). Whilst patient-reported outcome measures may be useful in terms of providing information regarding perceived outcomes of care as rated by patients, it does not necessarily follow that these measure issues of concern or importance to the patient (McKenna 2011). In light of these issues, capturing more closely the value created through patients' service experiences may be key in developing towards more patient-centric measures and services (WHO/Europe 2013). The advantages of incorporating these experiences may benefit those providing health services, as it has been proposed that lay perspectives grant a "novel positioned perspective of value to health service-providers" (Martin 2009, p.315).

For proponents of patient engagement, an important aim is to move the emphasis from the clinical paradigm of determining 'what is the matter?' with patients, to one of investigating 'what matters to patients?' (Laurance et al 2014). Approaches such as shared decision-making have been proposed as a way of selecting treatment choices that improve outcomes which patients 'value'. There is, however, a lack of emphasis within such literatures on what 'value' actually means to patients and how value is created (Coulter 2012; The Health Foundation 2012). Through understanding how 'value' is perceived and conceptualised by users of a service, it may be possible to gain insight into factors which facilitate the creation of 'value' and contribute to positive health care experiences.

Given these insights, this study advocates drawing on the S-D logic framework as a way of framing 'value' within a health care context from a patient perspective. The rationale for choosing this phenomenological and contextual perspective on 'value' relates to the centrality of service user perspectives and participation in value creation (Akaka and Vargo 2015). This leads to the primary aim of this study; to investigate how value, when framed as value that is perceived and determined on the basis of use, is conceptualised by service users and service providers in a specialist cancer service setting. The prolonged period of engagement that patients have with a specialist service, provides the opportunity to explore trajectories of value in more detail than would be warranted in 'one off' health service encounters. Before moving to discuss the application of S-D logic to a health care context any further, the historical development of S-D logic, foundational premises underpinning this framework and critiques of this approach are outlined in section 2.

Section 2: Service-dominant logic, development, key premises and critique

The S-D logic approach has contributed to marketing in terms of sparking international academic interest in service "as more than a category of products" but also as "a perspective on business and marketing" (Grönroos and Gummerus 2014, p.210; Edvardsson et al 2005). Whilst it has been described as a 'theory,' Vargo and Lusch define the S-D logic framework as 'pre-theoretic', a 'mindset' and a 'meta-idea' which could serve as a foundation for: a "theory of the market"; a more limited related general theory of marketing and a "more encompassing theory of economics" (Lusch and Vargo 2006, 2014, p.211; Vargo 2007, 2011a; Vargo and Lusch 2008, 2016a, p.6). S-D logic is an evolving framework which is additionally described as open source, "a work in progress" (Lusch and Vargo 2014, p.211) and requiring the support of other scholars to co-create, refine, advance and elaborate (Vargo and Lusch 2008, 2011; Williams 2012). This section expands further on the development of S-D logic, the key premises underpinning this framework, and critiques of this approach.

2.1 Historical development

The foundational premises of S-D logic were first introduced in the services marketing literature in 2004 as an alternative perspective on how value is created through exchange (Vargo and Lusch, 2004a; Akakka and Vargo 2015). Services marketing emerged initially as a sub discipline of marketing and traditionally has been seen as distinct from 'goods marketing' due to differences in characteristics between services and goods (Zeithaml et al 1985; Vargo and Lusch 2004b). The archetypal characteristics of services in such debates are: intangibility (services are performances rather than objects and lack the tactile quality of goods), inseparability of production and consumption (these processes occur simultaneously), heterogeneity (services can vary from producer to producer) and perishability (services cannot be produced in advance or inventoried) (Zeithaml et al 1985; Vargo and Lusch 2004b).

Vargo and Lusch (2004b) dispute these characteristic distinctions between goods and services and instead propose that "goods are distribution mechanisms for service provision", and that "economic exchange is fundamentally about service provision" (Vargo and Lusch 2004b p.326). In other words, service is common within all exchange whether it is goods or service based. A similar view is offered by Gummesson (1993, p.250) who suggests that "customers do not buy goods or services: they buy offerings which render services which create value". Instead of focusing on value-in-exchange, or the price paid for something, S-D logic directs attention to the phenomenological and contextual aspects of value (i.e. value-in-use) and the centrality of the customer in creating and determining value (Akaka and Vargo 2015).

Whilst S-D logic represents a shift in terms of viewing service as the basis of all economic exchange, the underlying ideas are not entirely new (Vargo and Lusch, 2016b). The notion that 'services are exchanged for services' was first introduced in the work of the nineteenth century French philosopher, Basiat (Grönroos and Gummerus 2014; Vargo and Lusch 2016b). Similarly, scholars such as Prahalad and Ramaswamy (2000) and Ramirez (1999) had been advocating value co-creation for

several years before Vargo and Lusch published their 2004 paper (Vargo and Lusch 2016a). Grönroos (2011) argues that S-D logic compiled the service research that had been undertaken since the 1970's and combined it with a view of 'service reciprocity' in the marketplace into a system of foundational premises or propositions. A feat which had not been achieved by previous scholars (Grönroos and Gummerus 2014). The authors of S-D logic acknowledge that the ideas in the framework are not entirely 'new', this is reflected in the extract from their most recent paper (Vargo and Lusch 2016b, p.2):

“In fact, S-D logic was, from its beginning, more about the identification and extension of apparent coalescence in the ongoing development of marketing thought [...] than a radically new idea. That is, it has been grounded on a foundation built by many others, as has been its progress”.

This aside, S-D logic has continued to develop and undergo a series of consolidations, extensions and elaborations since it first was proposed in 2004. These are summarised in Table 2 and discussed in more detail in sections 2.1.1 and 2.1.2. Attention is drawn to the revisions to S-D logic that are most relevant for the focus of this study rather than an account of all of the modifications to date.

2.1.1 Modifications to foundational principles

The foundational premises (FPs) underpinning S-D logic have undergone a series of revisions. The premises were extended from an initial eight to ten premises between 2004 and 2008. The addition of FP9 (see Table 2, column 3) was to recognise more fully not only resource-application, but also the resource-integration role in creating value (Vargo and Lusch 2008). This foundational premise posits that value is created through resource integration, by “customers integrating their own resources with those provided by organisation and other network actors” (Hibbert et al 2012, p.247). This leads to a view of value co-creation “that sees all actors as resource integrators, tied together in shared systems of exchange” (Vargo 2011b, p.220). In adopting this view, 'actors' (i.e. service users and service providers) are in themselves an 'operant resource'.

Table 2: Development of S-D logic foundational premises and axioms (adapted from Vargo and Lusch 2016a)

	Vargo and Lusch 2004a	Vargo and Lusch 2006/ Vargo and Lusch 2008	Lusch and Vargo 2014/ Vargo and Lusch 2016a update
FP1	The application of specialized skill(s) and knowledge is the fundamental unit of exchange	Service is the fundamental basis of exchange	<i>Remains the same but given <u>AXIOM STATUS- Axiom 1</u></i>
FP2	Indirect exchange masks the fundamental basis of exchange	<i>Remains the same</i>	<i>Remains the same</i>
FP3	Goods are distribution mechanisms for service provision	Goods are a distribution mechanism for service provision	<i>Remains the same</i>
FP4	Knowledge is the fundamental source of competitive advantage	Operant resources are the fundamental source of competitive advantage	Operant resources are the fundamental source of strategic benefit.
FP5	All economies are services economies	All economies are service economies	<i>Remains the same</i>
FP6	The customer is always a co-producer	The customer is always a co-creator of value	*Value is cocreated by multiple actors always including the service beneficiary. <u>AXIOM STATUS-Axiom 2</u>
FP7	The enterprise can only make value propositions	The enterprise cannot deliver value, but only offer value propositions	Actors cannot deliver value but can participate in the creation and offering of value propositions.
FP8	A service centred view is customer oriented and relational	A service-centred view is inherently customer oriented and relational	<i>Remains the same</i>
FP9		All social and economic actors are resource integrators	<i>Remains the same but given <u>AXIOM STATUS- Axiom 3</u></i>
FP10		Value is always uniquely and phenomenologically determined by the beneficiary	<i>Remains the same but given <u>AXIOM STATUS- Axiom 4</u></i>
FP11			*Value cocreation is coordinated through actor-generated institutions and institutional arrangements. <u>AXIOM STATUS-Axiom 5</u>

*The terms 'cocreated' and 'cocreation' are not hyphenated in Vargo and Lusch 2016a

Foundational premise 10 was added to reflect the experiential and phenomenological nature of value, as this was not explicit in the original S-D logic framework (Vargo and Lusch 2008). These ten premises were later consolidated into four axioms in 2014, from which the remaining six FPs are derived (Vargo and Lusch 2016a). The S-D logic framework has also recently been updated and a new axiom (Axiom 5/FP11) incorporated regarding institutions and institutional arrangements (see Table 2, column 4). The extended S-D logic framework emphasises a ‘zooming out’ in terms of perspective and levels of analysis (meso and macro levels) to incorporate a wider configuration of ‘actors’ (service eco-systems) than those at the micro level (dyads i.e. firm and customer). A service eco-system is defined as:

“a relatively self-contained, self-adjusting system of resource integrating actors that are connected by shared institutional logics and mutual value creation through service exchange” (Lusch and Vargo 2014, p.161).

This wider perspective on value co-creation enables structural details (institutions and institutional arrangements) influencing value co-creation to be considered that may not be apparent at the micro-level (Vargo and Lusch, 2016a). Revisions have accordingly been made to the wording of FP6, to emphasise that value co-creation involves multiple actors. Despite these shifts, micro-level processes are viewed within the updated S-D logic framework as factors influencing organisational-level logics (Vargo and Lusch 2016a). This new axiom 5/FP11, along with the emphasis on service eco-systems are described as “bridging concepts” (i.e. topics or research streams) in that they currently have been introduced rather than explored (Vargo and Lusch 2016b, p.3). These two bridging concepts (service eco-systems and institutions) are not the main concerns of this study. Instead, the emphasis in this work, (as discussed in the first section of this thesis and earlier in this chapter) is on value co-creation in micro-level service interactions.

Whilst modifications have been made to the wording of a number of foundational premises, the most notable has been to foundational premise 6 (FP6). Although the S-D logic framework originally advocated “the customer is always a co-producer” (see column 1 in Table 2), this was modified to “the customer is always a co-creator of

value” (Vargo and Lusch 2008) and more recently to “value is cocreated⁹ by multiple actors, always including the beneficiary” (Vargo and Lusch 2016a). This differentiation has been made because the term ‘co-producers’ was seen as too closely associated with goods dominant logic. The refined versions of FP6 view co-production as an optional component of the co-creation of value. It is instead, value co-creation within S-D logic which is not viewed as ‘optional’. This is viewed by Vargo and Lusch (2008, p.10-11) as a critical revision to the S-D logic framework.

“Because the distinction between co-creation of value and co-production is critical to the S-D logic thesis, we changed FP6 to refer to co-creation the first time we had a chance (see Vargo and Lusch 2006). [...] However, we believe that co-production, though distinct from (but nested within) co-creation of value, has a place in S-D logic. Thus, we further emphasized the change to FP6 and the distinction in Lusch and Vargo (2006a). In short, we argue that co-production is a component of co-creation of value and captures ‘participation in the development of the core offering itself’ (p. 284), especially when goods are used in the value-creation process”.

The modification to FP6 has, however, caused substantial misunderstanding. This has been exacerbated by the lack of clarity and agreement in the services marketing literature regarding the concepts of ‘co-creation’ and ‘co-production’ (Chathoth et al 2013; Prahalad and Ramaswamy 2004; Chathoth et al 2013; Grönroos and Voima 2013; Vargo and Lusch 2016a). From an S-D logic perspective, ‘co-production’ refers to “the creation of the value proposition - essentially design, definition, production etc” - and ‘value co-creation’- “the actions of multiple actors, often unaware of each other, that contribute to each other’s well-being” (Vargo and Lusch 2016a, p.8). In contrast, co-production within the S-D logic framework concerns participation in direct service provision activities i.e. service design, self-service and new service development (Vargo and Lusch 2011; McColl-Kennedy et al 2012). This is viewed as optional. Co-creation of value in contrast is a positive statement that:

“[...] at least in human systems, which are characterised by specialization and thus interdependency, value is always

⁹ The terms ‘cocreated’ and ‘cocreation’ are not hyphenated in Vargo and Lusch 2016a, hence are quoted in the same style as the paper.

cocreated. Hence, cocreation of value, unlike coproduction, is not optional” (Vargo and Lusch 2016a, p.9).

Chathoth and colleagues (2013, p.11) argue that co-production and co-creation are two approaches “which can be adopted by organisations in their attempts to respond to customer expectations”. They propose that one of the main differences between co-production and co-creation is “[...] whether value creation is derived through a production or consumption process” (Chathoth et al 2013, p.13). The distinction between the concepts of co-production and co-creation is however blurred and represents “a continuum rather than a dichotomy” (Chathoth et al 2013, p.11).

The confusion concerning the concepts of value co-creation and co-production in the marketing literature extends beyond the revisions to the S-D logic framework. A systematic review by Ranjan and Read (2016) of 149 papers on value co-creation identifies two primary conceptual value co-creation dimensions: co-production and value-in-use (Ranjan and Read 2016). Co-production is found to predominantly focus on the aspect of ‘exchange’, whilst ‘value-in-use’ is aligned with the view that value is always created in use. The review includes papers pre 2000 and post 2000 as the literature on value co-creation was evolving, and suggests that earlier papers are skewed toward the concept of co-production.

Following their review, Ranjan and Read (2016) suggest that value co-creation has two dimensions (value-in use and co-production) which each have underlying elements. This leads them to identify six elements as influential in value co-creation: experience, personalisation, relationship, knowledge, interaction and equity. The first five of these dimensions are reflected, to an extent, within the current FPs in the S-D logic framework (see Table 2). It is less clear, however, how equity is integrated within S-D logic. Whilst S-D logic asserts that “actors themselves are operant resources” (Lusch and Vargo 2014, p.119), and views all actors as resource integrators, the nature of operant resources and capacity to engage and exchange may vary amongst actors. The capacity of actors to engage equally has also been raised by Prior and Marcos-Cuevas (2016) in relation to value co-destruction processes (see section 1.3.2). Vargo and Lusch (2016a, p.7) do, however, state that

the 'generic actor' designation in S-D logic "should not be confused with a position that all actors are identical".

The distinction between the terms co-production and co-creation in the S-D logic has been emphasised here as when terms travel between disciplines (i.e. services marketing and public management), it cannot be assumed that they have the same meaning (Vargo and Lusch 2016b). Difficulties can arise with synthesising knowledge in transdisciplinary research due to differing conceptualisations of terms or because different terms are used for seemingly similar phenomenon (Vargo and Lusch 2016b). This is pertinent when considering the application of S-D logic to a public service context and is discussed further in section 4.

2.1.2 Elaborating 'value-in-use'

The term 'value-in-use' has been modified in later elaborations of S-D logic to 'value-in-context', and this also includes 'value-in-social context' (Chandler and Vargo 2011; Edvardsson et al 2011; Vargo and Lusch 2016a). These elaborations have been undertaken to capture the contextual nature of value and value co-creation (i.e. the value created may be unique to a specific situation), and how institutionalised social norms and rules may influence how 'actors' integrate resources and co-create value (Edvardsson et al 2011, 2014). This latter view argues that the value co-creation process is shaped by social forces, reproduced in social structures and can be asymmetric for those actors involved (Edvardsson et al 2011, p.327). For ease of reference and consistency with the wider marketing literature, this study uses the term 'value-in-use' as a 'catchall' for these various terms, noting as outlined above the contextually specific and dynamic nature of this concept. The next section discusses the foundational premises and axioms of interest in this study.

2.2 Foundational premises of interest

In considering the contribution of S-D logic and the concepts of 'value-in-use' and 'value co-creation' to understandings of patient engagement, this study focuses on four of the axioms underpinning S-D logic and one additional foundational premise

(Axiom 1/FP1, Axiom 2/FP6 and FP7, Axiom 3/FP9 and Axiom 4/FP10). For ease of reference these are restated in Table 3. The rationale for selecting these specific axioms and foundational premises is previously outlined in the introductory chapter. To briefly recap, these are the foundational premises that are seen as central to S-D logic framework, most directly concern ‘value’ or underpin the process of value co-creation (Gummesson et al 2010; Vargo and Lusch 2012; Kryvinska et al 2013; Lusch and Vargo 2014).

Table 3: Selected S-D logic axioms and foundational premises (adapted from Vargo and Lusch 2016a)

Axiom/Foundational premise (FP)	Description
Axiom 1/FP1	Service is the fundamental basis of exchange
Axiom 2/FP6 FP7 (Derived from Axiom 2)	*Value is cocreated by multiple actors, always including the beneficiary Actors cannot deliver value but can participate in the creation and offering of the value propositions
Axiom3/FP9	All social and economic actors are resource integrators
Axiom 4/FP10	Value is always uniquely and phenomenologically determined by the beneficiary

* The term ‘cocreated’ is not hyphenated in Vargo and Lusch 2016a

The premises outlined in Table 3 imply that service exchange is an essential, collaborative process, during which value is co-created through the interactions and activities of multiple actors e.g. service users, service providers, family members (Wieland et al 2012). Service exchange enables ‘actors’ to access resources for their own benefits and through resource integration to create new and exchangeable resources (Vargo and Lusch 2011; Wieland et al 2012, p.12). Resources may extend beyond those of the service provider and customer (or patient in this study) to also include private sources, such as family and friends and customer self-generated activities i.e. positive thinking and sense making (Vargo and Lusch 2011; McColl-Kennedy et al 2012).

The dynamic nature of resources are highlighted by Vargo and Lusch (2004a, p.2) who state, “resources are not: they become”. The usefulness of any potential resource is seen as highly contextual, as the beneficiary’s (i.e. customer’s or service user’s) context moderates access to other potential resources and the willingness

and ability to integrate these (Wiebland et al 2012, p.14). Each instance of service exchange is thus seen as creating a different experience and benefit (value) which is assessed and determined in relation to, 'if not by' the beneficiary (Vargo and Lusch 2012, p.6). The beneficiary, therefore, has an active role in the value creation process as both a co-creator of value and resource integrator (Vargo and Lusch 2004a; Vargo and Lusch 2006, 2008, 2012; Wieland et al 2012).

The issue of integrated resources and experiences is one which has been raised in the context of health care by Porter (2010). He suggests that value accumulates through the care cycle and may include multiple health care providers. Indeed, O'Hara and Isden (2013, p.2) state that "the individual patient is the one common denominator across all their care experiences, making them a natural source for information across healthcare boundaries, health professionals, services and care settings". This is an important consideration, as this implies that experiences (positive and/or negative) travel with the patient and may be drawn upon in future service encounters. It has additionally been argued that value co-creation is conceptualised predominantly in terms of interactive processes between the customer and the service provider, with a lack of attention paid to co-creation as customers interact with each other (Rihova et al 2013). In considering value co-creation within a health service context, the capacity for patient-to-patient value co-creation or conversely value co-destruction, also requires consideration.

2.3 Critiques and further elaborations

The S-D logic framework has been critiqued by a number of scholars. This has been on the grounds of S-D logic being perceived as seeking to displace other marketing theories, and attempting to become an all-encompassing paradigm (O'Shaughnessy and O'Shaughnessy 2009), a stance that Vargo and Lusch (2011) have openly challenged. Other scholars have suggested that S-D logic operates primarily at an abstract level and as such requires further elaboration (Brodie et al 2011; Karpen et al 2012; Grönroos and Voima 2013).

A number of areas within the S-D logic framework have been identified as requiring additional insight including: the value co-creation process, and the potential for customer to customer value co-creation, the nature of resources and resource integration, and more recently value propositions (Payne et al 2008; Brodie et al 2011; Hibbert et al 2012; Kleinaltenkamp et al 2012; Rihova et al 2013; Peters et al 2014; Chandler and Lusch 2015). A variety of research has also been undertaken which applies middle range theories (i.e. institutional logics; structuration theory; practice theory; consumer culture theory; conservation of resources) as a means of bridging the gap between the broader and abstract S-D logic premises and empirical evidence and practice (Brodie et al 2011; Echeverri and Skålén 2011; Edvardsson et al 2011; Karpen et al 2012; Kleinaltenkamp et al 2012; Kowalowski et al 2012; McColl-Kennedy et al 2012; Smith 2013; Edvardsson et al 2014; Peters et al 2014). In contrast to a general theory, which attempts to explain everything about a general subject, middle range theory focuses “on a subset of phenomena relevant to a particular context” which means this can be used as a basis for investigating empirical research (Brodie et al 2011, p.80). This is seen as a necessary development by Vargo and Lusch (2016b, p.1), who state:

“[...] for S-D logic to move forward over the next decade, it needs more midrange theory development, as well as evidence-based research”.

It is not possible within the remit of this study to elaborate in detail or provide a critique of the middle range theories applied to S-D logic. Nor is it possible to synthesise the vast literature in relation to S-D logic. Instead, a brief summary is provided of key papers of relevance to: (a) the issue of patient engagement within micro-level encounters, and (ii) those which have explored the application of S-D logic in a health care context. These papers have tended to focus on the following areas: the resource integration process; the role of value propositions; customer engagement, value co-creation and more recently value co-destruction.

2.3.1 Considerations in S-D logic

Resource exchange and integration

The value co-creation process in S-D logic is underpinned by the processes of resource exchange and integration. The assumption that resources are exchanged and integrated within S-D logic is inherent within two of the foundational premises: FP1 and FP9 (Peters et al 2012; Brodie et al 2012). S-D logic implies that value is not accomplished until resources are integrated. This means that 'value' is not necessarily realised at the point of service use. Conversely, this view of resource integration also implies that failure to integrate resources may result in an absence of value creation (McColl-Kennedy et al 2012). It is perhaps unsurprising that the nature of resource exchange and integration processes has been questioned in the services marketing literature (Hibbert et al 2012; Kleinaltenkamp et al 2012; Spanjol et al 2015; Anderson et al 2016).

According to Anderson and colleagues (2016, p.265), the view of resource integration in S-D logic is one where capability (person's ability or competency) is "an essential precondition to resource integration". Anderson and colleagues (2016) draw on the work of Spanjol and colleagues (2015) regarding customer co-production in negative, prolonged service contexts, and argue that capability is not a simple issue of skill and motivation, but a "laborious and interactive set of processes and activities" (Anderson et al 2016, p. 265). A similar view is outlined by Hibbert and colleagues (2012, p. 247) who argue that the implication of the S-D logic perspective on resource integration is that customers must acquire the required knowledge and skills to be effective resource integrators, whilst engaging in activities which facilitate or create value. This implies that a degree of learning is required before customers are able to utilise and integrate resources.

Kleinaltenkamp and colleagues (2012) also posit that there is a need to question the nature of resources that are exchanged and integrated, and also to understand how

resources are mobilised and utilised. They explore these issues in a theoretical paper which draws on structuration theory, and views resource integrators as “actors with agency (individuals and organisations) using operant resources acting on operand resources in the resource-integration process”, with agency defined as “the ability of self-reflexive actors to act with choice” (Kleinaltenkamp 2012, p.202; Peters et al 2012, p.51). Kleinaltenkamp and colleagues (2012, p.202) argue that there are fundamental preconditions for resource integration taking place which “includes actors possessing the ability and allowance to use or integrate a resource”. These preconditions are viewed as necessary for actors to be able to utilise resources as well as engage in service for service exchange.

Service user capability and knowledge/skills acquisition as pre-requisites for resource integration, and subsequent value co-creation, are important concerns within the context of an expert and complex service such as cancer care (Anderson et al 2016). It is unclear, in the face of a high emotion service such as cancer, if service users can truly be ‘self-reflexive actors’ acting with choice (Berry et al 2015). Nor is it clear, given Anderson and colleagues (2016) comments regarding ‘capability’, if all service users will possess the ability and allowance to use or integrate a resource. If value co-creation is premised on the integration of resources, there is the risk that value will not be created or potentially be destroyed.

The nature of resource exchange and integration processes are also raised in relation to value co-destruction. As alluded to earlier in this chapter, the concept of value co-destruction, was proposed in a theoretical paper by Plé and Chumpitaz Cáceres (2010). This concept was subsequently explored empirically in a study of the Swedish transport sector by Echeverri and Skålén (2011). This latter paper draws on practice-theory, (which “holds that action is only possible and understandable in relation to common and shared practices and that social order is constituted by practices” (Echeverri and Skålén 2011, p.355), to analyse interactive value formation processes (negative and positive). These papers propose that value co-destruction arises when there is misalignment or misuse of resources and/or practices (Prior and Marcos-Cuevas 2016).

Whilst still focusing on resources, Smith (2013, p.1892) draws on Conservation of Resources theory (an approach which emphasises the role of resource loss in causing psychological distress), rather than practice theory, as means of analysing value co-destruction incidents. The findings of Smith's empirical study suggest that misuse of customers' resources (i.e. finances, time, self-esteem) negatively impacts on well-being. This is a view reinforced by Robertson and colleagues (2014) who explore value co-destruction within the context of online self-diagnosis (where consumers engage with technology by applying their knowledge and skills to generate a medical diagnosis without the participation of a health care professional). Robertson and colleagues (2014, p.246) attribute value co-destruction to "deficiencies in or misuse of resources" on the part of the consumer or e-health provider (i.e. customer knowledge or poor quality offerings). Robertson and colleagues' findings would seem to support the earlier conceptual and empirical work on value-destruction outlined above in other service industries (Plé and Chumpitaz Cáceres 2010; Echeverri and Skålén 2011; Smith 2013).

Customer resources, resource usage and value propositions

It would seem, on the basis of the studies discussed in the previous subsection, that the resource integration process as well as the nature of customers own resources, are areas which warrant further investigation within S-D logic. Jaakkola and Alexander (2014, p.247) state that "firms should focus greater attention on the resources that customers contribute". An emphasis on customer resources and usage of resources is also advocated by Pfisterer and Roth (2015, p.401) who argue that customer usage processes (which includes resource integration) are pivotal in creating value for customers. However, these are processes which are difficult for the provider to access and manage. This leads to usage processes essentially being a "black box" (Pfisterer and Roth 2015, p.402). As a means of potentially unpacking this 'black box', Pfisterer and Roth (2015) propose three dimensions from which to differentiate customers' resource usage processes: actor intensity (low to high), interaction intensity (low to high), and resource intensity (low to high). These relate respectively to: the number of actors involved in usage (i.e. customer and provider

only, or multiple actors), whether interactions are indirect or direct throughout customer usage processes and finally the amount of integrated customer resources used.

Pfisterer and Roth (2015) suggest that value propositions should be adapted accordingly to reflect these differing types of customer resource usage and the extent to which customers wish to be actively or passively involved in the usage process. This should take into account the role of the provider in these processes and the extent of guidance the customer requires to use resources. The framework outlined by Pfisterer and Roth (2015) could additionally serve as a tool for differentiating approaches to patient involvement during health care interactions and processes.

Kowalkowski and colleagues (2012) also draw attention to value propositions and resource exchange and integration processes. Their work draws on practice theory to explore the co-creative practice of forming a value proposition. Kowalkowski and colleagues conceptualise a co-creative practice as “reciprocal exchange of knowledge that is mediated by the practice-related script- understandings, procedures, and engagements – that each resource-integrating actor draws upon” (Kowalkowski et al 2012, p.13). Understandings are defined as “the practice-related knowledge (know-how), skills, and experiences of each resource-integrating actor”. Procedures are “the practice-related rules, principles, and cultural norms of each resource-integrating actors”. Engagements are defined as “the practice-related wants and needs, goals, and purposes to which each resource-integrating actor is committed” (Kowalkowski et al 2012, p.1556). The authors of this paper argue that these three ‘characteristics’ essentially constitute the ‘script’ that actors draw upon when engaging in forming a value proposition. The challenge for knowledge exchange arises when ‘actors’ draw on differing scripts which are incommensurable, which can lead to restrictions in the exchange of knowledge between them. It could be implied from this latter assertion, that failure to co-create value propositions, could potentially lead to value co-destruction. These are important considerations for firms wishing to integrate customers within value co-creating activities as they may draw on ‘differing scripts’

than those providing the service. This is of particular relevance in a health care sphere, given the range of professional groups and lay perspectives in any given context.

Chandler and Lusch (2015), also consider the role of value propositions in a conceptual paper exploring the relationships between engagement, value propositions and service experience. Their paper considers how value propositions can change over time over the duration of the service experience, which they define as “many-to-many encounters” (Chandler and Lusch 2015, p.8). They argue that the service experience develops in accordance with value proposition intensity (how closely the proposition represents an actor’s connections and dispositions) and engagement (alignment of connections and dispositions) and argue that this occurs over four phases (repeat, stimulation, replication, synchronisation and dissipation). In a similar vein to Kowalkowski and colleagues (2012), Chandler and Lusch (2015, p. 9) posit that the service experience can be disrupted if value propositions are not aligned, or where there is conflict between actors due to lack of resources or divergence in meanings. Whilst this paper usefully considers how service experience is influenced by value propositions and engagement over time, the phase ‘dissipation’ refers to the period when engagement is not attainable (due to a lack of alignment in connections and dispositions), and where ‘actors’ consider other value propositions, rather than a phase during which there is some form of misuse or depletion. In a health care context, it may not be possible for patients’ to access other resources or seek out ‘value propositions’ from other service providers. This is an issue to consider within the context of this study.

On the basis of the literature discussed within subsection 2.3.1, it appears there are assumptions within the S-D logic framework which require further consideration when applied to a health care context. Particular attention is drawn to: (a) the processes of service exchange and resource integration which underlie value co-creation, and (b) the nature of service users own resources which may enable them to understand, apply and integrate those offered by service providers. The next

subsection considers studies in the services marketing literature which have applied S-D logic to a health care context.

2.3.2 Applications of S-D logic to healthcare

A small, but slowly increasing number of studies in the services marketing literature has started to explore value co-creation within a health-related context (i.e. Barile et al 2014; Elg et al 2012; Gallan et al 2013; Hau et al 2016; Krisjanous and Maude 2014; Merz et al 2013; Nambisan and Nambisan 2009; McColl-Kennedy et al 2012; Osei-Frimpong et al 2015; Robertson et al 2014; Sweeney et al 2015). These papers range in focus from conceptual papers to empirical work, exploring for example: value co-creation in online communities, co-creation of service in aged care, value co-creation practice styles, partnership models in health care and value co-destruction (Nambisan and Nambisan 2009; Gill et al 2011; McColl-Kennedy et al 2012; Krisjanous et al 2014; Robertson et al 2014). Attention is drawn in this section to those papers which are of most relevance to understandings of patient engagement in micro-level cancer service encounters. There are, however, no current published empirical studies which explore either value co-creation or the application of S-D logic to a UK health care context. Neither are there any published empirical papers which explore service user perceptions of value (i.e. value-in-use) in a UK specialist cancer service context.

The work of McColl-Kennedy and colleagues, (conducted in an Australian private oncology context) is one of the first studies to consider value co-creation within a health care context. This empirical study draws on practice theory to propose five groupings of customer value co-creation practice styles: team management, insular controlling, partnering, pragmatic adapting and passive compliance. McColl-Kennedy and colleagues (2012) empirical work also proposes that value co-creation can include third parties (i.e. family, friends etc.) and customer self-generated activities (i.e. positive thinking). This initial piece of work is extended in a paper by Sweeney and colleagues (2015) who explore customer effort in value co-creation activities in the context of three chronic illnesses (cancer, diabetes and heart disease). This latter paper identifies a hierarchy of activities which range in degrees of customer effort

from those such as compliance with basic requirements (less effort and easier tasks) to extensive decision making (more effort and more difficult tasks). Customer effort in value co-creation activities is defined as “the degree of effort that customers exert to integrate resources, through a range of activities of varying levels of perceived difficulty” (Sweeney et al 2015, p.318).

Of importance to this study, is the finding from Sweeney and colleagues’ study (2015) that participation in value co-creating activities is more likely to be undertaken if they require minimal effort (i.e. co-operating with basic clinic requirements) than more difficult activities requiring greater effort (i.e. proactive involvement in active decision making, emotional regulation). These findings have significance in a specialist cancer service context as this implies that involvement activities, such as active engagement in decision making, may not be undertaken due to the high level of effort required by service users to integrate the resources they need to be able to actively participate. The previous section drew attention to factors influencing resource integration which included ‘capability’. (Anderson et al 2016). Within a cancer service context, it could be argued that emotional capability as well as intellectual capability are influential factors in resource integration and value formation processes. This proposition is supported by work undertaken by Gallan and colleagues (2013), outlined below.

Gallan and colleagues (2013) suggest that many service interactions require customers to participate, but this is not always at levels which optimise outcomes, particularly in a health care context. They develop a model of participation based on data from medical clinic customers which suggests that customers’ affect levels (i.e. emotions) are related to levels of participation. Higher levels of participation are found as affect levels become more positive (Gallan et al 2013, p.338). This implies that when affect levels are negative, which may be the case when service users are under undue emotional stress, that there will be lower levels of participation. The role of emotions is also explored from a service perspective by Berry and colleagues (2015). Whilst not focusing specifically on value co-creation or S-D logic, they argue that in ‘high-emotion’ services (defined as those which trigger strong feelings before

the service even begins) such as cancer care, there is likely to be a lack of familiarity with the service being delivered; lack of control over the performance of the service; major consequences if things go wrong; complexity which renders the service 'a black box' and hence gives its provider the upper hand, and a long duration across a series of events (Berry et al 2015, p.4).

The work of Berry and colleagues implies that information asymmetry is a key feature of high-emotion services and thus a source of potential anxiety. Barile and colleagues (2014), additionally highlight how information asymmetry is related to value co-creation. They argue that there are three conditions necessary for value co-creation to occur: effective communication, reciprocal understanding and strong commitment. Barile and colleagues (2014) also suggest that 'trust' is a key aspect in co-creation. This is a view supported by Jaakkola and Alexander (2014) who commenting in the mainstream literature on value co-creation (i.e. not specifically health related), identify 'trust' as a factor influencing customer engagement in value co-creation.

The emphasis of most of the early studies exploring value co-creation within health contexts is on the customer or user of the service, rather than the service provider. There is, however, one study by Hau and colleagues (2016) which explores the roles of interaction behaviours of service providers in activating customer participation and creating customer value within the context of chronic illness services in Vietnam. Hau and colleagues (2016) argue that the extent of customers' (i.e. patients') participation and resource contribution, is dependent on how service frontliners (i.e. service providers) interact with patients in the role of an initiator. This team of authors suggest that individuated, relational, and empowered interactions of service 'frontliners' (i.e. service providers or health care staff) play a critical role in activating customer participation (Hau et al 2016, p.1). These authors additionally suggest that these interactions can be further broken down into-activating interaction and value-enhancing interaction. Both of which, they argue, lead to the improvement of customer value. Hau and colleagues (2016, p.7), additionally discuss customer value in terms of process value (i.e. positive experiences perceived by the customer during

the co-creation process) and outcome value (i.e. final benefits perceived by a customer when service concludes). Hau and colleagues' study is useful for considering the nature of value co-creation in a health care context as it draws attention to the nature of health care interactions and their potential influence upon engagement and value creation processes. This particular study also draws attention to differing 'types' of value which may be experienced by the customer, (i.e. service user/patient). This is of relevance in a cancer service context where outcomes of treatment interventions may not be immediately obvious or realised.

The literature reviewed in this sub-section suggests that value co-creation within health care contexts is influenced by factors including the nature of interactions between service users and service providers, and the 'capability' of service users (emotionally and intellectually). This would also seem to suggest that levels of participation can vary and may reflect service users 'practice styles' as well as the extent of information asymmetry which exists in specific service contexts. These are pertinent issues which warrant further investigation in the empirical phase of this study, when considering the application of S-D logic to a UK specialist cancer service context.

It is evident that the S-D logic framework is still evolving and undergoing refinement. Despite this, on the basis of the literature reviewed thus far (including section one), it is argued that S-D logic has the potential to further insight into articulations of value from a patient perspective, as well as the positioning of the service user in micro-level health encounters. The next section elaborates further on the role of the patient in engagement initiatives and how extant approaches could be enhanced through adopting an S-D logic perspective.

Section 3: Patient engagement, value and health care

As can be seen in the preceding section, S-D logic positions the service user as an active and central participant in value co-creation with knowledge and skills to contribute to this process. The introductory chapter of this thesis discussed how perceptions of the role of the service user in health care is shifting, with emphasis

increasingly placed on patients becoming active, empowered participants and partners in the management of their health (Laurance et al 2014; Coulter 2011). This also highlights how, in striving to make such a shift, there is the risk that involvement initiatives will lead to responsabilized, rather than empowered service users (Fotaki 2011; Anderson et al 2016). This section elaborates further on these issues and argues that to date, patient engagement initiatives in the UK have been hampered by a lack of clarity over both the terms and the approaches to involvement in health and health care.

3.1 Challenges to patient engagement and participation

Patient engagement (often referred to as 'involvement' or 'participation') in the planning, development, evaluation and analysis of health care has received increasing attention in policy initiatives, the press, and a number of research literatures (Department of Health 2002; Bate and Robert 2006; Renedo and Marston 2011; Coulter 2012; Ocloo and Fulop 2012; Armstrong et al 2013; Francis 2013). Indeed, patient engagement has been proposed as a means of delivering safer healthcare; maintaining stability and additionally improving accountability; equity and the delivery of health care (Department of Health 2002, 2008; WHO 2007, WHO 2008-9; Coulter 2012; Ocloo and Fulop 2012; Francis 2013; Hor et al 2013; Ocloo and Matthews 2016). There is also evidence to suggest that patients who are more actively involved in their health care experience better health outcomes and incur lower costs of care (Coulter et al 2008; Hibbard and Greene 2013; Laurance et al 2014). This has led some commentators to liken patient engagement to the 'holy grail' of health care (Carman et al 2013).

Ultimately, the fundamental purpose of an involvement activity should be to improve the health and the experience of services for patients (including family members and carers), users of health and social care services, and the wider public (Gibson et al 2012; Ocloo and Matthews 2016). Progress in the UK in relation to patient and public involvement has, however, been patchy, variable and slow, with 'consultation' rather than 'collaboration' viewed as the norm (Ward et al 2011; Ward and Armitage 2012; Ocloo and Fulop 2012; Ocloo and Matthews 2016). Additionally, despite variation in

the methods and mechanisms for delivering patient and public involvement, it is argued that these lack attention to the varying nature of the knowledge production arena, and the influence of power, professional status and resistance within organisational cultures status on the outcomes of involvement initiatives (Renedo and Marston 2011; Gibson et al 2012).

This situation is further complicated by a number of other factors which includes the range of levels at which to apply engagement (i.e. micro-, meso - or macro- level). Disagreements also exist concerning who to involve and why in terms of democratic, technocratic or experiential representation. There are also opposing ideas concerning the nature of 'lay' and expert' knowledge; the relationship between professional service providers and the public they serve, and the variety of possible roles which users may adopt (LéGaré et al 2007; Martin 2008a, Martin 2008b, 2009; Fotaki 2011; Greenhalgh et al 2011; Gibson et al 2012; WHO/Europe 2013).

Despite the increasing centrality of the concepts of patient centred care and patient involvement in health policy in the UK and elsewhere, there is little consensus regarding how to define these terms or how 'patient centred' care can be achieved in everyday practice (Lord and Gale 2014). There is also considerable variation in terms of definitions of 'patient engagement' and conceptions of how this improves care (Carman et al 2013). This is important, as engagement in health care may vary in terms of: who is involved (i.e. patients, families, caregivers, other citizens and consumers) and the level at which engagement is undertaken (i.e. direct care, organisational design and governance, policy making). Variation may additionally exist in terms of the continuum of engagement activities (i.e. consultation through to involvement, then partnership and shared leadership), and the willingness and ability of participants to engage (Carman et al 2013).

Confusion and lack of clarity over terms is an important area of consideration as this has implications for the unit of analysis in engagement or involvement initiatives. Elaborating upon the issue of unit of analysis and roles of users, Fredriksson and Tritter (2017) challenge the lack of attention placed on distinctions between patients and the public in involvement health care decisions. Their concerns relate to the

assumption that patients can be used as proxies for the public. In a nutshell, they argue that crucial differences exist between patients and the public in that “patients have sectional interests as users of health services”, in contrast to “citizens who engage as a public policy agent reflecting societal interests” (Fredriksson and Tritter 2017, p.95). They perceive that this lack of attention to differences represents a contributory factor in failing to achieve goals and benefits of engagement. A similar view has been articulated by Coulter (2011, p.5), who argues that the needs of the patients and public (citizens) should be considered separately. The rationale for such a view is that the focus of patients is more likely to be on the quality of care and everyday interactions with health professionals. In contrast, the focus for citizens is potentially about the nature and pattern of service provision (Coulter 2011, p.5). The emphasis in this study (as outlined in the introductory section of this thesis and earlier in this chapter) is on patients’ engagement in direct care (micro-level service encounters), rather than involvement in organisational design and governance or policy making.

The introductory chapter of this thesis drew attention to a developing critique of patient involvement initiatives that propose that efforts to ensure patient participation in healthcare have been similar to those of manufacturers in engaging consumers in designing and marketing products (Batalden et al 2016; Joiner and Lusch 2016). This view may place limits on the success of attempts to partner with patients as a means of improving health care (Batalden et al 2016). In the face of such concerns, the role of the patient in engagement initiatives and health care improvement strategies necessitates further consideration.

“In considering how best to develop an effective system that delivers quality care and value for health consumers – and one that is able to meet future care demand – the role that patients play has become ever more important: giving them back a starring role is today a priority for health policies both at an ethical and pragmatic levels” (Graffigna and Barelo 2016, p.192).

Whilst widespread attention has been given to concepts of patient activation and patient engagement, value is mainly defined by the health care system (James 2013; Joiner and Lusch 2016, p.31). The S-D logic framework offers an alternative way of

defining the role of the patient within engagement initiatives as this posits that value is defined by the customer or service user. In adopting this approach, the centrality of the service user in service exchange and resource integration is emphasised in the process of creating value, rather than 'value' being delivered to the user by the service provider (Akaka and Vargo 2015; Joiner and Lusch 2016). This view of service exchange is one underpinned by notions of collaboration with S-D logic described as:

“[...] the logic of togetherness where actors use their applied knowledge and skills (competences) to provide benefit to another and to benefit themselves” (Joiner and Lusch 2016, p.26).

The framing of value within S-D logic as a phenomenological and experiential concept (i.e. value-in-use) enables the benefit(s) arising through service use to be explored from a user perspective. This is missing from economic articulations of value such as that of Porter (2010). Through understanding how 'value' is perceived and conceptualised by users of a service, insight may be gained into factors which facilitate the creation of 'value' and contribute to positive health care experiences. This knowledge could usefully inform patient engagement initiatives in micro-level health care encounters.

Despite the potential relevance of services marketing concepts to the sphere of health being raised in health-related literature some time ago (e.g. Corbin et al 2001; Jaakkola 2007), it is only recently that it has started to feature more significantly within health care and public management research. Hardyman and colleagues (2015) recently outlined the importance of examining 'value co-creation' in furthering understandings of patient engagement in micro-level health encounters. McDermott and Pedersen (2016, p.203), also emphasise the potential for “theoretical lens from services marketing” to contribute to enhanced understandings of both patient role, and the factors which may assist or restrict involvement in service delivery and improvement.

The capacity for various models of co-creation in health care (which includes: value co-creation; experience based co-design; technology co-design and community based participatory research) to contribute to achieving research impact in

community based health services has also been considered in a recent literature review and case study by Greenhalgh and colleagues (2016). The experience based co-design approach also adopts a transdisciplinary approach (as is proposed in this study) to the issue of patient engagement (Bate and Robert 2006, 2007; Robert et al 2015). Experience based co-design draws on design sciences, organisational learning and patient engagement research and applies these as a means of improving health care quality through participatory action research (Boaz et al 2016, p.258).

A developing body of work by Osborne and colleagues (Osborne 2010, 2013; Osborne et al 2013; Osborne and Strokosch 2013; Strokosch 2013; Osborne et al 2014a, Osborne et al 2014b; Osborne et al 2016) which draws together service management and public management literatures, has increased the prominence of services marketing literature and theory in recent public management research. Their work focuses on the contribution of services marketing theory and literature and proposes that a 'public service-dominant approach' should be applied to public services delivery and management (Osborne 2010; Osborne et al 2013). The rationale for such an approach is premised on the centrality of the 'user' in the services literature, where consumers are viewed as 'co-producers' and 'co-production' is an integral component of service delivery (Osborne et al 2013). It should be noted that the emphasis on co-production in Osborne and colleagues' work, whilst related to service-dominant logic, differs from this latter perspective in that S-D logic emphasises co-creation of value rather than co-production. Further exploration of Osborne and colleagues work is undertaken in the next section.

Section 4: Public management and public service-dominant logic

The work of Osborne and colleagues focuses on the contribution of services marketing theory and literature. It proposes that a 'public service-dominant approach' should be applied to public services delivery and management (Osborne 2010; Osborne et al 2013). Osborne and colleagues argue that the core theory that has been used to understand public services delivery is no longer 'fit for purpose' (Osborne 2010; Osborne et al 2013). According to this view, 'public goods' should be conceived of as 'public services' (this includes health care) rather than 'public

products'. Their work advocates that public management should be underpinned by service management approaches (including the work of Lusch and Vargo 2006b), rather than business management theories. In doing so, Osborne and colleagues propose the application of a public service-dominant approach to the delivery and analysis of public services (Osborne 2010; Osborne et al 2013; Radnor and Osborne 2013).

Osborne (2013) proposes that there are two core concepts in services theory which have significance for public services. First, the performance of a public service should not only be about whether its design is 'fit for purpose', but also equally consider the service users subjective experiences of that service. This is likely to be influenced by both expectations of the service and views regarding the service delivery process. Second, the service delivery process is created through interaction between the service provider and service user, with co-production a core characteristic of service delivery. The upshot being that "service delivery affects service outcomes as much as design" (Osborne 2013, p.64). In commenting on the service-dominant approach to innovation in public services Osborne suggests that;

"[...] a genuinely services-dominant approach to innovation in public services is predicated upon the role that co-production plays in service delivery" (Osborne 2013, p.65).

According to Alford (2016, p.675), the public service-dominant approach (which he terms 'public service-dominant logic') emanated from critiques regarding the limitations of public management theory in general, and in particular, the so-called 'New Public Management' (NPM). Osborne and colleagues (2013) argue that the premises underlying much of such contemporary management theory are flawed. Instead of creating a basis for sustainable public service organisations, Osborne and colleagues argue that the body of theory in relation to NPM has undermined the sustainability of public service organisations and has encouraged an approach to the delivery of public services which is "short-term, introspective and transactional" (Osborne et al 2015, p.424; see also McLaughlin, Osborne and Chew, 2009; Radnor, 2007). Osborne and colleagues argue that public service organisations must move

beyond this and adopt a relational and public service-dominant approach which emphasises:

“[...] building relationships across the public service delivery system; understanding that sustainability derives from the transformation of user knowledge; and professional understanding of the public service delivery process which is predicated upon the inalienable co-production with service users” (Osborne et al 2015, p.424).

The initial emphasis in the stream of work undertaken by Osborne and colleagues directs attention towards enhancing typologies of ‘co-production’ in public services and exploring the benefit of ‘public service business logic’ to lean methodologies in healthcare (Osborne 2010, 2013; Osborne et al 2013; Radnor and Osborne 2013; Osborne and Strokosch 2013; Strokosch 2013). This focus has recently widened and further developed to: (a) unpack how co-production can be operationalised through the application of service blueprinting; (b) propose a SERVICE framework (based on seven key propositions) for a sustainable business model for public service organisations; (c) explore the role of marketing as a route to sustainability for social enterprises providing public services; and (d) consider the relationship between co-production and the co-creation of value through public service delivery (Osborne et al 2014a; Osborne et al 2014b; Radnor et al 2014; Osborne et al 2015; Powell and Osborne 2015; Osborne et al 2016).

The work of Osborne and colleagues, whilst drawing on services marketing literature, (which includes the work of Lusch and Vargo 2006b), adopts a wider definition of co-production than is used in the S-D logic framework.

“We define co-production as the voluntary or involuntary involvement of public service users in any of the design, management, delivery and/or evaluation of public services” (Osborne et al 2016, p.640).

The work undertaken in this study, differs to that of Osborne and colleagues. Whilst the most recent work of Osborne and colleagues (2016) conceptualises the relationship between co-production and value co-creation or value co-destruction,

the main emphasis in this stream of work concerns enhancing typologies of co-production and developing a public service-dominant logic. The proposed typologies of co-production are rooted in both public management and service management theory and as such offer a different definition of co-production than that conceived within S-D logic.

The work undertaken in this study specifically explores the application of S-D logic to a health care context. S-D logic defines co-production in much narrower terms than Osborne and colleagues (i.e. “participation in the development of the core offering itself”, (Lusch and Vargo 2006a; Vargo and Lusch 2008- see section 2.1.1). Emphasis within S-D logic is upon the co-creation of value, rather than co-production (which is viewed as optional). This study focuses on perceptions of value and value-co-creation processes from an S-D logic perspective rather than the wider conceptualisation of co-production forwarded by Osborne and colleagues (2016). The focus of the empirical work in this study, (outlined later in this chapter and Chapter 2) does however, respond to a call by Osborne and colleagues to consider differing conceptualisations of value in public services (Osborne et al 2016, p.648).

McGuire (2012), commenting in public management literature, highlights that there is a need to carefully look at context when considering borrowing good management idea from elsewhere. Such caution is also expressed by Osborne (2013, p.65) who notes that given the distinctive characteristics of public services:

“[...] any services-dominant approach cannot simply be a mechanistic transfer of insights from private sector experience”.

This is an important consideration in this study. It is currently unclear how the S-D logic framework maps into any given UK health care context. Given this gap in empirical knowledge, this study intends to contribute knowledge in this field. The next section considers potential implications applying the S-D logic in a specialist cancer service context and outlines areas which require further consideration.

Section 5: Applying S-D logic to a health care context

Although the S-D logic framework has potential to contribute to research concerning value, value co-creation and patient engagement in health care, it is important to consider how far this framework maps across into health care contexts. Healthcare whilst sharing some common characteristics with other service industries, is importantly, dissimilar in a number of ways. According to Berry and Bendapudi (2007), customers are typically sick and under stress and hence potentially more demanding, sensitive and emotional than they would normally be as consumers. Healthcare consumers may be reluctant customers, in that the service may be 'needed' but not necessarily 'wanted'. Customers may, therefore, be unwilling to perform the co-producer role. Nordgren (2008) comments on this issue and posits that the assumption that patients wish to be party of their value creating processes has implications. Given that the responsibilities and tasks of health care professionals are regulated and institutionalised, these cannot necessarily be delegated to patients, as "a matter of course" (Nordgren 2008, p.510). This is a useful point to consider when contemplating value creation and co-creation in the sphere of health.

Whilst there is increased recognition that patient and public engagement is central to health reform, it does not, however, necessarily follow that all patients should choose to be involved or should take responsibility for monitoring care (Ocloo and Matthews 2016). Indeed, when customers are unwilling co-producers, their perceptions have been found to be negative (Bendapudi and Leone 2003). This is also recognised by Thompson (2007, p.1297) who argues that little attention has been paid to the role which patient's themselves wish to play or to the conceptual meanings behind participation or involvement. This is apparent in patient experience surveys, such as the Welsh Cancer Patient Experience Survey (Quality Health 2014). Although this survey found that three quarters of those completing the questionnaire responded that they 'were involved in decisions and care as much as they wanted to be', this survey does not clarify what involvement means to patients, nor does it question the issue of 'over-involvement'.

Sweeney and colleagues (2015, p.318) suggest that participation in value co-creating activities aimed at enhancing health and quality of life are more likely to be undertaken if these require minimal effort (i.e. co-operating with basic clinic requirements) than more difficult activities requiring greater effort (i.e. regulating one's emotions). The findings of this study and those highlighted above, imply that there may be differing interpretations of involvement as well as levels of participation. An additional consideration is that cancer care has been classed as a "high-emotion need-based service" (Berry and Mate 2016). The nature of the illness and the service may shape the extent to which individuals feel able, are willing or desire to participate in their direct care and treatment. In considering the nature of the service exchange within a cancer service context, and the empirical application of S-D logic, how service users and providers perceive and describe involvement is an area which warrants further investigation.

In addition to the issues raised above, health care is a high risk service, which can mean that service users do not attain the outcomes they hoped to achieve, despite the best efforts of service providers (Zayer et al 2015, p.303). However, variation in perspectives on value is not necessarily negative. Value propositions in multiple stakeholder domains can provide an important mechanism for aligning value, which in turn may be reflected within the 'service promise' of service organisations (Frow and Payne 2011; Osborne et al 2013). There is, however, scarce research exploring value co-creation in the context of multiple interactions with multiple stakeholders (Fyrberg Yngfalk 2013; Pinho et al 2014).

In a specialist service context such as cancer, patients and their family members are likely to interact with a range of providers, across multiple service encounters, over an extended period of time. It cannot be assumed that patient perceptions of value and the benefits they realise through service use will be aligned with those of health care providers, or indeed other patients. Nor can it be assumed that the service offered will be perceived as that which is of value to the service user. Perceptions of 'value' in this context may continue to evolve and develop across the cancer service experience. In considering value co-creation within a cancer service context, further

insight is required into differing perceptions of the value that is potentially offered via value propositions, as well as that which is co-created through service interactions. Consideration is also required of the factors which facilitate or restrict value co-creation.

The S-D logic perspective on value co-creation implies that value is not accomplished until resources are integrated, this potentially means that 'value' may not be realised at the point of service use. Furthermore, failure to integrate resources may result in an absence of value creation (McColl-Kennedy et al 2012). These are important points to consider within a specialist health care context, as treatment and care tend to extend beyond 'one off' health service encounters. A number of authors have suggested a degree of 'co-learning' may be necessary before 'customers' or service users are able to integrate resources (Kleinaltenkamp et al 2012; Hibbert et al 2012). Bracher and colleagues (2014, p.12) analysed open text comments in a recent national cancer patient experience survey and found a consistent preference for information provision directly from staff rather than approaches such as video, print material or interactive electronic sources. The need for tailored approaches to information exchange is also raised by Bracher and colleagues (2014) in that not all patients require information at the same time or indeed the same level. In considering the application of S-D logic to a health care context and to patient engagement, which incorporates strategies such as patient activation (Hibbard and Mahone 2010), the nature of resources drawn upon, exchanged and utilised across cancer service encounters requires further consideration.

It can be seen then that there are a number of areas which require further investigation when considering the application of the S-D logic framework to a UK specialist cancer service context. These specifically concern: (i) how value is conceptualised by service users and service providers within this context; (ii) factors facilitating or restricting value co-creation in this context; (iii) the nature of service exchange and perceptions of involvement; (iv) how resources are exchanged, integrated and utilised and (v) how value is created in this context and who are the actors involved. The subsequent section summarises the main literatures drawn

upon within this study; identified research gaps and the focus of the empirical work undertaken in this study.

Summary

This chapter has discussed the relevance of the concepts of 'value-in-use' and 'value co-creation' to enhancing understandings of patient engagement in health care (direct engagement in own health, care and treatment) within individual, micro-level service encounters. In doing so, this work has adopted a novel transdisciplinary approach and combined insights and approaches from across services marketing and public management domains concerning differing conceptions of value; service-dominant logic, public service-dominant logic and patient engagement and participation in health care.

Drawing from the literature reviewed in this chapter, it is argued that whilst economic articulations of value dominate health care, they do not necessarily reflect the perspectives of those using the service (Tilburt et al 2011; Ramsey and Schickedanz 2010). Instead, a user-centric, phenomenological and experiential perspective on value is advocated, such as that offered in S-D logic (i.e. value-in-use). Furthering insight into how 'value' is actually conceptualised and experienced by those using and providing services is seen as a way informing and enhancing strategies which promote engagement and co-creation in health care. Through understanding how 'value' is articulated, this chapter argues that it may be possible to identify factors which lead to the creation and/or destruction of value. The S-D logic framework is proposed as the perspective from which to explore value (i.e. value-in-use) and value co-creation within the context of health care.

The S-D logic framework emphasises the centrality of 'customers' in service exchange and value co-creation (Akaka and Vargo 2015). The emphasis on the customer or service user as an 'operant resource', positions service users as an active participant, rather than passive recipient of service. Acknowledging that service users also have knowledge and skills to exchange (from which service providers can benefit) challenges more paternalistic, asymmetric approaches to engagement which are

provider-determined, rather than patient- or co-determined (Thompson 2007, p. 1306). In doing so, there is potential to shift towards more collaborative models of patient engagement rather than typical approaches dominated by one off consultation exercises; formal complaints procedures and satisfaction surveys (Social Care Institute for Excellence 2012; Robert et al 2015; Boaz et al 2016).

It is apparent, however, that empirical work in relation to value co-creation, whilst expanding, is still limited. The evolving literature within this field has tended to be more conceptual in orientation. This is reflected in the number of recent calls to extend knowledge of value co-creation as outlined in the introductory chapter (Grönroos 2011; Leroy et al 2013; Nordgren and Åhgren 2013; Chandler and Lusch 2015; Danaher and Gallan 2016; Ostrom et al 2015). Although there are a small number of published empirical studies which explore value co-creation (and one exploring value co-destruction) in a health care context, the application of S-D logic to health care is still under researched (McColl- Kennedy et al 2012; Robertson et al 2014; Sweeney et al 2015; Osei-Frimpong et al 2015; Hau et al 2016; Joiner and Lusch 2016). Additionally, there is an absence of published empirical research which explores (i) the application of the S-D logic framework in UK health context, and (ii) how value is conceptualised by service users when framed as value-in-use.

Given these gaps in empirical knowledge, the overall research question this study seeks to address is: What does 'value' mean in a specialist cancer service setting, and to what extent can S-D logic enhance understandings of 'value' in this health care context? This study intends to contribute knowledge by investigating : (i) trajectories of value in a specialist cancer setting, by exploring how service users and service providers conceptualise value when framed from an S-D logic perspective (i.e. value-in-use or benefit); (ii) the potential barriers, facilitators and supports for value co-creation, and (iii) the extent to which four axioms/five foundational premises within the S-D logic framework have relevance to the selected study context (see introductory chapter; study approach, aim and objectives, p.9). In investigating these research areas, attention is also given to: the nature of service exchange and perceptions of involvement within this study context; how resources are exchanged,

integrated and utilised within this context and the actors involved in value formation processes. This study addresses these issues through undertaking exploratory research in a UK specialist cancer centre.

The next chapter (two) discusses the research design and methods adopted to undertake this empirical work. For ease of reference, the aim and objectives of the study are briefly restated in this subsequent chapter.

CHAPTER TWO: RESEARCH DESIGN AND METHODS

“Qualitative methods used in an exploratory manner can afford the flexibility to investigate rigorously and thoroughly emergent phenomena, or those that are single and distinctive and for which description, not hypothesis testing, is most appropriate” (Hurley 1999, p.1132).

Introduction

This chapter describes the systematic research methodology that has been used to investigate: (a) trajectories of ‘value’ within the context of cancer service encounters, (b) barriers, facilitators and supports for value co-creation and (c) the empirical application of the S-D logic framework to a UK specialist cancer service setting. Specifically, this study seeks to extend knowledge regarding the relevance of the S-D logic framework to the arena of health care. This exploratory study investigates how ‘value’ is conceptualised, constituted and experienced within a UK cancer service context. In doing so, it aims to extend knowledge regarding the extent to which the S-D logic maps across to the arena of UK health care (Mason 2002). The frame of reference drawn upon in this study is, therefore, largely interpretive and at the subjective end of Burrell and Morgan’s continuum (1979, p.22). This study adopts a qualitative approach drawing on principles of case study research (Eisenhardt 1989, 1991; Stake 2005; Yin 2009).

Qualitative methods are viewed as having particular relevance in a health care context as they enable rich descriptions of complex, dynamic phenomena at a specific time point, and also as these develop over time (Rundall et al 1999, p.1091). These methods facilitate detailed understandings of phenomena within ‘real-world’ contexts and they assist in the generation and operationalisation of theories and conceptual frameworks (Shortell 1999). These are also methods which seek to emphasise understanding and portray social action from the perspective of ‘social actors’ within a naturally occurring setting (Schwandt 2001, p.173). Furthermore, qualitative research methods offer researchers flexibility and capacity to modify research designs during research projects (Hurley 1999). This is important in

exploratory research such as this, given it may be necessary to adjust the research design as the research progresses in order to capture emergent phenomenon.

In order to judge the quality of qualitative research inquiry, explicit reporting of data management and data analysis procedures are required. Transparency of these processes is expected so that the reader will be confident of, and able to verify, conclusions. Transparency also facilitates potential replication (in principle) of the study and so increases the visibility of any fraud or misconduct (Huberman and Miles 1994, p.439; Schwandt 2001, p.258). Furthermore, explicit reporting of the research context and assumptions underlying the research may enhance the transferability or relevance of the findings to other settings or contexts (Lincoln and Guba 1985; Seale 1999; Schwandt 2001, p.107). In short, there are three related but distinct enquiry elements which impact on the credibility of qualitative inquiry: rigorous techniques and methods for data gathering and careful analysis, the credibility of the researcher and philosophical belief in the value of qualitative enquiry Patton (1999, p.1190).

The remainder of this chapter demonstrates each of the three main elements of this study's credibility and is structured into three main sections to explain the processes of data collection, preparation and analysis used in this study. The first section explains the research methods selected to fulfil the study objectives. This includes a discussion of qualitative and case study research and outlines the reasons for conducting this specific research study. The second part of the chapter describes and illustrates the research experience and it pays particular attention to: (a) features of the case study site; (b) negotiating access (c) participant sampling; (d) methods of data collection and analysis and (e) ethical considerations. Finally, this chapter reflects on the research process and how issues such as credibility, transferability and reactivity were managed within this study.

Section 1: The selection of research design and methods

1.1 Methodological perspective

One of the common ways of classifying research methodologies is to distinguish

between quantitative and qualitative research. It is, however, argued that there is no simple distinction and that this dichotomy is often over stated (Pope and Mays 1995; Silverman 2013). Broadly speaking, quantitative research has tended to be associated with a positivist epistemological position, with emphasis placed on quantifying or measuring phenomena (Schwandt 2001; Thomas 2004).

In contrast, qualitative research entails an interpretive and naturalistic approach to the world. Phenomena are studied in qualitative research projects within their natural settings in order to discover world views or perspectives of people and to make sense of the meanings assigned to behaviours and experiences (DePoy and Gitlin 1994; Denzin and Lincoln 2000). Qualitative research comprises a range of approaches intended to emphasise lived experiences, and they are advocated as well suited for locating:

“...the meanings people place on events, processes and structures of their lives and for connecting these meanings to the social world around them” (Miles et al 2014, p.11).

It is a set of approaches however, which are not possible to pigeon hole, or reduce to a set of simple and prescriptive set of principles (Mason 2002, p.3). Some common elements of qualitative research which Mason identifies are: (1) that it is grounded in a broadly interpretivist philosophical position, in that it is concerned with the interpretation and understanding of the social world and how this is produced, constituted and experienced; (2) the methods of data generation are flexible and sensitive to the social context in which data are produced and (3) are based on methods of analysis, explanation and argument building that entails understandings of detail, complexity and context. For purposes of clarity, the aim and objectives of this study are briefly restated (see introductory chapter, pp.9-10 for full details).

Aim and objectives

The primary aim of this study is to investigate how value, when framed as ‘value-in-use’ is conceptualised by service users and service providers (health care staff) in a specialist cancer service setting.

Objectives

1. To investigate trajectories of value in a specialist cancer setting by exploring how service users and service providers conceptualise value.
2. To identify potential barriers, facilitators and supports for value co-creation by exploring conceptualisations of value and service user and service provider accounts of service experiences.
3. To explore how the following axioms/ foundational premises underpinning service-dominant logic: Axiom 1/FP1; Axiom 2/ FP6 and FP7; Axiom 3/FP9 and Axiom 4/ FP10, relate to and/or have relevance to the selected study context.

Rationale for chosen perspective

A qualitative case study research design is viewed as being most consistent with, and having the greatest potential to address, the research questions under investigation within this study (Dreher 1994; Goulding 2002). There are four main reasons for making this choice.

First, given the dearth of empirical studies in this field, there is limited knowledge regarding the relevance of the S-D logic framework and 'value and value co-creation' within a UK specialist cancer context. The research undertaken in this study is therefore exploratory in nature. A qualitative research design is viewed as appropriate for exploring areas not yet thoroughly researched or where researchers are breaking new ground and little data are available (Shortell 1999, p.1085). As outlined earlier, it is also often the choice of approach when examining the inner experiences of participants and how such meanings are formed and or transformed (Corbin and Strauss 2015, p.5).

Second, within the focal S-D logic framework, value is viewed as phenomenologically determined by individual actors within a given context (Vargo and Lusch 2004, 2008, 2016a). The researcher is therefore of the view, that in order to understand this 'reality', it is necessary to explore this through the eyes of the participant i.e. service

user and service provider (Glaser and Strauss 1967). This warrants an interpretive, phenomenological frame of reference.

Third, an interpretivist perspective offers a view of the world where humans are seen as different from other 'entities in the universe' (Thomas 2004, p.44), in that they are self-aware and construct meaning and social reality (Berger and Luckmann 1967). According to this view, behaviour is not able to be understood unless the observer understands those meanings which also need to be interpreted within the context that they occur. Adopting such a view, however, also leads to the assertion that researchers are not passive observers, and that they themselves also engage in the process of constructing and interpreting the world through the act of observation (Easterby-Smith et al 2008; Thomas 2004, p.44). The role of the researcher within qualitative research needs to be recognised, as they are essentially the research instrument (Piantanida and Garman 1999, p.24).

Whilst drawing on interpretive approaches and viewing subjective experiences of everyday life as social constructs, this researcher is also of the view that these perceptions relate to something 'real' in the outside world. The researcher's position in this study is that there is an objective reality of the natural world which exists outside of the researcher's mind, but how this world is experienced and understood is largely socially defined (Berger and Luckmann 1967).

Finally, the investigation of this study's focal phenomena warranted a holistic approach and the use of combined research methods i.e. semi-structured interviews, and observations (Eisenhardt 1989). Such insights may best be facilitated through a case study design. This form of enquiry investigates contemporary phenomenon within its real life context. It is particularly useful in settings such as health care, where boundaries between phenomenon and context are unclear, and where contextual conditions are also highly pertinent (Yin and Davis 2007; Yin 2009).

It should be noted that case study research is viewed by Stake (2005 p.443) as "neither new nor essentially qualitative". It is viewed as a choice of what is to be studied rather than a qualitative choice. Some case studies may opt for both

qualitative and quantitative evidence, depending on the issues of interest (Yin 2009). As qualitative research methods also assist in the provision of rich descriptions of phenomena; enhance understanding of context as well as events themselves and “enhance peripheral vision”, a qualitative case study design is viewed as the most appropriate methodological approach for the conduct of this research study (Sofaer 1999, p 1101-1102). Details of the specific research methods adopted in this study are outlined further in section 1.2.

1.2 Research methods

This study has drawn on a range of techniques in order to interpret and understand how ‘value’ is produced, constituted and experienced within the context of the UK cancer service encounter (Mason 2002; Rubin and Rubin 2005). The research design adopted draws from interpretive approaches and the following techniques and procedures for gathering and analysing data:

- Case study approach
- Constant comparative method
- Data triangulation
- Observation
- Interviews

1.2.1 Case study approach

The case study approach is a form of empirical enquiry which enables comprehensive understanding of a phenomenon within real life contexts from the perspective of those involved (Boblin et al 2013; Creswell et al 2007; Stake 2005; Yin 2009). The case study method draws upon multiple data sources to facilitate rich, contextual understanding (Creswell et al 2007). It is a choice of approach which is influenced by the nature of the inquiry research questions. This method is viewed as relevant when questions seek to explain some present circumstances such as “how” or “why” some social phenomenon works, or when extensive and “in-depth” descriptions of social phenomenon are required (Yin 2009, p.5). This approach is also seen as

advantageous when exploring “a contemporary set of events” and in situations “over which the investigator has little or no control” (Yin 2009, p.13).

Three types of case study have been identified, which vary in terms of intent of the analysis: (i) intrinsic case study, (ii) instrumental case study and (iii) multiple case/collective study (Creswell et al 2007; Stake 2005). An intrinsic case study is where the case is selected on the grounds of enabling understanding of the particular case, rather than of some specific construct or generic phenomenon. In contrast, an instrumental case study, uses the case mainly to gain insight into a particular issue or phenomenon (Stake 2005, p.445; Creswell et al 2007). The third type of case study, a multiple or collective case study, selects multiple cases to illustrate the issue of concern i.e. several programmes from several research sites or multiple programmes within a single site (Creswell et al 2007; Stake 2005).

This study adopts a single site *instrumental* case study design. One of the reasons for selecting a single case study design is when the case study is a critical or new test of an existing theory or body of literature (Yin 2009, p.52). A single case study design is therefore viewed as appropriate on a number of grounds that characterise the setting of this study. First, there is an absence of published empirical studies which explore the application of this framework in a UK specialist healthcare context. Second, the application of the S-D logic concept to health care is deemed as ‘new’ and “scant literature exists under that nomenclature” (Joiner and Lusch 2016, p.28). Third, there is a lack of published empirical studies exploring service user and provider perceptions of value in a UK cancer service context.

In this study, the specialist cancer centre (Hospital A) is the organisation site in which the empirical application of the S-D logic framework and value and value formation processes are explored. Although the organisation (Hospital A) forms the primary basis of the case, it is necessary to additionally explore permeable boundaries in order to take into account individual’s case history. For example, the majority of patients attending the Centre have undergone diagnostic, investigative and/or treatment related procedures in other health care settings prior to attending Hospital A. Within a cancer service context, healthcare service encounters are often complex,

not necessarily discrete and may involve multiple service providers and multiple episodes of care during the overall cancer-service experience. As the patient is the common feature across these multiple cancer service encounters, the influence of case history on trajectories of value are additionally considered within this study (O'Hara and Isden 2013).

In summary, the focal study phenomena are considered within the context of cancer service encounters (both within and permeating the boundaries of the specialist centre) from the perspectives of service users and service providers receiving treatment, attending or working within the specialist cancer centre (Hospital A). The units of analysis within this study are service users, service providers, and emergent trajectories of care. Patients, as the main beneficiary or recipient of 'service', are the predominant focus of interest in this study.

1.2.2 Constant comparative method

The constant comparative approach was developed as a method of generating theory systematically through the joint coding and analysis of data (Glaser and Strauss, 1967, p.102). It is an analytic process which compares and contrasts data (newly collected or previously collected or compiled data) for similarities and differences and can be applied to a range of qualitative data i.e. interviews, observations, documents etc. (Glaser and Strauss 1967, p.102-104; Corbin and Strauss 2008). Although this research study does not adopt a pure grounded theory approach, the constant comparative approach has been drawn upon to guide the iterative processes of data gathering and interpretation.

1.2.3 Data triangulation

A range of data collection methods are used in this case study to facilitate triangulation of data sources. The term triangulation, according to Sofaer (1999, p.1106) is often used by researchers to describe the process of:

"[...] examining differing perspectives in order to identify at a minimum what all informants seem to agree took place".

Triangulation is also a strategy which is adopted to reduce systematic bias in the data (Patton 1999). There are four main types of triangulation (i) triangulation of quantitative and qualitative data; (ii) triangulation of qualitative data sources (iii) triangulation through multiple analysts and (iv) theory triangulation (Patton 1999, p.1197). This study has drawn on the second of these approaches and collected and compared interview and observational data. This study has also investigated perceptions of value within the context of the cancer service encounter from potentially different realities (Stake 2005) i.e. from service user and service provider perspectives.

1.2.4 Observation

Observation enables the researcher to be placed “[...] in the center of the action where they can see as well as hear what is going on” (Corbin and Strauss 2015, p. 41). It is an approach which is viewed as important because understanding behaviour and interaction cannot solely be gained from asking questions. Indeed, the routines and practices of actors must also be observed (Gobo 2011; Silverman 2011). This is an important consideration, as it is not uncommon for “persons to say they are doing one thing but in reality they are doing something else” (Corbin and Strauss, 2015, p.41).

Observation is often differentiated in terms of participant and non-participant observation, with the former concerning observations where the researcher is carrying out a specific role. It is a dichotomy which scholars such as Atkinson and Hammersley argue is not useful, as this simple distinction implies that a non-participant observer plays no role at all (Atkinson and Hammersley 1994, p.248). These scholars draw attention to the more subtle classification of participant observer roles offered by Gold (1958, pp.219-222) i.e. the complete participant; the participant as observer, the observer as participant and the complete observer. Other scholars such as Mason, draw on the work of Coffey (1999) who suggests that researchers should be actively reflexive about their ethnographic selves rather than trying to locate themselves on a participant-observer continuum. In this study, the researcher adopted dual roles of ‘observer as

participant' and also of 'participant as observer' as opportunities presented during the research process (Gold 1958). Further details are provided in the last paragraph of this sub-section.

Observation provided the opportunity to gain insight into the physical and social contexts in which cancer service encounters take place. These insights could not have been gained solely through interview data, particularly as the vast majority of interviews were conducted in a room which was outside of clinical areas and treatment areas. The researcher was of the view that the cancer service experience could not fully be appreciated without awareness of these contexts, particularly given the physical nature of treatments which patients received i.e. chemotherapy, radiotherapy. Undertaking observation prior to conducting semi-structured interviews enabled the researcher to gain familiarity with the research context, to refine the study design and consider practical as well as methodological considerations i.e. privacy, feasibility of conducting observations within busy clinical environments.

Having previously worked in a health care setting, the researcher was mindful of the number of gatekeepers which exist in a health care setting to safeguard patients. The researcher perceived that access to patients within Hospital A would require an ongoing process of negotiation at a range of levels within the organisation i.e. senior management through to individual ward/unit or individual staff member. Observation, whilst providing the researcher with insights into physical and social contexts, was also viewed as an opportunity to establish relationships with staff and as a possible means of facilitating access and recruitment to the study.

In light of the setting within which this research study was conducted, the researcher had anticipated that observations undertaken would be overt, and completed in the role of observer-as-participant. This would take the form of shadowing staff in their daily work as well as observations within wider clinical settings. It was necessary, however, for the researcher to move skillfully between

a variety of observer roles, rather than taking a “once and for all decision” on the approach (Coffey 1999; Mason 2002, p.92).

After negotiating ethical approval and access to the study site, the nature of the planned observations widened. In addition to the ‘purer’ forms of observation outlined above, the researcher was invited to administer patient experience questionnaires on behalf of Hospital A for a period of three months. The researcher administered approximately 75 patient experience questionnaires during a three month period (January-March 2014) in four different areas of Hospital A (2 wards, 1 day unit, main outpatients department). This additional activity granted the researcher greater legitimacy in terms of role and presence in clinical settings, than had been previously anticipated. This also potentially widened the extent of observations to incorporate more ‘covert’ observations, whilst the researcher was in this hybrid role of researcher/temporary staff member. Further details regarding the nature of observations undertaken in this study are provided in Section 2.4.

1.2.5 Interviews

Qualitative interviews, also referred to as intensive or in-depth interviews (unstructured or semi-structured), are one of the most widely used methods for collecting qualitative data (Bryman 2004, DiCicco-Bloom and Crabtree 2006). Interviews may be used to gain understanding of individuals’ knowledge, views, experiences and interpretations, which make up the social reality of what is being studied (Mason 2002, p.63). Interviews have been defined by Rubin and Rubin (2005, p.5) as: “[...] conversations in which a researcher gently guides a conversational partner in an extended discussion.”

The term ‘conversational partner’ is used by these authors to emphasise the active role of the interviewee as well as the co-operation between the interviewer and interviewee during the interview process. This term is also used to highlight the uniqueness of each individual in terms of knowledge and the manner in which they interact. This latter point is important as this requires the researcher to be flexible

and customise questions accordingly in accordance with the knowledge of the 'conversational partner' and those topics which the interviewee is comfortable discussing (Rubin and Rubin 2005, p. 14). In other words, one approach or 'cap' will not or should not fit all. Flexibility and sensitivity were key within this study due to the wide range of participants involved in this study and the potentially difficult and emotive nature of the cancer service experience.

One of the most commonly used interview formats for qualitative research is semi-structured interviews (DiCicco-Bloom and Crabtree 2006). Semi-structured interviews are an approach which aim to evoke the perspectives of importance to respondents rather than the direction dictated by the researcher, as may be the case with more "structured approaches" (Barbour 2008, p.119). When adopting this method, the researcher uses an 'interview guide' i.e. a list of questions, prompts and topics to cover during the conversation. The format of these interviews, can be flexible to enable the researcher to follow trajectories in the conversation which may stray from the guide when appropriate. It is a style of interviewing which may be particularly useful when researchers have only one opportunity to speak to someone (Bernard 1988 cited in Cohen and Crabtree 2006, Cohen and Crabtree 2006).

Semi-structured 'in-depth' interviews were the choice of approach adopted in this study and were used to encourage participants to share rich descriptions of the study phenomena (DiCicco-Bloom and Crabtree 2006). The rationale for selecting this approach was to increase understanding of 'value' and trajectories of 'value' based on the meanings held and attributed to these phenomena by service users and service providers within a cancer service context. (Tong et al 2007, p351). As the researcher was interested in understanding phenomena from the perspectives of study participants, rather than seeking some form of 'truth', no attempt was made to corroborate interview accounts against any formal documents i.e. medical records. Additionally, the researcher was aware that interview data may confirm previous accounts but can also highlight discrepancies and alternative interpretations. This was found to be the case in this study in relation to negative accounts of service use. Contrasting staff views regarding the nature of service

offered within the Centre were also found i.e. nurturing patients Vs disempowering patients.

Section 2: The research experience

This second section of the chapter discusses some of the main issues the researcher encountered as a result of adopting the range of methods outlined in Section 1.

2.1 Selection of the case study site

Before moving to discuss the choice of case study site, it is useful to provide a brief overview of how this particular research study evolved. This study developed initially in response to a call for a funded PhD studentship in Cardiff Business School, exploring patient engagement within healthcare improvement. Early into this programme of study, the researcher became interested in the area of services marketing, specifically the empirical application of the S-D logic framework, as a potential conceptual framework from which to explore service user engagement and experiences within health care (Vargo and Lusch 2004, 2008).

This developing interest coincided with the publication of work within public management which drew upon the service literature and advocated that an alternative approach 'public service-dominant logic' should underpin public management theory (Osborne et al 2013). At this point in time, it was apparent that the majority of work undertaken in relation to S-D logic was predominantly conceptual with very limited empirical applications of this framework within a health care context. The researcher viewed this as a potential gap in the emergent literature and sought to undertake exploratory work to investigate the extent to which the S-D logic framework mapped across to a health care setting.

The opportunity to undertake research exploring the application of this literature within a health care context first arose in May 2013. The researcher was aware that a programme of work was underway across Wales in relation to measuring and capturing patient experience and had started to explore opportunities for access within health care sites. The researcher was keen to undertake empirical work within

a specialist service context. The rationale for selecting a specialist service context mainly concerned the under-researched, prolonged period of engagement that patients have with this type of service and the potential to explore patient experiences and perceptions of value across the service journey (McColl-Kennedy et al 2015).

A member of staff within the Business School provided the researcher with a named contact at a specialist cancer centre (Hospital A) in May 2013. Meetings were subsequently held with the named contact and a senior manager at the Centre, who expressed interest in the researcher's proposed area of study. This presented an ideal opportunity to potentially pursue empirical research within a UK specialist health care context. Formal access to this case study site was subsequently negotiated. Relevant ethical approval was also sought and granted (see Appendix 4). Further details are outlined in section 2.2.

Case study features

The case study site (Hospital A) is one of the ten largest specialist tertiary centres in the UK. This Centre serves a population of around 1.5 million people and delivers a range of services (i.e. chemotherapy, radiotherapy, palliative and supportive care) through inpatient, day case, and outpatient services (Hospital A Carer consultation strategy document 2012-2015, Hospital A Annual report 2014/2015). There are over 670 staff within the Centre who provide approximately 60,000 radiotherapy sessions per year, 45,000 outpatient appointments and 22,000 day cases (Hospital A Annual report, 2015). The Centre also has approximately 5,000 new referrals and 50,000 new outpatients each year (Strategy document 2012-2015, Hospital A Annual report 2015). As a specialist cancer centre, this organisation could be seen as patient and carer facing, with strategy documents and annual reports emphasising such a focus (Carers information consultation strategy document 2012-15).

The specialist centre encompasses a range of departments and units including: inpatient units, two chemotherapy day units, a clinical trials unit, a radiotherapy trials unit, main outpatients' department, radiotherapy outpatient provision, planning

department, therapies, palliative care and supportive care). The Centre also has three inpatient wards and a total of 47 beds. The bulk of care, in the Centre, however, is provided on an outpatient or day case basis.

An interesting feature of the Centre is its physical layout. The majority of units and departments are connected by one long corridor, with various offshoots, (mainly to radiotherapy departments) which extend between chemotherapy based services down to the main outpatient and planning department. The corridor is an interesting aspect of the Centre that staff and patients refer to in semi-structured interviews and appears to be viewed as an “in-between” space where business is done and service is provided i.e. staff arrange meetings/discuss issues, patients looking lost are identified by staff and escorted to the appropriate destination.

Although this study focuses on a single case study site (Hospital A), the selected site is a complex entity. The nature of the specialist centre, as outlined above, required exploration of the phenomenon of interest in this study (‘value’ and value co-creation processes) from a wide range of patient and staff perspectives within this organisation. Additionally, as the ‘boundary’ around the specialist centre is viewed as permeable within this study (see section 1.2.1), cancer service encounters external to the specialist centre that contributed to the case history of patient participants are also explored. In doing so, this study gained insight into value and value formation (positive and negative) across the spectrum of cancer service encounters during the cancer service experience instead of being confined to one specific ward, unit or organisation. This broader approach could increase the transferability of findings to other similar research contexts, and potentially other professionally knowledge intensive industries.

2.2 Access negotiation

The negotiation of access to study sites and subjects, as well as good understanding of sampling strategies (discussed in section 2.3) are viewed by Devers and Frankel (2000) as critical parts of the research process. Negotiating access can, however, be time consuming and require the researcher to demonstrate both credibility and

trustworthiness to a range of potential 'gatekeepers' in order to secure permission to undertake the research (Devers and Frankel 2000). During this study, identification of gatekeepers and the building and maintenance of relationships with these staff, within and across the specialist centre were central activities throughout access negotiation and fieldwork processes. Whilst these points may seem somewhat obvious, their importance in this study should not be underplayed. The nature of the relationships the researcher secured in the early phases of the study, whilst essential for facilitating access to the site and study participants, also influenced the extent of data collection. These points are elaborated on in the subsequent sections.

2.2.1 Overview of the stages of access negotiation

Access negotiation in this study was essentially a two stage but ongoing process. It should be noted that these stages of access negotiation, whilst differentiated for ease of discussion, had periods where they overlapped (i.e. during the setting up of observation and shadowing opportunities). The first stage of access negotiation was concerned with gaining entry to the study site and attaining relevant ethical approval to undertake the study within the organisation. First, access to undertake observation or shadowing in clinical settings was sought in order to enable the researcher to gain familiarity with the context in which cancer-related service was provided, and also to assist with identifying gatekeepers in the organisation.

The second phase of access negotiation was far more resource intensive in terms of the researcher's time, than was the first phase. In addition to having the approval of department, unit and ward managers, the researcher also needed to seek permission to access study subjects from staff working within the range of clinical settings. Access negotiation at these differing organisational levels was an ongoing process. This was partly due to the changing faces of staff, as many staff worked shifts, hence a requirement for the researcher to continually introduce or reintroduce herself in some settings. This was also dependent on how 'well' patients were (particularly on the inpatient units) and the workload of staff i.e. the ratio of staff to the number of patients requiring monitoring, treatment or review.

Given the nature of this 'shifting' service context, it was not always possible to arrange access in advance to clinical settings, with this often negotiated on a daily basis. Indeed, securing access on one particular day to a clinical setting i.e. inpatient unit/ ward or day unit did not guarantee access the next day, or even later that week. In light of this, the researcher had to be flexible in terms of strategies to seek access, as well as sensitive to the needs of both staff and patients within the organisation.

The researcher considered carefully whether she should inform staff and patients that she had previously trained and worked briefly as a nurse (although this was more than 20 years ago), or whether she should present herself as a research student. This was partly due to uncertainty on the part of the researcher whether this information would help or hinder the research process. The researcher did not want her previous nursing background to adversely affect any contact with staff within the organisation.

The researcher anticipated that she would be 'quizzed' by staff within the organisation regarding her previous background, potentially as a means of protecting the interests of patients and also of assessing the credibility and trustworthiness of the researcher. In light of this, the researcher introduced herself to staff and patients (and family members) as a research student (outsider) and outlined that although she had trained and worked as a nurse many years ago, she had no experience of working within or attending a specialist cancer centre. The researcher emphasised in these conversations the importance of staff and patient views and that she had much to learn from participants sharing their experiences and knowledge of this service setting.

Sensitivity was required on the part of the researcher to ensure there was a balance between: (i) reassuring staff that the researcher would act in a professional manner in clinical settings due to previous work experience, and (ii) not overstating the extent of this experience. The researcher took care to present herself as a research student, who had undertaken a range of different jobs (of which nursing was one), with a specific interest in undertaking research in a health care context from the perspectives of people working within and also receiving a service.

This approach seemed to put most staff and patients at ease, in terms of providing assurances that the researcher would be sensitive to the needs of patients as well as the demands of a busy clinical environment. In one instance, this also alleviated concerns that the researcher was actually an external consultant conducting a 'time and motion study'. The researcher perceived that her previous nursing experience, although limited, was advantageous and assisted, rather than hindered, access negotiation and recruitment to the study.

2.2.2 Stage 1-Negotiating access to the organisation

The researcher first gained 'access' to the specialist centre through a named contact provided by a member of Cardiff Business School Staff in May 2013 (as noted earlier in section 2.1). The proposed research was received positively by the named contact, because it had the potential to contribute to wider understandings of patient experience within Hospital A. Following this initial meeting, a further meeting was scheduled with a senior member of the management team in Hospital A in September 2013. Access to the specialist centre was agreed in principle.

As the researcher did not have experience of working within, or attending, a specialist cancer centre, a 'shadowing experience/observation,' was agreed, prior to formal approval of study documentation. This would enable the researcher to gain familiarity with the organisation and refine the research design of the study as needed. Informal access was granted in September 2013, after which clearance for the researcher to work within Hospital A was sought from and granted by the Disclosure and Barring Service. Moreover, an honorary contract was drawn up for the researcher by the Human Resources department within Hospital A. Without these documents, the researcher would not have been able to undertake fieldwork without the direct supervision of a member of staff.

Formal access to Hospital A was also subject to approval from two other senior managers and the research and development department within the health care trust that the specialist centre was located. A series of meetings were held in October 2013 between the researcher and these various staff members to discuss the

proposed study, the nature of ethical approval required to undertake the study, and the required processes for ensuring the work complied with organisational governance regulations.

In addition to meetings with senior management/senior research and development staff, the researcher also attended one of the monthly meetings of the Patient Liaison Group (PLG) within Hospital A in September 2013. This provided an opportunity to introduce the proposed study and to seek views from patient representatives. The PLG was supportive and the researcher requested input from this group at a later stage once study documentation was in final draft form. Following this meeting, the PLG invited the researcher to attend a regional patient and cancer carer research network. This provided the opportunity to gain early insight into patient and carer experiences beyond the specialist centre and to meet with a range of staff from Hospital A.

Permission to commence the interview phase of the study within Hospital A was granted after three conditions were met: (1) the study documentation (including the study proposal, participation information leaflets and consent forms) were approved in terms of organisational governance requirements, (2) the Trust Research Risk Review Committee were aware of the work which was to be undertaken, and (3) ethical approval was granted by Cardiff University. The final go ahead to commence study recruitment was given at the end of March 2014.

2.2.3 Stage 2-Negotiating access to clinical settings and study participants

On returning to Hospital A in January 2014 to undertake preliminary observations, the researcher was invited to spend time with a named staff member in the supportive care team. The daily work included observing the administration of patient experience questionnaires. The researcher was subsequently invited to participate in the administration of the patient experience questionnaires and did so until the end of March 2014. Although the questionnaires were designed for self-completion, they were administered face-to-face by staff within Hospital A.

Administering the questionnaires was incredibly valuable, as this widened the scope of planned observations in this study and assisted with building relationships with staff across the organisation. This activity became a useful tool for negotiating access to clinical settings. In addition, it also provided the opportunity to speak directly with patients about experiences of service use, prior to commencing the interview phase of the study. This activity potentially contributed to perceptions of credibility and trustworthiness of the researcher within the organisation, in terms of being 'approved' or given authority to 'speak' with patients (and family members) and undertake work on behalf of Hospital A. These points are illustrated with two specific examples below.

The first example relates to access to 'inpatient' units within Hospital A. After meeting with one of the managers of two of the inpatient wards and viewing the physical layout of all three inpatient wards, it was apparent that the researcher would be unable to undertake 'overt' observations in these areas (i.e. patients were in individual rooms, shared rooms or shared 'bedded bay areas'). The manager expressed concerns about 'shadowing' in these settings and implied that there needed to be a legitimate reason for presence on the wards, (Field research notes January 2014). Fortuitously for the researcher, this legitimacy, presented itself in the form of administering patient experience questionnaires.

The second example relates to the researcher being invited (by the named staff member and manager of the supportive care team) to attend two meetings (March 2014) in the organisation which related to patient experience. Although the researcher was introduced in these meetings as a research student, she was thanked publicly for her involvement in the administration of the questionnaires and contribution and invited to comment on specific questionnaires. This public acknowledgement of the researcher's contribution, in addition to the physical location of the researcher, potentially created a perception of the researcher as a 'temporary insider'.

The researcher was mindful that adopting the role of 'temporary insider' had potentially negative as well as positive implications. The main concern was that

perceptions of the 'independence' of the researcher from 'Hospital A' could be compromised. Care was taken to inform patients and staff that the researcher was administering questionnaires on behalf of Hospital A, but was also undertaking a separate study of her own. This approach provided the researcher with opportunities to clarify her role within the organisation, discuss her own work and negotiate access to clinical settings.

The researcher was aware of her potential influence upon the specific study context, when undertaking work on behalf of Hospital A. After conducting patient experience questionnaires within one setting, the researcher had several requests from patients for additional information regarding aspects of their treatment. The researcher had been advised by the named staff member and manager of the supportive care team to act on these requests and inform staff accordingly. These requests were fed back to the named staff member in the supportive care team, who subsequently considered taking an information 'trolley' through specific units to assist with patient information requests. Although at times such as this it was difficult not to potentially influence the nature of service provision, the researcher took care when undertaking work on behalf of Hospital A to remain as objective and neutral as possible.

As the researcher's knowledge of the range of 'gatekeepers' across Hospital A grew, she was able to identify the key players with whom access would need to be negotiated. A range of approaches were used by the researcher to contact these staff, which included introductory emails and requests for meetings, telephone and face-to-face requests. In some instances, informal introductions from other staff members facilitated access. The researcher met with a wide range of department, ward/unit and team managers as well as senior clinical, medical and nursing staff across the organisation between October 2013 and July 2014. The researcher also gave brief presentations on her work and proposed area of study at three departmental meetings. A breakdown of these meetings is provided in Table 4.

Opportunities to negotiate access (to undertake observations and later recruit study participants) increased as the researcher became more widely known across the organisation. On one such occasion, the researcher was invited to spend time on an

inpatient unit observing a nurse-led ward round after speaking with the ward sister in the cafe at lunchtime. During this particular observation, the researcher was invited by a different senior nurse to attend the lunchtime Acute Oncology Service (AOS) meeting being held that day. The researcher was introduced to a wide range of clinical, nursing and medical staff at this AOS meeting, which led to additional invitations to: (i) observe palliative care team multi-disciplinary meetings and ward rounds, and (ii) to attend a cancer-site specific multi-disciplinary team meeting (Upper-Gastro Intestinal cancers) and give a brief presentation of the researcher's proposed study. These activities all assisted with the later recruitment of patient and staff study participants.

Table 4: Summary of meetings during second stage of access negotiation

Dates of Meeting	Nature of meeting	Number of hours
		17 hours of meetings (see below)
October 2013	Therapies team	4
February 2014	Supportive care team manager	1
March 2014	Senior nurses meeting	2
April 2014	Volunteer manager	1
April 2014	CTU meeting with unit and dept. manager	1
May 2014	Radiotherapy services manager	1
May 2014	MDT meeting upper GI (presentation)	1
April 2014	Outpatient manager	0.5
April 2014	Radiotherapy reviews clinic	0.5
April 2014	Manager two inpatient units	0.5
April 2014	Chemotherapy services manager	1
April 2014	Manager/Senior nurse Day unit	0.5
April 2014	Team meeting Day unit	0.5
June 2014	Acute oncology service lead	0.5
June 2014	Radiotherapy staff meeting (presentation)	1
July 2014	Therapies team meeting (presentation)	1
		Observations in relation to meetings recorded in field notes / research diary

Hospital A proved to be a very generous host in terms of general support for the researcher's doctoral work and the resources offered to the researcher (i.e. staff time, use of an office to conduct semi-structured interviews). By employing the mixture of strategies outlined in this section (observation, meetings, presentations and administration of patient experience questionnaires); careful building of

relationships with centre staff, perseverance and potentially the previous experience of the researcher, access was established throughout Hospital A.

2.3 Participant sampling

It has been argued that all sampling in qualitative research can be classed as forms of purposive sampling, where the sample is selected intentionally based upon the needs of the study (Barbour 2008). Purposive sampling has been defined as an approach to sampling which relies on “selecting interviewees or focus group participants by virtue of characteristics thought by the researcher to be likely to have some bearing on their perceptions or experiences” (Barbour 2008, p.52). It is an approach which enables the researcher to select a case as it illustrates a feature or process in which they are interested (Silverman 2015, p.60). This is the form of sampling adopted within this study.

Whilst it is difficult to establish the appropriate sample size in qualitative research, given this should be based on “theoretical saturation”, (Bryman 2004, p.334), it has been suggested that 20-60 knowledgeable individuals may be a sufficient number to gain understanding of any specific lived experience (Bernard and Ryan 2010, p.360). Sampling stopped in this study only when a thorough understanding of the phenomenon under study had been gained (Kuper et al 2008a). The total number of participants in this study amounts to 96, of which 56 were patients (29 male, 27 female), 16 family members or a friend (3 male, 13 female) and 24 health care staff (7 male, 17 female). Participant characteristics are presented in Appendix 2 of the thesis. For patients this includes: gender, age, length of time diagnosed, length of time a patient at Hospital A, whether treated as an inpatient or outpatient and reported cancer site. For family members (including a friend), this includes gender, age and relationship to the patient. For staff this includes gender, age range, length of time worked at the Centre and roles. A depersonalised profile of interview participants indicating type of participant, sex and age is provided in Appendix 3. The role of staff is not provided in the table in Appendix 3 as this could potentially compromise anonymity of participants. Further details of the patient, family member and staff samples are provided in sections 2.3.1 and 2.3.2.

2.3.1 Patient participants

The sample of participants invited to take part in this study were patients (including family members when in attendance) using both inpatient and day/outpatient treatment facilities (15 and 41 patients respectively) at Hospital A. The perspectives of patients who had previously received treatment at Hospital A were also sought via Hospital A's Patient Liaison Group (PLG). This enabled a longer term perspective on the nature of the cancer journey to be gleaned, outside of the treatment period. The researcher attended a PLG meeting in October 2013, where a one page summary of the proposed study was presented and discussion invited. A member of the PLG specifically asked if the views of 'ex-patients' would also be sought in the proposed study, and suggested that this was a very important perspective not to be excluded from the study. In light of this, members of the PLG were invited to participate in the semi-structured interviews.

The sampling approach adopted in this study was refined during the first three months (January to March 2014) of the researcher entering the organisation. Before undertaking observation, administering patient experience questionnaires and spending time within Hospital A, the researcher had considered focusing on one particular unit or ward within the organisation. It was apparent, however, after spending time in the range of departments/units within Hospital A and after meeting with staff and patients across the organisation, that such an approach would not reflect the range of cancer-service encounters and patient experiences within the Centre. For example, the perceptions and experiences of a patient receiving only radiotherapy treatment could differ to those of a patient receiving only chemotherapy, which in turn could differ from those of a patient receiving multiple treatment interventions. Variation could also be apparent in relation to type of attendance at the Centre (i.e. inpatient or outpatient) and whether patients were undergoing experimental treatments rather than more 'established' treatment regimens.

In light of this, patients were selected on the basis of: treatment type and setting; outpatient or inpatient status, gender and length of time they had been a patient at

Hospital A. Type and site of cancer was not a criteria for selection, but the researcher aimed to recruit patients across a range of cancer groupings, to reflect the potential range of patient experiences (i.e. breast, prostate, head and neck cancer etc.). The rationale for adopting such an approach was to ensure coverage of the diverse range of patient experiences across the organisation rather than attempting to produce a representative sample (Barbour 2008).

The patient sample included similar numbers of patients from a range of service areas across Hospital A (i.e. 13 chemotherapy outpatients, 13 radiotherapy outpatients, 15 inpatients, 12 trials patients) to enable a range of patient experiences to be explored across the organisation. This sample additionally included three participants who had previously received treatment at the Centre. There was variation within the sample selected to reflect the range of patient perspectives and experiences within the specialist centre needed, to include those of: very new patients (i.e. less than 2 months, 15 participants); relatively new patients (i.e. between 3 and 6 months, 8 participants, not known approximately 6 months, 1 participant); more established patients (i.e. between 6 months and 3 years, 21 participants) and 'experienced' patients (i.e. 6 years or more, 11 participants). Further details are provided in Appendix 2.

As treatment is predominantly provided by the specialist centre on a day or outpatient basis, larger numbers of the patient interview sample (21 male, 20 female) were selected from this category of attendance when compared with those attending as inpatients (7 males, 8 females). The researcher was mindful that patients in this latter category (inpatients) were likely to be less well than those seen on an inpatient basis and anticipated recruiting smaller numbers of this sub-sample of participants.

Additionally, six of the patients included in the sample had experienced a reoccurrence of cancer and were attending the Centre for the second or third time. In four of these instances, participants were discharged from Hospital A in between the separate occurrences of cancer. The time that these four patients had been attending the Centre was calculated from the most recent treatment referral rather

than first contact with the specialist centre. The length of attendance time at the specialist centre was, therefore, largely indicative but not always completely representative of the total time that patients had attended Hospital A.

Although this study did not attempt to recruit patients on the basis of age or cancer site, the demographic of patients in this study shares some similarities to those of respondents in the Welsh national cancer patient experience 2013 survey (Quality Health 2014). The vast majority of patients in this study sample (56 participants) are aged 50+ (91%) with 74% of this group of participants between 51 and 75 years of age. Similar sample characteristics are apparent in the Welsh 2013 cancer patient survey (7352 participants), where 92% of participants were aged 50+, with 68% of those participants between 51 and 75 years of age. This similarity does not hold, however, when the age bands of participants are broken down further (i.e. 51-65, 65-75). Variation was found in this study in the cancer-site that patients reported, with breast cancer (15 females) and prostate cancer (10 males), the most commonly reported. This again is similar to the sample in the Welsh national cancer patient experience survey, which had higher number of participants with breast and prostate cancer (as well as colorectal and lung cancer). Diversity in terms of ethnicity of patients is also extremely limited in this study (100% white British participants) and also in the national survey (99% white British participants).

Family members (including 1 friend) of patients were not sampled on any basis. These participants were invited to take part in interviews if they were present when patients were approached by the researcher and informed of the study, or if a patient requested their attendance. The majority of family members were the patient's spouse or partner (3 male, 10 female). Characteristics of family members are summarised in Appendix 2.

2.3.2 Staff participants

The sample of staff was drawn from a range of staff groupings involved in patient treatment and care across Hospital A (i.e. 7 nursing; 3 radiotherapy; 4 therapies; 2 support; 4 medical/clinical, 1 management and 2 volunteer staff). Given the

difficulties freeing staff up from activities to participate in interviews, whilst attempts were made to be representative of staff groupings in the sample recruited, the staff sample could be viewed as a 'convenience sample'. In addition to this approach, the snowball technique was adopted and staff were also identified through the recommendations of staff informants within Hospital A (Corley and Gioia 2004). The access negotiation process outlined in section 2.2 assisted with the identification of named staff who could contribute to the interview phase of the study. Issues regarding the recruitment of staff and strategies employed to facilitate recruitment to the interview phase of the study are discussed in Section 2.4.2.

2.4 Data collection

A range of data were collected in this study (observational and interview data), and these are summarised in Table 5.

2.4.1 Observation

Insight into the cancer service experience began for the researcher in the six month period prior to conducting the semi-structured interviews within Hospital A (as discussed in section 1.2.4 and 2.2.2). During this time, the researcher met with a range of staff across the organisation, attended meetings (department, team and organisation level), observed in a number of treatment-related settings, and administered patient experience questionnaires on behalf of Hospital A (see breakdown in Table 5). These 'experiences' enabled the researcher to have a greater understanding of both the service setting and service experience contributing to value formation that may not have been gleaned purely through interview data.

As discussed in section 1.2.4 and section 2.2.2, the collection of observational data was wider and deeper than initially anticipated. The combination of overt and more covert observations (during the administration of patient experience questionnaires) culminated in nearly 100 hours of observations (See Table 5 for detailed breakdown). A research diary was maintained throughout this study which included contextual details such as settings, nature of activities undertaken and emergent ideas.

Table 5: Range of data collected

Data source	Type of data	Nature of the data
Observations Sept. 2013 Jan.- July 2014	Total hours of observation Overt observation: 2 chemotherapy day units Shadowing member of supportive care team 1 inpatient unit nurse-led ward round (chemotherapy inpatient unit) Planning department, radiotherapy treatment and mould room 2 consultant led outpatient clinics 1 nurse-clinician led outpatient clinic 1 Palliative care team ward round and team meeting 2 Palliative care team meetings 1 multi-disciplinary ward based meeting 1 patient education pre-treatment session (chemotherapy) 1 Acute oncology service meeting Shadowing receptionist/reception area two inpatients wards Psychology team, 1 OP appointment and 1 patient support group Radiotherapy reviews clinics Covert/Partial participant observation: Observations during administration of 70-75 patient experience questionnaires (see next page) 2 organisation level meetings i.e. Dignity group meeting, Patient experience group meetings	90.5 hours (see breakdown) 57.5 hours (see below) 9 5 1.5 5.5 8.5 4 3.5 3 1 1.5 1 2 6 6 33 hours (see below) Approx. 30 hours 3 (2 x1.5)
Patient experience questionnaires (see observations above)	January to March 2014 Observations noted by the researcher whilst administering approximately 75 patient experience questionnaires on behalf of Hospital A. The questionnaire comprises mainly structured questions but has two open ended questions. Questionnaires took on average between 15 minutes to 30 minutes to complete depending if patients wished to discuss 'other issues'.	Questionnaires administered in 5 settings: Main outpatients, 2 chemotherapy day units, 2 inpatient units. Observations noted during questionnaire administration were incorporated in the researcher's diary/ field notes and subsequent data analysis.
Interviews	81 interviews in total (fully transcribed) 40 Patient only 1 combined patient/patient interview (2 spouses) 1 family member only *15 Patient and family member/friend combined 24 Staff	Total of 2930 mins (approx. 49 hours) of recorded interview data 2001 mins patient/family member 929 mins staff 1309 pages of transcribed text (508,372 words)
Research diary/ Field notes	Researchers field notes pertaining to observations, process of administering patient experience questionnaire data and semi-structured interviews.	Research diary/field notes document 108 pages/ 34,166 words in length
Meetings/ presentations (see breakdown in Table 4)	Meetings/presentations to familiarise the interviewer with the organisation, to introduce PhD work and to facilitate recruitment to the study. 16 'formal' meetings with staff across Hospital A 3 presentations given by the researcher at 3 of the 16 meetings	17 hours Observations in relation to meetings recorded in field notes/research diary

*1 patient was interviewed on two occasions. The first time alone and the second time with a friend

This form of documentation facilitated the recording of feelings, thoughts and observations to be recorded as soon as possible after they were encountered. This was also a useful tool for reminding the researcher of events and happenings during subsequent research phases.

In this study, the process of undertaking observations was closely related to that of negotiating access within the Hospital A. Whilst undertaking observations, the researcher moved between the roles of 'participant as observer' (temporary-insider) and 'observer as participant' (outsider) depending on the nature of the activities she was involved in (i.e. administration of patient experience questionnaires, attending a meeting) and also the setting. These issues are discussed in section 1.2.4 and 2.2 of this chapter so are not elaborated upon further here. It should be noted, however, that in addition to 'role shifting' during the conduct of observations, the researcher moved from the role of 'temporary-insider' to 'outsider' once she commenced the interview phase of the study. This necessary shift in roles assisted with the identification of the researcher's study as relevant to but independent of the work of Hospital A. This potentially put participants at ease when sharing their views and experiences during interviews.

2.4.2 Interviews

A total of 81 semi-structured interviews were undertaken which included 96 participants (56 patients, 16 family members/friend, 24 staff). One of the family members was also a patient. One patient was interviewed on two occasions, first alone then in a follow-up interview with a friend. One patient and family member were interviewed separately, at the request of the spouse. One interview although initially intended as an interview with a patient and family member (spouse) was an interview with two patients, as it transpired the spouse was also a patient. In the words of these participants, this particular interview was a "two for one!" (Interview 4).

Although sixteen of the patients participating in this study had a family member or friend also attend the semi-structured interviews, the level of participation of family

members in the interviews varied, and ranged from minimal to active involvement in the discussion. A summary of the type, number and length of interviews is provided in Table 6. As can be seen from Table 6, the majority of patient and patient/family member interviews were between twenty and forty minutes in length (n=37). Similar findings were also apparent for staff interviews.

Table 6: Summary of participant interviews

Type of interview	Length of interviews	Number of interviews
Patient only	Range 13-77 minutes	
	13-20 minutes	4
	21-30 minutes	12
	31-40 minutes	15
	41-50 minutes	6
	51-60 minutes	1
	60+ minutes	2
Patient-patient (spouses)	87 minutes	1
Patient and family member/friend	Range 17-87 minutes	
	17-20 minutes	1
	21-30 minutes	4
	31-40 minutes	4
	41-50 minutes	5
	51-60 minutes	1
Family member only	29 minutes	1
Staff interviews	Range 17-76 minutes	
	17-20 minutes	1
	21-30 minutes	4
	31-40 minutes	13
	41-50 minutes	4
	50 minutes+	2

Interview conduct

A semi-structured interview approach was selected as the most appropriate choice of interview method in this study. The rationale for this choice of method is outlined in section 1.2.5. In addition to using this approach to elicit rich descriptions of the study phenomena, this approach was also selected for pragmatic reasons. The researcher anticipated that she would only have one opportunity to interview patients (and family members). The majority of patients attended for interview immediately after undergoing treatments or an hour before their appointments for treatment/follow-up, hence time was of the essence. Similarly, the majority of staff could only guarantee between thirty minutes to an hour of their time for interviews.

The researcher did not wish to 'over burden' patients (and family members) nor did she wish to impact on the work commitments of staff. Semi-structured interviews provided the opportunity to maximise discussion of issues of relevance to the study with all participants in a timely manner. A guided but flexible approach to conducting interviews was, therefore, employed. Using open-ended questions, study participants were encouraged to discuss issues pertinent to the key research questions, which focused on the four S-D logic axioms and five foundational premises of interest in this study. The researcher made conscious attempts to pose questions in a neutral manner, to minimise the potential of bias and also to encourage deeper reflection on the part of participants in relation to their thoughts, feelings and views.

Despite limitations in terms of space within Hospital A, one of the managers whose team the researcher had assisted in administering patient experience questionnaires, arranged for the researcher to have use of the Chaplain's office (a small non-clinical room containing a small sofa, chair and a desk and chair) two days a week to conduct the semi-structured interviews. This was invaluable in terms of providing a private and potentially 'neutral space' for participants to share their experiences. The majority of participant interviews were conducted in this room. Exceptions to this were interviews conducted with inpatients, which in all but two instances were conducted in private side rooms. The two interviews which were conducted in shared 'bedded bay' areas were done so on the insistence of the patients. In these two instances, the researcher also consulted with other patients in close proximity to request their permission to undertake the interviews. Nine of the staff interviews were conducted in Unit or Department Managers offices in close proximity to staff members' places of work. This choice of location was to facilitate staff recruitment and is elaborated upon at a later point in this section.

Inviting patients

Patient recruitment to the study was mainly undertaken through face-to-face discussions about the research project. Prior to approaching patients, the researcher consulted with relevant nursing and clinical/medical staff in the inpatient/outpatient facilities about the appropriateness of inviting/approaching patients to participate in

the study. Patients were initially identified and approached by a member of nursing or medical/clinical staff to ask if they would be happy for the researcher to provide further details about the study and what was required in terms of their contribution, should they wish to participate. If patients' family members were also in attendance at this time they were also invited to participate. Where family members were not present, the researcher asked patients if they wished to have a family member or friend present with them at the interview.

The downside of having staff members approach patients on behalf of the researcher, was that it was not possible to attain a picture of the numbers of participants who chose not to participate in the study. The upside, however, was that patients had an opportunity to refuse participation to a person other than the researcher, and so not feel coerced or obliged to take part. This was an important consideration given the dependency relationship which existed between patients and staff within Hospital A, particularly within inpatient settings.

In addition to the approach outlined above, the researcher gained permission to leave information leaflets about the study in the main radiotherapy waiting areas. Patients (and family members) in these areas were made aware of the researcher's location, should they to find out further details of the study and participate.

Inviting staff

Staff at Hospital A were invited to participate in the study using a number of different approaches which included: (i) the researcher meeting with managers and heads of departments, units or teams to introduce herself and discuss the study; (ii) e-mail invitations from the researcher sent via managers or heads of departments, units or teams; (iii) attendance of the researcher at relevant department, unit or team meetings during which an overview of the study was provided as well as an invitation to participate in the study; (iv) open 'drop-in' sessions located in close proximity to staff member work areas; (v) direct face-to-face invitation to participate on the basis of personal contact or recommendations of other staff and (vi) targeted email invitation to named staff recommended by other staff within the organisation. In

addition to these strategies which were used singularly or in combination, hard (paper) copies of information regarding the study (participant information leaflets) were left with department, unit or team managers.

Consent

All potential participants were provided with participant information leaflets which outlined what was required in terms of their contribution, should they wish to take part in the study. It was made clear to patients, family members and staff that participation was voluntary. Written consent was obtained from patients (and where applicable family members) and staff. All participants were informed that consent to participate could be withdrawn at any point and for any reason.

Three participants withdrew from the study after providing initial consent. All these participants were patients. Two patients withdrew because they became unwell in the time that elapsed between agreeing to participate and the interview slot. The third patient forgot about the interview slot and did not wish to reschedule for a future date.

Flexibility and sensitivity

In conducting research in a clinical environment, such as a specialist cancer centre, it was necessary for the researcher to be sensitive to the needs of staff and patients. Given the emotive nature of cancer; the potential gravity of this disease; the highly technical and specialised nature of service provision and the gruelling nature of treatment regimens that patients undergo to eradicate or manage this disease, it was important for the researcher to minimise the impact of study participation on all participants.

In terms of staff, it was important that they felt able to reschedule or rearrange interviews if wards or units were too busy. Having drop-in sessions for interviews was a useful way of achieving this, as staff could attend in accordance with their work schedule. Where necessary, interviews were condensed and key questions asked in order to optimise staff time and the relevance of interview data. Additional

considerations related to staff feeling at ease with the researcher and their willingness to openly share views and experiences. As the researcher had previously been introduced to, or spent time with, a number of the staff prior to conducting the interviews, opportunities had been provided to chat informally, which contributed to more relaxed interviews. Although some staff had previously encountered the researcher whilst she adopted the role of 'temporary insider', the researcher emphasised her role as an 'outsider' during the conduct of the interviews. Differentiating the purpose of this research activity as assisting in doctoral research, rather undertaking research on behalf of Hospital A, seemed to put staff at ease and encourage more open dialogue. A small number of staff shared views about the ethos and nature of service provision in the organisation which were negative i.e. the paternalistic nature of care provision whilst protecting patients also fostered dependency on the organisation.

Prior to commencing the interview phase of the study, it was agreed that patient interviews would be arranged in liaison with the supportive care team within Hospital A. This was to ensure that a member of staff from this team would be available if patients (including family members where relevant) required additional information or support. It was also agreed that if patients (and family members) became distressed or upset during interviews, the researcher would ask if they wished to stop and/or discontinue the discussion. Whilst recognising that patients and potentially family members had agreed to a 'confidential' discussion, in the event of becoming distressed they would be asked if they wished to speak to staff in the supportive care team to address any concerns and/or to be referred for other 'support services' which the Hospital A offered. In practice, neither of these 'safeguarding' approaches needed to be implemented during the conduct of the study.

Interviews with patients attending the Centre on an outpatient or day basis were scheduled for days that patients were already attending the Centre. This tended to be their next appointment slot. This approach minimised additional demands on participant's time as well as providing a 'cooling off' period in case they decided to withdraw from the study. As delays were possible in terms of completing treatment

regimens, particularly in radiotherapy where high volumes of patients were using the service each day, the researcher allowed an hour window either side of the allotted interview slot to accommodate potential delays. The researcher met with patients in reception areas prior to their treatment appointments to check if there were any delays and to assure participants that it was not problematic if their treatment over ran. The researcher also emphasised that it was not problematic to change their minds about participating if they felt tired, unwell or had a change of heart.

A slightly different approach was adopted in the inpatient units. The researcher was mindful that patients attending the Centre on an inpatient basis could feel obliged to participate in the study due to the intensive nature of care and treatment they were receiving in the Centre. As these patients were generally unwell, due to symptoms of their cancer, or were recovering from an acute period of illness (i.e. after an infection post chemotherapy treatment), the researcher was aware that their health status could change by the hour. This was managed in an inpatient setting through ward staff approaching patients on behalf of the researcher prior to agreeing to participate in the study and also prior to conducting interviews. This provided the opportunity for patients to withdraw from the study should they wish. An additional consideration in the conduct of interviews in this setting was how to handle concerns raised by patients if they related to current care provision, whilst still being respectful of confidentiality. After consulting with her PhD supervisors, it was agreed that unless patients expressed a wish to discuss their concerns with relevant staff in Hospital A, or were perceived as 'at risk' if no action was taken, that confidentiality of interview data would be maintained.

Reassurances of the nature outlined in this section were important in establishing relationships with staff, patients and family members prior to conducting interviews. As the content of the interviews concerned highly personal experiences, having study participants feel at ease with the researcher was a vital step in the conduct of the interviews. Prior to commencing the interviews, permission was sought to use a recording device. A small unobtrusive dictaphone was used in all interviews. The researcher did not take notes during the interviews, in order to facilitate more

natural conversations and limit potential reactivity to the researcher through taking notes. Any thoughts or observations were instead recorded immediately after interview completion into the dictaphone. The use of a recording device facilitated storage of rich qualitative data as well as allowing the researcher to reflect on her interview style and technique. Interviewing stopped when a point of theoretical saturation was reached, when interviews were only adding marginal increases to the researcher's knowledge and the findings (Eisenhardt 1989).

Pope and colleagues (2000) suggest that qualitative research, in contrast to popular beliefs, generates vast amounts of data. This was certainly the case in relation to the recorded interview data which was approximately 49 hours in total length. Once interviews were transcribed in full, this resulted in 1309 pages (single line spaced sized 12 font) of transcribed text (508,372 words).

Given the sensitive and personal nature of the interview topic in this study, the researcher's flexibility and responsiveness to study participants was very important. Four patients got upset during the conduct of the interviews when they described their cancer-related service experiences. In three instances this related to the nature of their cancer diagnosis and the impact this had upon their lives and family members. In the fourth instance, this related to the recall of a negative experience whilst being treated in a different hospital. In all of these instances, the researcher turned off the recording device and only recommenced the interviews at the request of participants. Three of the participants chose to continue with the interview. These participants indicated that it was helpful to be able to talk about and share their experiences, as these issues were not discussed at home for fear of upsetting family members. In the case of the fourth participant, the researcher chose not to continue the interview. All four participants declined the offer of speaking to a member of staff within the supportive care team in Hospital A. One staff member participant became emotional during the conduct of the interview; this related primarily to their sense of pride in terms of working within the specialist cancer centre.

The researcher also required a degree of resilience when conducting the interviews to absorb and reflect upon the range of experiences and views shared in this study.

Whilst many interview accounts recounted positive experiences of service use and in turn positive aspects of 'value', a number of patients shared highly personal and difficult experiences.

Interview content

Data collected primarily through semi-structured interviews often uses open ended questions as well as probes (Hsieh and Shannon 2005). Both of these approaches were adopted during the conduct of semi-structured interviews in this study. Patients and staff were invited at the start of the interview to provide background details regarding: (a) how they came to be a patient within the specialist centre and the nature of their experiences during their cancer 'journey', and (b) how they came to work at Hospital A; the length of time they had worked at the Centre and the nature of Hospital A as a place of work. A number of key open-ended questions were then raised in patient, family member and staff interviews, which related to S-D logic axioms and the foundational premises of interest in this study. These question prompts focused on: involvement in healthcare processes and decision making (FP1); identifying which aspects of care and treatment were important to the patient and how value was perceived and experienced by patients/patients and their family member and staff (FP6, FP10); the perceived nature of the service staff felt they offered (FP7), previous experiences of cancer and the range of resources drawn upon through the cancer journey (FP9).

In addition to open ended questions, probes (Hsieh and Shannon 2005) were used by the researcher to facilitate further discussion of topic areas (i.e. "Can you tell me more about that?") and to clarify the meaning of participant responses (i.e. "Could you explain what you mean by that?"). As the researcher had previously had a nursing background, she was conscious that her experiences of working in a health care context could influence her interpretation of participant responses. The researcher took great care to avoid this potential source of bias and whenever possible sought clarification of meaning directly from participants themselves.

The iterative nature of the qualitative research is one where data collection and preliminary data analysis collide (DiCiccio and Crabtree 2006). This means investigators are able to alter questions as they learn about the subject from their informants and, in some instances, depart from the planned itinerary and follow the interviewee's interest and knowledge. Questions found not to be effective in eliciting information can be refined or new ones added. Additionally, through comparing and contrasting sources of data, there is the potential to identify similarities and differences amongst the data and to explore emerging concepts which may not have been anticipated at the start of the research project (Silverman 2013). These points all have relevance to this study.

Eliciting responses regarding conceptualisations of 'value' from patients (and family members) required flexibility on the part of the researcher in terms of; the framing of the question, the interview style adopted and the inference of meaning from the data. The abstract nature of 'value' as a concept, necessitated 'value' also being framed in some instances as perceived benefit(s) or 'gain' from using the service or even more simply, what participants felt they had 'got out' or hoped 'to get out' of using of the service (Vargo and Lusch 2004, 2008; Lusch and Vargo 2014). In some instances, 'value' was not overtly discussed and participants discussed aspects of the service that mattered to them or conversely factors deemed as negative in previous experiences of healthcare. It was also evident in a small number of interviews that participants wished to 'share their story' and in such cases a more 'open' interview style was adopted with the researcher intervening only if interview topics were not raised by participants.

Although this study set out to explore conceptualisations of 'value' and to enhance understandings of trajectories of value and the processes underlying value co-creation (service exchange and resource integration), the researcher was mindful that value could be destroyed as well as created through service encounters. It became apparent during the administration of patient experience questionnaires within Hospital A and after the first five participant interviews (Interviews 2, 4, 5) that value co-destruction was a phenomenon of interest in this study. The identification

and comparison of subsequent contradictory evidence or deviant cases illustrating value co-destruction, led to further exploration of this concept, during data collection and analysis (Spiggle 1994). This refinement is further elaborated upon in Section 2.5.

2.5 Data analysis

Data analysis in this study commenced at the point of data collection as data already gathered influenced and informed ongoing data collection. Analytical categories were developed during the course of this analysis to describe and explain focal study phenomena. These categories were derived inductively, in that they were obtained from the study data as well as deductively, in that they were initially informed by the S-D logic framework as well as key concepts in the extant literature regarding 'value', value co-creation and value co-destruction (Pope et al 2000).

All interview recordings were played back several times during the course of the study, field notes were read and expanded upon and once transcribed, all transcripts read thoroughly. This allowed the researcher to consider tentative categories which could be refuted or confirmed during the main analysis of the study data (Braun and Clarke 2006). This analysis then followed the methods outlined by Spiggle (1994), which involved categorisation (classifying the data based on coherent meaning), abstraction (developing more encompassing and general categories), comparison (within and between categories) and dimensionalisation (conceptualising the finalised categories). According to Spiggle (1994), these are not discrete activities, they do not occur in an ordered sequential fashion, nor are they stages in the research process. These are data manipulation operations that can be used in the various stages of analysis through which researchers can:

“[...] organise data, extract meaning, arrive at conclusions, and generate or confirm conceptual schemes and theories that describe the data” (Spiggle 1994, p.493).

Before discussing data analysis in more detail it is important to first outline how data were stored and retrieved in this study.

2.5.1 Storage and retrieval of data

As alluded to earlier in this chapter, all interview transcripts were transcribed in full and all study participants allocated a pseudonym. Transcripts were individually password protected and stored on the researcher's personal computer. Pseudonyms were later changed to (at the point of writing up study findings) interview codes and participant identification numbers. As fifteen of the interviews had patient and family members, it was necessary to differentiate between study participants, hence participant identification numbers. Quotations taken from interview scripts are indicated by the letters *IN* followed by an interview code (between 1 and 81) and participant identification number, indicated by the letters *ID* and a participant code (between 1 and 96), i.e. *INT 4: ID 5*. Two interviews (Interview 9 and Interview 25), were conducted in two parts, and have additional notations of 'part 1' and 'part 2' after the interview codes.

A research diary containing typed observational field notes was initially stored as a password protected document on the researcher's computer. References to the field notes in the findings section of this thesis are indicated by the term 'Research diary', followed by the date of the observation. The researcher used NVivo 10 to assist with the management, categorisation and retrieval of study data. Given the vast nature of the data set it would have been difficult to undertake these activities manually.

2.5.2 Stages of analysis

There were four main stages to the analysis undertaken in this study. These are summarised in Table 7. Although for ease of reference they are described as discrete stages, in reality the movement was fairly fluid, as the researcher moved iteratively between data sources, data collection and analysis processes.

Stage 1. Value formation by foundational premise (see Table 7, column 1)

The initial categorisation of the data was predominantly deductive and informed by the S-D logic literature (Vargo and Lusch 2004, 2008).

Table 7: Data analysis process

Stage 1. Value formation by foundational premise	Stage 2. Preliminary dimensions by foundational premises and value co-destruction	Stage 3. Value co-creation (VCC) and value co-destruction (VCD) by emergent theme & dimensions	Stage 4. Value co-destruction (VCD) by episode (based on patient- reported data)
<p>FP1 AX1 - Service is the fundamental basis of exchange</p> <p>FP6 AX2- Value is co-created by multiple actors always including the beneficiary.</p> <p>FP7 AX2- Actors cannot deliver value but can participate in the creation and offering of value propositions</p> <p>FP9 AX3- All social and economic actors are resource integrators</p> <p>FP10- Value is always uniquely and phenomenologically determined by the beneficiary.</p> <p>Value co-destruction/Value can be co-destroyed through service exchange (FP1, FP6,FP9, FP10)</p> <p>OTHER</p>	<p>FP1 *Information asymmetry *Types of involvement *Capacity to exchange resources/Info.asymmetry</p> <p>FP6 *Manging expectations *Patient to patient value co-creation *Relationships *Value recovery</p> <p>FP7 *Value propositions staff *Expectations patients (Low, high, unknown)</p> <p>FP9 *Types of resources (personal, family, other) *Previous experiences</p> <p>FP10 *Interpersonal skills/care *Access and support *Timely access/responsiveness *Specialised and expert *Time for the patient *Trust *Emotional safety *Reduction of information asymmetry *Effectiveness of treatment *Time for normal life *Manging Expectations</p> <p>Value co-destruction *Lack of control *Delayed diagnosis *Dependency *Poor staff interpersonal/communication skills *Lack of access/relationships ended *Lack of knowledge/information asymmetry *Nature of information *Negative aspects of treatment *Organisational level issues *Negative patient interactions *Technical failure</p> <p>Other Organisation features/extra mile/behaviour/roles</p>	<p>1. ACCESS TO RESOURCES (VCC) Ongoing access and support (VCC) Specialist knowledge and skills (VCC) Timely access/responsiveness (VCC) Reduction of information asymmetry (VCD) Lack of access (VCD) Relationships ended</p> <p>2. QUALITY OF INTERACTIONS (VCC) Interpersonal skills/language of care (VCC) Person-focused care (VCC) Time for the patient (VCD) Poor staff interpersonal/communication skills (VCD) Negative impact of other patients (VCD) Quantity of interactions</p> <p>3. RESOURCE USE/RESOURCE MISUSE (VCC)Types of involvement (VCC)Types of resources (VCC) Capacity to exchange/ integrate resources (VCC) Nature of value propositions (VCC) Expectations/Managing expectations (VCC)Perceived outcomes (VCD) Delayed diagnosis/misdiagnosis (VCD) Technical failure (VCD) Lack of knowledge (VCD) Nature of information (VCD) Dependency</p> <p>4. ORGANISATIONAL FACTORS (VCC) Organisation features/extra mile (VCD)Negative effects of treatment (VCD) Lack of control (VCD) Organisational constraints</p> <p>ADDITIONAL INTERTWINED THEMES EMOTIONAL SAFETY TRUST</p>	<p>8 VCD EPISODES: ACCESS TO RESOURCES VCD further explored in each episode by: Level of impact (High, Medium, Low) No. of elements No. of occurrences of elements No. of organisational sites</p> <p>17 VCD EPISODES: QUALITY OF INTERACTIONS VCD further explored in each episode by: Level of impact No. of elements No. of occurrences of elements No. of organisational sites</p> <p>15 VCD EPISODES: RESOURCE USE/MISUSE VCD further explored in each episode by: Level of impact No. of elements No. of occurrences of elements No. of organisational sites</p> <p>10 VCD EPISODES: ORGANISATIONAL FACTORS VCD further explored in each episode by: Level of impact No. of elements No. of occurrences of elements No. of organisational sites</p> <p>8 VCD EPISODES: COMBINED THEMES VCD further explored in each episode by: Level of impact No. of elements No. of occurrences of elements No. of organisational sites</p>

This involved identifying and classifying units of data based on the coherence of its meaning (Spiggle 1994, p.493) in relation to the axioms/foundational premises of interest in this study (Axiom1/FP1; Axiom 2/ FP6, FP7, Axiom 3/FP9 and Axiom 4/FP10). *This process is represented in column 1 of Table 7.*

As discussed earlier in this chapter (see Section 2.4.2: Interview content), the interview schedule was constructed to ask key questions which were linked to specific S-D logic foundational premises and axioms concerning 'value' and processes underlying 'value formation'. These interviews explored conceptualisations and experiences of 'value' arising through cancer service encounters within and external to Hospital A (see Section 1.2.1). Where interviews undertook a more narrative form, and topics were raised within interviews without prompting from the interviewer, relevant question headings were inserted within the transcripts to indicate the discussion of these topics. At this stage of categorisation, data pertaining to negative experiences of service use and perceived destruction of value were initially grouped into a separate category/heading, '**VALUE CO-DESTRUCTION**', rather than categorised according to a specific foundational premise. The reason for adopting this approach was 'value co destruction' appeared to relate to number of foundational premises, in particular those concerning the nature of service exchange and resource integration processes.

The researcher used the autocoding function in NVivo 10 to initially categorise the data according to foundational premises and value co-destruction. This preliminary stage of categorisation led to the creation, within NVivo 10, of five nodes (Parent nodes) which each related to the foundational premises of interest in this study: FP1, FP6, FP7, FP9, FP10 and one additional parent node '**VALUE CO-DESTRUCTION**'. All of the data contained within these six categories/parent nodes were reviewed by the researcher in terms of relevance to the assigned category. As NVivo 10 enables the user to move easily between sections of coded text and full interview transcripts, the researcher additionally categorised data relevant to the cancer service encounter, but not captured within the previous six categories.

This led to the addition of the category 'OTHER', which predominantly concerned organisational features of Hospital A.

Stage 2. Preliminary dimensions by foundational premises and value co-destruction (see Table 7, column 2)

The second step in the data analysis process adopted a more iterative approach that entailed 'open coding' within each of the 7 categories (parent nodes) identified in Stage 1 (see also the first column of Table 7). All of the data contained within each of these 7 categories were reviewed and patterns and common units of meaning were identified. This layer of analysis led to the generation of a large number of additional sub-dimensions (created as child nodes within NVivo) within each of the 7 initial categories identified in Stage 1. These additional sub-dimensions are outlined in column 2 of Table 7.

Data contained within the 7 main categories and sub-dimensions which related to other foundational premises were additionally coded at other relevant parent and child nodes. This meant that some units of data had multiple coding, this potentially reflecting the inter-related nature of S-D logic foundational premises.

Stage 3. Value co-creation (VCC) and value co-destruction (VCD) by emergent theme & dimensions (see Table 7, column 3)

Once the researcher had explored initial patterns and linkages in the data, as outlined in Stage 2, it was important to look for rival or competing themes and explanations. This was done by looking for other ways of organising the data that could lead to different findings, and by looking for data that supported alternative explanations (Patton 1999). In this study, this was undertaken through the development of categories which captured variation in relation to cancer service experiences in terms of 'value co-creation' and 'value co-destruction'. Exploration of this latter category facilitated greater insight into the nature of negative experiences within and external to Hospital A. This also aided exploration of contrasting staff views regarding the potential of the Centre to on the one hand

promote 'emotional safety', but on the other create 'dependency' on the organisation.

This third stage of data analysis involved developing more encompassing and general categories (Spiggle 1994) through constant comparison of the data and sub-dimensions identified in Stage 2. This led to the identification of four main emergent themes: (1) Access to resources, (2) Quality of interactions, (3) Resource use/ Resource misuse, and (4) Organisational factors. Two additional underlying themes, 'Emotional safety' and 'Trust', were also identified. Sub-dimensions identified in Stage 2 (Table 7, column 2) were then further refined and classified as factors /elements pertinent to value co-creation (VCC) or value co-destruction (VCD). The four emergent themes and associated sub-dimensions are detailed in column 3 of Table 7. The sub-dimensions are preceded by (VCC) or (VCD) to indicate whether these relate to the phenomena of value co-creation or value co-destruction. This additional phase of coding and analysis was managed within NVivo 10. It is possible within this software to create overarching 'nodes' which reflect different phases of coding and analysis. The researcher adopted this approach to differentiate between the stages of analysis, and to create relevant new parent and child nodes to reflect the emergent study themes and refined sub-dimensions.

The researcher's understanding and interpretation of the data were not confined to the interviews, it was also informed by the time spent in the field and observations and notes and relating to this, as well as extant literature. The researcher had noted preliminary themes in her research diary whilst undertaking the research in relation to observational and interview data which related to conceptualisations of value and also value co-creation and co-destruction. The research diary was reviewed in line with the four main study themes and two underlying themes outlined above. Observational data relating to these themes and concepts are incorporated within the analysis presented in the subsequent section to complement the findings from the analysis of the interview data and also provide insight into the context in which the study was conducted.

Stage 4. Value co-destruction by episode (see Table 7, column 4)

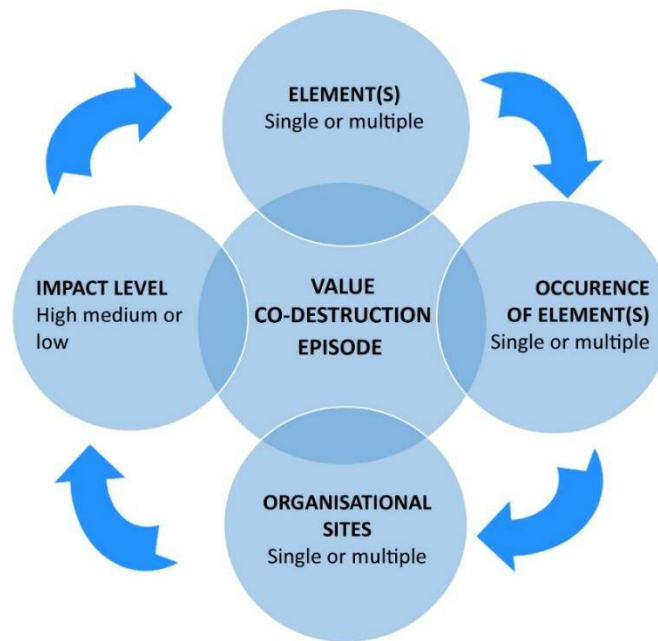
The fourth stage of the analysis extended the categorisation of the conceptualisation of value co-destruction within the study to additionally classify 'value co-destruction' in terms of 'episodes'. This is summarised by episode and overarching theme in column 4 of Table 7. This was possible as the data in relation to value co-destruction in this study (generated largely from patient interview data) tended to relate to very specific (negative) examples of service use during diagnostic, consultation or treatment processes within one or more health care organisational sites. This sat in contrast to positive accounts of service use and conceptualisations of value which tended to be framed much more generally. Similar findings have also been noted in the analysis of open text comments in the Welsh Cancer Patient Experience Survey (Bracher et al 2014, 2016). Kensinger (2009) has also reported how focal enhancement of memory appears to occur more often for negative experiences than for positive ones.

The value co-destruction examples identified in this study also surfaced perceived reason(s) for value co-destruction arising through service use (see sub-dimensions preceded by VCD in Table 7, column 4). In light of these data, examples of value co-destruction were classified as 'episodes' of value co-destruction. These episodes were then additionally classified according to a number of characteristics; impact levels; number of elements; number of occurrences of elements and number of organisational sites. These are summarised in Figure 2.

Episodes of value co-destruction

An episode of value co-destruction was defined in this study as a discrete event (i.e. a patient having an allergic reaction whilst undergoing a specific chemotherapy treatment) or an overall process (i.e. the process of being diagnosed) which occurred during cancer-related service use, that is perceived, by the recipient, as having negative consequences, and which culminated in value co-destruction.

Figure 2: Characteristics of value co-destruction episodes



Patients who reported value co-destruction episodes were additionally classified as those experiencing, either: (a) a single episode (one reported episode per individual), or (b) multiple episodes (two or more reported episodes per individual). Family member reports of value co-destruction are incorporated within the relevant patient-specific value co-destruction episode(s). The researcher excluded from value co-destruction episodes, accounts regarding negative aspects of having, or having had, cancer. This is because these cases related more to the disease itself, than to service use (i.e. uncertainty about the future, impact on family members). Although staff interviews made reference to value co-destruction, these accounts were not integrated into value co-destruction episodes. The main reason is this study did not directly compare patient, family member and health care professional dyads. Staff perceptions of value co-destruction were, however, useful in contributing to wider perceptions of negative service experiences and value co-destruction.

Level of impact

Episodes of value co-destruction in this study were classified as having high, low or medium impact on participants, physically or emotionally. High impact

episodes were those episodes with consequences which were perceived as either: (a) irrecoverable, or (b) still having a considerable impact on physical and emotional health of individuals (patients). Medium impact episodes were those with consequences which were temporary or partially resolved through other actions, events or the overall quality of care. Low impact episodes were those in which individuals raised issues or aspects of service use which could have been different, but had not unduly affected them emotionally or physically.

Elements of value co-destruction

Contributory reasons for perceived value co-destruction, were classified as 'elements' of value co-destruction. These included lack of access to resources, poor interpersonal and communication skills of staff, and technical failure. Each value co-destruction episode contained either a single or multiple elements. These elements could occur once (single occurrence, e.g. single occurrence of a single element, single occurrence of multiple elements) or more than once (multiple occurrences, e.g. multiple occurrences of a single element; multiple occurrences of multiple elements) during each individual episode of value co-destruction.

Organisational sites

Each episode of value co-destruction was further classified in terms of whether it related to service use at a single organisational site (e.g., one health care provider) or at multiple organisational sites (more than one health care provider). Classifying value co-destruction episodes in this manner according to single or multiple elements, occurrences and organisational sites led to 8 possible combinations of these characteristics at each impact level. (See Chapter 3 for further details).

Timeframe for value co-destruction

In addition to classifying value co-destruction episodes as outlined above, an estimate of the timeframe in which value co-destruction occurred was made. An

element of caution should be exercised in interpreting these results. Eight episodes of value co-destruction (relating to five patients) contained insufficient detail to estimate narrow timeframes. Two approaches have been used to handle such episodes and assign timeframes. Value co-destruction episodes relating solely to service use within Hospital A are based on the total length of time patients have attended the specialist centre. This applies to four episodes of value co-destruction (1 medium, 3 low). Value co-destruction episodes involving other service providers or more than one service provider are based on the overall period of time patients have reported they have been living with cancer or undergoing treatment and/or follow-up. This applies to four value co-destruction episodes, reported by two patients (2 high impact episodes each), currently classified as occurring within the last 4 year or 35 years. Future work could consider more focused questions regarding when value co-destruction was perceived as occurring.

Structure of the analysis

Due to the additional layer of analysis undertaken in this study in relation to value co-destruction, the subsequent chapter presents the findings from the analysis of study data concerning the creation and destruction of value separately. Emergent study themes identified in Stage 3, and the dimensions (see Table 7, column 3) viewed as pertinent to positive conceptualisations of value and value co-creation (labelled in brackets as VCC) are discussed in section 1 of the next chapter. The analysis of value co-destruction is presented in section 2 of the next chapter. Value co-destruction whilst presented initially in terms of overall emergent themes, is discussed mainly in terms of episodes of value co-destruction and the associated characteristics (levels of impact; elements, occurrence of elements, organisational sites). This analysis incorporates the 13 sub-dimensions or 'elements' of value co-destruction, presented in Stage 3 of Table 7 which are labelled in brackets as (VCD).The penultimate section of the next chapter (section 2.4) discusses trajectories of value (incorporating co-creation and destruction) within the context of cancer service encounters.

Section 3: Reflections upon qualitative data

As qualitative methods have become more commonplace in health services research, there has been increasing interest in the scrutiny of qualitative research (Mays and Pope 2000). The issue of quality appraisal in qualitative research is one that is contentious. There has been disagreement about the characteristics defining good quality qualitative research and concerns that some papers outlining quality appraisal methodologies imply that qualitative research is homogeneous, when it is not (Dixon-Woods et al 2004, Kuper et al 2008b). According to Mays and Pope (2000, p.50), the issue of 'quality' in this field is part of a larger and contested debate regarding the nature of knowledge produced by qualitative research, whether quality can be judged legitimately and how this can be undertaken.

Whilst acknowledging this epistemological debate, these issues are not explored here as it is beyond the remit of this study. Instead, this section draws on wider post-positivist criteria viewed as more in keeping with interpretive approaches to research such as; credibility, reactivity and transferability (Lincoln and Guba 1985, p.42; Devers 1999, p.1165), to reflect on the qualitative data in this study.

3.1 Credibility

According to Patton (1999, p.1189-1190), the assessment of quality and credibility in qualitative inquiry depends on three distinct but related inquiry elements: rigorous techniques and methods for gathering data and careful analysis which address issues of validity, reliability and triangulation; the credibility, competence and perceived trustworthiness of the researcher and the philosophical beliefs in the value of the qualitative enquiry. Techniques used in this study, such as triangulation testing rival explanations; attention to negative cases and respondent validation are approaches which may enhance the quality of the enquiry (Patton 1999; Mays and Pope 2000). Measures undertaken in this study to enhance the quality and credibility of this study are detailed in the remainder of this subsection.

The sampling strategy undertaken in this study was adopted to (i) enhance understanding of the relevance of the S-D logic framework to a health care context and (ii) explore how 'value' is conceptualised and experienced through cancer service encounters. This study selected patients with a wide range of experiences of cancer-related service use and staff with a range of roles (see section 2.3), to capture a broad spectrum of service-related experiences and perspectives on 'value' and also "yield data" on the main study questions (Patton 1999, p.1197; Rubin and Rubin 2005). This approach was additionally adopted to assist in the understanding and illumination of important cases rather than to facilitate generalisation from the study sample to a wider population (Patton 1999, p.1197). This enabled exploration of 'differences' and 'commonalities' in terms of experiences and perceptions of 'value'. In addition to this strategy, interviews were also undertaken in surroundings and at times that were part of participants treatment-related (patients) or working day (staff), so were not isolated from the context in which study phenomena were investigated.

Qualitative data sources (interviews and observational data; patient and staff accounts) were triangulated in this study to facilitate richer understanding of the context within which cancer service encounters were experienced and of the focal study phenomenon; conceptualisations and trajectories of value. Results from these sources were compared to enable the researcher to explore patterns of convergence and to develop overall interpretations of the data (Mays and Pope 2000). Caution should be exercised, however, in the extent to which these approaches would be viewed as a genuine test of validity, as this could assume that particular accounts are privileged or more valid than others. Triangulation in this study was adopted primarily as a means of ensuring comprehensiveness in the exploration of study phenomenon rather than as a 'pure test of validity' (Mays and Pope 2000, p.51).

Respondent validation or 'member checking' includes techniques where the investigator's account is compared with those of the research subjects to assess the degree of correspondence between the two (Mays and Pope 2000). It is a

method, however, that some authors argue has limitations as a means of assessing the credibility of a project. One of the concerns expressed is that the account produced by a researcher will inevitably be different from that of individual informants as researchers seek to provide an overview and present findings to a wider audience, which may not reflect the individual concerns participants (Mays and Pope 2000; Barbour 2001). Whilst viewed as useful in forms of action research, it may be more difficult to implement in a health services research which typically involves a one off data collection exercise (Barbour 2001). This has led authors such as Mays and Pope to suggest this should perhaps instead be viewed as a means of reducing error than establishing validity (Mays and Pope 2000).

It was not possible in this study to directly compare the researcher's analysis of the study data with those of patient participant's interpretations. The majority of patients participating in this study were undergoing treatment at the point that they were recruited. Requesting additional input beyond participation in the interviews would have placed unreasonable demands on participants in terms of time and energy. The sensitive nature of the interview data and study findings may also have been distressing for some study participants at a time when emotions are potentially already running high. The anticipated time lapse between undertaking the interviews and finalising the analysis of the study data, meant that some patients could become more unwell over time. Additionally, it was not possible to provide feedback on the study findings to staff on a group basis, as this would have compromised the anonymity of study participants. This was an important consideration in the context of a relatively small organisation. A number of strategies were adopted to overcome these limitations.

During the process of conducting the interviews, the researcher was careful to probe participants in relation to their responses, in order to elicit fuller responses and interpretations from a participant perspective. When possible, the interviewer summed up the issues that had been discussed during the course of the interview and invited comments and/or questions before the interview

closed. All participant interviews were recorded and transcribed in full, which reduced the potential for misinterpreting annotated or shortened responses.

The researcher sought feedback on the study findings informally through discussions with staff across Hospital A. The researcher also met with senior management staff within Hospital A to provide interim feedback while data collection was ongoing as well as after analysis was completed. Some of these senior staff were involved in other projects or had roles within the organisation which pertained to patient experience. The study findings were welcomed by these senior staff and viewed as supporting other work undertaken in the Centre. There was particular interest expressed in the concept of value co-destruction. One piece of work undertaken by a staff member within Hospital A explored patient values with cancer survivors who had attended Hospital A. This work was undertaken sometime after the researcher had completed data collection within Hospital A. This staff member commented that the themes identified from the researcher's analysis were very similar to those raised by patients in their study.

In addition to these strategies, the researcher also compared findings from this study with themes identified in secondary data sources (Quality Health 2014, Bracher et al 2014, 2016).

3.2 Reactivity and confidentiality

Reactivity is the extent to which the research process affects responses (Maxell 2005, p.108). This can have implications for the reliability of the data if ignored. A number of strategies to minimise this form of bias have been undertaken in this study, some of which were reported earlier in this chapter (i.e. positioning of the researcher as 'insider' and 'outsider'; building trust and gaining familiarity in the organisation through undertaking work on behalf of Hospital A prior to commencing the interview phase of the study; interviews were mainly conducted away from clinical and/or treatment areas in a private room). The researcher also consciously chose to interview the majority of patients prior to conducting staff

interviews, to minimise the potential for questions to be framed and interpreted from a service provider rather than service user perspective.

In addition to these strategies, the researcher sought permission to use a dictaphone to record interviews at the beginning of every interview. All participants agreed to the use of the recorder and this was moved into a discrete position in the room. The researcher did not take notes during the interviews to enable a normal conversation to be maintained. Thoughts or comments in relation to the interview were recorded immediately after the interview had closed and the participants had left the room.

All of the interviews commenced with an assurance of confidentiality. Staff were additionally assured that job titles would not be used in the write up of the study, to maintain the anonymity in a small organisation. Information was then provided on the project and participants reassured that their contributions were extremely valuable and would not be judged in any way. With confidentiality assured, participants responded openly and provided sometimes extremely personal insights into their social worlds, as alluded to earlier in this chapter.

3.3 Transferability

Transferability concerns the extent to which results of qualitative research can be transferred to other contexts or settings (Murphy et al 1998). A perceived limitation of the single case study approach is that it is not possible to generalise findings from the results of one study (Yin 2009). There also appears to be some debate regarding whether it is the responsibility of the researcher or the reader to assess the potential transferability of findings to other contexts (Murphy et al 1998; Miles et al 2014). In this study, the aim was to identify patterns and linkages which may be of interest in other settings and contexts, rather than to infer findings from the sample of participants to a population (Bryman 1989).

To facilitate the potential for transferability, Miles and colleagues (2014) suggest that the write up of the research is important. In light of this, the researcher has

taken care in this study to: (i) outline characteristics of the sample of participants and the study context to facilitate comparisons with other samples; (ii) undertake sampling which was diverse enough to encourage broad coverage of the study phenomenon; (iii) provide 'thick description' in the write up of the analysis reported in the subsequent chapter, and (iv) explore the extent to which findings are congruent with extant theory and literature (reported in the discussion chapter 4). In doing so, it is the researcher's view that the findings from this study may be transferable to similar research contexts i.e. specialist cancer service settings and potentially other professional knowledge intensive industries, where there may be high information asymmetry between the provider and the user of a service i.e. Law.

Summary

This chapter has described the systematic methodology for investigating: (a) trajectories of value in a cancer service setting, (b) barriers, facilitators and supports for value co-creation, and (c) the empirical application of the S-D logic framework to a health care context. Attention has been drawn throughout this chapter to the challenges and intensity of effort required to undertake this study. Particular features of interest relate to the nurturing of relationships with staff within the organisation as important steps in establishing 'trust' and subsequent access to study participants. The subsequent chapter reports the findings from this study.

CHAPTER THREE: TRAJECTORIES OF VALUE IN CANCER SERVICES

Introduction

The analysis presented in this chapter draws upon interview and observational data to investigate: (1) conceptualisations and trajectories of ‘value’ (i.e. value-in-use) in a specialist cancer service context; (2) potential supports, barriers and facilitators for value co-creation, and (3) the application of the S-D logic framework to a UK specialist cancer service setting (Hospital A; see chapter 2 sections 1.2.1 and 2.1). These three areas of investigation address the primary aim and specific objectives of this study (see introductory chapter, pp. 9-10, for full details). This investigation of ‘value’ was located within the context of service user and service provider micro-level cancer-related service encounters.

Additional areas of concern relate to: (i) the nature of service exchange and perceptions of involvement during service encounters; (ii) the range and type of resources offered (i.e. value propositions) and drawn upon during service use, and how these were exchanged, integrated and utilised by patients, and (iii) the range of actors (e.g. patients, family members, other patients, health care staff) and/or organisation(s) involved in interactive value formation processes. In undertaking this work, this research study considered how four of the five axioms underpinning S-D logic (Axioms 1-4) and associated foundational premises (FP1, FP6, FP7, FP9 and FP10) mapped across to a health care context (see introductory chapter pages 10-11). The discussion concerning the extent to which study findings map to S-D logic axioms and extant literature is reserved for Chapter 4.

Structure

The analysis presented in this chapter is undertaken in two main sections. Section 1 reports service user and service provider conceptualisations of ‘value’ within the context of a UK specialist cancer service setting. This section additionally considers the processes viewed in S-D logic as facilitating value co-creation i.e. service exchange and resource integration.

Section 2 presents an analysis of the nature of value trajectories (positive and negative) within the context of a cancer service setting. This additionally considers how 'value' accrues, or diminishes, across service encounters. This analysis is presented in a series of sub sections and at two levels. The first level of analysis presented in Section 2.1 and Section 2.2 provides a descriptive overview of study findings. The second level of analysis presented in section 2.3 provides richer illustrative data and integrates findings from both interview and observational data. Section 2.4 draws on both of these levels of analysis to consider the various trajectories of value in a cancer service context.

In presenting the findings of this analysis terms specific to S-D logic are used (i.e. service; service encounter; value proposition; resource(s); resource integration; value co-creation; value co-destruction and value recovery. These terms have each been defined in the first use and are re-stated in the glossary in Appendix 1. Unless otherwise noted, the term 'value' is used in this chapter as shorthand for 'value-in-use'.

Section 1: Value and value co-creation

The section explores conceptualisations of 'value', and value co-creation processes, within the specific study context. The main study themes developed within this section of the analysis are presented in section 1.1 and further expanded upon in sections 1.2-1.5.

1.1 Value and value co-creation

Whilst recognising that the cancer service experience, and perceptions of 'value', could be unique to each 'individual', it is apparent from this study that such experiences and perceptions are also characterised by a number of common themes and concerns. Analysis of participant interview data using both inductive (data driven) and deductive approaches (literature/ framework driven) identified four main study themes in relation to value conceptualisations and value co-creation: 1. Access to resources; 2. Quality of interactions, 3. Resource use and 4. Organisational factors.

A summary of main themes and associated value co-creation sub-dimensions identified from the interview data is presented in Table 8.

Table 8: Value co-creation themes by participant responses

Theme	Sub- dimensions	Patient	Family member	Staff
Access to resources	Ongoing access and support	21	5	9
	Specialist knowledge and skills	23	2	4
	Timely access/responsiveness	20	2	6
	Reduction of information asymmetry	23	6	0
Quality of interactions	Interpersonal skills/language of care	38	6	10
	Person-focused care	25	3	10
	Time for the patient	12	2	1
Resource use	Types of involvement	43	3	15
	Types of resources	46	7	5
	Capacity to exchange/integrate resources	26	2	17
	Nature of value propositions	-	-	24
	Expectations/Managing expectations	20	5	16
	Perceived outcomes	31	3	3
Organisational factors	Organisation features/extra mile	21	5	18
Intertwined themes	Trust	10	1	4
	Emotional safety	12	2	11

*The numbers in this table reflect the number of responses per respondent ‘type’ coded within each subtheme. Text may have been dual/multi- coded, hence the total number of overall responses exceeds the total number of study participants.

The first theme, ‘access to resources’, concerned the ability of patients to use or draw upon the specialist resources (knowledge and skills i.e. operant resources) of health care providers (at an individual practitioner and/or organisational site level). Although this theme predominantly related to resources within Hospital A, this also incorporated access to specialist resources in other organisational sites prior to referral to Hospital A. The second theme, ‘quality of interactions’, concerned the nature of social interactions, (verbal and non-verbal communication) between ‘actors’ including: patients, staff, and in some instances, other patients during health service encounters. The third theme, ‘resource use’, was essentially shorthand for resource exchange, utilisation and integration processes. This concerned the way in which knowledge and skills were exchanged during service use. This also incorporated: the types of resources drawn upon, perceived types of involvement in decision making processes, and the perceived

capacity of patients to optimise, integrate and utilise resources. The fourth theme, 'organisational factors', concerned aspects of service, treatment and care that were viewed as treatment centre or cancer specific.

In addition to the four main themes, two additional themes, 'emotional safety' and 'trust', were also evident and reflected the interplay of the themes above. Emotional safety related to participants (patient, family member and staff) reporting 'feeling safe', or being 'made to feel safe'. This also incorporated participants indicating that they felt reassured and that anxieties were reduced or alleviated. Trust concerned perceived belief in the ability and reliability of health care staff and the service provided. This also incorporated expressions of confidence in the staff. Both of these themes were initially identified as 'in-vivo' terms within the interview data. Although the themes 'trust' and 'emotional safety' are listed separately within Table 8, they are closely intertwined. It is unclear whether 'trust' arose as a result of 'feeling safe' or whether patients reported 'feeling safe' because of their confidence in the skills and abilities of health care staff. This is illustrated in the following extract:

"I think it's all one thing really. I trust them, and I feel safe and I feel safe because I trust them, and I trust them because they make me feel safe" (IN 54: ID 69, patient).

While the four main themes outlined in Table 8 appear to be distinct, they were also often interlinked in participant accounts of 'value'. This may imply that within this health care context, 'value' has multiple component parts. This point is illustrated in the extracts below which emphasise access to specialist knowledge and skills, on-going access and support; person-focused care; information exchange and the interpersonal aspects of care.

"[...] there were four things I wrote down: caring; support, information and advice and stress reducing. Those are the four things that I think are most important to me" (IN 38: ID 51, patient).

"Value is being considered as an individual in a hospital that's very, very busy and everybody has got the same problems and

far worse than I've got, you know. I consider myself lucky because I'm going to come out the other end and I'm sure I'm going to be alright, but it's just feel as if you're being treated as a person not a patient, not a number, you know, and the fact that you can get in touch with somebody twenty-four hours a day as well, and that was important during the chemotherapy" (IN 43: ID 57, patient).

The four main themes identified in this section are elaborated upon and further illustrated with study data in the following sections: 1.2. Access to resources; 1.3. Quality of interactions; 1.4. Resource use and 1.5. Organisational factors. The two additional themes, 'emotional safety' and 'trust', are not 'unique' categories and were identified in relation to two or more of the four main study themes. These themes were, therefore, not treated in the same manner as the main study themes. Instead of being treated as discrete themes, discussions concerning these aspects of 'value' are embedded throughout the discussion presented in sections 1.2-1.5.

1.2 Access to resources

Access to resources is a key aspect of 'value' emphasised within this study. This theme features across the range of data sources within this study and it relates to the diagnostic, treatment, and follow-up stages of the cancer service experience. This concerns both access to 'physical resources' (i.e. operand resources) as well as the 'knowledge and skills of staff' (operant resources). Swift diagnosis and prompt commencement of treatment (surgical and non-surgical) were viewed as important by study participants for future health outcomes. Emphasis on access to specialist operant resources, was apparent from the point that cancer-related symptoms were first reported to a health care provider or detected (i.e. via routine screening or acute hospital admission). The seriousness, and potentially life limiting nature of the disease, contributed to such emphasis. Transitioning between a 'generalist' (knowledge and skills are applied to field as a whole or a variety of different fields) and 'specialist' health care cancer service provision also features as an important aspect of 'value' emphasised within this theme.

In considering the theme, 'access to resources', a number of sub-dimensions emerged which relate to: ongoing access and support, the concentration of specialist knowledge and skills, timely access to resources and the reduction of information asymmetry. These are addressed in the sections 1.2.1-1.2.4.

1.2.1 Ongoing access and support

Ongoing access and support relates to having named contacts onsite and offsite so that in the event of an incident or query, patients (and family members) felt that there was someone on a 24-hour basis from whom they could seek advice. This ultimately led to a sense of feeling emotionally supported even whilst at home. It was something that was noted by many of the participants within the study.

"The value to me is the fact that I'm comfortable. If I've got any issues, any concerns that there's no hesitation in coming back and that's a huge value to me. Huge. [...] It makes me able to relax which makes me able to concentrate on getting myself well, because I don't have to worry and I think when you're going through treatment like this the worst thing you can do is worry, you know" (IN 44: ID 59, patient).

Through being able to access specialist staff both on and off-site, and having a named contact or specific telephone number, patients and family members reported feeling emotionally safe and reassured. Emotional safety featured in many accounts as an important component of 'value'. This sense of safety also extended beyond the treatment period for patients to the monitoring and follow-up period, as indicated in the extracts below.

"We've got no end of contacts. So whatever the problem might be in different areas, I know I can just go to the phone and there's always someone there who will give you help. It's somebody to talk to, to alleviate those worries" (IN 30: ID 41, family member).

"I think it's because I am being monitored so I am sort of checked even when my Treatment/drug A is finished [...]. I find a bit of comfort with that" (IN 27: ID 36, patient).

This was not just noted by patients and family members; it was also an aspect of the service that staff commented on, as illustrated in the extract below.

“They get good care. They get support. They get specialist care. They get confidence, you know, and there’s always someone around. If we don’t, if we aren’t able answer their query there’s always someone around to answer their question about their cancer” (IN 66: ID 82, staff).

The concentration of specialist knowledge and skills in one centre was also raised within participant reports as a key aspect of value. This is outlined in more detail in section 1.2.2.

1.2.2 Specialist knowledge and skills

In considering the nature of ‘value’ arising through service use, many participants emphasised the specialist focus of the Centre. The concentration of specialist staff within one centre was highlighted in patient, family member, and staff accounts. Such accounts emphasised the overall service focus of Hospital A, where cancer was viewed as core business and as facilitating flexible, responsive, fast and efficient care. These accounts often also highlighted ‘emotional safety’ and trust or confidence in the abilities of staff within the Centre. This was often contrasted to experiences within non-specialist hospitals as illustrated below.

“When you come here whatever hits you there’s somebody that will have that answer or somebody. So that comfort zone or that comfort blanket you get as soon as you walk in the door. And someone will give you an answer, and if they haven’t got it they know somebody who has. Well when you’re in a general hospital and if you’re not in a specialist area, right then they’ve only got limited resources to be able to give you that. So when you walk in here it’s like a comfort. You know with a little child with a comfort blanket. I’m safe, I’ve got it and if I want to know something now I’ll go and find it” (IN 5: ID 6, patient).

Patients (and family members) perceived the level of staff knowledge and technical expertise (operant resources) within the Centre to be higher than in other health care settings. This seemed also to be linked to greater confidence in

the care and treatment that was provided, as well as perceptions that the standard of care was higher than in other health care settings. This is illustrated in the extract below.

“The important parts are that they have been dealing with cancer for fifty sixty years. To me, if you live in Country A this is the place to come. They are all specialists they know their jobs inside out and you can put plenty of trust in them because they know what they are doing” (IN 10: ID 13, patient).

By accessing the operant resources of staff within the Centre, participants (patients, family members, staff) in this study highlighted how they ‘felt safe’ or were ‘made to feel safe’ as concerns were alleviated, with the ‘burden of worry’ essentially shared or ‘off loaded’ to staff, i.e. *“You feel as if you’re in good hands so you haven’t got to worry yourself”* (IN 30: ID 40, patient). There were also indirect benefits associated with attending the specialist centre. A staff member commented on how this facilitated a sense of honesty, as most patients were aware of their diagnosis, which was felt to not always be the case within general hospitals.

“[...] Like when I was on a general hospital I remember you were go into handover and perhaps somebody was about to have a diagnosis about cancer, and it would be you know something they didn’t know” (IN 60: ID 76, staff).

This was viewed by the staff member as creating a sense of camaraderie amongst patients. This sentiment was also echoed by patients who highlighted how this reduced the sense of isolation associated with a cancer diagnosis. For others, viewing patients who they perceived to be ‘worse off’ than themselves, was viewed as a benefit of a specialist centre, as illustrated in the next extract.

“You know when I first walked into the hospital it opened my eyes to see how many people have got this disease. And I couldn’t believe it you know. To come into this hospital and see twenty/thirty people to see the amount that I have seen it’s just mind boggling. And you are not the only one in this world with a disease as bad as cancer” (IN 16: ID 20, patient).

In considering the theme ‘access to resources’, it was apparent that in addition to ongoing access and support and the specialist skills and knowledge of staff, timely access to ‘resources’ was also an important aspect of ‘value’.

1.2.3 Timely access/responsiveness

Fast access to specialist health care resources at the time they are needed was emphasised by a number of participants (patients and staff) within this study. The issue of ‘timely’ access featured in participant conceptualisations of value, with a short waiting time viewed as a very positive aspect of the service experience.

“It was so quick I meanI just think how lucky I am when I read in the papers about how people have to wait so long for appointments and consultations” (IN1: ID 1, patient).

For the majority of patients in this study (33/56), the general practitioner (GP) was the first contact point identified by patients for the initial reporting of symptoms or investigation of cancer or for screening (n=3/33). This was followed by national screening programmes (n=8), with smaller numbers reporting their cancer being diagnosed as a result of an emergency hospital admission, or whilst undergoing treatment and follow-up elsewhere. Patients whose cancer was detected after presenting to their health care provider (GP or hospital doctor) emphasised the importance of being listened to and having prompt action taken. Those patients whose cancer was detected via routine screening emphasised speed of access, efficiency and relief at early detection. In total, 22 other hospitals, aside from Hospital A, were identified as being involved in diagnostic, screening or treatment processes for patients within this study.

Most of the patients within the study indicated that they were diagnosed and accessed treatment fairly quickly after being screened, or first reporting symptoms to a health care provider (i.e. 0-2 months). There were, however, a small but important number of exceptions to this finding. A small number of patients experienced delays obtaining diagnosis and also accessing specialist service provision. Five patients perceived that there was a substantial delay

(between five months and four years) in obtaining diagnosis, which they viewed as having impacted negatively upon them (this is reported in more detail in section 2). Two of these patients (subsequently diagnosed with ovarian cancer) also indicated that they were initially misdiagnosed by one or more GPs before obtaining diagnoses post hospital admission and eventual referral to a specialist service provider, as illustrated in the next extract.

“So I went to see another doctor in my surgery, and he wasn’t happy with the kidney chart on the computer and so he sent me to see a specialist Doctor Q. And she sent me for a scan thinking it was the kidneys but when the scan came back they seen it was ovarian cancer” (IN 16: ID 20, patient).

For two patients, fast access to specialist diagnostic services was of particular importance. These two patients paid privately for diagnostic scans due to concerns over the time it would otherwise have taken to access publicly funded (NHS) health care facilities (an estimated wait of 7-14 weeks for an appointment). Both of these patients reported that their tumours were subsequently viewed as sizeable and fast-growing. They both perceived that their situation would have been far more negative had they otherwise waited. The extract below, from one of these patient accounts, illustrates this point.

“[...] as soon as they saw the scan they realised how sizeable the, which we now know was a tumour, how sizeable the tumour was. [...] And yet as we said, okay were lucky as it was only 1a and it hadn’t spread, but if they had waited for the full seven or could even have been more for the eight or nine weeks by then the cancer could have spread” (IN 23: ID 29, family member).

As treatment ensued very quickly after diagnostic scans, the importance of transitioning quickly between generalist and specialist service provision was raised in both of these patient accounts. Value appears to have been co-created in both instances from the point at which access was gained to specialist resources (diagnostic scans) which in turn facilitated faster access to treatment interventions. This would seem to indicate that value can both diminish (due to delayed access to resources), and accrue over the service experience.

Minimising the length of time between reporting initial symptoms/attending for screening and carrying out investigations and obtaining diagnosis, featured as an important aspect of the service experience. A number of patient accounts highlighted how the most stressful period for them was waiting for the results of investigations and for a diagnosis to be made. These concerns appeared to relate to periods of time where there was a lack of information exchange between service providers and service users, as illustrated in the extract below:

“I think the most stressful time was the fortnight waiting to go back to SCREENING UNIT NAME to start with then. That was very stressful and the week then that I had to wait for the results” (IN 07: ID 08, patient).

Timely access to specialist resources, therefore, also appeared to concern timely access to the operant resources of staff. This was noted within the specialist centre, with responsiveness described in terms of speed of response to queries, perceptions of ‘care’ and a means of alleviating anxiety, as illustrated below.

“And I asked him a question on alternative medicine. His viewpoint was I can’t give you a genuine answer but he said I will ask one of my colleagues. Within the hour there was a pharmacist by my bedside while my mother was still there and my wife and she gave me all the answers I needed to know within that hour. Now that to me is care” (IN 03: ID 03, patient).

“Everything is instant here and you know you haven’t got to be afraid of anything because you know they will deal with it straight away and that’s what takes the fear out of it.” (IN 76: ID 93, patient).

1.2.4 Reduction of information asymmetry

It is evident from the study data that there was an imbalance in knowledge between patients and health care professionals (information asymmetry), and expertise concerning disease and treatment processes and outcomes. Reduction of information asymmetry, through dialogue with specialist health care professionals, is emphasised within this study when considering ‘value’ arising through service use.

Sharing of information and knowledge appears to be an essential part of cancer service encounters. By having questions and concerns addressed promptly by knowledgeable and informed staff, part of the 'emotional burden', of the disease appeared to be shared, off-loaded or reduced. Reduction of information asymmetry and uncertainty regarding treatment processes and outcomes featured as important aspects of 'value', but also the experience of living with the disease, as highlighted in the extract below.

“One of the critical things is being able to feel in control and with the condition you have lost control (sighs upset). So it's a need to be able to get access to the information at a pace that you can process and deal with it” (IN 38: ID 51, patient).

Although uncertainty existed for many patients in relation to disease progression and/or response to treatment, there appeared to be a degree of confidence about the capacity of staff to respond to queries or concerns and to keep patients and family members informed of developments. Patients and family members reported feeling reassured by the 'honesty' of staff responses, “*There is no bull you know they are straight upfront with you*” (IN 40: ID 53, patient), and the sense that things would not be hidden from them “[...] *they don't keep you in the dark*” (IN 55: ID 71, family member). Patients also highlighted how dialogue with specialist health care staff, facilitated access to information that would otherwise be unknown, “[...] *just people explaining what was happening because obviously as I said I knew nothing about cancer*” (IN 58: ID 74, patient).

In order for staff to tailor information requirements to individual patient needs, service users also needed to engage in the service exchange and impart information regarding their knowledge of their disease and specific requirements for care and treatment. Information provision was viewed as an essential part of the service encounter. There was, however, variation amongst service users in terms of the level of information they wished to receive, and the way in which this was delivered. Some patients expressed a desire for information provision to be a staged process i.e. step by step through stages of treatment, or for certain types of information to be kept from them, such as length of life remaining, or possible

future outcomes. Some patients highlighted difficulties processing information early on in their cancer journey and reported requiring a staggered approach to information sharing. This was also recognised by a staff member who described information provision as a process of “*chunk and check*” (IN 42: ID 56, staff member). These points were also illustrated in the extracts below.

“I think that if you start looking into things too deeply I think you can make things worse for yourself. [...] You know, sort of a friend of mine, and she’s done it with the best will in the world, she’s spending hours going on the Internet and I’ve said to her, I don’t want to know. I don’t want to know” (IN 44: ID 59, patient).

“[...] Some people would want to know from, sort of, from treatment to death, where I don’t want to know that. I would rather know slowly because I think that if you know what’s going to happen then you could possibly think about it too much, and it would make your life quite miserable I think” (IN 51: ID 66, patient).

Variation in terms of information requirements, was evident between some family members and patients. These family members potentially desired more information than the patient wished to receive, as illustrated in the next extract.

“[...] I think she’s had the hard bit of it really because she wants to know what is going on and I am quite happy to accept well they are going to do this or do that and that’s up to them you know. [...] She says to me ‘Oh you let them cut your head off if they wanted to,’ and I say ‘well it’s up to them’ (laughs)” (IN 25 part 2: ID 33, patient).

These findings reveal that the nature of resources (i.e. information) exchanged during service use and the style of delivery varied according to individual patients. This required staff to be sensitive to a patient’s preferred delivery style and also to be able to adapt the resources offered accordingly. The sensitivity of staff to a patient’s emotional needs and individual requirements during diagnostic and treatment related processes is an issue raised in the study data. This is addressed in the second main study theme, ‘quality of interactions’.

1.3 Quality of interactions

The nature of interactions between patients and health care staff appeared to be a key element in shaping health care experiences for service users. Indeed, two thirds of the patients in this study commented on the nature of interactions during service use and highlighted the relational aspects of treatment and care. Emphasis was placed on the interpersonal skills of staff and the language of care; person-focused care and staff having time for the patient. These issues are addressed in sections 1.3.1-1.3.3.

1.3.1 Interpersonal skills/language of care

In defining the value arising through service use, the ‘language of care’ emerged as an important area of focus in the analysis of patient (and family member) interview data. Emphasis was placed not just on ‘what treatment patients received’, but also ‘how patients were treated’ (verbally and non-verbally, including listening to patients) during service encounters. The interpersonal skills of staff were viewed as a key part of the service experience. Clinical outcomes, whilst important, were therefore not the only area of concern for patients, as illustrated in the extract below.

“So objectively I want them to deliver the right chemicals to me as soon as possible to do as much as possible to the cancer cells in my body that’s the objective truth but subjectively it makes a big difference to me actually when I now reflect on it how I am treated. That may always be true of me, that I am the kind of person who wants not just to be a body with needs that have to be dealt with in terms of you know injections but as a person who probably needs to feel valued and respected and all of that sort of aspect of it” (IN 18: ID 23, patient).

Patients highlighted the personal, empathetic and sensitive nature of interactions and associated this with a sense of feeling valued as a person and the provision of emotional support.

“[...] It’s not always ‘We’ll try this and I’m off. ‘We’ll get there now’. ‘We’ll get you back up now’. ‘We’ll build you back up’. And

little things like that it means a lot to a patient I think, you know it's encouraging. [...] No, it's that little couple of words after 'We'll get you there' "(IN 12: ID 16, patient).

The importance of non-verbal cues, as a way of interpreting the approachability of health care staff was also raised in participant accounts.

"When you walk along the corridor if you make eye contact with somebody they will smile and that makes a big difference to a lot of people, because I think as well that once you get a smile that person becomes approachable as well if you need to ask a question" (IN 46: ID 61, patient).

Additionally, for a number of patients, being able to have conversations with staff which were not cancer-related was an important aspect of service interactions. In doing so, patients implied that they were viewed as a person and a sense of normality was created in what, for many patients, might initially have been an 'abnormal' situation i.e. "*[...] I can talk them to them about our families, what they are doing in their holidays. It gives me a feeling of normality*" (IN 24: ID 30). These findings suggest that the operant resources of staff were perceived by patients in terms of their interpersonal skills as well as specialist knowledge of their disease and treatment processes.

1.3.2 Person-focused care

Providing person-focused care was also raised as an important aspect of interactions, with many participants relaying the significance of feeling they were treated as an individual and not just another number, "*[...] the whole system is geared to me or the patient or whatever it is and not just to producing you know facts and figures*" (IN 25 part 2: ID 33, patient). When these aspects of 'care' were combined with the ability to access specialist resources on an 'ongoing basis,' service users reported feeling reassured and emotionally safe. This suggests that value may accumulate across the service experience, as highlighted in the next patient extract.

“I can’t really put it into words. I just feel safe. I think it’s everything. People are nice. They’re genuine. They’re always interested in your story. You’re not treated as ‘you’ve all got cancer’, you know. There’s genuine interest in you and just to see the way that the people work here. Their dedication I think as well” (IN 54: ID 69, patient).

1.3.3 Time for the patient

In addition to emphasising the interpersonal skills of staff and providing person-focused care study, participant accounts also highlighted how staff making time for them as an individual enhanced the perception and feeling that they mattered. *“Even when they are busy when you are having the chemo they don’t make you feel like they are busy, they are there for you [...] and they all seem to put you first”* (IN 23: ID 28, patient). This is often contrasted to experiences in larger, non-specialist hospitals, where there may be fewer staff available per patient, as illustrated below.

“I mean when I was in Hospital D you didn’t get the attention you wanted there if you know what I mean. If you wanted something ‘Oh yeah I’ll be there in a minute’ it would be two or three hours later you would probably get em” (IN 22: ID 27, patient).

This perception was also shared by a staff member (IN 66: ID 82), who likened care within the specialist centre to giving “top to toe care” compared to “skimming to get by” in other hospitals due to lack of staff and lower staffing levels. The implication of such, is a reluctance of patients to be treated or transferred to other hospital contexts. This finding implies that the nature of resources within a specialist centre differs in terms of expertise, but also in terms of the relative volume and ratio of staff to patients.

1.4 Resource use

Whilst patients drew on a range of resources during service use, including personal resources (i.e. previous experiences of health care, personal skills and personality attributes; family members and friends) they were largely reliant on

health care staff to navigate treatment-related decisions and processes. This theme contains several sub-dimensions: types of involvement; types of resources; capacity to exchange/ integrate resources; value propositions, expectations and perceived outcomes. These are addressed in section 1.4.1-1.4.6.

1.4.1 Types of involvement

The study data reveal that perceptions of involvement in service exchange range from 'feeling included' and 'being informed' to ones of 'partnership' and 'a joint decision maker'. There were, however, very few patients in this study who described involvement in terms of 'shared' or 'joint decision making'. Involvement in service exchange and decision making during service encounters was mainly described by patients in terms of being included and informed in relation to health care decisions and processes. Patients described themselves as being part of a team, with health care staff, but this largely relates to a sense of inclusion in 'the team' and of being an informed decision maker, as illustrated below.

“Doctor E said, we’ll work as a team on this, you know. There’s us and there’s you but were a team together, and that’s how I feel because the very fact that they keep you informed and then they ask me questions as well” (IN 44: ID 59, patient).

Although health care professionals and patients may share knowledge, in terms of patients’ knowledge of their condition and the health care professional’s knowledge of disease and illness, the type of involvement in service exchange appears heavily skewed towards the health care professional having the ‘more dominant role in information exchange’. This is perhaps unsurprising given the differentials in terms of training and medical background; a point raised by a member of staff within Hospital A.

“But yes, there is definitely an issue but in the end you have only got so long with the patient to treat, you cannot give them every bit of your medical schooling information” (IN 69: ID 86, staff).

The nature of the information provided to enable patients to be included in decision making processes may therefore be difficult to understand or digest.

“I had read it so I kind of knew what he was saying but you know it’s coming at you at a speed plus the fact that you can get I think...[...] jargon. Well if you are talking to someone outside of the industry you don’t use the jargon because they don’t understand it and I think that you have got to put in laypersons terms...” (IN 17: ID 22, patient).

The type of involvement in service exchange described by patients in this study leans more towards ‘passive forms of engagement’. Patients (patients/family members) indicated that they were informed and included in discussions but mainly provided ‘informed final consent’, rather than actively choosing between treatment options, “*Well they give me the option and they said is it all right with you, and I say yes*” (IN 75: ID 92, patient).

While small numbers of patients reported actively choosing between treatment options in the specialist centre, this tended to relate to decisions prior to attending the Centre i.e. in relation to surgical treatment options. Patients mainly reported being guided by clinical staff in terms of treatment options and following their advice. This was a preference also recognised by some staff members, who acknowledged that emphasis on ‘shared-decision making’ did not necessarily reflect the reality of the clinical situation or the preferences of the majority of patients. These points are illustrated in the next two extracts.

“I haven’t been involved as such in that I want this drug and I want that drug. We’ve had conversations about what’s best for me, and how we go about it” (IN 03: ID 03, patient).

“I think what people and the general public or journalistic spheres or possibly political spheres as well, sometimes believe is that all patients are the sort of shared decision making experts who have a really good knowledge and will come to a round table discussion with the clinical team as to what the best care is. That’s the model of it, but the reality really is that there’s only a few people who are like that and that a lot of things happen in dialogue, but a lot of people also just want their clinical team to make the decisions on their behalf, and certainly update them on what’s going on and what the positives and the negatives are, but the reality is that they just want you to get on with it really” (IN 56: ID 72, staff member).

Indeed, some patients indicated that it was outside of their remit to make decisions, with such responsibility perceived as the domain of health care professionals. This appears to be related to information asymmetry between patients and staff but also shaped by patients' beliefs about the roles of 'patients' and 'staff', as can be seen in the extract below:

"I don't really want to be involved in making decisions because it is not my job I am a patient and I am just a cook at the end of the day. (Laughs) It's not my job to know anything about cancer I leave that up to the professionals" (IN 16: ID 20, patient).

A small number of patients who had previous experiences of cancer, or longer experiences of having lived with or being treated for cancer, implied that a degree of 'learning' was required before feeling able to ask the necessary questions to participate in decision making, as illustrated in this next extract.

"I didn't really know what to expect, so I sort of just went along with what they... you know what they suggested and I didn't really ask any questions and in hindsight I found that perhaps they didn't offer any more if you didn't ask questions. [...] But then when I was diagnosed with my secondary cancer which was last [NAME OF MONTH] I... I think I've become braver so I ask an awful lot more questions. [...] I think unless you ask questions the consultants don't know how much you can handle, so they only start to offer once you start asking questions [...]" (IN 09: ID 11, patient).

Additionally, a small number of staff challenged approaches to involvement in care and treatment processes and suggested that the specialist centre, whilst protecting and nurturing patients, also disempowered patients in the longer term if they were not actively involved in managing their cancer. Emphasis was instead placed on patients having a proactive role from the beginning of their treatment and care, as illustrated in the extracts below.

"My idea is to support them and keep enabling them to carry on, and like I said a bit earlier, about being proactive. [...] So by actually giving patients some of those tools and those kits early on, you know, we're hoping that it would actually prevent then

some of the, you know, a sort of a major crisis occurring”(IN 65: ID 81, staff).

“And to have those conversations with patients right from the beginning it gives them an idea that it’s co-production... the word in the NHS at the moment, yes. It’s working together as a team to provide treatment that fits with who they are as a person and what we know is clinically effective”(IN 45: ID 60, staff).

These findings would appear to suggest that ‘involvement’ in service exchange had a spectrum of meanings to both patients and staff within a cancer service context. This may have been influenced by personal preferences but also the desire to participate; the operant resources (i.e. knowledge and skills) patients and family members require in order able to participate, and how patients were invited to participate by staff members.

1.4.2 Types of resources

In considering the nature of the service exchange in a cancer service context, it emerges that patients drew on a range of resources during service use, aside from those of health care staff, including personal resources (i.e. personality traits/attitude, family members and friends, previous experiences). These resources could concern a general attitude towards undergoing treatment i.e., “*a positive attitude, that is half the battle and when you go for the treatment you are halfway there already*” (IN 67: ID 83, patient). Or they could draw on professional work experiences as a means of navigating treatment processes, “*Professionally I was quite used to this sort of thing. You know I mean chasing people on the phone [...]*” (IN 38: ID 51, patient). Some patients highlighted how they managed their own emotions as well as protecting those of family members. In doing so, they drew on both their own coping mechanisms and the support of friends or family, as illustrated below.

“Yes friends have been important to me to be fair. In fact sometimes I’ll probably talk to them more than I do... because I probably too much protected my son and my family from it. Put a shield there so they know but I don’t let them see like, none

of them have been in the chemo with me because I wouldn't let them, because I didn't want them to... so I protected my family" (IN 05: ID 06, patient).

Other patients highlighted how they drew on the experiences or expertise of other family members or friends in dealing with their own diagnosis and treatment. Indeed, family or friends were the most common resource discussed by patients (and family members) aside from Centre staff. Previous experiences of having cancer and having undergone treatment (a patient's own or family member's experience) were additionally drawn upon, when faced with new decisions about treatment options. In one instance, a patient's previous experience was used to advise a member of staff about their treatment regimen, as illustrated in this next extract.

"I think she was a new member of staff, I'd had all the pre-meds and my alarm went off and she came over and she was going to put the [DRUG NAME] in and I said 'Oh haven't had my 30 minute wait yet' and she said 'Why do you have to have that?' and I said 'Well I just do' and she went and asked somebody and they said 'Oh yes you must wait 30 minutes' and I was just glad it wasn't my first chemo because I wouldn't have known any different" (IN 23; ID 28, patient).

In addition to personal resources, patient and family members also emphasised how they drew upon the experiences of other patients, implying that there was also potential for patient-to-patient value co-creation. This relates to furthering understanding of treatment processes from a personal perspective but also providing tips or tricks.

"[...] There was a chap in the next bed to me and he had already had chemo here. So I was a bit worried about having the chemo but he told me what it's like and what it was going to be like here and he told me the way he explained it you know then I didn't mind coming here you know my worries had gone because he explained everything to me" (IN 34: ID 45, patient).

This is potentially a reciprocal process as a small number of patients outlined how, over time, they became a resource for other patients.

A small number of patients reported accessing other sources of information, such as written materials or internet-based resources (i.e. research based cancer charity websites, patient forums and Hospital A website), which they brought to health care consultations (draw upon). In one or two instances, this information was combined with other resources such as expertise, or the experiences of friends and family members, as demonstrated in the next extract.

“My son used to come with me because he has a PhD well not in oncology but in medicine. And suppose he researched a lot online ‘rather than me’? He talked to Doctor C about my options and that and that was really good” (IN 01: ID 01, patient).

Most patients, however, indicated a preference for information exchange through face-to-face dialogue with health care professionals. This seems to suggest a preference for the ‘spoken word’ over other forms of information exchange.

“One thing I was told quite early in my illness. Don’t go on the internet. And I said I won’t. Because for one thing I am not very capable with the thing, I can send emails but... I haven’t looked once I don’t want to know what.. What I want to know from Doctor E I ask her and she tells me and that’s been enough” (IN 04: ID 05, patient).

Some patients expressed a reluctance to use online resources, including the materials on Hospital A website, due to difficulties finding, filtering and understanding the vast array of available information. Others, expressed a desire to be informed about the materials family members or friends retrieved but did not wish to carry out this activity themselves.

“I like to know but I wouldn’t sit there on my own and get to know. [...] I don’t really want to look stuff up on my own. But I want to every know everything that she knows” (IN 55: ID 70, patient).

Of the fifteen patients and six family members who discussed internet/online-based resources, a third expressed concerns over using this type of resource and their capacity to understand and use the information they retrieved.

“And I made a bad mistake with the prostate one going on the internet and researching a lot of gobbledygook I knew nothing about. [...] if you don’t know what you are talking about in the first place it’s just a minefield” (IN 35: ID 46, patient).

This would seem to imply that when service users do not feel they have the operant resources to assess the nature and/or quality of information they are offered, or have accessed, this can restrict the benefit they are able to gain from such resources and in some instances, lead to negative consequences.

1.4.3 Capacity to exchange/ integrate resources

Some patients highlighted how, despite having information provided, they were not always able to digest and understand this. Others highlighted how the capacity to make decisions, and draw upon resources, was restricted by the timescale in which they were required to undertake such activities. These points are illustrated below.

“Sometimes I felt that I was a bit out of my depth. I know they say they give you as much information as they can, but we’re not, you know, we’re patients unless you have some sort of medical training, it’s difficult to take it all in and to understand it” (IN 15: ID 19, patient).

“I think if you’d have been given maybe a couple of weeks, you know, that you’d have the luxury of that type of thing I possibly would have come to the right decision, but I don’t think I could have possibly in the timescale I wanted. I wanted it gone” (IN 54: ID 69, patient).

There were a small number of patients within the study who experienced repeat occurrences of cancer and thus had a longer experience of living with the disease. These individuals implied that their knowledge of the disease and capacity to absorb information and increase knowledge of their condition (i.e. operant resources) had increased over time. The capacity to more ‘actively’ participate in service exchange and ask questions seemed to increase as they become more ‘experienced patients’, as illustrated in the next extract.

“[...] Anything that I have taken from that forum then I am bringing it here to talk about. They are actually saying ‘Yes well we know that’ or ‘that drug might not be available here but we know where it is’ or ‘we might be able to get funding but let’s wait and see how this goes’ ” (IN 09: ID 11, patient).

Additionally, patients who viewed their cancer as being ‘managed’, or those with longer experiences of undergoing cancer-related treatments, tended to emphasise value in terms of ‘outcomes’ such as ‘quality of life’, ‘living a normal life’, ‘spending time with the grandchildren’.

1.4.4 Nature of value propositions

Given the reliance on staff as a resource, the nature of the service that staff perceived they offered patients was an important part of the resource exchange and integration process. Staff perceptions regarding the nature of the service they offered appeared to be closely aligned with key aspects and elements of ‘value’ that were emphasised by service users. Access to specialist skills and knowledge, provision of information, person-focused care and providing emotional safety and reassurance featured in the vast majority of staff reports, as illustrated in this next quote.

“So I think just the values would be that it is patient centred and it’s what the patient wanted and to be most comfortable whether it be you’re putting the cannula in or whether it be somebody dying. The patient is foremost [...]” (IN 60: ID 76, staff)

This finding suggests that Hospital A staff were closely tuned into those aspects of service which patients value.

1.4.5 Expectations/ managing expectations

Although staff accounts also identified access to expertise, person-focused care and emotional support as important elements of service provision, they additionally defined ‘value’ in terms of managing and matching patient expectations of both the service provided, and treatment outcomes.

“If they are not getting the service they want at the time they want they are not going to be happy so they are not going to get value” (IN 73; ID 90, staff).

Staff accounts also indicated that value may be perceived differently by patients than staff which may also have shaped expectations, as outlined below.

“Don’t forget we are health professionals who’ve had training and we are taught to think that way. Think in a wider way. Who knows, patients value might just be that they want to get through the treatment and be cancer free and that’s all it means to them” (IN 02: ID 02, staff).

In considering the role of expectations in influencing perceptions of value, it is apparent that a small number of patients and family members reported having high expectations of the specialist centre due to either previous experiences, or their knowledge regarding the perceived reputation of the Centre. For many patients, however, expectations of service were low or unknown as they had not experienced cancer previously.

“No I just didn’t know. I didn’t know whether radiation was going to be painful. I didn’t know whether I was go home glowing. I just didn’t know, you know” (IN 64: ID 80, patient).

Some of these patients expressed fears regarding: their future health; fear of dying, or encountering other extremely unwell patients prior to attendance at the centre, which were later found to be unsubstantiated. These points are illustrated in the next two extracts.

“Because it’s cancer which makes you think you’re dying and you think you are going to see lots of very ill people. [...] Yes that is what I pictured. I would come here. There would be lots of very ill people with no hair, very thin, very, very ill people and that was my roads up, you know. That was my future. [...] It wasn’t what I expected at all, you know. There are lots of fit and healthy people here that have either finished treatment or having treatment. Yes completely different to your perspectives” (IN 54: ID 69, patient).

“When I used drive past the Hospital A I used to think ‘Oh I would never want to go in there’, but it is not sort of like...it... it’s hard to explain but it’s not like a depressing hospital because you come in here and you know people are trying to help you get better and I think it’s the care and attention of the nurses. Anything you want, if you are nervous about anything they will explain everything and every nurse is the same. I haven’t had one bad experience” (IN 27: id 36, patient).

1.4.6 Perceived outcomes

Just over half of the patients discussed ‘value’ in terms of long term goals i.e. future or anticipated outcomes. These discussions focused on the effectiveness of the treatment, in terms of providing a cure or having extra time to spend with loved ones i.e. *“It’s just giving me that little bit of extra time”* (IN 22: ID 27, patient). These were not, however, the only issues raised. A third of the patients commenting on future outcomes perceived these in terms of resuming or continuing on with a ‘normal life’. This includes several patients who indicated that their cancer was being managed rather than cured. Of interest is that the majority of the patients commenting on perceived outcomes had been receiving treatment, or had been a patient at the Centre, for six months or longer, with a small number of these patients, receiving treatment or living with cancer for three years or more.

The study data presented in the sections 1.1-1.4, indicates that ‘value’ is defined by many patients in terms of ‘short term goals’ i.e. to have uncertainty reduced regarding treatment processes. Emphasis is placed on the ‘process based aspects of value’, such as access to resources and interpersonal aspects of care. These are more immediate, and potentially more ‘visible’, than unknown treatment outcomes.

The data presented in these sections additionally illustrate the temporal nature of the concept of ‘value’ in that this varies over time and is experienced ‘in context’, i.e. within the context of individuals lived experiences. This issue is returned to in section 2 of this chapter.

1.5 Organisational factors

In exploring participant conceptualisations of value, it is apparent that patients, family and staff identified features within Hospital A as unique to the specialist centre or a specialist cancer service context, and which facilitate positive conceptualisations of value. This relates predominantly to the nature of the staff resource within the Centre, but also concerns geographical features such as the size and layout of the organisation. The presence of a large volunteer workforce was viewed by one staff member as a unique feature of the Centre, which contributed substantially to the running of the organisation.

“[...] But I think that there are so many other things with so many different parts to Hospital A that you don't get in other organisations. Like the volunteers who are essential. We wouldn't run, I don't think, we wouldn't run anywhere near as well without our volunteers as an organisation because they provide so much” (IN 74: ID 94, staff member).

Indeed, the first day the researcher attended Hospital A, she observed a number of volunteers meeting and greeting patients at the doors of the main outpatient department, and several volunteer staff fervently knitting 'Easter chicks' in one section of the waiting area. This is an aspect of the Service that is also noted by patients, *“But here from when you walk in through the door there's the volunteers, somebody smiling...”* (IN 04: IN 05, patient). The nature of the volunteer workforce within the Centre was discussed informally with a staff member, who indicated that around 60- 70% of the volunteers within the Centre are previous patients or family members of patients who had attended Hospital A (Research diary 08/04/14). This may indicate that value continues to be created beyond the period that there is a direct service relationship with the Centre. This is possibly also reflected in the substantial fund raising activity also undertaken in the specialist centre.

The majority of staff within this study described the specialist centre as a positive environment in which to work and one which fostered a sense of belonging to a community or 'family'. This was partly attributed to staff perceiving that most

people working within the Centre had actively chosen to work within the Centre or a cancer service context. Additionally, there was a perception that many staff members working within the organisation had done so for a number of years. Indeed, nine of the staff in this study had worked for the specialist centre for six years or more (see Appendix 2). As the organisation was perceived as small, compared to large non-specialist hospitals, this was also viewed as contributing to the 'community' feel, as there was greater familiarity of staff. In doing so, staff perceived that this may lead to some common sharing of values and outlook, with one staff member informally commenting that they were a 'pleaser' and that perhaps so were other people working within the organisation (Research diary 29/07/14). The notion that staff within the Centre were prepared to go the 'extra mile' was also emphasised by a number of staff, which was viewed as contributing to positive service experiences for patients and staff. This is illustrated in the extract below.

"So we are specialised, we are small and we focus on what we do and I think that leads us to sort of really focus on the delivery of excellence of care. I think we support our staff, who I think because of the size and possibly because of the speciality as well, we have the feeling of family almost. It's an atmosphere in Hospital A where people go the extra mile for each other and for patients" (IN 69: ID 86, staff).

This also relates to the notion that staff were committed to the organisation as, in the case of volunteer staff, they willingly invested their time for free. One staff member account highlighted how, in going the extra mile, there were many staff who "*do a huge amount of unpaid work*", and implied that this was an aspect which may contribute to the overall perception of the organisation, as one which was committed to patients (IN 74: ID 94, staff).

A number of patient and family members perceived the nature of the staff resource within the Hospital A as differing to other larger hospital service contexts in terms of their approach to patients, and having a shared set of values. In line with staff, patients also discussed how staff seem prepared to go the 'extra mile' in terms of their commitment and the service they provided.

“You do feel as if everybody values you as an individual and, you know, goes that little bit... makes that little extra mile. It feels different from walking into an acute hospital” (IN 28: ID 37, patient).

The study data suggest that the physical layout and size of the organisation also contributes to the sense of community within Hospital A. The Centre has one long corridor which connects the majority of units, wards and departments. This means there is a substantial volume of both patient and staff ‘traffic’ in this space. A number of staff commented on how this ‘in-between’ space was used as a place of ‘business’ or providing a service, “[...] you sort of stop on the corridor have a chat to someone, and have an action point from that chat” (IN 56: ID 72), as did patients, “When you stop a nurse in the corridor, you’ve got a query, the next thing you know she’s dealing with it” (IN 30: ID 40, patient).

Whilst the majority of staff viewed these aspects of the organisation as positive features, a small number also outlined that it could be difficult to challenge the prevailing views and ways of working. This was viewed as having implications for patients and family members in the longer term if the dominant philosophy of care remained as one of nurturing and protecting patients.

“There’s a way of doing things and it’s a bit like, if it hasn’t broken why fix it, why change and in any system change is quite challenging, and in Hospital A, I think, there’s been big changes over the last two or three years that have encouraged a different way, a different philosophy of looking at care, but the Hospital A way is doing for, nurturing, looking after much more than working with empowering patients which works beautifully in the short term. In the long term it disables and disempowers the patients” (IN 45: ID 60, staff).

The findings in relation to organisational factors suggest that the nature of the overall staff resource (as an operant resource in itself) within Hospital A contributed to the overall service experience of patients. This works in terms of specialist skills and knowledge, but also with regard to their perceived commitment to patients and the organisation itself.

Although the majority of patients identified positive consequences of service use, it is also apparent that value destruction is an outcome of service interactions. The next section discusses the nature and extent of value co-destruction within the context of this empirical study.

Section 2: Value and value co-destruction

The section draws from interview and observational data to analyse value co-destruction within the specific study context. Analysis of these data is undertaken at two levels. The first level of analysis presented in Section 2.1 and 2.2 provides a descriptive overview of study findings and characteristics of value co-destruction episodes. The second level of analysis presented in sections 2.3 provides richer illustrative data and integrates findings from the data sources described above. Terms specific to the analysis of value co-destruction i.e., episodes, level of impact, elements, occurrences and organisational sites within the study context are introduced in the Chapter 2 (see section 2.5.2, pp. 112-114) and are also restated in Appendix 1.

2.1 The broad picture

Sixty three percent of patients (35/56) interviewed for this study reported experiencing either a single episode (22 patients) or multiple episodes (13 patients) of value co-destruction during cancer-related service use (screening, diagnosis, treatment and follow-up). A total of 58 episodes of value co-destruction were reported by these 35 patients (24 single patient interviews, 10 patient/family member interviews, 1 patient/patient interview as a family member was also a patient). Seven family members contributed to patient accounts of value co-destruction. Additionally, 22 members of staff commented on negative consequences of service use. Forty episodes of value co-destruction related to health service encounters taking place during the previous 12 months. The remaining 18 episodes related to health service encounters taking place more than 12 months ago. Value co-destruction episodes were found to vary in terms of the severity of impact. Over half of all episodes (30 episodes) were perceived

to be of medium level impact. The remainder were split between low impact value co-destruction episodes and high impact respectively (14 low impact, 14 high impact). Interestingly, most of the high impact episodes (11/14 episodes) related to patients reporting multiple episodes of value co-destruction (5 patients). It emerges that the majority of value co-destruction episodes reported a single contributory element. Reported value co-destruction episodes were not confined to Hospital A.

Episodes including a range of health care providers, involved in screening, diagnostic and treatment processes were also described. It also appears that a greater proportion of the high impact episodes involved multiple elements, multiple occurrences of elements and multiple health care sites than found in comparison with the medium or the low impact episodes. More than half of all value co-destruction episodes, however, related to the single occurrence of a single element at a single organisational site. Additionally, two of the possible eight combinations of characteristics of value co-destruction episodes were found in episodes at all impact levels (single element, single occurrence, single site and single element, multiple occurrences, single site).

Analysis of patient (patient/family member) interviews identified 13 elements as contributing to value co-destruction episodes which corresponded to four overarching themes. These are outlined in Table 9, alongside the number of value co-destruction episodes within each theme.

Three of these themes are identified in section 1 in relation to value co-creation (quality of interactions, access to resources and organisational factors) The analysis presented here differs, as this considers these themes from a negative rather than positive perspective. In light of this, a lack of any interaction is perceived as relevant to the theme quality of interactions. The theme 'access to resources' in this chapter also incorporates difficulties accessing resources, which may be physical (i.e. diagnostic scans) or care and treatment related (i.e. nursing care or request for assistance) in other organisational sites. The remaining theme, resource misuse (i.e. includes knowledge and skills and 'physical resources'), is

viewed as specific to value co-destruction but related to the theme ‘resource use’. This theme captures both the ‘inability’ of the patient to exchange, use and integrate resources (i.e. lack of knowledge and skills to understand and choose between treatment options), and the inappropriate use of resources (including patient resources) by staff (i.e. technical failure in terms of staff skills or equipment, failure to request investigations and reach a ‘timely’ diagnosis of cancer). Potential overuse of resources by patients, leading to dependency on the specialist centre is also incorporated within this theme.

Table 9: Value co-destruction episodes, themes and elements

Theme	Elements
Quality of interactions (17 episodes)	Poor staff interpersonal/ communication skills Negative impact of other patients Quantity of interactions
Resource misuse (15 episodes)	Delayed diagnosis/misdiagnosis Technical failure Lack of knowledge Nature of information Dependency
Organisational factors (10 episodes)	Negative effects of treatment Lack of control Organisational constraints
Access to resources (8 episodes)	Lack of access Relationships ended
Combined themes (8 episodes)	Combined elements

A small number of value co-destruction episodes involved multiple elements which related to two or three themes (7 episodes, 1 episode respectively). The dominant themes which emerge in patient value co-destruction episodes are quality of interactions and resource misuse. The contributory elements (single and multiple) captured by these two themes account for 60% of all reported value co-destruction episodes (10 high impact, 14 medium impact, 11 low impact). Poor staff interpersonal and communication skills and delayed diagnosis or misdiagnosis are key contributory value co-destruction elements in high impact episodes captured within these themes. The impact of these elements is heightened when there are perceived to be substantial breaches in expected behaviour and/or knowledge of health care professionals. These points are

illustrated in the next two extracts. Both concern service experiences outside of Hospital A.

“I wanted to ask her a question and she went like that to me [patient places vertical palm of hand directly in front of the researchers face] and said, ‘I am no longer your nurse’. [...] But it was just that hand, ‘I’m no longer your nurse’. You’re a nurse, you know, you don’t have to... you’re no longer mine. I just wanted to ask you a question” (IN 68: ID 85, patient: high impact episode).

“Yes, that upset me terribly that did because I thought if they had done it, if they had found it earlier perhaps I wouldn’t be going through this now. It would be hysterectomy out and chemo or whatever radium and it would have been done with. But now it’s not curable” (IN 16: ID 20, patient: high impact episode).

Additionally, negative emotional and physical effects of treatment (including pharmacological, radiotherapy and surgical interventions) feature strongly as an element in value co-destruction episodes (1 high impact, 6 medium impact, 1 low impact). For the majority of patients reporting such effects, whilst having a substantial impact at the time they are experienced, they were mainly short term and resolved when treatment was completed. Unfortunately, this was not always the case. The account below illustrates the potential severity of physical and emotional effects post-treatment, leading to a failed suicide attempt.

“[...] And my futile attempt at suicide. I mean I felt it was a rational decision. I was in an awful lot of pain, the cancer was gone, I wasn’t getting any better and I couldn’t face another six months of absolute bloody misery or it maybe going on for years and years and years” (ID not specified to protect identity).

Variation is also apparent in terms of how value co-destruction accumulates across patients’ service experiences. The data reveal that patients who reported multiple value co-destruction episodes experienced episodes either at the same level of impact (6 patients) or with differing levels of impact (7 patients). Value co-destruction may also be partially negated through value recovery or subsequent value formation. Value recovery is defined here as actions taken by individuals (i.e.

patients, family members or service providers) to prevent further value co-destruction and to reduce the impact of previous adverse consequences or effects on a patient's well-being (physical and emotional).

It also appears that recovery of value can be instigated by patients, the health care organisation in which the episode occurs, or by other organisations providing a service to the patient. It is also observed that value recovery is not necessarily undertaken by the organisation in which value co-destruction occurs. This suggests that a number of organisations may contribute to value co-creation, co-destruction and also value recovery processes. These issues are discussed further in section 2.4.

Staff accounts (interview and observation based) additionally contributed to a wider range of perceptions regarding value co-destruction and negative aspects of service use. These accounts mainly focused on (i) the negative emotional impact on patients when the service relationship ended with the specialist centre, and (ii) the dependency of patients upon centre resources and a reluctance to consult other health care providers or be transferred to other health care settings. Additionally, in contrast to patient accounts which mainly focused on specific employees, staff accounts emphasised constraints with the service delivery process and, in a small number of instances, 'customer or patient misbehaviour'. These points are illustrated in the extract below.

“Some patients only want to come here and not to other DGH's.
[...] Patients may pull the card of 'Well I won't come in then' and we need to say 'Well that's your call' ” (Staff member: informal discussion, Research diary 14/01/2014).

Value co-destruction was experienced by a wider group of patients than those interviewed for this study. Insight into this phenomenon was first gained during the administration of Patient Experience questionnaires on behalf of Hospital A (see chapter 2, section 1.2.4). Sixteen patients completing these questionnaires discussed with the researcher, aspects of service use which they perceived as negative. Ten of these experiences related to Hospital A, and five concerned

experiences at other hospitals. One patient raised concerns about service use which was not site specific. The reasons for such negative perceptions varied i.e. patients not feeling they had been listened to; dignity being compromised; lack of knowledge about the future; lack of knowledge and skills to choose between treatment options; lack of access to centre resources; poor support post-discharge, technical failure in terms of both staff skills and treatment intervention, and inability to process information regarding treatment and cancer due to anxiety.

Additional observation, undertaken within a range of clinical settings and attendance at meetings within Hospital A, also revealed challenging aspects of treatment and service use. These observations varied from those which the researcher had experienced personally (i.e. the researcher lying on a treatment bed and being positioned as would a patient undergoing planning and radiotherapy treatment for breast cancer), to those which the researcher observed patients experiencing (i.e. distress after having a treatment administered to minimise chemotherapy related hair-loss) to those which were reported by patients or staff within Hospital A (i.e. awareness of negative patient experiences raised by staff in various meetings). Whilst the number of negative observations were reasonably small, they also lend support to the themes identified from patient interview data.

2.2 The extent and nature of value co-destruction

Table 10 displays the distribution of value co-destruction episodes across the patient sample. The aggregation of multiple episodes of value co-destruction is discussed further in Section 2.4, so is not elaborated upon further at this point.

The timeframe within which value co-destruction episodes occur at each impact level is outlined in Table 11.

Table 10: Number of value co-destruction episodes per patient

No. of episodes reported	No. of patients (N=35)	No of episodes reported in total (N=58)
1	22	22
2	6	12
3	4	12
4	3	12

Table 11: Timeframe for occurrence of value co-destruction episodes

EPISODE BY IMPACT LEVEL TIMEFRAME IN WHICH REPORTED	HIGH IMPACT (N=14)	MEDIUM IMPACT (N=30)	LOW IMPACT (N=14)
≤12 MONTHS (N=40)	N=4	N=25	N=11
WITHIN LAST MONTH	-	-	4
WITHIN LAST 3 MONTHS	2	7	3
WITHIN LAST 6 MONTHS	-	6	4
WITHIN LAST 12 MONTHS	2	12	0
≥12 MONTHS (N=18)	N=10	N=5	N=3
WITHIN LAST 2 YEARS	3	-	-
*WITHIN LAST 3 YEARS	1	2	-
**WITHIN LAST 4 YEARS	3	-	-
WITHIN LAST 6 YEARS	-	2	-
WITHIN LAST 9 YEARS	1	-	-
WITHIN LAST 10 YEARS	-	1	-
***WITHIN LAST 15 YEARS	-	-	3
****WITHIN LAST 35 YEARS	2	-	-

*1 episode timeframe estimated,** 2 episodes timeframe estimated,***3 episodes timeframe estimated,****2 episodes timeframe estimated.

Although broad categories are used to classify timeframes, value co-destruction episodes are only assigned to one category (i.e. within the last 6 months) and are not double counted. Clarification of exact timeframes for value co-destruction episodes beginning and ending was not always possible, and this is also discussed earlier in the methods section (see chapter 2, section 2.5.2). The majority of value co-destruction episodes relate to service encounters within the previous 12 months. How recently the health service encounter took place appears to be a feature of low, medium and high impact value co-destruction episodes.

As alluded to earlier in this chapter, the categorisation of value co-destruction episodes according to the level of impact (high, medium, low) is related to the permanence of ill effects experienced by individuals. The results presented here appear to also indicate a similar pattern. The reporting time frame within which value co-destruction occurs increases when moving from low through to high

impact episodes. This observation potentially also reflects the longevity of negative consequences on physical or emotional health.

2.2.1 Impact levels, themes, elements, occurrences and organisational sites

A summary of value co-destruction episodes in terms of impact level, contributory elements, occurrence of elements and organisational sites is presented in Table 12. Value co-destruction contributory elements are also additionally summarised according to theme and impact level in Table 13. As we move from left to right across the columns in Table 12, it can be seen that over fifty percent (52%) of all episodes relate to those which have either temporary or partially resolvable consequences (30 medium impact episodes). Contributory elements may occur on more than one occasion within an episode of value co-destruction (single or multiple occurrences). Within this study, the tendency is for episodes to contain a single contributory element and single occurrence of such an element (31 episodes).

2.2.2 Overview of themes, elements and impact levels

High impact episodes

As can be seen from Tables 12 and 13, high impact episodes were found to contain six of the thirteen value co-destruction elements. The dominant themes found at this level of impact were quality of interactions and resource misuse. Of particular note is that poor interpersonal and communication skills of health care staff was the main single and multiple element reported in episodes at this impact level. Also of note is that 'delayed diagnosis/misdiagnosis' is the element with the largest number of multiple occurrences in high impact episodes. This is partially explained by the diagnosis process in such episodes involving repeated visits to single or multiple health care providers before patients were referred for investigative procedures and cancer diagnosis was finalised. Four out of five of episodes reporting delayed diagnosis or misdiagnosis involved General Practitioners (2 single site; 2 multiple sites, GP+ other hospitals).

Table 12: Elements and sites of value co-destruction

	IMPACT	ELEMENT(S) (SINGLE OR MULTIPLE) Single element (N=50) Multiple elements (N=8)	OCCURRENCE OF ELEMENT(S) (SINGLE OR MULTIPLE) Single occurrence (N=33) Multiple occurrences (N=25)	SITE (SINGLE OR MULTIPLE) Single site (N=52) Multiple sites (N=6)
EPISODE	HIGH 14 *(8 patients)	<i>Single</i> 11 <i>Multiple</i> 3	SINGLE OCCURRENCE (n=3) 2 Single element single occurrence <i>2 poor interpersonal and communication skills</i> 1 Multiple elements single occurrence <i>1 poor interpersonal and communication skills/ nature of information/ lack of knowledge</i> MULTIPLE OCCURRENCES (n=11) 9 Single element multiple occurrences <i>2 poor interpersonal and communication skills</i> <i>5 delayed diagnosis/misdiagnosis</i> <i>2 negative effects treatment</i> 2 Multiple elements multiple occurrences <i>2 poor interpersonal and communication skills/ lack of access</i>	SINGLE SITE (n=10) 2 Single site, single element, single occurrence <i>(2 Other Hospital)</i> 1 Single site, multiple elements, single occurrence <i>(1 Hospital A)</i> 5 Single site, single element, multiple occurrences <i>(1 Hospital A, 1 community nurses, 2 GP, 1 other hospital)</i> 2 Single site. Multiple elements, multiple occurrence <i>(2 Other hospitals)</i> MULTIPLE SITE (n=4) 4 Multiple site, single element, multiple occurrence <i>(2 other hospitals + Hospital A, 2 GP+ other hospitals)</i>
	MEDIUM 30 *(23 patients)	<i>Single</i> 25 <i>Multiple</i> 5	SINGLE OCCURRENCE (n=21) 20 Single element single occurrence <i>3 poor interpersonal and communication skills</i> <i>2 negative impact of other patients</i> <i>2 technical failure</i> <i>1 lack of knowledge</i> <i>5 negative effects treatment</i> <i>1 lack of control</i> <i>1 organisational constraints</i> <i>3 lack of access</i> <i>2 relationships ended</i> 1 Multiple elements single occurrence <i>1 lack of access/ poor interpersonal and communication skills</i>	SINGLE SITE(n=28) 19 Single site, single element, single occurrence <i>(10 Hospital A, 6 other hospital, 1 community-breast nurse screening, 1 community, 1 GP)</i> 1 Single site, multiple elements, single occurrence <i>(1 Hospital A)</i> 5 Single site, single element, multiple occurrences <i>(5 Hospital A)</i> 3 Single site. Multiple elements, multiple occurrences <i>(3 Hospital A)</i> (continued next page)

Key: **High** -Impact on physical and/or emotional health which is irrecoverable which had or is still having a considerable effect
Medium-Impact on physical and/or emotional health which is either temporary or partially resolved through other actions/events/quality of overall care.
Low-Commented on as an issue or as an aspect which could be different but was not affected unduly emotionally or physically

Table 12: Continued

	IMPACT	ELEMENT(S) (SINGLE OR MULTIPLE)	OCCURRENCE OF ELEMENT(S) (SINGLE OR MULTIPLE)	SITE (SINGLE OR MULTIPLE)
EPISODE	MEDIUM (continued)		MULTIPLE OCCURRENCES (n=9) 5 Single element, multiple occurrence <i>1 poor interpersonal and communication skills</i> <i>1 negative impact of other patients</i> <i>1 quantity of interactions</i> <i>1 nature of information</i> <i>1 negative effects of treatment</i> 4 Multiple elements, multiple occurrences <i>1 poor interpersonal and communication skills/ nature of information</i> <i>1 dependency/lack of access,</i> <i>1 poor interpersonal and communication skills / technical failure</i> <i>1 technical failure/negative effects of treatment)</i>	MULTIPLE SITE (n=2) <i>1 Multiple site, single element, single occurrence (1 GP/Other hospital/Hospital A)</i> <i>1 Multiple site, multiple elements, multiple occurrences (Hospital A and outreach clinic Hospital A)</i>
	LOW 14 *(12 patients)	<i>Single</i> 14 <i>Multiple</i> 0	SINGLE OCCURRENCE(n=9) 9 Single element single occurrence <i>3 poor interpersonal and communication skills</i> <i>1 negative impact of other patients</i> <i>1 lack of knowledge</i> <i>1 technical failure</i> <i>1 nature of information</i> <i>1 lack of access</i> <i>1 relationships ended</i> MULTIPLE OCCURRENCE (n=5) 5 Single element-multiple occurrence <i>1 poor interpersonal skills</i> <i>3 technical failure</i> <i>1 lack of access</i>	SINGLE SITE(n= 14) <i>Single site, single element single occurrence</i> <i>9 (7 Hospital A, 2 other hospital)</i> <i>Single site, single element, multiple occurrences</i> <i>5 (1 community, 1 GP, 2 Hospital A, 1 other hospital)</i>

*The total number of patients shown exceeds 35 as 13 patients experience multiple episodes of value co-destruction

Table 13: Value co-destruction episodes by theme, element and impact level

	Level of impact	High impact (N=14)	Medium impact (N=30)	Low Impact (N=14)
Theme and elements				
Quality of interactions (N=17)		4	8	5
<i>Poor interpersonal and communications skills staff</i>		4	4	4
<i>Negative impact of other patients</i>		-	3	1
<i>Quantity of interactions</i>		-	1	-
Resource misuse (N=15)		5	4	6
<i>Delayed diagnosis/misdiagnosis</i>		5	-	-
<i>Technical failure</i>		-	2	4
<i>Lack of knowledge</i>		-	1	1
<i>Nature of information</i>		-	1	1
<i>Dependency - see combined elements</i>				
Organisational factors (N=10)		2	8	-
<i>Negative Effects of treatment</i>		2	6	-
<i>Lack of control</i>		-	1	-
<i>Organisational constraints/issues</i>		-	1	-
Access to resources (N=8)		0	5	3
<i>Lack of access</i>		-	3	2
<i>Relationships ended</i>		-	2	1
Combined themes (N=8)		3	5	0
Quality of interactions/Access to resources (n=3)				
<i>Poor interpersonal and communication skills/lack of access</i>		2	1	-
Quality of interactions/Resource misuse (n=3)				
<i>Poor interpersonal and communication skills/nature of information/lack of knowledge</i>		1	-	-
<i>Poor interpersonal and communication skills/nature of information</i>		-	1	-
<i>Poor interpersonal and communications skills/technical failure</i>		-	1	-
Resource misuse/Access to resources (n=1)				
<i>Dependency/Lack of access</i>		-	1	-
Resource misuse/Organisational factors (n=1)				
<i>Technical failure/negative effects of treatment</i>		-	1	-

Additionally, whilst the element ‘lack of access’ featured in two high impact episodes with combined themes (poor interpersonal skills/ lack of access), these related to experiences outside of the specialist centre.

Medium impact episodes

Two thirds of medium level impact episodes (20/30 episodes) involved a single contributory element which occurred once during the reported episode. Although multiple occurrences of elements were reported in medium impact episodes, a smaller proportion of such episodes were observed than in high impact episodes (see Table 12). The elements identified in medium impact episodes also related to all four

study themes. Quality of interactions and organisational factors were dominant themes at this level of impact (see Table 13). Greater variation in types of elements was, however, seen in medium impact than high impact episodes. Twelve of the thirteen contributory elements (only excluding *delay in diagnosis*) outlined earlier were present in the 30 episodes. There was also greater variation in the types of elements which occurred more than once during medium impact episodes than high impact episodes. The negative effects of treatment featured more prominently as a contributory element in medium level impact episodes than high impact episodes. Interestingly, this element was not reported at all in low impact episodes. Lack of access was also reported more at this impact level, and was apparent as both a single and multiple element within five medium impact value co-destruction episodes.

Low impact episodes

Low impact episodes only involve single elements in contrast to high and medium episodes which contain multiple elements (three high impact episodes, five medium impact episodes). Seven elements were identified in the fifteen low impact episodes. Interestingly, elements raised in low impact episodes related to only three of the overarching study themes: quality of interactions, resource misuse and access to resources (see Table 13).

A number of important findings emerged from the analysis of value co-destruction episodes in Tables 12 and 13. The quality of interactions during service use was the most common single theme identified in value co-destruction episodes (17 episodes). This was closely followed by resource misuse (15 episodes), organisational factors (10 episodes) and access to resources (eight episodes). Poor interpersonal skills featured as a contributory element in a third of all episodes reporting multiple occurrences of elements (both single and multiple elements). Additionally, when resources were inappropriately used by health care staff value co-destruction could occur. Delays in reaching diagnosis and commencing treatment, information asymmetry between patients and health care professionals and technical failure in terms of equipment or staff skills all acted as contributory elements to value co-destruction.

2.2.3 Organisational sites

A summary of the organisational sites (single and multiple) involved in value co-destruction episodes at each level of impact is provided in Table 14.

Table 14: Organisational sites involved in value co-destruction episodes

Number of episodes	HIGH IMPACT	MEDIUM IMPACT	LOW IMPACT	Total number of episodes
Single site				
Hospital A	2	19	9	30
Other Hospital(s)	5	6	3	14
General Practice	2	1	1	4
Community Based	1	2	1	4
Multiple sites				
Hospital A/Other Hospitals	2	-	-	2
General Practice/Other Hospitals	2	-	-	2
General Practice/Other Hospitals/Hospital A	-	1	-	1
Hospital A/Hospital A Outreach Clinic	-	1	-	1
Total Number of Episodes	14	30	14	58

All of the 35 patients reporting value co-destruction episodes had undergone diagnostic, investigative or treatment related procedures(i.e. surgery) elsewhere prior to receiving treatment at Hospital A.

2.2.4 An emerging pattern?

Table 15 summarises the combinations of characteristics (impact level, elements, occurrence of elements and organisational sites) found in reported value co-destruction episodes.

Whether value co-destruction episodes have either single or multiple elements and occurrences appears to contribute to the overall level of impact. Review of the data appears to suggest an emerging pattern across the high, medium and low impact episodes. A higher proportion of the total high impact episodes contain multiple elements and multiple occurrences of elements (3/14 and 11/14 respectively) than found when comparing proportions of such in total medium and total low impact episodes. High impact episodes also appear to have larger numbers of episodes involving multiple health care sites (n=4) than medium and low impact episodes. This pattern also holds when comparing the overall proportion of medium impact

episodes containing multiple elements and multiple health care sites (5/30 and 2/30 respectively) to low impact episodes. The latter only contains single elements and involve single health care sites. This does not apply, however, when comparing the overall proportion of medium episodes with multiple occurrences of elements (single element and single occurrence 5/30, multiple elements and multiple occurrences 4/30) to the overall proportion of low impact episodes with multiple occurrences of single elements (5/14). Importantly, these findings suggest an increased tendency for the presence of multiple elements, multiple occurrences of elements and multiple sites in value co-destruction episodes as the level of severity progresses from medium to high impact.

Table 15: Combinations of characteristics in value co-destruction episodes

Combination no.	Impact level	Element(s)	Occurrence of element(s)	Organisational site(s)	No. of episodes
1	High	Single	Single	Single	2
2	High	Multiple	Single	Single	1
3	High	Single	Multiple	Single	5
4	High	Multiple	Multiple	Single	2
5	High	Single	Multiple	Multiple	4
6	Medium	Single	Single	Single	19
7	Medium	Multiple	Single	Single	1
8	Medium	Single	Multiple	Single	5
9	Medium	Multiple	Multiple	Single	3
10	Medium	Single	Single	Multiple	1
11	Medium	Multiple	Multiple	Multiple	1
12	Low	Single	Single	Single	9
13	Low	Single	Multiple	Single	5

This section has presented an overview of the nature of value co-destruction episodes and in combination with section 2.1 represents the first phase of the analysis of these study data. The remaining sections concern the second, richer phase of analysis and illustrate how value co-destruction is conceptualised and experienced by study participants. Additionally, the extent to which value co-destruction can either accumulate or value can be recovered during service experiences is also analysed.

2.3 Conceptualising value co-destruction

Cancer-related service use within this study extends beyond the bounds of the specialist treatment centre. All of the patients in this study had undergone diagnostic or treatment related procedures in other health care settings prior to attending Hospital A (see chapter 2, section 1.2.1; Tables 12 and 14). Perceptions of value co-destruction are therefore explored across patients' overall cancer service experiences, and are not confined to analysis of service use within Hospital A. Analysis is primarily undertaken by exploring perceptions of value co-destruction using study participants' own words. Also incorporated throughout this analysis are additional data sources (family member and staff interview data and observational data/field notes) which also highlight the phenomenon of value co-destruction.

Thematic analysis of value co-destruction episodes using both inductive (data driven) and deductive approaches (literature/ framework driven) reveals 13 contributory value co-destruction elements which are categorised under four main themes: quality of interactions, resource misuse, organisational factors and access to resources (See Table 8). The themes and elements categorised within each theme will be discussed in the following sections: 2.3.1 Quality of interactions; 2.3.2 Resource misuse, 2.3.3 Organisational factors and 2.3.4 Access to resources.

2.3.1 Quality of interactions

The quality of interactions during service use is a key factor in contributing to value co-destruction. Critiques of service interactions in this study relate to a range of health care staff both within and external to Hospital A including: general practitioners; nursing staff (breast care screening nurses, district nurses, non-specialist hospital nurses, Hospital A nursing staff); medical staff (Consultants within non-specialist hospital doctors, Consultant oncologists within Hospital A) and clinical staff (Hospital A radiotherapy staff).

When problems are identified with communication it is largely attributed to *poor interpersonal and communications skills of staff*. This may, however, also concern

patient to patient interactions, and these are captured under the element *negative impact of other patients*. Additionally, the *quantity of interactions* between patients and staff was also raised by a patient and staff member. The next section elaborates further on these elements and the varying level of impact these have on service experiences.

2.3.1.1 *Poor interpersonal and communication skills*

The way in which patients are treated by health care staff on an interpersonal level was important to study participants. The critiques of staff interpersonal and communication skills concerned not only how patients and their family members were spoken and related to, but also whether patients felt they had been listened to. Importantly, this also included the inactions of staff and lack of interactions between patients and staff. There appeared to be additional components which influenced the impact that poor interpersonal skills had upon the overall service experience and the level of value co-destruction incurred. These are as follows: breaches in the expected behaviour of health care staff; the reason for the interaction; differing perspectives of health care staff and patients, previous experiences.

Breach in expected behaviour of staff

The impact of negative interactions during health service encounters appeared to be amplified if interactions were perceived by patients as representing a substantial breach in 'expected behaviour' or 'roles' of health care staff (i.e. patients felt they were being ignored, perceived lack of empathy, lack of attention to patient dignity, perceived lack of regard for the patient, staff not telling patients the truth, staff being rude to the patient, lack of any interaction). This impact was further compounded if the result of the interactions, or the lack of interaction, resulted in the denial of access to resources (e.g. knowledge, treatment, advice). Additionally, these interactions appeared to have a higher impact if it was not possible to challenge or redress the actions of staff. These points are illustrated in the next two extracts. The first is a high impact episode and concerns an experience outside of Hospital A. The second is medium impact and concerns a GP consultation, where a follow-up

appointment was subsequently offered to the patient.

“I just can’t believe it in this day and age how abysmal it was on that ward. It was cruel. It created no amount of suffering, not just for me there were other patients there that were ignored. No point ringing the buzzer. I crawled on my hands and knees to the nurse’s station to ask for some painkillers to be told, ‘Oh I was going to come back and tell you but I forgot, you can’t have any more for two hours’ ” (IN 41: ID 55; patient, high impact episode).

“[...] And I didn’t go willy-nilly, I just went if there was something wrong and she said ‘I haven’t got time for this. You should be fighting the cancer that you’ve got.’ Clapped her hands and said ‘I’m late for my son’s after school appointment and got up and showed me the door’ ” (IN 08: ID 10; patient, medium impact episode).

The researcher also observed how limited interactions between staff and patients and lack of opportunity for patients to raise and discuss concerns with staff may have contributed to interactions being viewed as negative. On one such occasion, whilst administering patient experience questionnaires in a specific unit, the researcher noted that staff appeared to only interact with patients whilst administering or undertaking treatment related activities. This possibly reflected the very busy nature of the unit on that day. Two different patients raised concerns with the researcher during the completion of the patient experience questionnaire regarding treatment related symptoms, outcomes, and the nature of their diagnosis. The first patient, who also had recently undergone cardiac surgery, was worried about the degree of fatigue they were experiencing, the impact it was having on their life, and whether it was usual. As providing advice was beyond the remit of the researcher, the patient’s concern was relayed to a staff member. Unfortunately, this information was not received positively by the particular staff member, who looked extremely cross and responded with:

“Well what do you want me to do with this? Now that you have told me this I will have to act on it. It is a really big thing to talk about! I am very busy trying to do more than one thing at once and I have already been told I have been spending too long with patients”.

The researcher, whilst surprised by this reaction (which was subsequently reported to an appropriate member of staff), stayed on the unit and administered another questionnaire to a different patient. During the process of administering the second questionnaire, the patient told the researcher that communication was often not pursued with them as they found it difficult to talk. After completing an item on the questionnaire regarding whether their communication needs were met the patient remarked, *"People tell you lies when you have cancer"*. When asked what they meant by this, the patient responded, *"Well, they don't always have the answers"*. Later, adding *"People should say what they mean, if it says suspicious cells when they mean cancer they should just say so"* (Research diary February 20/02/14). The patient also expressed concerns about the nature of their diagnosis and the effectiveness of the treatment they were undergoing. Again, a staff member (a different one) was informed that the patient had concerns regarding their diagnosis. The unit at this point was extremely busy, with only two staff members visible due to other staff being on lunchtime break. It led the researcher to wonder whether the concerns the patients raised would be addressed at all. Additionally, the researcher contemplated whether staff had time to interact with patients other than when administering treatments or if this instead reflected a treatment-oriented focus of staff working in this setting. Incidentally, the researcher was subsequently informed by a staff member that there had never been any requests for a member of the information and support team to attend this unit. This may imply a number of options; that all patient concerns are dealt with by unit staff, staff are unaware of the roles of supporting teams or there isn't always an opportunity for patients to raise concerns.

The observations above also highlight that lack of interaction may be purposeful on the part of health care staff, potentially due to lack of time and capacity to respond to patient concerns. These observations may, however, reflect the actions of one or two particular individuals rather than staff in the unit as a whole. Patients may, however, have been reluctant to raise issues with staff if they were concerned that staff seemed too busy. Additionally, these observations suggest that lack of interaction also incorporates lack of meaningful interaction about subjects of

concern to the patient. The absence of such discussions lead to concerns over the validity of information provided, and the notion of ‘untruths’.

Reason for the interaction

When the service interaction concerned the delivery of difficult or unexpected news (i.e. diagnosis, extent of disease, non-response to treatment), poor interpersonal and communication skills from staff appeared to have a greater emotional impact on patients than when this concerned more general aspects of treatment. This was particularly the case if patients (and family members) felt that information was conveyed insensitively and delivered ‘clinically’. This is illustrated in the accounts below. The second of these accounts is rated as medium impact as the situation has been redressed through the inclusion of a specialist nurse in subsequent meetings.

“It is only when I came for a routine check just before Christmas 2012 and they did an internal and the surgeon that I saw just went ‘Oh’, walked out of the room, sent a nurse in who introduced herself as a cancer specialist nurse and I’m... ‘Who’s got cancer?’ ” (IN 40: ID 53; patient, high impact episode).

“[...] Right we came to a clinic to see an oncologist and when we asked was there any hope, there was a shaking of the head to say no... and was there anything we could... and it was, ‘We’ll have to see’ and that was it. So we went out and [PATIENT’S NAME] said to me, ‘I think it’s curtains and that’s what they’ve told us today’. [...] We both sat in the car heartbroken and drove home. How we drove home I don’t know” (IN 29: ID 39; family member, medium impact episode).

Negative interactions may be unintentional and possibly reflect the inexperience of staff in breaking difficult news. The account below highlights this, but additionally draws out the fragility of value and how a simple gesture has the potential to destroy value. This episode of value destruction was rated as low impact as the patient was sent immediately to see a specialist at another hospital who discussed possible outcomes in more detail. This action potentially limited the extent of value co-destruction experienced.

“[...]..And then all of a sudden he turned the screen away and he said ‘Whoops I haven’t been doing this long I just want to get my boss a minute’ and from that time then on I knew something was up” (IN 34: ID 45; patient, low impact episode).

Differing perspectives of health care staff and patients

Insensitivity in communication style may reflect the differing perspectives and experiences of professional health care staff and patients regarding health and illness. This was notable when patients perceived that they were treated as clinical objects rather than as individuals during service interactions. The concerns outlined below relate to medical and clinical staff within Hospital A.

“[...] We are sort of looked at and it’s just like being in a test tube. [...] If the oncologist is in a positive place during treatment, I mean what else can you do, you can either stand there and observe and look at the thing in the test tube or you can just be human, be cheerful and be sort of you know sort of be more encouraging” (IN 18: ID 23; patient, high impact episode).

“[...] You would go in there and some are very clinical. It is bang, bang, bang, numbers that’s it. They can come in all set and part the room and not say a word to you” (IN 05: ID 06; patient, medium impact episode).

This is also acknowledged in comments from a family member, in relation to the academic approach adopted by the Consultant which lacked the optimism the patient and family member required.

“I don’t think there was any intention of upsetting anybody. It was just not having quite the best bedside manner [...] but if someone had said to us, ‘We know nothing now. Who knows? We can be optimistic, but we must also think it could be bad and let’s leave it at that.’ We would have understood, but the way it was put across, I’ve never seen PATIENT’S NAME so desperate. She said “I just don’t want to go on. I don’t want my treatment. I don’t want anything” (IN 29: ID 39; family member, medium impact episode).

Conversely, staff being viewed as ‘over familiar’ with patients also may lead to patients perceiving their experience as negative. Whilst the researcher observed the administration of a patient experience questionnaire, one patient remarked to the

interviewer how they did not like nurses to be “*over familiar*” as this stripped them of their identity as a person and instead gave them one of a “*frail old*” person (Research diary 24/09/14). Patients also may perceive their experience as negative if they feel they are being spoken over or if staff appear disinterested. This was raised during the administration of a patient experience questionnaire in March (2014). One patient indicated how a member of staff was “*very short*” with them when they asked to have a dressing changed. They commented that the staff member appeared to be more focused on non-work related discussions with a younger member of staff. This had concerned the patient enough to raise this matter with staff on another unit, and indicated they would pursue the matter should it happen again (Research diary 13/03/14).

The researcher also witnessed how differing perspectives may influence the nature of health care interactions. This occurred during a presentation for new patients about to start chemotherapy. The researcher sat at the back of the room, immediately behind one new patient who appeared visibly distressed and was trying to discreetly wipe their eyes throughout the presentation. At one point in this presentation, when addressing the side effect of hair loss, the staff member presenting stopped briefly, looked down at what the researcher presumed was a list of patient names and treatment regimens and then announced in front of everyone in the room, ‘*Mrs X you will lose your hair as will Mr Z...*’ and continued to name all the patients who would experience chemotherapy related hair loss. The distressed patient directly in front of the researcher was one of the people named. The announcing of names in this manner was perhaps done in the spirit of being honest and open with new patients and to inform rather than distress patients. Nevertheless, this surprised the researcher who wondered subsequently about how this affected the ‘named’ patients. The researcher was unable to address this issue with the staff member, mainly as it was only the third time the researcher had attended Hospital A. To have questioned this practice may have led staff to perceive the researcher as antagonistic or critical and compromised the remainder of the research project (Research diary 7/10/13).

Differing perspectives of staff and patients regarding health and illness also influenced perceptions of validity of knowledge. Interactions were also viewed as negative when patients felt that the knowledge they provided was not viewed as valid by staff and potentially ignored. In the next account, this lack of acknowledgement is perceived as continuing to delay the process of diagnosis. This account relates to experiences at a non-specialist hospital.

“[...] Because I have a science background I also spent months trying to figure out what was wrong with me, I was trying to figure it out and in fact I actually came up with the diagnosis in the first week of January and the guy, my Consultant at the time, said you are way too young for that, don't be ridiculous. Well that's what it was you know” (IN 18: ID 23; patient, high impact episode).

The issue of validity of patient knowledge was also raised during the administration of a patient experience questionnaire to an inpatient within Hospital A. This came to light when the patient was asked a question regarding how long they felt they needed to wait to use the service from the time they knew they needed to come. The patient became quite cross and said: *“Well those idiots, not here, meant I had to wait”*. When asked what they meant by this, the patient explained how they had suddenly collapsed at home as their legs gave way. Luckily, they had a telephone nearby and managed to phone an ambulance and were subsequently admitted to their local hospital. The patient recounted how *“They came to see me and asked me to stand up. I had already told them that I couldn't use my legs”*. The patient then described how they were asked to try and stand up using some form of aid/ metal frame and remarked:

“As I had already said my legs didn't work. So I then collapsed onto the floor and they couldn't lift me up. [...] They wouldn't treat an animal like that” (Research diary 05/03/14).

The patient then described the device used to lift them from the floor as *“another cage to get me up”* also adding, *“After all that happened they then left me alone”*. The patient was subsequently transferred to Hospital A for treatment to relieve pressure on their spinal cord from a tumour. The patient indicated that they were very happy with their care in Hospital A remarking *“You only have to ask a question*

and someone will answer". A possible explanation for this situation occurring was offered by a ward manager at Hospital A who indicated that not all hospitals or General Practitioners have the expertise or results from diagnostic scans to recognise this condition. The importance of the information provided by the patient was possibly not able to be fully realised or acknowledged by staff within the previous hospital. This also highlights a potential downside to concentrating expertise within specialist centres.

Previous experiences

Speed of diagnosis, the extent of disease progression and previous experience of cancer also seem to influence the level of impact of negative interactions. Three of the patients reporting high impact value co-destruction episodes perceived that there was a delay in reaching their diagnosis of cancer. Two of these patients also described their diagnosis as terminal and the third that their cancer was no longer curable. The nature of subsequent interactions between such patients (and family members) and staff were potentially more closely scrutinised, particularly if they felt that they had been previously been ignored or that their concerns had not listened and responded to. This point is illustrated in the next extract and relates to service use outside of Hospital A:

"[...] And then a nurse came round and then said 'Oh we have been ringing your home, we wondered where you had been we have been looking for you'. Well it was a load of rubbish. When I got home I rang 1471 and there had been no phone calls, the last call had been with my daughter the previous day. So they lied to me, they forgot about me..."(IN 40: ID 53; patient, high impact episode).

Two additional patients also reported experiencing more than one occurrence of cancer. When patients have recurrent cancer diagnoses, emotions may already be running high during health service encounters. These patients may have experienced a greater number of cancer-related health care interactions and potentially were more aware of how they were communicated with by staff. These findings further illustrate that the impact of value co-destruction episodes can accumulate over the course of service encounters.

2.3.1.2 *Negative impact other patients*

Interactions between patients are also viewed as contributing to a small number of value co-destruction episodes. These interactions may be direct i.e. face-to-face conversations or indirect i.e. through observing other patients within the Centre. Interactions between patients were viewed as negative when this led to heightened patient anxiety. This may be due to the nature of the information shared by other patients who had differing experiences and outcomes of treatment.

Patient interactions were also viewed as negative if actions were viewed as breaching expected behaviour (i.e. being disrespectful of other patients on the ward, being rude or angry to health care staff and/or other patients, not accepting their diagnosis). This had a higher impact when patients were unable to intervene or challenge the behaviour of the other patient, as illustrated in the extracts below. The first relates to an experience in a non-specialist hospital and the second to Hospital A. The second account also illustrates how patient to patient interactions can potentially create value, with knowledge of the condition being shared with the newer patient.

“[...] But the other one was quite a spoilt little girl. She was about seventeen or eighteen, I think, but she wanted all the painkillers going. She couldn't swallow. She couldn't eat. Complained about everything, but she sat up all night on her laptop watching things on her laptop. She has her light thing on and because her bed was like opposite mine I kept thinking you selfish girl, but then in the morning they would change her bed and she'd get back into bed and sleep all day. So I felt like going up and shaking her really” (IN 51: ID 66; patient, medium impact episode).

“It was a patient and he come in here expecting miracles and straight away he had a go at one of the doctors actually a nurse. [...] ‘Oh you are not doing your job right’, you know you. [...] And I said ‘The trouble with you is you expect miracles it's your first time in and this is my fourth time’ and I said ‘I know I haven't got nowhere yet. It's your first time in and you want to be walking out of here all cured’ I said ‘It's not going to happen’ ” (IN 22: ID 27; patient, low impact episode).

Two out of the four episodes describing negative interactions concerned waiting areas within one department (radiotherapy) of Hospital A. Although there are several

waiting areas in the Centre, the radiotherapy waiting areas vary in terms of size, location, and visibility. When distributing patient information leaflets (concerning this study), the researcher became aware that patients could feel isolated within some of the smaller waiting areas. In several of these areas, the researcher needed to actively look for staff to gain permission to leave materials. The proximity to other patients in the small waiting areas and the lack of visibility to clinical staff potentially heightening anxiety in these confined spaces. Additionally, patients may have found that they saw the same patients at every radiotherapy session if they used one particular radiotherapy treatment room or attended at the same time. Not all patients wished to share stories, particularly if they were already experiencing high levels of anxiety. This is illustrated in the extract below.

“I think it’s the patients during the radiotherapy that are the problem [...] Negative, attentively and utterly negative. That was the only time... I’ve been through chemotherapy, I’d been through the surgery. That was the only time that I ever doubted that the cancer was still there. [...] So as soon as I could get out... well I did change my times on the radiotherapy” (IN 08: ID 10; patient, medium impact episode).

Alternatively, it may have been the visual impact of cancer on other patients’ physical appearances which caused distress, particularly if patients were still adjusting to a cancer diagnosis and the nature of treatment themselves.

“I think the difficult thing has been and the only word is medieval you know it is people who have got the visual you know the facial and head problems where there they obviously have got some difficult conditions going on. That I find really hard that is really difficult. And then it’s part of it. You can’t...I’ll just you know, if it’s very bad I just go and take a diazepam” (IN 38: ID 51; patient, medium impact episode).

Heightened anxiety of patients in waiting areas was also raised with the researcher on two occasions by members of the management team within Hospital A. On the first of these occasions, the staff member indicated that patients may be awaiting news, which could potentially be bad, regarding the outcomes of investigations and response to treatment, as well as attending for general treatment reviews and

follow-up (Research diary 09/09/2013). On the second occasion (September 2014), during a preliminary feedback session with two senior managers, the researcher indicated that some patients found the radiotherapy waiting areas distressing. This view was supported by one of the senior managers, who earlier that morning had noticed a very distressed patient in one of these waiting areas and had gone to speak to them. Despite small numbers of people reporting this in this study, managers indicated that they had thousands of patients coming through the Centre and it was likely to be a larger problem than anticipated. A decision was made by the most senior manager to review the role of radiotherapy helpers and consider how to support patients further in waiting areas. The researcher had also observed the main waiting area in the radiotherapy department and noted on one occasion, during a one and a half hour timeframe, that there was no interaction at all between patients. This led the researcher to wonder whether this helped or hindered patients' emotional state (Research diary 03/06/14).

2.3.1.3 Quantity of interactions

The number of interactions that patients experience during inpatient treatment in Hospital A is raised by one patient as challenging, particularly when undergoing intensive therapies as an inpatient. Large numbers of interactions seem to reflect the specialist nature of the hospital and the number of teams patients may have involved in their care. This was also an issue which was acknowledged by a staff member within Hospital A, as illustrated in the accounts below.

“[...] You are feeling dreadful you have just been down to... (inaudible)... and they are sticking their head around the door and you said you know, ‘Can you just leave me alone for a couple of hours and you know. I don’t mean to sound rude but I just want to be left alone for a couple of hours. I have just had therapy and you know, can I just be left alone?’ ” (IN 76: ID 93; patient, medium impact episode).

“So often... there are a lot of teams. It’s a small environment here, but there are a lot of teams involved in the patients. You’ve got their oncology team. You’ve got their ward team. If we’re involved you’ve got our teams. So that’s a lot of people going to see a patient in one day...” (IN 47: ID 62, staff member).

2.3.2 Resource misuse

Resource misuse is a main factor in contributing to value co-destruction episodes (high impact n=5, medium impact n=4, low impact n=6). A range of health care staff and health care sites are involved in value co-destruction episodes within this theme including: general practitioners; nursing staff (district/community nurses, Hospital A nursing staff); medical staff (Consultants within non-specialist hospitals, Consultant oncologists within Hospital A). This theme is related to delayed diagnosis and misdiagnosis, technical failure of equipment or staff skills and difficulties with information exchange, and integration processes between health care staff and patients. The latter reflects the level of information asymmetry existing between health care staff and patients in relation to knowledge and understandings of disease and treatment processes and outcomes. Dependency on health care staff and the specialist centre are also viewed as a form of resource misuse. These elements are explored in sections 2.3.2.1 to 2.3.2.5.

2.3.2.1 Delayed diagnosis and misdiagnosis

Speed of reaction to the presenting symptoms of cancer and the ability of health care staff to accurately diagnose cancer are key issues reported within five high impact value co-destruction episodes in this study. Misdiagnosis of initial symptoms also features within three of the value co-destruction episodes reported by patients. Those patients reporting a delay in diagnosis had numerous interactions with health care professionals prior to initial investigations being undertaken and a cancer diagnosis being reached. Although there was variation in the health care professionals involved in these five value co-destruction episodes, in two of these episodes patients perceived that the sole responsibility for failing to reach an earlier diagnosis lay with specific general practitioners within their GP practice. One of these accounts also indicates that a second member of staff in the practice also failed to recognise early symptoms. The remaining three value co-destruction episodes involved single (1 other hospital) or multiple health care sites and health care professionals (2 GP/other hospitals). These points are illustrated in the next two extracts.

“After 10 months of misdiagnosis of diverticulitis it was discovered that I had ovarian cancer. And before they were able to operate I had to have 9 litres of fluid removed, which had given me this huge bloated stomach that should have been a clue to what was wrong but it had been missed. [...] I had gone to the GP with pains and colicky funny pains and immediately without any test he said it’s probably diverticulitis [...] I went back to my GP more than once and then I saw a different doctor and she announced it was wind!” (IN 4: ID 5; patient, high impact episode)

“They couldn’t find anything on the scans so I then got booked for an exploratory operation which I had in March, end of March. In between these times there was still the attacks going on so frequent admissions to A and E and it was starting to wear me down now because there was no diagnosis” (IN 41: ID 55; patient, high impact episode).

The implications of delayed diagnosis, or initial misdiagnosis, are viewed as extremely high by all of the five patients reporting this element, with the impact perceived as irrecoverable. This is particularly important as two of the patients reporting a delay in reaching diagnosis perceived themselves to have a terminal diagnosis, with the remaining three perceiving their cancer to only be manageable rather than curable. Patients also questioned whether outcomes would have differed had an earlier diagnosis been reached. The extent of the disease and capacity for this to have been curable are dominant issues within such. These points are illustrated in the extracts below.

“Because I’ve known people who had ovarian cancer and had a tumour removed and had chemo and they are fine. And I try not to dwell on that and now I’ve come away from that again because there is no point in dwelling on that. Oh but it would have been different if I had been diagnosed sooner” (IN 4: ID 5; patient, high impact episode).

“[...] Well if they had diagnosed it sooner you know they could have taken the prostate away and I could have been cured of cancer but they decided to leave it is so long which has left me pretty bitter, as you can imagine” (IN 40: ID 53; patient, high impact episode).

Observation undertaken by the researcher within Hospital A also reveals that delayed diagnosis is an issue for other patients attending the Centre. On one such occasion,

whilst the researcher was providing information leaflets regarding this research project in the radiotherapy area, a patient approached the researcher. This patient indicated that they did not wish to participate in the project, as they had just undergone their last treatment, but wished to share their story informally. The patient relayed how it had taken nearly two years for the diagnosis of their cancer to be reached and for their GP to acknowledge that there was a problem. It transpired that the lump was actually a tumour which was subsequently found to have also spread to their lungs. The patient indicated that this was very rare and wondered if this would have happened if they had not had the delay in diagnosis (Research diary 3/06/14).

The negative impact of delayed diagnosis extends beyond the physical effects of the disease and also places a substantial emotional toll on patients. Two of the patients revealed that they had undergone counselling post diagnosis of their cancer. Other patient accounts portray frustration and anger regarding the time it took to reach diagnosis. Such accounts question why health care staff and/or investigative procedures failed to suspect and detect that their symptoms were cancer-related. Additionally, these patients also implied that they did not feel that their concerns were taken seriously, as illustrated in the next two extracts.

“And I was angry because I couldn’t understand how this wasn’t picked up because the cancer had spread you know it’s all across my abdomen and in the fat around the liver and bowel area and I just can’t understand why you know blood tests scans or anything else hadn’t picked this up sooner. So the bottom line was you know it was terminal” (IN 41: ID 55; patient, high impact episode).

“The worst aspect was finding out that I had it in the beginning. Knowing that I had been complaining about it for months and months. That was the worst thing I had to get over” (IN 16: ID 20; patient, high impact episode).

The issue of the validity of patient knowledge is raised within the theme quality of interactions, but also has direct relevance here. Access to diagnostic investigative procedures and subsequent treatment regimens are mainly facilitated through consultations with health care professionals, who in essence are gate keepers to

additional resources. Although patients in this study describe how they have accessed resources privately, this did not apply to those patients reporting delayed diagnosis or misdiagnosis. Failure of health care professionals to respond to patient concerns is perceived to extend time to diagnosis and subsequently delay the onset of treatment for cancer. Lack of expertise, skills or knowledge of health care professionals to recognise and react to the symptoms patients reported potentially also accounted for delays in reaching a cancer diagnosis. These issues also relate to those of technical failure which are discussed in the next sub-section.

2.3.2.2 Technical failure

Technical failure in terms of both equipment and in the knowledge and skills of health care professionals accounts for six of the value co-destruction episodes within the theme 'resource misuse' (2 medium impact, 4 low impact) and two with multiple elements (poor interpersonal and communications skills/ technical failure, technical failure/negative effects of treatment). Two of the low impact episodes relate to equipment breakdown within Hospital A, with the remaining six episodes concerning failure in the technical skills of staff (2 Hospital A, 4 other hospital or community). An illustration of technical failure is provided below, in a medium impact episode, which concerns staff members choosing not to act on the advice offered by the patient (who had undergone approximately 40 chemotherapy treatments) and which results in technical failure (inability to site a cannula in order to administer intravenous medication). This episode relates to an experience in Hospital A.

"I know where they're going to get in and bless them they think they know what they're doing. You soak your hand in a bowl of water and then try somewhere and I know they're not going to get in. I try to be polite, and I say 'you're not going to get in there because...' and then they're allowed two goes each, did you know that?" (IN 57: ID 73; patient, medium impact episode).

Concern over the technical skills of staff outside of the Hospital A was raised in four of these value co-destruction episodes, with patients subsequently expressing reluctance to receive treatment in community settings, or in outreach clinics linked to the specialist centre.

2.3.2.3 Lack of knowledge

Lack of knowledge in relation to the illness and or treatment processes accounts for two value co-destruction episodes within this theme (1 low impact, 1 medium impact) and one high impact episode with multiple elements (poor communication skills/ nature of the information/ lack of knowledge). All of these episodes relate to experiences within Hospital A. The high impact episode, differs slightly to other value co-destruction episodes, in that the impact largely concerned the patient's spouse. The next extract highlights how value co-destruction can occur when discrepancies occur between family members and health care staff in terms of their perceptions and understandings of the patient's illness and future prognosis. This also highlights how resources offered by staff in terms of 'information' cannot always be used, understood, and integrated by patients and/or family members, due to the nature of the terminology used and how the information is delivered. It also illustrates how this situation was exacerbated by a perceived lack of sensitivity and insight into the family members' understanding of the patient's illness.

"[...] Well basically at the second meeting when [NAME OF SPOUSE] became sort of very shocked by what was being discussed, [NAME OF SPOUSE] felt, that they were talking about dismal prognosis and using all sorts of vocabulary as if [NAME OF SPOUSE] should know what this all meant. [...] Well that's what it was you know and so my sciencey bit meant that I didn't care so much about what was being spelt out to me. I kind of already knew what was coming. But [NAME OF SPOUSE] on the other hand who doesn't have a science background and is different kind of person, [NAME OF SPOUSE] needed things more spelt out but [NAME OF SPOUSE] lacked the empowerment to be able to say anything about it and so [NAME OF SPOUSE]... felt very disregarded in the end when [NAME OF SPOUSE] finally realised how untreatable my situation was, [NAME OF SPOUSE] felt bitterly disregarded by everyone who they had spoken to. [NAME OF SPOUSE] felt patronised, overlooked [...]" (IN 18: ID 23).

Value co-destruction is also found to occur when patients perceive they lack the skills and knowledge (resources) to make decisions about treatment options. This is illustrated in the next extract.

“Doctor E came in and said ‘Well it is possible that you may need [DRUG NAME] but the views out there are very varied. Some people say you should have [DRUG NAME] because it’s grade 3 and some people say you don’t so really the choice is yours’. At the time I did feel that I went away a bit bemused not knowing well if the professionals can’t tell me what I should do so then I was googling it and get along an awful lot reading things I really didn’t want to read” (IN 23: ID 28; patient, medium impact episode).

These examples illustrate that patients and family members can vary in their capacity to use the resources offered by health care staff. When they are unable to utilise and integrate these resources, it can lead to emotional distress and/or anxiety, and in these instances, the destruction of value.

2.3.2.4 Nature of information

The nature of information provided by staff accounts for two additional episodes of value co-destruction (1 medium impact, 1 low) and one medium impact episode with combined elements (poor interpersonal skills/ nature of the information). Two of these episodes relate to inconsistencies in the information provided by staff, in terms of (i) long term side effects of treatments, or (ii) treatment processes. This is illustrated in the extract below, with the patient highlighting how they may have made differing choices had they been fully informed of the negative effects of the treatment regimens.

“[...] I asked them how long would I lose my taste for and then they said about up until about two or three weeks after your treatment stops. And then when I asked again now last week they told me that my taste might never ever come back, so I think they should tell you that before you start your treatment because they tell you one thing and now they are telling me another. [...] I would rather have had the truth at the beginning you know maybe, taste is a big thing see, because if there was doubts over my taste not coming back you know maybe I would have decided that you know I didn’t want to have treatment on my tongue [...]” (IN 34: ID 45; patient, medium impact episode).

The episode with combined elements relates to the language used by staff in relation to the outcomes of the patient’s treatment (i.e. fair chance, good chance, very good

chance), with the patient questioning the meaning and usefulness of these terms at a time when there was uncertainty regarding their condition.

2.3.3 Organisational factors

Organisational factors account for 10/58 of the value co-destruction episodes (2 high impact, 8 medium). These mainly relate to episodes in Hospital A as these predominantly concern the negative effects of treatment interventions (2 high impact, 6 medium impact). For most of the patients reporting negative effects, they were rated as medium impact as these were time limited, and/or seen as a 'small price' to pay for the overall treatment benefit, particularly in those patients who perceived their cancer as being managed rather than treated. This is illustrated in the extract below.

"They did turn round and say to me that you become impotent or 'important' as I really like to say it (laughs) but we had discussed this because this had crossed up fairly early in the treatment hadn't it? And we had no qualms about it at all [...]. If I am going to live another ten years and I have got to give up something I'm quite happy with that" (IN 67: ID 73, patient).

However, for two patients, the cumulative impact of the negative effects of treatment interventions over time, was perceived as having a substantial emotional impact. This point is illustrated in the extract below.

"But if you said to me now there is a switch on the wall and I can switch your life off now I would say okay go ahead because I worry about the future. So much has happened and I have ended up in hospital on about four or five occasions since the cancer was diagnosed, sort of overnight..." (IN 53: ID 68; patient, high impact episode).

The two other value co-destruction episodes within this theme relate to: a perceived lack of control over access to a non-routine drug treatment (medium impact), and lack of co-ordination between the specialist centre and an outside agency (a department within a larger general hospital).

2.3.4 Access to resources

The theme access to resources accounts for eight (single element) value co-destruction episodes which relate to an inability to access resources (3 medium impact, 2 low impact) or where relationships with service providers have ended (2 medium impact, 1 low impact). Restricted access to resources relates to an inability to access diagnostic procedures or scans promptly in other organisational sites prior to attending the specialist centre (2 medium impact episodes). This theme also concerns access to potentially life prolonging drug treatments that Hospital A is unable to provide unless it is either: privately funded, or approved by a specialist panel at health board level (2 medium impact episodes). Four patients, when faced with difficulties accessing either preliminary diagnostic scans or drug treatments used their own personal resources (either financial or skills based) to facilitate access. If they had not done so, these episodes may have been viewed as high impact episodes for two reasons. The first was that two of these instances were related to access to potentially life prolonging or saving treatments that were not routinely funded. The second was that the scans which were paid for privately revealed tumours which the patients perceived to be fast growing and aggressive in nature (see section 1.2.3).

An additional three value co-destruction episodes (2 high impact, 1 medium impact) contain multiple elements. Two of these concern poor communication skills and lack of access to resources. In both of these accounts, the manner in which the patients were treated by staff at an interpersonal level led to them being denied access to resources within the hospitals where they were receiving treatment.

“Well patients were actually looking after me at this point. And they were really, it’s a surgical ward you know and they weren’t well. One of them had four drains in her you know and she was giving me the vomiting bowls. She was wiping the sweat from my head you know and the patient across me who was very confused was screaming at the nurses ‘ somebody is being ill in here come and help’, but all they had done was close the curtains off and just leave me”(IN 41: ID 55; patient, high impact episode).

The remaining value co-destruction episode with multiple elements concerns dependency/lack of access. This account highlights the potential implications of attending the Centre as a long term inpatient, as the patient lost confidence in their ability to return home.

“I think, I think the length of stay. That you got used... I didn't want to be here in a lot of ways, but at the same time I was afraid to go home and I think it was purely, as I said, like the comfort of the safety net, you know, if I started to choke what will happen if I... it's just having the health professions, if you like at your beck and call” (IN 46: ID 61, patient: medium impact level).

The remaining value co-destruction episodes within this theme (2 medium impact, 1 low impact) highlight how value can be destroyed when relationships with the specialist centre, or external agencies, end abruptly. This is illustrated below.

“So the contact that I had had with the nurse, breast nurse, in Hospital E, basically came to an abrupt halt as my care was taken over here, and that was a little bit out of the frying pan into the fire. (IN 54: ID 69; patient, medium impact episode).

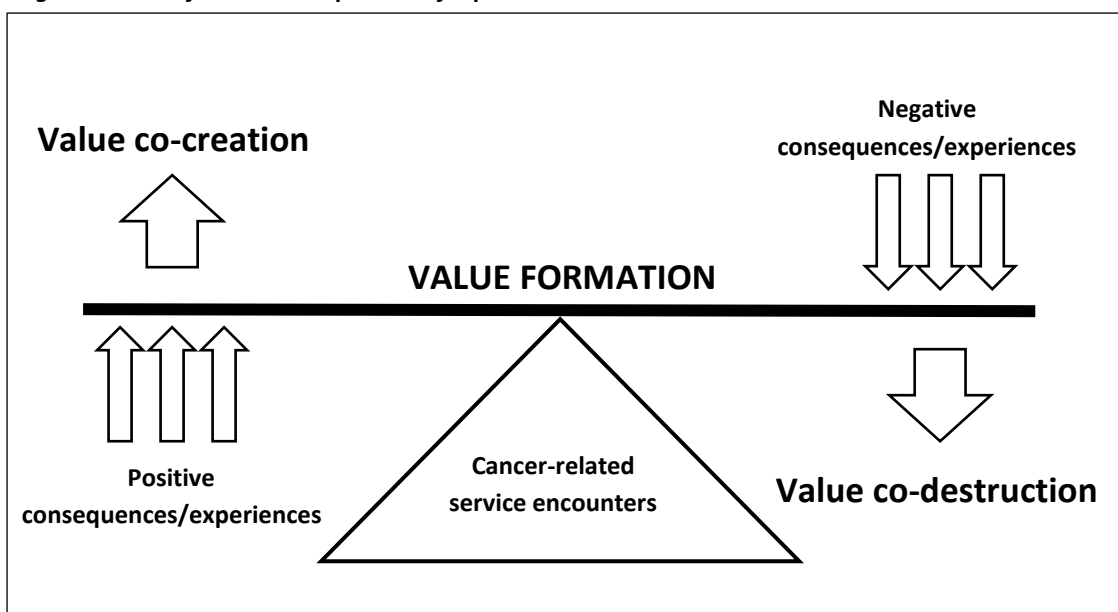
This also relates to the relationship ending with the specialist centre due to the treatment and monitoring period coming to an end. This is an issue that is only raised by one patient, possibly because the majority of patients were all undergoing treatment at the point at which they participated in the study. It is, however, an issue which is raised and recognised in fourteen of the staff interview accounts, which outline how patients could feel anxious and isolated once their contact with the Centre ended i.e., “*[...] I think they find it challenging that suddenly at the end of active treatment or having had all this nurturing, looking after care, it's suddenly gone and they're left bereft.*” (IN 45: ID 60, staff member).

2.4 Accumulation and dissipation of value

Sections 1 and 2.1-2.3 of this chapter have illustrated how, by exploring service user and service provider conceptualisations of value within a cancer service context, that the concept of 'value' is temporal, in that this changes over time and is experienced 'in context', in relation to lived experiences. These findings have also shown that

there is potential for value to be created and destroyed during individual or across multiple cancer service encounters. These findings illustrate how key elements or factors contributing to perceived benefit(s) of service use (i.e. the quality of interactions, access to specialist knowledge and skills, resource use/ resource misuse and organisational factors), also have the potential to negatively impact on patients' well-being. Whilst the value formation process could be viewed as analogous to one of equilibrium, this process may more aptly be considered in terms of a 'see-saw' effect when positive and negative consequences arise. This is illustrated in Figure 3.

Figure 3: Value formation as process of equilibrium



While Figure 3 assists in visualising the value formation processes, it does not, however, capture how value accrues over the course of multiple service encounters or diminishes. All of the patients in this study experienced multiple cancer-related service encounters across multiple organisational sites. As indicated earlier in this chapter, 35/56 patients experienced episodes of value co-destruction. Of the 58 value co-destruction episodes identified, 34/58 relate to Hospital A, (as a single or multiple site, see Table 14). Although 22 patients experienced single episodes of value co-destruction, 13 experienced multiple episodes at either the same level of impact (6 patients, 15 episodes), or multiple levels of impact (7 patients, 21 episodes). Tables 16-18 provide a summary of these data.

Table 16: Single episodes of value co-destruction (N=22 patients, N=22 episodes)

NO OF PATIENTS AND TYPE OF EPISODE	IMPACT	ELEMENTS (SINGLE OR MULTIPLE) Single element N=18 Multiple elements N=5	OCCURRENCE ELEMENTS (SINGLE OR MULTIPLE) Single occurrence N=16 Multiple occurrences N=7	SITES (SINGLE OR MULTIPLE) Single site N=23 Multiple sites N=0
SINGLE EPISODE N=3	HIGH 3	SINGLE 2 MULTIPLE 1	Single element multiple occurrence 2 Multiple elements multiple occurrence 1	SINGLE SITE Single site single element multiple occurrence 2 (1 Hospital A, 1 GP) Single site, multiple elements multiple occurrence 1 Other hospital
SINGLE EPISODE N=14	MEDIUM 14	SINGLE 10 MULTIPLE 4	Single element single occurrence 9 Single element multiple occurrence 1 Multiple elements single occurrence 1 Multiple elements multiple occurrences 3	SINGLE 14 (12 Hospital A, 2 other hospital)
SINGLE EPISODE N=5	LOW 5	SINGLE 5 MULTIPLE 0	Single element single occurrence 3 Single element multiple occurrence 2	SINGLE SITE 5 (5 Hospital A)

Table 17: Multiple episodes of value co-destruction at the same level (N=6 patients, N=15 episodes)

TYPE & NO OF EPISODES	IMPACT	ELEMENTS (SINGLE OR MULTIPLE) Single element N=13 Multiple elements N=2	OCCURRENCE ELEMENTS (SINGLE OR MULTIPLE) Single occurrence N=7 Multiple occurrences N=8	SITES (SINGLE OR MULTIPLE) Single site N=13 Multiple sites N=2
MULTIPLE HIGH N=1 PATIENT 3 EPISODES	HIGH 3 HIGH	<i>Single</i> 2 <i>Multiple</i> 1	<i>Single element single occurrence</i> 1 <i>Single element multiple occurrences</i> 1 <i>Multiple element multiple occurrences</i> 1	SINGLE SITE <i>Single site single element multiple occurrences</i> 1 (Community) <i>Single site multiple elements multiple occurrences</i> 1 (Other hospital) MULTIPLE SITE <i>Multiple sites/single element single occurrence</i> 1 (GP and other hospital)
MULTIPLE MEDIUM N=3 PATIENTS 1 PATIENT- 2 EPISODES 2 PATIENTS- 3 EPISODES EACH	MEDIUM 2 MEDIUM 3 MEDIUM 3 MEDIUM	<i>Single</i> 7 <i>Multiple</i> 1	<i>Single element single occurrence</i> 3 <i>Single element multiple occurrences</i> 4 <i>Multiple element multiple occurrences</i> 1	SINGLE SITE (N=7) <i>Single site single element single occurrence</i> 1 (Community-breast screening) <i>Single site single element multiple occurrence</i> 4 (Hospital A) <i>Single site, single element, single occurrence MEDIUM</i> 1 (Other hospital) <i>Single site, single element, single occurrence MEDIUM</i> 1 (Hospital A) MULTIPLE SITES (N=1) <i>Multiple site, multiple elements, multiple occurrence</i> MEDIUM 1 (Hospital A and Hospital A outreach)
MULTIPLE LOW N=2 PATIENT 2 PATIENTS-2 EPISODES EACH	LOW 2 LOW 2 LOW	<i>Single</i> 4	<i>Single element single occurrence</i> 3 <i>Single element multiple occurrences</i> 1	SINGLE SITE (N=4) <i>Single site single element single occurrence</i> 3 (1 other hospital, 2 Hospital A) <i>Single site single element multiple occurrences</i> 1 (GP)

Table 18: Multiple episodes of value co-destruction with varying impact levels (N=7 patients, N=21 episodes)

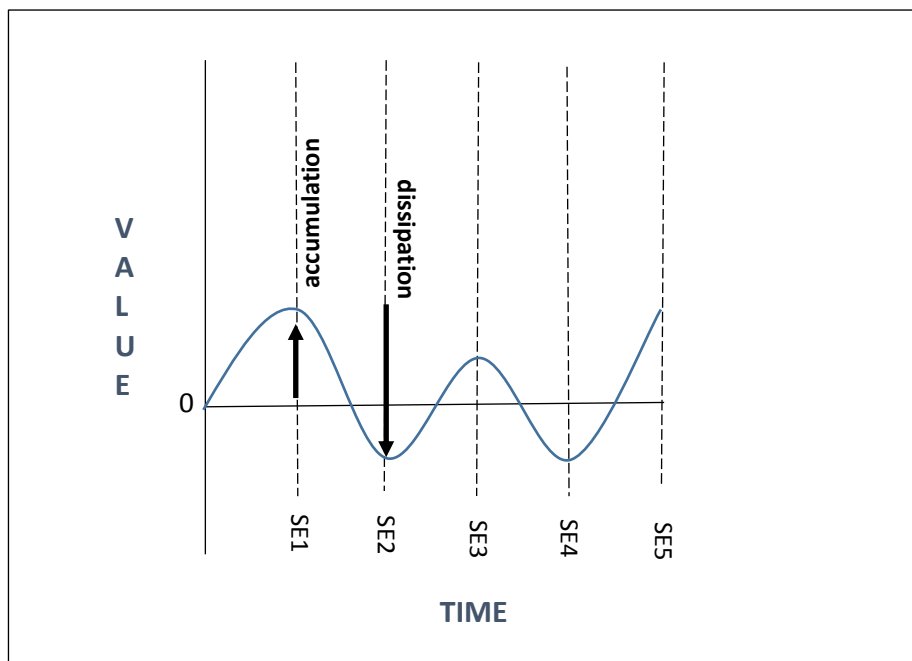
NO OF EPISODES	IMPACT LEVELS	ELEMENTS (SINGLE OR MULTIPLE) Single N=20 Multiple N=1	OCCURRENCE OF ELEMENTS (SINGLE OR MULTIPLE) Single N=12 Multiple N=9	SITES (SINGLE OR MULTIPLE) Single N=17 Multiple N=4
2 EPISODES (N= 3 PATIENTS) N=1 patient N=2 patients	1 HIGH + 1 MEDIUM 1 LOW + 1 MEDIUM	<i>Single</i> 1 HIGH 1 MEDIUM <i>Single</i> 2 LOW 2 MEDIUM	<i>Single element single occurrence MEDIUM</i> 1 <i>Single element multiple occurrences HIGH</i> 1 <i>Single element single occurrence LOW</i> 2 <i>Single element single occurrence MEDIUM</i> 1 <i>Single element, multiple occurrences MEDIUM</i> 1	<i>Single site, Single element single occurrence MEDIUM</i> 1 (Hospital A) <i>Single site, single element multiple occurrence HIGH</i> 1 (GP) <i>Single site single element single occurrence LOW</i> 2 (1 Hospital A, 1 Other hospital) <i>Single site single element single occurrence MEDIUM</i> 1 (Other hospital) <i>Single site single element multiple occurrences MEDIUM</i> 1(Hospital A)
3 EPISODES (N=1 PATIENT)	2 HIGH + 1 LOW	<i>Single</i> 2 HIGH 1 LOW	<i>Single element multiple occurrences HIGH</i> 2 <i>LOW</i> 1	<i>Single site single element multiple occurrences LOW</i> 1 (Community) <i>Multiple sites single element multiple occurrences HIGH</i> 2 (Other hospitals+ hospital A)
4 EPISODES (N=3 PATIENTS) N=1 patient	3 HIGH + 1 MEDIUM	<i>Single</i> 3 HIGH 1 MEDIUM	<i>Single element single occurrences HIGH</i> 2 <i>Single element multiple occurrence HIGH</i> 1 <i>MEDIUM</i> 1	<i>Single site, single element single occurrence HIGH</i> 2 (Other hospital) <i>Single site, single element, multiple occurrences HIGH</i> 1 (Other hospital) <i>Single site single element single occurrence MEDIUM</i> 1 (Hospital A)

Table 18: Continued

NO OF EPISODES	IMPACT LEVEL AND COMBINATION	ELEMENTS (SINGLE OR MULTIPLE)	OCCURRENCE ELEMENTS (SINGLE OR MULTIPLE)	SITES (SINGLE OR MULTIPLE)
<p>4 EPISODES (Continued)</p> <p>N=1 patient</p>	<p>2 HIGH + 2 MEDIUM</p>	<p><i>Single</i> 1 HIGH 2 MEDIUM</p> <p><i>Multiple</i> 1 HIGH</p>	<p><i>Single element single occurrence MEDIUM</i> 2</p> <p><i>Single element, multiple occurrence HIGH</i> 1</p> <p><i>Multiple elements, single occurrence HIGH</i> 1</p>	<p><i>Single site, single element, single occurrence MEDIUM</i> 1 (Community)</p> <p><i>Single site, multiple elements, single occurrence HIGH</i> 1 (Hospital A)</p> <p><i>Multiple sites, single element, single occurrence MEDIUM</i> 1 (GP/Other hospital /Hospital A)</p> <p><i>Multiple sites, single element multiple occurrences HIGH</i> 1 (GP/Other hospitals)</p>
<p>N=1 patient</p>	<p>2 MEDIUM+2 LOW</p>	<p><i>Single</i> 2 MEDIUM 2 LOW</p>	<p><i>Single element single occurrence MEDIUM</i> 2</p> <p><i>Single element single occurrence LOW</i> 1</p> <p><i>Single element Multiple occurrences LOW</i> 1</p>	<p><i>Single site, single element, single occurrence MEDIUM</i> 2 (1 Community, 1 other hospital)</p> <p><i>Single site, single element, single occurrence LOW</i> 1 (1 Community)</p> <p><i>Single site, single element, multiple occurrences LOW</i> 1 (1 Hospital A)</p>

All of the patients who experienced multiple episodes of value destruction each encountered these across different organisations. This implies that value co-destruction can span across differing service providers over multiple service encounters. It is, however, apparent from patient interview accounts, that all but one of the 35 patients reporting episodes of value co-destruction also described positive aspects of service encounters in relation to Hospital A and/or another organisational site. This finding shows that value can accrue and diminish or dissipate over the course of single and multiple service encounters. This is not necessarily a linear process, with 'value' potentially oscillating over the course of multiple service encounters as it is co-created and destroyed, or naturally dissipates over time. This process is represented in Figure 4.

Figure 4: Accumulation and dissipation of value across multiple service encounters (SE)



When the service relationship ends, patients do not necessarily have the opportunity to recover lost value or address the negative consequences of previous episodes of service use. However, all but one of the 56 patients in this study reported positive aspects of service use, which potentially implies that value has either previously been created through service use or subsequently created after experiencing value co-

destruction. This does not mean that all value co-destruction episodes were resolved at the point the interviews were conducted for this study. Indeed, the effects of some value co-destruction episodes are not reversible i.e. where this concerned delayed diagnosis or misdiagnosis. It is, however, apparent from some participant accounts that some patients experienced subsequent episodes of positive value formation in Hospital A. This appears to partially negate, and in some cases recover, value that was destroyed through service use in other organisations.

The potential for value recovery by the specialist centre is illustrated in the following accounts of two patients, who both had experienced multiple high impact episodes of value co-destruction in other organisations. Both these patients also perceived that there had been a delay in reaching diagnosis or an initial misdiagnosis of their cancer.

“[...] So when I walked in here, I wasn’t particularly hopeful you know. It’s you know here we go again and I walked in and I was grey, I was like an old woman and I had no will to live and no hope, no dignity no self-respect, no energy, no life. [...] In twenty-four hours they had given it me all back you know. Within 10 to 15 minutes, well immediately there was a sister who was introduced to me and put in charge of my care. Within half an hour I had three doctors round my bed taking my case history and doctors who were not patronising, who were listening, they actually listened, who didn’t stand over you and look down on you, and if they had to knelt on the floor, you know, and looked you straight in the eye, who were so professional, who so worked like a team that you know within two hours I could start feeling, I am starting to feel safe now. I feel safe you know. Do what the hell you like to me. I feel safe. [...] So this place owes me my life, my self-respect, my dignity and my life force and it has given me the resources and the strength, the support... to fight, to go on. And that’s my story (laughs)” (IN 41: ID 55, patient).

[...] I feel better in myself now than I did twelve months ago. I’m a lot more confident in these than I had in people in Hospital D. So I feel they are doing all they can for me and they are very helpful here.[...] And getting answers you know. There is no bull you know they are straight upfront with you. Yes I find the treatment, everything here, the staff. I wouldn’t have any other way now I

certainly wouldn't go back to Hospital D.[...] So all round service here I have got every trust in them, every faith in them" (IN 40: ID 53, patient).

Not all accounts of subsequent value formation were quite as extreme as these two examples, nor did they always involve the actions of health care staff. In some instances, patients (and family members) could resolve negative consequences. This latter point is illustrated in the next account, where staff behaviour was challenged when a patient felt that they were being ignored. This behaviour was challenged in an unexpected manner by the patient, and led to the successful resolution of this situation.

"[...] Because the first time I went I roared... I couldn't get my breath because of this one radiologist it was. I couldn't get my breath that was terrible. [...] I absolutely roar I must've sounded terrible. [...] I thought you know, I thought she wasn't paying attention... but after she was, afterward she was. She has been fine. So. She knows what is coming!" (IN 31: ID 42; patient, low impact episode).

In other instances, the impact of value co-destruction was lessened due to the overall positive experience within an organisation, or because the overall benefit of the treatment was seen to outweigh the negative consequences, or due to the speed of response of staff in alleviating an adverse situation. This is illustrated in the following extract.

"The only thing that made me realise that it was a crisis, [SPOUSE'S NAME] had been with me and he had just gone for a cup of tea or something and when all this was going on, the pain was just dreadful. I just heard a voice somewhere because I had an oxygen mask I couldn't talk they were asking questions I couldn't answer them. I didn't want to think about answers to questions anyway and I just heard a voice somewhere 'Where's her husband?' And I thought 'Oh well this is it, they want to find him so they can tell him what has happened'. But even though there probably was an element of panic with a small 'p' you know, but it was sorted out and I was prepared to have a go again (Laughs) even though that had happened" (IN 04: IN 04, patient).

These findings suggest that value can accumulate and dissipate or diminish over the duration of multiple service encounters. These insights also illustrate that the specialist centre in this study, whilst appearing to co-create value through service interactions with patients within this organisation, also appears to recover value that has been destroyed at earlier points in the cancer service experience through subsequent, additional value formation. It is, however, unclear how value co-destruction episodes at varying impact levels aggregate, as this is unlikely to be a linear process.

Summary

This chapter has presented the first empirical application of the S-D logic framework to a UK specialist cancer service setting. In doing so, sections 1 and 2 explored conceptualisations and trajectories of value (positive and negative) across single and multiple health care encounters in the context of service user and service provider cancer service experiences. A key finding arising from such analyses, is the temporal, experiential and contextual nature of the concept of 'value' in this setting.

The analyses of interview and observational data led to the identification of four main study themes pertaining to positive and negative trajectories of value (i.e. access to resources, quality of interactions; resource use/resource misuse and organisational factors, see sections 1.1-1.5 and 2.1 and 2.3). The capacity to access, exchange, utilise and integrate resources, were found to be central factors in both the creation and destruction of value in this service context. These processes were shown to be influenced by the quality of interactions during service encounters, and features perceived as specific to the specialist cancer service context, such as the nature of the 'staff resource'. In undertaking this work, this chapter also developed and reported on a classification system for the analysis of episodes of value co-destruction (see section 2.2). The potential for 'value' to accrue and diminish across service encounters during cancer-related service use was also explored.

On the basis of the analyses reported in this chapter, key findings have been identified in five main areas. These findings specifically concern: (1) trajectories of value in cancer services (2) value conceptualisations; (3) value co-creation processes including (a) involvement in service exchange and (b) resource exchange and integration processes; (4) the nature and scope of value co-destruction; (5) the classification of value co-destruction and. These five key findings are considered in relation to the existing understandings in the final chapter of this thesis. The final chapter additionally considers the extent to which the S-D logic framework maps into a health care context.

CHAPTER FOUR: DISCUSSION AND CONCLUSION

Introduction

This thesis reports a study of service user and service provider conceptualisations of 'value' (i.e. value-in-use, Vargo and Lusch 2004a) in a UK specialist cancer service context. This is the first study to: (a) apply an analytical framework based on S-D logic to a UK specialist cancer service context, and (b) analyse trajectories of value (both value co-creation and co-destruction) within this setting. In presenting this work, this study adopted a transdisciplinary approach and combined scholarship from fields including services marketing and public management.

This chapter has two main purposes. The first is to consider the relationship between the key themes introduced in the empirical chapter and the S-D logic axioms and premises under investigation in this study (see chapter 1, section 2.2, Table 3). The second purpose is to consider the findings within the context of the services marketing and public management literatures. This chapter is organised into four sections. Section one discusses this study's findings in relation to the S-D logic framework. This section then considers the study findings within the context of the services marketing and public management literatures. Section two outlines the conceptual, empirical, methodological and policy contributions of this study. Section three details the limitations of the study. The final section considers the transferability of the study findings and highlights avenues for future research.

Section 1: Findings and relationships to S-D logic and current literatures

Table 19 presents a summary of the main study themes and key findings and their relationship to the S-D logic axioms/ foundational premises investigated in this study.

Table 19: Relationship between study themes, dimensions, key findings and S-D logic axioms/foundational premises

Theme	Dimensions	S-D logic axioms/FPs (Vargo and Lusch 2016a)	Key findings and S-D logic axioms/foundational premises
Access to resources	(VCC) Ongoing access and support (VCC) Specialist knowledge and skills (VCC) Timely access/responsiveness (VCC) Reduction of information asymmetry (VCD) Lack of access (VCD) Relationships ended	Axiom 1/FP1 Service is the fundamental basis of exchange.	Key finding 1. Trajectories of value in cancer services Axiom 1/FP1 Axiom 2/FP6 and FP7 Axiom 3/FP9 Axiom 4/FP10
Quality of interactions	(VCC) Interpersonal skills/language of care (VCC) Person-focused care (VCC) Time for the patient (VCD) Poor staff interpersonal/communication skills (VCD) Negative impact of other patients (VCD) Quantity of interactions	Axiom 2/FP6 *Value is cocreated by multiple actors, always including the beneficiary.	Key finding 2: Value conceptualisations Axiom 1/FP1 Axiom 2/FP6 and FP7 Axiom 3/FP9 Axiom 4/FP10
Resource use/ Resource misuse	(VCC) Types of involvement (VCC) Types of resources (VCC) Capacity to exchange/ integrate resources (VCC) Value propositions (VCC) Expectations/Managing expectations (VCC) Perceived outcomes (VCD) Delayed diagnosis/misdiagnosis (VCD) Technical failure (VCD) Lack of knowledge (VCD) Nature of information (VCD) Dependency	FP7-Derived from Axiom 2- Actors cannot deliver value but can participate in the creation and offering of the value propositions Axiom 3/FP9 All social and economic actors are resource integrators.	Key finding 3: Value co-creation processes <i>Finding 3a: Involvement in service exchange</i> <i>Finding 3b: Resources, resource utilisation and integration</i> Axiom 1/FP1 Axiom 2/FP6 and FP7 Axiom 3/FP9 Axiom 4/FP10
Organisational factors	(VCC) Organisation features/extra mile (VCD) Negative effects of treatment (VCD) Lack of control (VCD) Organisational constraints	Axiom 4/FP10 Value is always uniquely and phenomenologically determined by the beneficiary.	Key finding 4: The nature and scope of value co-destruction Axiom 1/FP1 Axiom 2/FP6 and FP7 Axiom 3/FP9 Axiom 4/FP10
Additional Intertwined themes <i>Emotional safety</i> <i>Trust</i>		<i>*The term 'cocreated' is not hyphenated in Vargo and Lusch 2016a</i>	Key finding 5: Classification of value co-destruction Episodes Levels of impact: High, Medium, Low Elements Occurrences Organisational sites

1.1 Mapping S-D logic into specialist cancer care

The findings from this study present a broad degree of support for the application of the S-D logic framework within a cancer service context. The empirical data presented in Chapter 3 reveal that 'value' in the context of a specialist cancer service context is perceived in terms of 'service' i.e. a process in which an 'actor' applies his/her knowledge and skills/competences for the benefit of others (Lusch and Vargo 2006a; Lusch and Vargo 2014). As can be seen in Table 19, access to resources is a key theme which emerged from the analysis of study data. In this study, this concerns the application of the operant resources of staff within the specialist centre for the benefit of the patient. The findings of this study reveal that the reduction of information asymmetry through ongoing access to the specialist knowledge and skills of staff within the specialist centre, is an important component of value. This was viewed by many of the patients and staff as a core part of the service exchange as implied by Axiom 1 of the S-D logic framework. The findings presented in Chapter 3 also reveal that value co-creation is a process which involves multiple actors (which includes other patients), with value largely defined in terms of interactions between patients and a range of health care staff. Additionally, the nature of the service that staff perceive they offer (value propositions) is found to be closely aligned with dimensions of value identified by patients. This lends support to Axiom 2 and FP7 within a cancer service context.

The findings presented in Chapter 3 also support Axiom 3, in terms of viewing study participants as 'resource integrators' who drew on a range of resources throughout their cancer service experience (i.e. personal resources, health care staff, family members and friends). This includes previous experiences of service use. The phenomenological, contextual and individually determined nature of value, as implied by Axiom 4/FP10, is also apparent within this study. This is exemplified by findings showing that patients and family members defined 'value' in terms of their individual cancer service and personal experiences. There are, however, common themes identified in relation to how value is conceptualised, as illustrated in Table 19. The findings of this study also underscore the inter-connected nature of the S-D

logic axioms/premises under investigation. For example, in considering how value is conceptualised (Axiom 4/FP10), it is apparent that perceptions of value are influenced by previous experiences (Axiom 3/FP9), as well as the nature of resources offered and exchanged and the actors involved in these processes (Axiom 1/FP1; Axiom 2/FP6, FP7). This relationship is illustrated in Table 19 (column 4).

The S-D logic framework usefully focuses attention on the interactional aspects of service, and how value is created through use of a service (Vargo and Lusch 2004a). The framing of the service user, as someone who brings their own operant resources (i.e. knowledge and skills) to service encounters as well as the determinant of value, fits with notions of co-production, patient engagement and patient activation in health care (Hibbard and Mahoney 2010; Hibbard and Greene 2013; Janamian 2016). There are, however, an important number of caveats and areas where S-D logic does not neatly map into this highly specialised service context. These are discussed below.

The S-D logic framework is premised on the idea of service being exchanged for service, whereby knowledge skills/competences are applied for the benefit of another (Lusch and Vargo 2006a; Lusch and Vargo 2014). Although the S-D logic framework acknowledges that the operant resources of various actors involved in value co-creation differ, it does not directly address how this affects levels of engagement in service exchange. The findings of this study demonstrate that perceived levels of engagement in service exchange vary. Patients were not always willing, or able, to actively participate in health care processes and the mutual exchange of knowledge and skills, as implied by Axiom 1/FP1. Instead, participation appears to be shaped by the nature of the resources that were offered and integrated by users of the service.

Whilst this study illustrates how value may be created through service use, it also shows how value destruction can be a consequence of service, thus necessitating further consideration of Axiom 2/FP6 within this specialist health care context. Although there are common themes in terms of those factors or elements which influence positive and negative perceptions of value, it should not be assumed that

value co-destruction is the exact reverse of value co-creation. The S-D logic framework implies that value co-creation is a collaborative process (Joiner and Lusch 2016). The findings presented in this study additionally indicate that value co-destruction is often instigated by one party i.e. the service provider, which questions the extent to which it is always 'co-destroyed'. The capacity of patients to utilise and integrate resources offered by service providers, as implied in Axiom 3 of the S-D logic framework, should also not be assumed. The empirical data presented in Chapter 3 illustrates how perceived resource misuse, of patient or staff resources, is a key contributory factor to value co-destruction.

Furthermore, conceptualisations of value in this study also relate to negative experiences or consequences of service use, as illustrated by the 58 value co-destruction episodes identified from the analysis of the empirical data. Axiom 4 of the S-D logic framework does not fully reflect the potential for value to be perceived and determined negatively. Although the S-D logic framework views service exchange, resource integration and subsequent value co-creation as interactional processes, the quality of interactions during service exchange, or the manner in which resources are exchanged and utilised, are not questioned or captured within the current S-D logic axioms. As the quality of interactions and nature of resource exchange and integration were found to be central aspects of positive and negative experiences of value in this current study, this is a limitation of the current S-D logic framework.

These issues are further considered within the context of the five key findings of this study and existing literature and research pertaining to S-D logic, value, value co-creation, value co-destruction and patient engagement in health care.

1.2 Key finding 1. Trajectories of value in cancer services

Findings presented in Chapter 3 show how conceptualisations of value can vary and change over time according to context and the lived experiences of study participants. In doing so this study has shown that value can be created, destroyed and potentially recovered through additional value formation at an individual patient

level, within single and across multiple health care encounters. Importantly, these findings illustrate how value recovery does not necessarily take place within the organisation where value co-destruction occurs. Instead, there is a recovery of 'value' by a different organisation from where value co-destruction is reported. This appears to arise through subsequent instances of 'value co-creation' in the 'new' organisation. These findings are new, and as such warrant a contribution to both the service marketing and public management literatures concerning value co-creation, and value co-destruction within a health care context. In doing so, this study addresses calls for research outlined by McColl Kennedy and colleagues (2015) concerning how the customer service experience develops over time.

Although the potential for value propositions to accumulate and dissipate over time is explored in the conceptual work of Chandler and Lusch (2015), this concerns the relationship between value propositions, engagement and the service experience and not value formation or destruction. Their work, therefore, differs in focus to this study. Chandler and Lusch (2015) consider dissipation in terms of a lack of alignment in value propositions so that engagement is no longer possible. When this happens actors seek new value propositions and hence the engagement cycle continues. Whilst Chandler and Lusch's (2015) conceptual model has relevance within this current study, and acknowledges that the service experience can be disrupted if value propositions are not aligned or where there is conflict between actors, this conceptual model does not reflect how value can be destroyed. Additionally, it does not incorporate the potential for no other service options to be available, as may be the case in a publicly funded health care context.

1.3 Key finding 2: Value conceptualisations

This study reveals that positive conceptualisations of value in the context of specialist cancer services relate mainly to the specialist centre, rather than other organisational sites (see chapter 2; section 2.5.2, Stage 4). Value was largely conceptualised in terms of: (a) the relational and interpersonal aspects of care and, (b) access to the specialist skills and knowledge of staff within the specialist centre. Emotional safety and trust in the skills of those providing the service were also viewed as important aspects of

value. The interplay among these factors, along with organisational factors such as the nature of the staff resource within the Centre, were perceived as contributing to increased well-being (see Table 19).

These findings build on the conceptual work of Ranjan and Read (2016) and provide empirical illustrations of five of the six factors that they suggest contribute to value co-creation i.e. experience, relationship, personalisation, knowledge and interaction. The empirical findings presented here also complement those of Longacre and colleagues (2015). Their work explored survey responses of oncology patients, and found that value was defined in terms of existential, practical or relational benefit, rather than economic terms (i.e. Porter 2010). The findings of this current study elaborate further the understanding of 'value' offered in Longacre and colleagues' work, by exploring both positive and negative trajectories of value in a UK cancer service context.

In defining value in terms of the nature of interactions during service use and access to specialist knowledge and skills, it is evident that patients conceptualised value in two different ways. Findings presented in Chapter 3 illustrated that value was largely perceived in terms of positive experiences during service use, rather than final benefits. The former tend to emphasise the positive relational aspects of the service experience (i.e. relationships with staff; interpersonal and communication skills). The latter, whilst highlighted by some newer patients as a desired future final benefit (i.e. hope that the treatment will work), tended to be raised by more experienced patients (those who had undergone several rounds of treatment or had experienced a subsequent recurrence(s) of cancer). In these instances, 'value' was often expressed in terms of direct health-related benefits (i.e. eradication or containment of the cancer, prolonging of life), or the impact of these perceived benefits on their daily life (i.e. having more time to spend with the family, capacity to undertake normal activities).

The differentiation between these 'two types' of value may reflect difficulties in evaluating technical aspects of the service, hence a focus on interpersonal aspects of care. Additionally, outcomes of the service (i.e. treatment effectiveness) may have

been unknown at the point of service use and/or participation in this research project, hence the emphasis on process-based aspects of value. These findings, do, however, illustrate that perceptions of value can vary over time across the trajectory of the cancer-related service experience, to reflect both short and long term goals. This is an important consideration given that cancer-related service use may vary in duration from several months to several years. In light of these findings, it could be argued that some patients undergoing treatment may not have integrated the necessary resources to appraise, determine and realise value in terms of longer term goals and outcomes (Vargo and Lusch 2011; McColl-Kennedy et al 2012).

The findings concerning differing ways of perceiving value also complement the work of Hau and colleagues (2016), in terms of value being perceived as both 'process value' and 'outcome value'. The findings of this current empirical study further develop and extend understandings of 'value' by illustrating empirically how perceptions of value are not static. The experiences of more 'seasoned' patients within this current study reveal that conceptualisations of value shifted over time as more 'resources' were gained in terms of knowledge of the disease and treatment processes, and also the effectiveness of treatment interventions.

The findings of this study also provide empirical support for the conceptual assertion within Axiom 4/FP10 of the S-D logic framework, that differing combinations of available resources during service exchange influence how value is phenomenologically perceived and determined (Vargo and Lusch 2012, p.6). In doing so, this study contributes to the extant literature concerning S-D logic, which is largely conceptual in orientation. More specifically, it responds to the array of research calls, outlined in the literature review, for qualitative research to further understanding of value co-creation (Grönroos 2011; Leroy et al 2013; Nordgren and Åhgren 2013; Chandler and Lusch 2015; Ostrom et al 2015).

The findings presented in Chapter 3 also reveal that dimensions of value identified by patients bear similarities to the concepts of both service quality and quality within services marketing and health related literatures. It is evident from the data presented in this study that emphasis was placed on the quality of interactions and

perceived expertise of staff. This observation builds on the conceptual work of Dagger and colleagues (2007), who posit that service quality in health care relates to the interpersonal and technical aspects of service quality. This current study provides empirical evidence to illustrate the importance patients assign to these respective 'quality' dimensions in a UK cancer service context.

Additionally, participants in this study conceptualised value similarly to the six dimensions of quality outlined by the Institute of Medicine (2001) framework i.e. safety, effectiveness, patient centeredness, timeliness, efficiency and equity. These findings highlight the potential overlap between conceptions of quality and value when applied in an empirical context. While a similar observation has been made by Medberg (2016), his study was undertaken in the Finnish banking sector, rather than a health care context, and related to perceptions of value-in-use from a service logic, rather than S-D logic perspective.

The findings of this study also reveal that staff defined value in terms of the extent to which patients' expectations were managed and met. This point is underscored by evidence of low or unknown patient expectations of 'service' before attending the specialist centre. As shown in Chapter 3, the relationship between low expectations of patients and value is interesting, as by exceeding low expectations there is potential for patient perceptions of value to be artificially inflated. This finding highlights the importance of staff clearly outlining to patients (and family members) the nature of the 'service' or 'value promise' they offer (Osborne et al 2013). These observations elaborate empirically the work of Parasuraman and colleagues (1985), who define service quality as the gap between expected and perceived service i.e. 'gap theory', by providing evidence of this phenomenon in a cancer service context.

There is, however, as noted in Chapter 1, debate in the services marketing literature regarding the extent to which the concepts of value and service quality overlap, and how to measure service quality (Dagger et al 2007; Gummesson 2008; Greer et al 2014; Medberg 2016). The findings of this study contribute empirically to these debates. Despite observed similarities with service quality dimensions, participants in this study defined value in terms of the impact on their emotional and physical

well-being. In doing so, it could be argued that 'value' is conceived in this study as a 'wider concept' which extends beyond the appraisal of quality and customer satisfaction (Gummesson 2008). In this respect, this study builds on the work of Medberg (2016) which suggests that service quality is the means in which customers operationalise value.

In considering the nature of value within a cancer service context and the application of the S-D logic framework, it is apparent that further work is required to disentangle the practical relationship between service quality and value-in-use. Additionally, the empirical findings of this current study suggest that perceptions of value can shift over time across the trajectory of the cancer-related service experience. This is an important consideration in the context of cancer-related service use, as patients may engage with the service for prolonged periods of time.

This study has shown that there is support for Axiom 4/ FP10 within a cancer service context in terms of value being conceptualised as a phenomenological, experiential and dynamic concept. It is also apparent that conceptualisations of value are influenced by the nature of the service exchange (Axiom 1/FP1), given the emphasis on the quality of interactions, interpersonal skills and access to the resources of specialist staff in participant accounts. The nature of the resources drawn upon, and the extent to which resource integration is perceived to have taken place, appear to be contributory factors in terms of the type of value (i.e. process or outcome value) that patients perceive. This finding suggests that Axiom 3/FP9 is influential in the process of value co-creation. Finally, the findings of this study illustrate that the nature of the service offered by staff within the specialist centre was related to patient perceptions of value. There appears, in the main, to be a close alignment between the nature of the service promised and that which patients perceived as eliciting value. This suggests that the foundational premise 7, is also influential in the creation of value.

It is, however, also apparent that value conceptualisations can be negative. This phenomenon appears to arise when there is a disconnect or breakdown in the

processes perceived as underlying value co-creation. These issues are addressed further in section 1.5.

1.4 Key finding 3: Value co-creation processes

This section explores the findings concerning the nature of processes viewed in S-D logic as facilitating value co-creation (i.e. service exchange, resource utilisation and integration).

Finding 3a: Involvement in service exchange

The findings presented in Chapter 3 reveal that 'involvement' is predominantly defined in terms of inclusion in discussions and decisions regarding health and treatment related processes, and providing consent to undergo treatments. Although the terms 'partnership' and 'joint decision making' are used, this mainly relates to inclusion in decision making and discussions rather than role distribution. Because so few patients reported leading on making decisions regarding their treatment and care, passive forms of 'engagement' seem to predominate in this context. These findings may, however, reflect: (i) the necessity to choose between treatments or interventions (i.e. surgery) arising prior to attending the specialist centre, or (ii) the availability of only one treatment option. These study findings could also reflect the relative newness of the cancer diagnosis and treatment procedures. Fifteen of the patients participating in this study had attended the specialist centre for two months or less (see Appendix 2).

There is, however, some empirical support from this study to indicate that a small number of patients actively sought information to enable participation in decision making. Perceptions of participation appear to be influenced by the desire and willingness of patients to participate, their perceived capacity to participate (i.e. whether they had the skills and knowledge to do so), beliefs regarding the relative roles of patients and clinical/medical staff, and how patients were invited to participate. Additionally, only a minority of staff discussed involvement in terms of co-production or shared-decision making.

The findings presented in Chapter 3 suggest that a degree of learning may have been required before patients were able to use the resources required to enable them to participate. This is demonstrated in the account of a patient who had several recurrences of cancer. In this particular instance, levels of engagement increased as the patient developed more knowledge of their cancer. This finding elaborates empirically on the theoretical work of Kleinaltenkamp and colleagues (2012) who posit that a precondition of utilising resources and engaging in service for service exchange is the capacity to use and integrate resources. This is an important consideration in relation to models of patient engagement in health care. It implies that in order for patients to be 'activated', they may firstly need to learn how to use resources before they are able to actively participate (Hibbard and Mahoney 2010; Hibbard and Greene 2013).

Additionally, as alluded to earlier, levels of patient involvement may be shaped by the manner in which staff invited them to participate. The empirical data presented in this study illustrates that only a small number of staff discussed co-production as an approach to involvement in health care decision. In these instances, staff members emphasised the proactive role of patients, with one staff member challenging the 'nurturing' approach they perceived was adopted in the specialist centre. In doing so, it is implied that there is a relationship between: (a) how patients are invited to participate and, (b) the extent to which patients take responsibility for their own health. These findings build on those of Hau and colleagues (2016), who in a study of chronic illness in Vietnam, suggest that the extent of customer participation and resource contribution depends on how service frontliners (i.e. service provers) interact with patients in the role of an initiator.

A number of possible explanations are offered in the literature reviewed in this study with regard to these empirical findings. Sweeney and colleagues (2015) posit that participation in value co-creating activities is more likely to be undertaken if they require minimal effort (i.e. co-operating with basic clinic requirements) when compared with more difficult activities requiring greater effort (i.e. proactive involvement in active decision making, emotional regulation). These findings have

significance in this current study context, partly because cancer was one of the three chronic illness contexts studied by Sweeney and colleagues, but also as a high emotion service used by anxious patients (Berry et al 2015). Active engagement in decision making in the current study may, therefore, not have been undertaken due to the high level of effort required by patients to integrate the resources they needed to be able to actively participate emotionally as well as intellectually.

The findings of this study concerning types of involvement build on the conceptual model of Gallan and colleagues (2013) which posits that participation levels are related to emotional affect, with higher levels of participation found when affect levels are positive. A key component of value identified in this study has been the reduction of information asymmetry as a means of alleviating anxiety concerning knowledge of treatment processes and outcomes. This finding implies that patients in this current study may have felt unable to participate in their care decisions due to their emotional status, as well as the extent to which they could use 'resources' to participate in service exchange.

Finding 3b: Resources, resource utilisation and integration

The findings presented in Chapter 3 reveal that there are multiple 'actors' involved in value co-creation. These include service providers and service users, but also include other patients, family and friends. Patient-to-patient value co-creation appears mainly to involve the sharing of experiential knowledge of cancer service use, and providing 'insider' tips or tricks for getting through treatment processes. These interactions possibly serve as a means of translating complex, technical knowledge into a more accessible form and facilitating a sense of feeling part of a wider patient community. However, when these shared experiences are negative, there is also the potential for value co-destruction to occur.

The main resources accessed and exchanged within this study, however, were the operant resources of staff within the specialist centre. These were accessed through direct interactions (face-to-face, or in some instances, telephone advice). The findings of this study reveal that although patients drew on a range of resources

during service use, they were largely reliant on health care staff to navigate treatment-related decisions and processes. The dependency of service users (patients and family members) on service providers is potentially amplified in this context for a number of reasons. First, treatment interventions are predominantly life-saving, or life prolonging. Second, the nature of the disease and treatment processes and interventions are complex and as such, there is asymmetry in terms of the knowledge and expertise of service users and service providers. Third, service users may be unwell at the point of accessing the service or as a consequence of treatment interventions.

These findings of this study can be seen to complement those of McColl-Kennedy and colleagues (2012) who posit that resources may extend beyond those of the service provider and 'customer' to also include private sources and customer self-generated activities (e.g. positive thinking and sense making). This current empirical study, differs, however, to McColl-Kennedy and colleagues' (2012) study in a number of ways. Their work was conducted in an Australian private oncology clinic and explores value co-creation behaviours, rather than conceptualisations of value-in-use. This current study, therefore, develops and extends the work of McColl Kennedy and colleagues (2012) by providing further empirical evidence of the nature of resources that patients draw upon in a UK publicly funded cancer service context.

Additionally, there is evidence in the findings of this study to illustrate the conceptual assertion within the S-D logic framework that resources are not static and that they 'become' as they are integrated and essentially form new resources which may generate 'value' (Vargo and Lusch 2004a). This is illustrated well in the accounts of patients who drew on previous experiences of service use to assist with decision making when faced with recurrences of cancer and to challenge a proposed treatment regimen. This finding implies that knowledge exchanged in previous health care encounters, is integrated to form a 'new resource' from which patients benefit in the context of an additional cancer service encounters.

It is apparent from the findings presented in Chapter 3 that patients in this study differed in terms of their desire to access information regarding treatment processes,

outcomes, and the extent of their disease. It was also shown that patients had differing preferences in terms of style of information delivery. This suggests that one cap does not fit all in terms of the nature of resources offered. These findings complement Bracher and colleagues' (2014, 2016) analyses of cancer patient experience survey data in relation to: (a) the preferences for information provision directly from staff over other types of resources, and (b) their assertion that tailored approaches to information exchange are required. The findings of this study also build on the conceptual work of Pfister and Roth (2015) who assert that service providers need to adapt value propositions in accordance with customer resource usage processes.

The S-D logic framework is premised on the capacity of 'actors' to integrate resources (Anderson et al 2016) as outlined in Axiom 3/FP9. The findings presented in this study illustrate that information was perceived as a key resource by patients. When patients were able to access and integrate the resources offered by staff within the specialist centre, this was associated with perceived increased well-being, or reduction in anxiety, as information asymmetry was reduced. It is, however, apparent that when the resource integration process breaks down, consequences are negative and lead to value co-destruction. Findings presented in Chapter 3 also showed that a number of patients perceived that they did not have the operant resources (i.e. knowledge and skills) to engage in service exchange or to integrate resources. In doing so, these findings illuminate empirically the assertions of Anderson and colleagues (2016) that asymmetry in terms of both expertise and information, can impact on the extent to which resource integration is possible. The findings presented here also build on the theoretical and conceptual propositions of Kleinaltenkamp and colleagues (2012) and Hibbert and colleagues (2012) by illustrating empirically how patients perceive a degree of learning may be necessary before being able to use resources and participate in value co-creation processes.

On the basis of findings discussed within this subsection, it would seem that the processes of service exchange and resource integration (Axiom 1/FP1, Axiom 3/FP9) influence the nature of and extent of value co-creation (Axiom 2/FP6, Axiom 4/FP10).

This can be seen in relation to the differing levels of patient engagement in the processes of decision making and direct care, as well as the capacity to use the resources which are offered and exchanged. Attention is also drawn in this section to the nature of 'value propositions' that staff offer to patients (FP7). It cannot be assumed that the offering of 'resources' results in benefit for patients. The extent to which resources can be used, optimised and integrated requires further careful consideration in a cancer service context.

1.5 Key finding 4: The nature and scope of value co-destruction

Findings presented in Chapter 3 illustrate how factors which facilitate positive service experiences and conceptualisations of value, may lead to value being destroyed when these are viewed as lacking, or absent from the cancer service experience. Dominant themes concerning value co-destruction relate to the quality of interactions during service use and resource misuse. The findings presented in Chapter 3 illustrate the importance of health care interactions during cancer-related service use in terms of the 'resources' offered to service users. These also show how value co-destruction arises when there is a perceived disconnect between the application and integration of resources. Key contributory elements relate to the poor interpersonal and communication skills of health care staff; delays in reaching diagnosis and commencing treatment; information asymmetry between patients and health care professionals and technical failure in terms of both equipment and staff skills. The impact of these elements is heightened when there are perceived to be breaches in expected behaviour and/or knowledge of health care professionals. Additionally, the data presented in this study reveal that in a high proportion of value co-destruction episodes, value co-destruction was instigated by health care staff, rather than the patients. In a smaller proportion of cases, value co-destruction was instigated by other patients.

The findings presented in this study elaborate further the work undertaken by Berry and colleagues (2016) in a US cancer service context. Evidence presented in Chapter 3 provides support from a UK context of their assertion that patients look for functional, humanic, and mechanic clues when negotiating a high emotion service

such as cancer. These clues are perceived as playing a role in terms of perceptions of the medical competence of staff, the interactions between staff and patients, and first impressions of the service. The management of these signals is viewed as influential on both positive and negative value trajectories. Evidence presented here demonstrates how these signals are also of importance in a UK cancer service context.

Findings from this study build on the developing body of research in relation to value co-destruction. This research stream posits that the phenomenon can arise through the intentional or accidental misuse or misalignment of resources and/or practices when a system (i.e. patient or service provider) acts in an inappropriate or unexpected manner. Such conditions can lead to failures in integrating and applying operant resources (Plé and Chumpitaz Cáceres 2010; Echeverri and Skålén 2011; Smith 2013; Robertson et al 2014; Prior and Marcos-Cuevas 2016). Findings of this study extend this body of work by illustrating that 'misuse of resources' is a phenomenon also experienced within a specialist cancer service context.

Evidence presented in Chapter 3 complements the work of Echeverri and Skålén (2011) regarding the potential to interpret the value co-destruction data from a practice theory perspective. Data reported in this study show that value co-destruction occurs in this current study when patients perceived that the actions of staff breached those which they expected. This relates to both: (a) interpersonal skills, and (b) technical knowledge. This study also highlights that incongruence in terms of the expected practice of staff and the resources that are offered can lead to value co-destruction. It could be argued that when this occurs, practices are not common or shared (Echeverri and Skålén 2011). This study also augments the findings of Smith (2013) in terms of the potential to interpret the value co-destruction data from a Conservation of Resources theory perspective. This approach emphasises the role of resource loss (i.e. patients' resources) causing psychological distress, with resources relating to time, finances and self-esteem. These issues emerged clearly within the findings of this study regarding value co-destruction. In

doing so, this empirical study further contributes to the developing evidence base in relation to value co-destruction.

There are, however, a number of important differences between this study and those conducted by Plé and Chumpitaz Cáceres (2010); Echeverri and Skålén (2011); Smith (2013) and Robertson (2014). First, the work of Ple and Chumpitaz Cáceres (2010) is conceptual rather than empirical. Second, the work of Echeverri and Skålén (2011) was conducted in a Swedish transport sector rather than a health care context, and is approached from the perspective of the service provider rather than the service user. Although their study considers the potential for value formation to be both positive and negative, and in some instances recovered, this is considered in relation to single value co-destruction events across the work experiences of service providers, rather than at an individual service user level. In contrast, this study considered how value is both created, destroyed, and in some instances recovered at an individual service user level across multiple service encounters. Third, the work of Smith (2013), whilst useful, mainly relates to retail experiences which differ significantly to those in health care contexts. Finally, Robertson and colleagues' (2014) study relates to the use of on-line patient forums, whereas this current study considers value co-destruction within the context of direct interactions during service encounters.

From the preceding discussion of study findings in relation to extant literatures, it can be seen that the nature of the service exchange (Axiom 1/FP1), as well as the extent to which the resources offered can be used and integrated by patients (FP7, Axiom 3/FP9), are important considerations in the phenomenon of value co-destruction. It also appears from this study that value co-destruction differs to value co-creation, in that engagement in this process is not necessarily collaborative and can be one sided. This highlights that Axiom 2/FP6 required further consideration in the context of negative encounters.

1.6 Key finding 5: Classification of value co-destruction

This empirical study has presented an early analysis of the emerging concept of value co-destruction, as experienced by patients within a specialist cancer service context.

The findings of this study have highlighted that the phenomenon of 'value co-destruction' appears to vary in terms of the level of severity of impact upon patients in a cancer service context. This relates to both the longevity of negative consequences, and the perceived impact on physical or emotional well-being. This analysis also shows that value co-destruction may be conceptualised in terms of a discrete event or process which occurs during cancer-related service use and may thus be considered in terms of episodes. The perceived reasons for value co-destruction occurring can be identified from both: (a) patient conceptualisations of value, and (b) their accounts of cancer-related service use. In doing so, contributory elements to value co-destruction were identified in Chapter 3. This consideration of value co-destruction episodes revealed that there can be single or multiple value co-destruction elements, which occur on a single or multiple occasions within any one episode. Value co-destruction episodes are found to relate to events in single or multiple organisational health care sites.

The combinations of these various components (number of elements, number of occurrences and number of organisational sites) appear to be related to the overall level of impact of the severity of an episode of value co-destruction. A greater proportion of the high impact episodes are found to involve multiple elements, multiple occurrences of elements and multiple health care sites than found in comparison with the medium or the low impact episodes. In considering these findings in relation to the extant value co-destruction literature, there are no other studies which have attempted to classify value co-destruction in this way.

Section 2: Contributions

This study offers conceptual, empirical, methodological and policy contributions to scholarship in the fields of public management, services marketing, and health services research. The nature of each contribution is outlined below.

1. Conceptual contribution

The main conceptual contribution of this study arises from the identification and exploration of trajectories of value (positive and negative) as a consequence of service use. In doing so the findings of this study have shown that value is a temporal concept, which varies over time and also in the context of individuals lived experiences. This study has illustrated how value can be created, destroyed and recovered at an individual service user/ customer level over the course of the service experience. This is not necessarily a linear process. This study has shown that 'value' can oscillate over the course of multiple service encounters, across a continuum which incorporates both value co-creation and value co-destruction. This phenomenon has not previously been conceptualised in this way in the services marketing and public management literature. This study is the first to explore trajectories of value across single and multiple service encounters, and to consider how value accumulates and/or dissipates at an individual service user/customer level within and across single or multiple micro-level service encounters in single or multiple organisations. Importantly, this study illustrates how value recovery does not always take place within the organisation where value co-destruction occurs. Recovery of 'value', by a different organisation than where value co-destruction is reported, appears to arise through subsequent instances of 'value co-creation' in the 'new' organisation. This is a role that may be undertaken 'unknowingly', with a single organisation playing two roles as both 'value facilitator' and 'value recoverer'.

Although this study was conducted in a specialised health care context, similarities may be found in other highly specialised knowledge industries when: (1) users of the service move between general and specialist service provision, and (2) service use entails multiple rather than single service encounters. These concepts have relevance

for other 'expert' service sectors where engagement with the service may be prolonged and involve ongoing rather than 'one-off' discrete encounters. Given the absence of other work which has considered trajectories of value at an individual service user/customer level across multiple micro-level service encounters, this study contributes to the development of a wider understanding and perspective on the phenomena of value co-creation and value co-destruction.

2. Empirical contribution

This study extends current empirical knowledge regarding the extent to which S-D logic maps into a UK specialist cancer service context. Until now, there have been no empirical applications of S-D logic within this specific service context. In undertaking this work, this study contributes to current knowledge in two main areas.

First, this study extends current understandings of the concepts of 'value-in-use', 'value co-creation' and 'value co-destruction' within a UK specialist cancer service context. Perceptions of 'value' have been explored from the perspectives of service users and service providers, an area that was under researched in both services marketing and public management literatures. There are currently no other empirical studies which explore the relationship between S-D logic, patient engagement and conceptualisations of value-in-use. Nor is there any research exploring how patients conceptualise value (when framed as value that is perceived and determined in use) in a UK cancer service context. Although a small number of studies have explored value co-creation in a health care context, these consider behaviours associated with value co-creation and the degree of effort that customers exert to integrate resources, rather than how value is conceptualised (McColl-Kennedy et al 2012; Sweeney et al 2015). By gaining insight into how value is conceptualised in a specialist cancer service context, it was possible to identify factors contributing to the creation and destruction of value in this service context.

Second, this study furthers understandings of the processes underlying value co-creation (service exchange and resource integration), which have previously been viewed as an unexplored black-box (Pfisterer and Roth 2015). In doing so, this study

has responded to research calls regarding the extension of knowledge in relation to value co-creation processes (Grönroos 2011; Leroy et al 2013; Nordgren and Åhgren 2013; Chandler and Lusch 2015; Danaher and Gallan 2016; Ostrom et al 2015). Specifically, this study has shown that the capacity to engage in service exchange, and to use and integrate the resources offered by staff, was shaped by both: (a) patients' perceptions of their capacity to undertake and engage in resource exchange and integration, and (b) the nature of the resources offered. It should not be assumed that all of the resources offered to patients could readily be used and integrated. The study findings also show that patients varied in terms of preferences regarding the mode or style of delivery of resources (i.e. written, verbal, electronic resources; information delivered all at once or staged). In some instances, co-learning was required to enable patients to optimise and benefit from the resources offered. This study has also highlighted the importance of interpersonal skills during service exchange and that the way in which resources were offered and exchanged mattered to patients.

On the basis of these findings, it can be seen that key assumptions within the S-D logic framework, in relation to the nature of the service exchange and resource integration processes, do not neatly map into a UK specialist health care context and require further elaboration. This study has illustrated that the capacity to access, exchange, utilise and integrate resources are perceived as pre-requisites for value co-creation. The findings of this study have shown that a disconnect or mismatch in these processes can result in result in negative rather than positive trajectories of value.

3. Methodological contribution

This is the first empirical study exploring value co-destruction to have assessed levels of impact of value co-destruction (i.e. high, medium and low) upon users of a service and to propose a basis from which to explore value co-destruction episodes in terms of various constituent parts (i.e. levels of impact, elements, occurrences, organisational sites). In doing so, this study offers an early typology for classifying value co-destruction and considering how this phenomenon can escalate across

multiple service encounters. Although this framework was developed in a health care context, this could be adapted to other service contexts. Additionally, this classification approach could be applied to further insight into factors contributing to value co-creation. Potential applications of this framework could concern work adopting similar qualitative research methods to those undertaken in this study. Alternatively, the framework could be incorporated within surveys of broader collections of organisations.

4. Policy contribution

The findings of this study have implications for health care policy and the delivery of services. This study has shown that consequences of service use can be negative as well as positive. Specific attention has been drawn to the quality and nature of interactions in health care encounters. These findings reinforce the importance of focusing on processes of care, and not just health care outcomes. Relational aspects of care matter to patients and impact on overall service experiences. In some instances, this can affect access to health care resources, treatment and care and the capacity to use and integrate the resources offered. This is an important consideration given recent service failings such as those outlined in the Francis Report (2013). These findings could be used to inform training and development programmes for staff working within a health care context.

Additionally, in considering trajectories of value within a cancer service context, this study has shown that service providers may need to recover negative service experiences encountered in other organisations, as well as providing the service required from their own organisation or speciality. This may require additional unexpected demands on the resources available within health care organisations.

This study also extends extant knowledge regarding 'patient value', a developing area of interest for a number of health care programmes in the UK (i.e. Prudent health care, Wales; Realistic Medicine, Scotland).

Section 3: Limitations

This study has a number of limitations. First, this study adopted a single case study design. Whilst one of the reasons for adopting this design is to conduct ‘a critical test of an existing theory or body of literature’, this potentially limits the transferability of the results to other contexts (Yin 2009, p.52). Features unique to the specialist centre as a case within itself may have influenced the nature of the study phenomenon, ‘value’, and how this was conceptualised, constituted and experienced in this study. This is illustrated in relation to the findings concerning organisational factors and the nature of the staff resource within the Centre. It is unclear whether the ‘staff resource’ within the Centre is one common to the field of oncology and specialist cancer services more generally or if the Centre itself, by the nature of its reputation attracts particular individuals to work there. As this study was conducted in a UK publicly funded health care context, it could additionally be argued that the results of the study are influenced by the nature of this health care system and the cultural context in which the study was conducted. The same could be true of the location within which the study was conducted in terms of reflecting regional differences in the nature of service provision.

Second, due to the exploratory nature of this study, concerns regarding the burden on study participants, and the time constraints concerning doctoral research, this study adopted a cross sectional design. This means that all study participants (bar one) were interviewed at one point in time. Although there is variation in the patient sample in terms of the duration of time that patients had been attending the Centre (see chapter 2, section 2.3.1), the study data is based on the recall and perceived experiences of patients at the particular time point that they were interviewed. Future work could adopt a longitudinal design and interview patients at two or three time points across the duration of the cancer service experience. Although a number of patients reflect on their experiences over time, the findings would be strengthened, particularly in relation to changing perceptions of ‘value’ across the service journey, through research conducted at multiple time points.

Third, most of the patients recruited for this study were first identified and approached by a member of health care staff within the specialist centre, rather than the researcher. This approach was adopted in order to prevent patients from feeling obliged to participate had the researcher approached them directly herself. However, this only related to permission for the researcher to provide information about the study. This could mean that those patients who participated were those who were perceived by staff within Hospital A as more vocal, and thus more willing to share experiences. Limitations were also apparent with the staff study sample in that participation was influenced by the capacity of staff to leave their work environments to take part in the interviews. Attempts were made to mitigate this issue through the researcher employing a wide range of strategies to recruit staff participants and through having a number of 'drop-in' interview slots which did not need to be pre-arranged, as detailed in Chapter 2.

The fourth limitation relates to the nature of qualitative research design, whereby the researcher is also an instrument in the research process (Piantanida and Garman 1999). This means that the researcher's beliefs and experiences could have influenced the nature of the study data collected as well as the interpretations of the data, particularly as she had worked in a health care context some years previously. Chapter 2 detailed how the researcher consciously attempted to minimise such bias within the study. It could be argued, however, that the researcher's previous background was advantageous in this study in that this seemed to facilitate access in the organisation. Additionally, this may have enabled the researcher to be more sensitive to the responses of study participants, so that they were more willing to share highly personal and in some instances quite distressing experiences.

Section 4: Transferability from the study and areas for future research

This study has explored conceptualisations of value and identified factors contributing to both positive and negative trajectories of value. Although this work was undertaken within one case study site, and was thus subject to the limitations outlined in section three, these findings may be transferable to other specialist cancer service contexts and cancer services more generally. The findings of this study

in relation to the four main study themes, resonate with the analyses of much larger national cancer patient experience surveys, such as that undertaken by Bracher and colleagues (2014; 2016).

Additionally, the study themes and dimensions may be transferable to other specialist health care contexts of health conditions which are potentially life limiting (i.e. coronary heart disease; pulmonary obstructive airways). It could be argued that the findings from this study are also of relevance to other highly specialised knowledge services outside of health care (i.e. Law) which: (a) involve a high degree of direct contact between users and providers of the service, (b) where the stakes are also viewed as high, and (c) where there is substantial asymmetry in terms of the expertise and knowledge of users and providers of the service. Future work could consider exploring the main themes identified in this study and assessing the extent to which they are also apparent in other service contexts. This would require some refining of sub-dimensions, such as the negative effects of treatment, but this could be reframed in terms of negative effects associated with interventions that are specific to other contexts. Additional areas for future research are elaborated in more detail below.

This work was undertaken adopting a cross sectional research design. Future research could investigate these issues adopting a longitudinal study design in order to assess how value is perceived at multiple time points over the period of service use. Further empirical research is also needed to identify the specific activities or practices in a health care context which constitute value co-creation. This study identified how this relates to four main areas in terms of the quality of interactions, access to resources, resource use and organisational factors.

Whilst this study identified specific examples of activities or behaviours contributing to the destruction of value, the data concerning positive conceptualisations of value were described at a more general level. This study does, however, represent a useful basis from which to explore value co-creation and value co-destruction within highly specialised service contexts. Future studies could usefully drill down even further to identify specific activities which are viewed as constituting value co-creation

practices. Although McColl-Kennedy and colleagues (2012) and Sweeney and colleagues (2015) start to undertake such work in their studies exploring value co-creation practices and customer effort in value co-creation activities, there is still little research exploring these 'activities' and 'practices' in health care and an absence of such in a UK health care context. Further work could usefully provide more detailed empirical examples of both value co-creation and value co-destruction activities and practices in relation to both users and providers of health care services. The classification framework developed in this study in relation to value co-destruction could usefully form the basis for such work.

The identification of specific activities and practices which positively contribute to, as well as restrict or diminish the creation of value and engagement in health care, are important areas of investigation in a public service context. As models of health care delivery increasingly emphasise co-production and the co-creation of health care, further clarity and empirical investigation of the strategies which promote these concepts is required (Health Foundation 2012). The work of Osborne and colleagues (2013, 2016) has started to address these issues in terms of proposing alternative typologies of co-production rooted in both public management and service management theory. It is apparent, however, that despite the common use of the terms co-creation and co-production in services marketing (specifically S-D logic) and public management literature, these concepts are interpreted slightly differently in these respective disciplines (Osborne et al 2016; Vargo and Lusch 2016b). Undertaking work within a health care context to more clearly identify specific activities or practices which lead to value co-creation or value co-destruction may assist in clearing these muddy waters.

There are a number of caveats within which the findings of this study should be interpreted. Exploration of the phenomenon of value co-destruction (conceptually and empirically) is underdeveloped, particularly in a health-related context. Indeed, this study represents the first empirical investigation of 'value co-destruction' in a UK cancer service context. Further research is also required to explore the relationship between the concepts of service failure and value co-destruction, as there is

potential for these concepts to overlap. This has been raised in the work of Skourtis and colleagues (2016) who posit that service failure is currently framed within a goods-dominant logic framework and should alternatively be reconceptualised as value co-destruction moments. The cumulative impact of negative service experiences and the potential for subsequent value recovery or additional value formation also warrants further investigation. Additionally, the concept of value co-destruction is not clearly integrated within the S-D logic framework and warrants further study. In light of such issues, it can be seen that value co-destruction is an area necessitating future research development.

This study constitutes an important starting point from which to undertake such work, aimed at developing productive dialogue concerning articulations and experiences of 'value' in health care policy, practice and research.

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In-house-Hospital A Documents

Carer consultation strategy document 2012-2015

Annual report 2014/2015

Annual report, 2015

Strategy document 2012-2015

APPENDIX 1: Glossary of terms

Actors - According to S-D logic actors are entities that have agency, the ability to act purposefully (Lusch and Vargo 2014, p.56). In this study this term is used to refer to people involved in value co-creation and/or destruction processes i.e. customers, providers, patients, their families and health care staff.

Elements of value co-destruction - Contributory reasons for perceived value co-destruction. Each value co-destruction episode contains either a single or multiple elements. These elements can occur once (single occurrence, e.g. single occurrence of a single element, single occurrence of multiple elements) or more than once (multiple occurrences, e.g. multiple occurrences of a single element; multiple occurrences of multiple elements) during each individual episode of value co-destruction.

Episodes of value co-destruction - A discrete event (i.e. a patient having an allergic reaction whilst undergoing a specific chemotherapy treatment) or an overall process (i.e. the process of being diagnosed) which occurred during cancer-related service use, that is perceived, by the recipient, as having negative consequences, and which culminated in value co-destruction.

Goods-dominant logic - This logic frames exchange in terms of units of output (goods) with the production and exchange of goods forming the central components of business and economics (Lusch and Vargo 2014, p.4).

Interactive value formation – Value that is co-created during the interaction between the provider and the customer. This is differentiated from non-interactive value formation, where value is produced by the provider and used up by the consumer (Echeverri and Skålén 2011, p.351-352).

Level of impact - Impact of value co-destruction episodes on the individual. Rated as high, medium or low impact episodes. **High impact episodes** are those with consequences which were perceived as either: (a) irrecoverable, or (b) still having a considerable impact on physical and emotional health of individuals (patients). **Medium impact episodes** - Episodes with consequences which were temporary or partially resolved through other actions, events or the overall quality of care. **Low impact episodes** are those in which individuals raised issues or aspects of service use which could have been different, but had not unduly affected them emotionally or physically.

Organisational sites - Each episode of value co-destruction was classified in terms of whether it related to service use at a single organisational site (e.g., one health care provider) or at multiple organisational sites (more than one health care provider)

Patient centred care - A vision of healthcare as a partnership, where patient values and preferences guide all clinical decisions and patients have the required education and support to enable them to make decisions and participate in their own care

(Institute of Medicine 2001, p.3; Carman et al 2013, p.223- 224; Montgomery 2013, p.15).

Patient activation - The extent that the individual understands their requirement to have an active role in the management of their own health and health care and specifically concerns their knowledge, skill, and confidence to undertake this self-management role (Hibbard and Mahoney 2010; Hibbard and Greene 2013).

Patient engagement - Patients (including their families and/or representatives) and health professionals working in active partnership at various levels across the health care system (direct care, organisational design and governance, or policy making) to improve health (individuals and/or populations) and health care. This additionally incorporates the interventions designed to increase activation and patients' resulting behaviour (Carman et al 2013, p.224; Hibbard and Greene 2013, p.207).

Resources - Anything that an 'actor' (e.g. customer or provider) can draw on for support. In S-D logic these are classified as 'operand', (resources which require other resources to act on them in order to provide benefit, which are often static and tangible i.e. medical equipment) or 'operant' (resources capable of acting on other resources to create benefit, often intangible and dynamic e.g. human skills and capabilities) (Lusch and Vargo 2014, p.57).

Resource integration - The process of combining resources, which may lead to the production of new resources, from which value/benefit is co-created.

Service - A process in which an 'actor' applies his/her resources (knowledge and skills/competences) for the benefit of others (Lusch and Vargo 2006a; Lusch and Vargo 2014).

Service encounter - A period of time during which a customer directly interacts with a service (Shostack 1985; Bitner 2000).

Service system - Configurations of resources (including people, information, and technology) connected to other systems by value propositions (Vargo et al. 2008, p.145).

Value - Benefit or increase in well-being that is co-created in using a service (value-in-use) which is always unique to a particular context (value-in-context) (Chandler and Vargo 2011; Vargo and Lusch 2012; Lusch and Vargo 2014).

Value co-creation - Relates to benefit (unique to a situation and context) created through actors integrating service offerings with other resources. According to S-D logic it is the beneficiary (typically the customer) of service who determines and assesses the nature of the value that is co- created (Vargo and Lusch 2012).

Value co-destruction - An interactional process between service systems that results in a decline in at least one of the systems' well-being (Plé and Chumpitaz Cáceres, 2010, p.431).

Value proposition -How an 'actor' co-proposes to positively affect another 'actor', or a promise of value to be delivered (Lusch and Vargo 2014, p.72).

Value recovery - Actions taken by individuals (i.e. patients, family members or service providers) to prevent further value co-destruction and to reduce the impact of previous adverse consequences or effects on patient's well-being (physical and emotional).

APPENDIX 2: Participant Characteristics

Characteristic	Patients (N=56)
Gender	
Male	29
Female	27
Age Range	
30-39 years	1 (male)
40-49 years	2 (1 male, 1 female)
50-59 years	12 (5 male, 7 female)
60-69 years	27 (14 male, 13 female)
70+ years	12 (7 male, 5 female)
Not known	2
Length of time diagnosed as reported by patients	
Detected 2 months ago awaiting official diagnosis	1
Diagnosed 2-6 months	19
Diagnosed 7-12 months	18
Diagnosed 13-18 months	1
Diagnosed 19-36 months	5
Diagnosed 3-5 years	0
Diagnosed 6-15 years	12
Number of patients with previous primary tumour	6 (diagnosis time based on most recent diagnosis)
Length of time a patient at the Centre	
< 1 month	6
1- 2 months	9
3-6 months	8
7-12 months	15
13-18 months	2
19 months to 3 years	4
6-10 years	8
11- 14 years	3
Not known approx. 6 months	1 (male)
No of patients who had previously been patients	6
Treated on an inpatient basis	15 (7 male, 8 female)
Treated on an Outpatient basis	41 (21 male, 20 female)
Receiving chemotherapy as an outpatient	22
Receiving radiotherapy as an outpatient	14
Receiving both chemotherapy & radiotherapy as an outpatient	1
Not receiving treatment for follow up	4
Cancer site reported	
Gynaecological	6
Breast	15
Prostate	10
Liver/Bile duct	3
Bowel	4
Oesophageal/duodenal/Stomach	8
Lung	1
Spine	1
Head and neck	8

APPENDIX 2: Participant Characteristics (continued)

Characteristic	Family members or friends (N=16)
Gender	
<i>Male</i>	3
<i>Female</i>	13
Age range	
<i>20-29 years</i>	1
<i>40- 49 years</i>	1
<i>50-59 years</i>	2
<i>60-69 years</i>	7
<i>70+</i>	1
<i>Not known</i>	4
Relationship	
<i>Spouse/Partner</i>	12
<i>Child</i>	1
<i>Other family member</i>	2
<i>Friend</i>	1
Characteristic	Staff (N=24)
Gender	
<i>Male</i>	7
<i>Female</i>	17
Age range	
<i>20-29 years</i>	3
<i>30-39 years</i>	6
<i>40-49 years</i>	4
<i>50-59 years</i>	1
<i>60+</i>	2
<i>Not known</i>	8
Length of time worked at the Centre	
<i>0-5 years</i>	12
<i>6-10 years</i>	4
<i>>10 years</i>	5
<i>Not known</i>	3
Roles	
<i>Nursing</i>	7
<i>Management</i>	1
<i>Medical/Clinical</i>	4
<i>Radiotherapy</i>	3
<i>Support</i>	2
<i>Therapies (allied professions)</i>	4
<i>Voluntary</i>	2
<i>Combined role Medical/Management</i>	1

APPENDIX 3: Interview Schedule 31.3.14-19.08.14

Interview date	Interview code	Participant id	Participant type	Sex	Age (Nk=not known)
31/03/2014	Interview 01	1	Patient	M	E
01/04/2014	Interview 02	2	Staff	F	Nk aprox C
03/04/2014	*Interview 03	3	Patient	M	E
07/04/2014	Interview 4 (2 participants)	4	Patient	M	F
		5	Patient	F	F
11/04/2014	Interview 05	6	Patient	F	D
11/04/2014	Interview 06	7	Staff	M	Nk approx. E
15/04/2014	Interview 07 (2 participants)	8	Patient	F	E
		9	Family member	M	E
22/04/2014	Interview 08	10	Patient	F	D
25/04/2014	Interview 09 part 1	11	Patient	F	D
16/05/2014	Interview 09 part 2	11	Patient	F	As above
		12	Friend	F	D
25/04/2014	Interview 10 (2 participants)	13	Patient	F	E
		14	Family member	M	E
28/04/2014	Interview 11	15	Patient	M	F
30/04/2014	*Interview 12	16	Patient	M	E
30/04/2014	*Interview 13	17	Patient	F	D
02/05/2014	Interview 14	18	Patient	F	E
02/05/2014	Interview 15	19	Patient	F	F
02/05/2014	Interview 16 (2 participants)	20	Patient	F	E
		21	Family member	F	Nk approx. E
02/05/2014	Interview 17	22	Patient	F	E
06/05/2014	*Interview 18	23	Patient	M	D
06/05/2014	Interview 19	24	Patient	M	B
06/05/2014	*Interview 20	25	Patient	F	F
09/05/2014	Interview 21	26	Patient	F	C
12/05/2014	Interview 22	27	Patient	M	E
13/05/2014	Interview 23 (2 participants)	28	Patient	F	D
		29	Family member	F	A
13/05/2014	*Interview 24 (2 participants)	30	Patient	M	F
		31	Family member	F	E
19/05/2014	Interview 25 part 1	32	Family member	F	Nk approx. F
19/05/2014	Interview 25 part 2	33	Patient	M	Nk approx. F
19/05/2014	Interview 26 (2 participants)	34	Patient	M	F
		35	Family member	F	E
23/05/2014	Interview 27	36	Patient	F	D
23/05/2014	Interview 28	37	Patient	F	E
23/05/2014	Interview 29 (2 participants)	38	Patient	F	E
		39	Family member	F	E
02/06/2014	Interview 30 (2 participants)	40	Patient	M	E
		41	Family member	F	E
02/06/2014	*Interview 31	42	Patient	F	Nk approx. E
02/06/2014	Interview 32	43	Staff	F	E
06/06/2014	Interview 33	44	Patient	M	D
06/06/2014	Interview 34	45	Patient	M	C
06/06/2014	Interview 35 (2 participants)	46	Patient	M	E
		47	Family member	F	Nk approx.. D
09/06/2014	Interview 36 (2 participants)	48	Patient	M	E
		49	Family member	F	D
10/06/2014	Interview 37	50	Staff	F	B
13/06/2014	Interview 38	51	Patient	M	E
13/06/2014	Interview 39	52	Patient	M	E

APPENDIX 3 (continued)

Interview date	Interview Code	Participant id	Participant type	Sex	Age (Nk=not known)
13/06/2014	Interview 40 (2 participants)	53	Patient	M	E
		54	Family member	F	Nk approx. D
13/06/2014	Interview 41	55	Patient	F	E
16/06/2014	Interview 42	56	Staff	F	C
16/06/2014	Interview 43 (2 participants)	57	Patient	F	E
		58	Family member	M	F
16/06/2014	Interview 44	59	Patient	F	E
16/06/2014	Interview 45	60	Staff	F	C
16/06/2014	Interview 46	61	Patient	M	D
20/06/2014	Interview 47	62	Staff	F	Nk approx. B
23/06/2014	Interview 48	63	Staff	M	A
23/06/2014	Interview 49	64	Patient	M	E
25/06/2014	Interview 50	65	Staff	F	E
25/06/2014	*Interview 51	66	Patient	F	E
25/06/2014	*Interview 52	67	Patient	M	F
27/06/2014	Interview 53	68	Patient	M	F
27/06/2014	Interview 54	69	Patient	F	D
27/06/2014	Interview 55 (2 participants)	70	Patient	M	D
		71	Family member	F	C
27/06/2014	Interview 56	72	Staff	M	B
30/06/2014	Interview 57	73	Patient	M	E
01/07/2014	Interview 58	74	Patient	F	E
02/07/2014	Interview 59	75	Staff	M	Nk approx. C
02/07/2014	Interview 60	76	Staff	F	Nk approx. B
03/07/2014	Interview 61	77	Staff	M	A
04/07/2014	Interview 62	78	Staff	M	A
08/07/2014	Interview 63	79	Staff	F	C
11/07/2014	Interview 64	80	Patient	M	E
21/07/2014	Interview 65	81	Staff	F	B
22/07/2014	Interview 66	82	Staff	F	B
27/06/2014	Interview 67 (2 participants)	83	Patient	M	F
		84	Family member	F	E
24/07/2014	*Interview 68	85	Patient	F	E
29/07/2014	Interview 69	86	Staff	M	Nk approx. D
29/07/2014	Interview 70	87	Staff	F	B
29/07/2014	Interview 71	88	Staff	F	D
29/07/2014	Interview 72	89	Staff	F	B
29/07/2014	Interview 73	90	Staff	F	C
30/07/2014	Interview 74	91	Staff	F	B
05/08/2014	*Interview 75	92	Patient	F	E
06/08/2014	*Interview 76	93	Patient	M	D
06/08/2014	*Interview 77	94	Patient	F	Nk approx. F
07/08/2014	*Interview 78	95	Patient	F	F
19/08/2014	Interview 79	96	Staff	F	Nk approx. C

*Inpatient/ward-based interview

Age

A-20-29 B-30-39 C-40-49

D-50-59 E-60-69 F-70+

APPENDIX 4: Cardiff Business School Ethical Approval Form

ETHICS 2



**FULL ETHICAL APPROVAL FORM
(STAFF/PhD STUDENTS) or students referring
their form for a full ethical review**

(For guidance on how to complete this form, please see Learning Central – CARBS RESEARCH ETHICS)

If your research will involve patients or patient data in the NHS then you should secure approval from the NHS National Research Ethics Service. Online applications are available on <http://www.nres.npsa.nhs.uk/applicants/>

Advice was sought in July 2013 from the National Research Ethics Service queries line, the Research and Development Manager at the NHS Trust Headquarters and Research Information and Enterprise Services (Cardiff University) to clarify whether NHS approval via IRAS was required. This has not been deemed as necessary as the view is the work is classified as service evaluation. Copies of correspondence concerning this matter are included with this approval form. I also met with the Executive Director of Nursing and Research and Development Manager at the NHS Trust in October 2013 to discuss the intended PhD Work and the view again was the work would be handled as service evaluation within the Trust (email confirming this has been included with this approval form). Additionally I have also met with the Director of Operations and Business Support Manager at the NHS Trust. An honorary contract has been drawn up for me by the Trust and a CRB check undertaken.

All documentation for this study has been reviewed from a governance perspective by the Research and Development Manager (R&D) at the Trust where the work will take place. Copies of email correspondence, including suggested revisions from the R&D Manager at the NHS Trust (which the R&D manager indicated could be made at the discretion of the research student) can be made available if required. Revised documentation has been sent for information purposes to the R and D manager on 10/03/14. Copies of the participant information leaflets and consent forms have been sent to the Patient Liaison Group at the NHS Trust for comments in terms of readability of the documents. These have also been sent to the Manager of the Supportive Care Services Team and Patient and Carer Information Co-ordinator for comments.

Name of Lead Researcher : Wendy Hardyman

School: Cardiff Business School

Email: hardymanw@cardiff.ac.uk

Names of other Researchers: n/a

Email addresses of other Researchers : n/a

Title of Project:

Patient engagement in healthcare: an exploration of 'value' and 'value co-creation' in specialist service provision

Start and Estimated End Date of Project: current date (as shadowing at present) to end September 2014

Aims and Objectives of the Research Project:

See page 2 of the proposal submitted to the NHS trust

Please indicate any sources of funding for this project:

n/a

APPLICATION APPROVED
RESEARCH ETHICS COMMITTEE
CARDIFF BUSINESS SCHOOL
CARDIFF UNIVERSITY

1. Describe the methodology to be applied in the project

See pages 1 and 2 of the proposal submitted to the NHS trust

Please note as this work was deemed as service evaluation by the NHS trust, the PhD student used the term 'semi-structured discussions' rather than 'interviews' within the documentation prepared for the NHS Trust

PLEASE ATTACH COPIES OF QUESTIONNAIRES OR INTERVIEW TOPIC GUIDES TO THIS APPLICATION

2. Describe the participant sample who will be contacted for this Research Project. You need to consider the number of participants, their age, gender, recruitment methods and exclusion/inclusion criteria

See proposal pages 2 to 4 of the proposal submitted to the NHS trust

3. Describe the method by which you intend to gain consent from participants.

See proposal pages 4 to 5

See also enclosed participant information sheets and consent forms

PLEASE ATTACH A COPY OF ALL INFORMATION WHICH WILL BE GIVEN TO PROSPECTIVE PARTICIPANTS (including invitation letter, briefing documents and, if appropriate, the consent form you will be using).

4. Please make a clear and concise statement of the ethical and health and safety considerations - <http://www.cf.ac.uk/osheu/index.html> - raised by the project and how you intend to deal with them (please use additional sheets where necessary)

See pages 5 to 6 of the proposal submitted to the NHS Trust where the project will take place.

In relation to Health and Safety considerations, the PhD student will undertake any induction training deemed necessary by the NHS Trust. This has been discussed with the Manager of the Supportive Care Services Team whom is currently investigating which training may be necessary and the format this would take.

STUDENTS SHOULD BIND THE SIGNED AND APPROVED FORM INTO THEIR REPORT, DISSERTATION OR THESIS

APPLICATION APPROVED
RESEARCH ETHICS COMMITTEE
CARDIFF BUSINESS SCHOOL
CARDIFF UNIVERSITY

STATEMENT OF ETHICAL APPROVAL

This project has been considered using agreed School procedures and is now approved.

Official stamp of approval of the School
Research Ethics Committee:

Date:

APPLICATION APPROVED
RESEARCH ETHICS COMMITTEE
CARDIFF BUSINESS SCHOOL
CARDIFF UNIVERSITY