

The metagovernance of power in collaboration innovation: a case study of transforming local systems in the Scottish Highlands

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ABSTRACT

This paper examines the dynamic and relational factors influencing collaborative innovation in public service delivery through an analysis of a regional innovation project in the Scottish Highlands. The study highlights the critical role of metagovernance in addressing power asymmetries, ensuring meaningful inclusion of diverse actors, and sustaining collaborative processes. By exploring how hands-on and hands-off metagovernance techniques can mitigate structural power imbalances and foster inclusive participation, the research advances understanding of how governance strategies shape innovation in public services. The findings provide actionable insights for policymakers, particularly in navigating the complex dynamics of collaborative governance and overcoming barriers to innovation.

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Introduction

Given the complex challenges public services must address, policymakers concur that innovation in public services is essential. Public administration scholars have proposed the concept of ‘collaborative innovation’ as a means to develop and analyse solutions to these challenges (de Vries, Bekkers, and Tummers 2016; Torfing 2016). Collaborative innovation involves diverse, interdependent actors who commit to solving shared, complex problems – often referred to as ‘wicked problems’, which have multiple causes, are hard to define, and lack clear solutions (Head 2008; Torfing 2013, 2016). Innovation here is understood as a distinct departure from previous practices, transforming service delivery (van Acker 2018).

While collaborative innovation is positioned as an effective vehicle for tackling complex social problems, its implementation is highly context-dependent (Ansell and Gash 2008; Sørensen and Torfing 2011; 2016). Studying how it unfolds across structural and national contexts offers insights into its mechanisms and processes (de Vries,

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Bekkers, and Tummers 2016; Sørensen and Torfing 2016). These insights are particularly relevant in health and social care, where collaborative innovation holds promise for transforming service delivery to address significant strains on public systems (Ferlie et al. 2005; Kosiol et al. 2024).

However, collaborative innovation faces challenges, particularly in managing power dynamics among actors, which can both enable and restrict collaboration (Torfing 2016). Much of the public innovation literature has focused on structural and institutional conditions for successful collaboration (Jessop 2023; Koppenjan, Kars, and Van der Voort 2011; Sørensen and Torfing 2009; 2016), acknowledging the influence of power asymmetries in shaping these conditions (Mu and Wang 2022; Purdy 2012; Torfing 2016). However, these studies often overlook how collaborative innovation operates at the dynamic and relational levels, where evolving interactions and stakeholder relationships play a critical role. In this context, *dynamic* refers to the evolving nature of innovation, shaped by shifting conditions and stakeholder engagement (Teece, Pisano, and Shuen 1997; Trivellato, Martini, and Cavenago 2021), while *relational* pertains to the quality of connections and networks stakeholders form, and how these relationships influence innovation (Ansell and Gash 2008; Purdy 2012; Sørensen and Torfing 2011).

This paper seeks to address these gaps by posing the research question: **What factors shape, facilitate, and constrain the processes of collaborative innovation at the dynamic and relational level?** This question highlights the complex, evolving interactions within collaborative innovation, areas often underexplored in both theory and practice.

Employing a conceptual framework of collaborative innovation, this paper examines a project in the Scottish Highlands aimed at transforming local systems (TEC Scotland 2019). By examining factors that shape, facilitate, and constrain innovation at a dynamic and relational level, this study provides deeper insights into the forces that support or hinder collaborative efforts to innovate public service delivery.

Following this introduction, the context of the NHS Highland Pathfinder project is presented to offer essential background for the case analysis. The conceptual framework of collaborative innovation is then introduced, along with a review of the relevant literature. The methodology section details the qualitative research approach used for data collection and analysis. Next, the findings are presented, interpreted through the conceptual framework to examine the dynamic, relational processes among key stakeholders. The discussion connects these findings to the broader public administration literature, offering insights into metagovernance and power dynamics in collaborative innovation. Finally, the conclusion summarizes the paper's conceptual and practical contributions and offers recommendations for future research.

Case study: transforming respiratory care in the Scottish Highlands

Project approach

This case study focuses on the NHS Highland Technology-Enabled Care (TEC) Pathfinders project, part of the TEC Transforming Local Systems Pathfinders Programme. The national programme aimed to transform local systems in four Scottish regions using digital technology and the 'Scottish Approach to Service Design' (SAatSD). Endorsed nationally, the SAatSD provides a structured

framework for redesigning public services through collaborative engagement and iterative problem-solving (The Scottish Government 2019). The SATSD adopts the **Double Diamond model** developed by the British Design Council, directly incorporating its four design phases – Discover, Define, Develop, and Deliver (MacLure and Jones 2021). The SATSD’s emphasis on iterative problem-solving and stakeholder-driven design aligns closely with the principles of collaborative innovation, particularly its focus on inclusion and co-creation (The Scottish Government 2019).

Project stakeholders

National coordinators

The national Pathfinder Programme was a collaboration between the Scottish Government’s TEC Programme, Healthcare Improvement Scotland’s ihub, the National Office of the Chief Designer, and the Scottish Government Community Health & Social Care Directorate (TEC Scotland 2019). These stakeholders formed the programme’s steering group, which oversaw a small team of ‘national coordinators’. These coordinators guided the four Pathfinder regions in implementing SATSD-based transformations. The programme funded four health boards over two years, contingent on performance and adherence to the SATSD, with this study focusing on NHS Highland.

Core team

While the national coordinators provided high-level guidance, a regional core team led the transformation of the respiratory care pathway. The NHS Highland TEC team – comprising seven members and responsible for regional telecare and telehealth services – collaborated with rural health scholars, respiratory care professionals, administrators, physicians, and third-sector representatives. The research team from the University of Highlands and Islands (UHI), acting as the ‘patient-project bridge’, consisted of approximately five individuals from the Division of Rural Health and Wellbeing.

As NHS Highland’s bid focused on respiratory health, the NHS Highland Respiratory care team joined, including consultants, a community nurse, a research doctor, and a service manager. Additional NHS Highland participants included a project manager, a second nurse, another research doctor, a health improvement specialist, and a GP. Third-sector groups in the core team included Let’s Get on With it Together (LGOWIT), a self-management initiative for those with chronic conditions, and Chest Heart & Stroke Scotland, which supports those with related conditions.

Peripheral participants

Peripheral participants included two additional GPs, the head of eHealth, a health improvement specialist, the head of community services, three Highland Council members, several housing associations, the Scottish Ambulance Service, and a member of the British Lung Foundation. Patients contributed through focus groups, phone interviews, and surveys conducted by the UHI team, and later participated in working groups during the implementation stage, along with an unpaid carer.

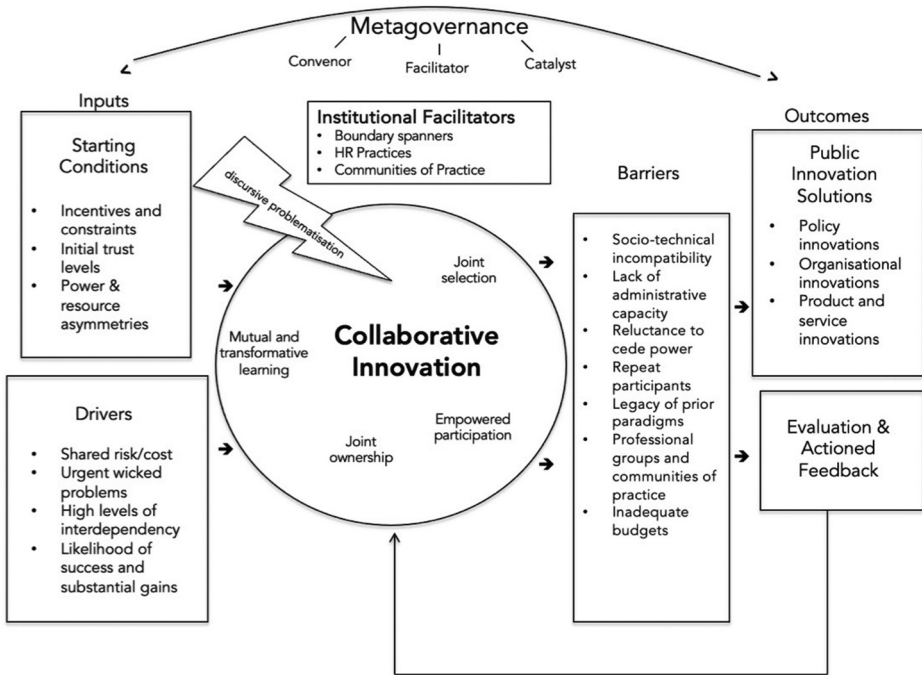


Figure 1. Conceptual framework of collaborative innovation in public services.

A conceptual framework of collaborative innovation

Collaborative innovation as a construct within public services is dynamic and complex (Torfing 2013). Scholarship highlights the importance of understanding how key components – such as the roles of stakeholders, resource dynamics, governance structures, and the evolving relationships among actors – interconnect to foster or impede innovation (Kattel, Lember, and Tõnurist 2020; Lindsay et al. 2018; Rubalcaba and Peralta 2022; Torfing et al. 2020). A framework of collaborative innovation (see Figure 1) was chosen specifically for its emphasis on the dynamic and relational aspects of collaborative innovation. This framework, refined and applied in previous research (R. Livingstone 2022, 2023), provides a structured approach to examining the inputs, processes, outcomes, and the role of metagovernance in supporting effective collaboration.

Rooted in New Public Governance (NPG), this framework of collaborative innovation aligns with NPG's focus on network governance, collaboration, and co-production in public services (Osborne 2006). Unlike traditional public administration and New Public Management (NPM), which prioritize hierarchical control and market mechanisms, NPG emphasizes the dynamic and relational aspects of governance that are essential to collaborative innovation. This orientation towards multi-actor networks, shared leadership, and inclusive decision-making aligns with the framework's focus on metagovernance and its role in facilitating collaboration (Osborne 2006; Sørensen and Torfing 2016).

Inputs: starting conditions and drivers

In public service innovation, the inputs that set the groundwork for collaboration include actors' initial conditions and drivers propelling collective action. These inputs, shown in [Figure 1](#), reflect the individual incentives, constraints, and trust levels each actor brings, along with existing resource and power asymmetries, critical in shaping the collaborative process (Ansell and Gash 2008; Voets 2021).

Key drivers of collaborative innovation include resource and risk sharing, which carry the potential to lower individual burdens and foster mutual accountability (Rakšnys, Valickas, and Vanagas 2020; Torfing 2016). Another driver is the urgency of wicked problems that demand immediate, innovative solutions beyond the capacity of any single entity (Lindsay et al. 2018). High interdependency among actors further compels collaboration to achieve mutual gains, motivating stakeholders to engage in innovation.

Discursive problematization: articulating the challenge

Discursive problematization, a foundational step in collaborative innovation, involves actors jointly articulating wicked problems and aligning on root causes (R. Livingstone 2022, 2023; Sørensen and Torfing 2017). This iterative dialogue fosters the shared understanding necessary for implementing creative solutions (R. V. Livingstone 2023). In [Figure 1](#), it is symbolized as a thunderbolt, indicating its role in energizing and advancing innovation.

Key processes: enabling collaborative innovation

At the core of the framework are the processes that bring to life the principles of collaborative innovation – empowered participation, mutual and transformative learning, joint ownership, and joint selection. These processes contribute to managing the dynamic and relational interactions between actors, although their implementation and impact can vary across contexts and studies (Lindsay et al. 2021; R. Livingstone 2022; Torfing 2013). *Empowered participation* emphasizes the reduction of power asymmetries by creating conditions for all actors to contribute equally and effectively as collaborators (Torfing 2013; Trivellato, Martini, and Cavenago 2021). *Mutual and transformative learning* emphasizes the need for stakeholders to reassess their understanding of problems and solutions, fostering deeper engagement and enriching the collaborative process (Lindsay et al. 2018; Torfing 2013). *Joint ownership* enhances commitment and accountability by allocating shared responsibility for both the collaborative process and its outcomes (Lindsay et al. 2021; Torfing 2016). *Joint selection* ensures decisions are made collectively through democratic deliberation, allowing all actors to shape outcomes equitably (R. Livingstone 2022). These processes are inherently dynamic and reciprocal, adapting continuously as relationships and contexts evolve, thereby refining the collaborative environment and enhancing its potential for innovative outcomes (Trivellato, Martini, and Cavenago 2021).

Metagovernance: the invisible hand of collaborative innovation

Metagovernance, the governance of governance, guides networks of actors towards shared aims by orchestrating the interplay of processes, resources, and relationships in governance networks (Sørensen 2014; Sørensen and Torfing 2009). In the context of public innovation, metagovernors perform three critical roles: convening actors to align on shared objectives, facilitating collaborative integrity by maintaining trust and managing power asymmetries, and catalysing action to overcome impasses and drive progress (Sørensen 2014, 2016; Torfing 2016). These roles are particularly vital in addressing the inherent complexities of governance networks, where power imbalances, fragmentation, and competing interests can obstruct collaboration (Ansell and Gash 2008). Such challenges demand a strategic approach to steer collaboration effectively. Metagovernance, by addressing these barriers, is uniquely positioned to mitigate risks of fragmentation and network egotism (Koppenjan, Kars, and Van der Voort 2011) and to create the conditions for empowered, inclusive collaboration (Torfing 2016). By employing a mix of hands-on and hands-off approaches, metagovernors can flexibly adapt their strategies to the dynamic interactions and evolving needs of governance networks (Sørensen 2007; Torfing 2013).

Facilitators: enhancing the collaborative climate

Facilitators in this framework act as supportive elements that enhance the collaborative innovation process (R. Livingstone 2022; Torfing 2013). The framework emphasizes relational processes between actors and workplace practices that institutionalize facilitation at a dynamic, relational level, highlighting facilitators especially relevant to this focus. Key facilitators include boundary spanners, HRM practices promoting innovative work behaviour (Bos-Nehles, Renkema, and Janssen 2017), and creating a community of practice (Lindsay et al. 2018; Torfing 2013). Boundary spanners, in particular, play a central role by bridging gaps across sectors; third-sector organizations often serve this role by bringing unique perspectives and resources (Osborne 2010). Facilitators operate subtly, bridging gaps and smoothing interactions to foster a conducive environment for innovation.

Barriers: obstacles to collaborative innovation

The collaborative innovation framework identifies several barriers to optimal outcomes (see Figure 1). Emphasizing dynamic and relational facets, this study emphasizes inter-actor and inter-institutional barriers within governance networks. These include insufficient administrative capacity, which can limit coordination and implementation within collaborative efforts (McCrea 2020), socio-technical incompatibility, which encompasses challenges such as lack of technical interoperability and misalignment between technological systems and collaborative processes (Cinar, Trott, and Simms 2019; Mu and Wang 2022), as well as power asymmetries, often reinforced by a reluctance among actors to cede power, thereby undermining equitable and inclusive collaboration (Bovaird and Loeffler 2012; Torfing 2016).

The reluctance to cede power presents a complex and pervasive barrier in collaborative innovation, as it often reflects entrenched hierarchical structures and asymmetries in both formal authority and resource control (Ansell and Gash 2008; Purdy

2012). Power – defined by actors’ resources, influence, and legitimacy (Purdy 2012) – is both a constraint and an opportunity in governance networks, shaping how decisions are made and whose voices are heard. Actors with institutional authority may be hesitant to relinquish control over decision-making processes, fearing the dilution of their influence and the potential for undesirable outcomes (Sørensen and Torfing 2017; Torfing 2016). This reluctance can undermine the inclusive and participatory nature of collaboration, eroding trust among less powerful stakeholders, and potentially diminishing their commitment to the innovation process (Edelenbos, van Meerkerk, and Koppenjan 2017). If left unmanaged, power asymmetries can reinforce existing hierarchies, ultimately limiting the scope of collaborative problem-solving and stifling the potential for innovative solutions (Ansell and Gash 2008; Purdy 2012).

Other common barriers include lack of collaborator diversity, which can limit creativity (Torfing 2013); legacies of prior paradigms that constrain transformative change (Lindsay et al. 2018); risk aversion driven by regulatory constraints (Mulgan and Albury 2003; Rakšnys, Valickas, and Vanagas 2020); inadequate budgets, which frequently limit resources (Fernandez and Wise 2010); and professional boundaries, such as those created by tight-knit networks impenetrable to outside influence, that can hinder knowledge exchange and collaborative innovation (Croft and Currie 2020; Ferlie et al. 2005).

Outcomes: advancing public services through collaborative innovation

The outcomes of collaborative innovation processes typically take three primary forms: policy, organizational, and product and service innovations (Torfing 2016). It is emphasized that post-implementation these innovations improve iteratively over time in response to evaluation or other sorts of feedback mechanisms (Mischen 2015; Sørensen and Torfing 2011). Evaluating the success of specific innovation projects is inherently challenging, as the complexity of the goals, contexts, and stakeholder dynamics often defy simple metrics (Fung 2015). However, in the realm of collaborative innovation, success hinges on the collective judgement of relevant stakeholders affected (Sørensen and Torfing 2011). That is, successful innovations effectively address the wicked problem at hand in ways that align with the needs and preferences of participant actors (Sørensen and Torfing 2011).

Materials and methods

This study applies the collaborative innovation framework through an in-depth case study, chosen for its exploratory nature and suitability for multi-actor collaboration in contextually situated projects (Ansell and Gash 2008; Yin 2017). The selected case study exemplifies a collaborative, multi-agency effort to facilitate innovation in health and social care. Purposive sampling ensured diverse perspectives from core and peripheral stakeholders, with the NHS Highland TEC team providing participant details, including names, professions, and project involvement.

During the first fieldwork phase (June – July 2020), 13 interviews identified key stakeholders, including the Highland TEC team and national coordinators, who acted as metagovernors through their roles in convening and guiding collaboration. The second fieldwork phase (January – February 2021) involved 9 additional

Table 1. List of project participants by role and fieldwork block.

Employer (at the time of Interview)	Position Held	Fieldwork Block	Project Role
Health Improvement Scotland	Senior Service Designer	Block 2	Coordinator of national TEC Pathfinders programme
NHS Highland	GP and District Medical Lead	Block 2	Peripheral team member
Chest Heart & Stroke Scotland	Lead Coordinator, Highlands & Islands	Block 1 and Block 2	Core team member
NHS Highland	Head of eHealth	Block 1	Peripheral team member
NHS Highland	TEC Project Manager	Block 1 and Block 2	Core team member
LGOWIT (hosted by Highland Third Sector Interface)	Manager	Block 1 and Block 2	Core team member
NHS Highland	Specialist Paramedic	Block 2	Peripheral team member
University of Highlands & Islands	Postdoctoral Researcher	Block 1	Core team member
NHS Highland	TEC Service Manager	Block 1 and Block 2	Core team member
Self-employed	Independent Management Consulting Professional	Block 2	Coordinator of national TEC Pathfinders programme
NHS Highland	Advanced Practice Respiratory Nurse	Block 1	Core team member
NHS Highland	Research Doctor	Block 1	Core team member
NHS Highland	Health Improvement Specialist	Block 1	Peripheral team member
University of Highlands & Islands	Acting Head of Division of Rural Health & Wellbeing	Block 1	Core team member
University of Highlands & Islands	Postdoctoral Researcher	Block 1	Peripheral team member
LGOWIT (hosted by Highland Third Sector Interface)	eLearning Development Officer	Block 1	Peripheral team member
NHS Highland	Head of Community Services	Block 1 and Block 2	Peripheral team member

interviews, with 5 repeat participants and 4 new members representing newly engaged stakeholder groups (see [Table 1](#) for participant details by role and fieldwork phase).

Semi-structured interviews, guided by the collaborative innovation framework (see [Appendix A](#) for interview guide), were conducted via videotelephony (primarily Zoom), lasting between 30 and 90 minutes, with an average of 47 minutes. Thematic analysis followed the systematic guidelines of Miles and Michael Huberman (1994), which emphasize the iterative process of coding and theme development (see [Figure 2](#)). The initial coding framework, based on the study's conceptual framework, provided a structured approach for categorizing key components of collaborative innovation (e.g. metagovernance, starting conditions, and collaborative processes). During iterative readings, emergent themes – such as resource allocation and shifting power dynamics – were identified, reflecting Miles and Michael Huberman's (1994) emphasis on adaptability in qualitative analysis. NVivo was used to facilitate manual coding and ensure a systematic approach to data organization and integration. To triangulate findings, internal performance reports and presentations shared with and commissioned by national coordinators were analysed alongside interview data, aligning with Miles and Huberman's emphasis on data source triangulation to enhance analytic validity.

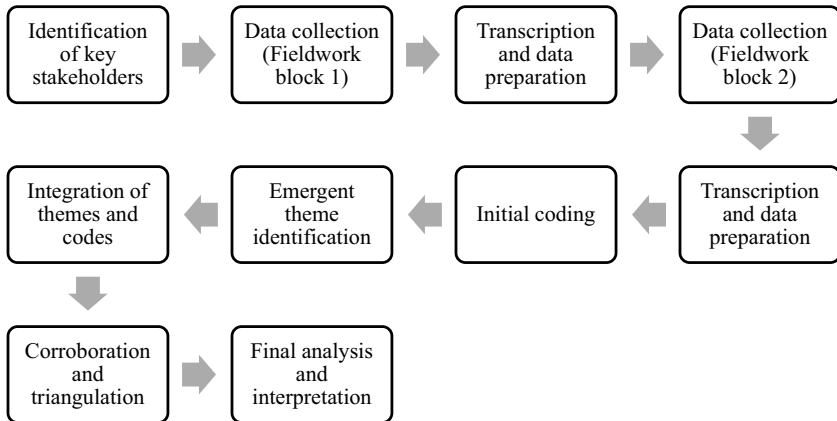


Figure 2. Phases of data Analysis.

Ethical approval was obtained from Strathclyde Business School and NHS Highland in 2019, with informed consent ensuring anonymity, confidentiality, and the right to withdraw at any time.

Results

This section presents findings from the case study through the lens of the collaborative innovation framework, highlighting elements central to the dynamic and relational aspects of the case: discursive problematization, key collaborative processes, metagovernance, and the outcomes achieved.

Discursive problematization

The core team spent over a year presenting expertise, deliberating shared research, and triangulating data to define the problem collectively. At the heart of the issue was the respiratory healthcare pathway in the Highland region, which failed to deliver seamless, person-centred, and holistic care to patients. This inadequacy represented a classic ‘wicked problem’ (Head 2008), with multifaceted causes, interdependencies, and no straightforward solutions.

While patients were involved, their early engagement was largely mediated through UHI scholars, limiting their direct input into core team discussions. Third-sector representatives, many of whom lived with chronic conditions and were deeply embedded in patient communities, served as advocates for the patient voice within the collaborative arena.

To reach consensus on key issues, the team conducted a prioritization exercise, identifying 25 issues across 10 areas and ultimately narrowing these to four main problem statements. Patient and GP survey feedback, conducted by UHI scholars, further refined the focus to three core themes:

- Patient information and support
- Clinician knowledge and understanding

- Data sharing and flow

Three working groups were established to develop solutions around these themes. Although the prioritization process aimed for broad input, the team's composition remained heavily weighted towards medical and professional stakeholders, leading to an underrepresentation of social care perspectives. The national coordinators, who oversaw the programme, were cautious about this medical emphasis, as it risked detracting from the holistic, patient-centred focus central to the SATSD framework. Although efforts were made to engage social care, limited follow-up meant their perspectives were underrepresented. This imbalance not only ran counter to the SATSD framework's ethos of bottom-up, service-user-centred innovation but also perpetuated gaps in the collaborative understanding of the problem, potentially limiting the scope and inclusivity of proposed solutions.

Key processes

Empowered participation

Both fieldwork phases revealed efforts by the NHS Highland TEC team to ensure core team members could voice their perspectives. For instance, the core group's 'chair' actively sought contributions from less vocal members. Despite making significant contributions to the project, these organizations faced financial strain due to a lack of funding, which reinforced existing hierarchies and implicitly signalled that their input was less valued. This funding disparity reinforced existing hierarchies and sent an implicit message that their contributions were less valued. One third-sector participant described their involvement:

And so, I just started attending the meetings, I suppose, in the hope that at some point somebody somewhere might give us some funding. So, we're still here.

A turning point came when third-sector participants learned that GPs were being compensated for their involvement while their own requests for support had been ignored. Feeling undervalued, they made a joint funding request, which ultimately resulted in the allocation of funds. With this support in place, third-sector participants reported a renewed sense of empowerment and legitimacy. No longer concerned about the sustainability of their involvement, third-sector participants could focus on the collaborative process.

And that makes it miles easier for me when I'm having conversations with the senior management team here about my time. Because they now basically say that's your respiratory TEC time and I don't have to justify it. They make sure that my work is covered and stuff, so it's been fab. What a difference. - Core team member (third sector)

This evolution highlights the role of metagovernance in balancing power within collaborative structures. When resource allocation addressed these disparities, third-sector actors could participate on a more equal footing, reinforcing the collaborative environment's foundation of mutual respect and shared responsibility.

Mutual and transformative learning

Nearly every participant expressed that they had learned from fellow collaborators and from participating in the project. This learning was often transformational, in the sense that it deepened their understanding of the care pathway and the problem from multiple perspectives, which informed their ideas for solutions.

I mean, I've certainly learned. I had no idea that primary care didn't speak to secondary care. I mean, I've learned a lot about the NHS. I had no idea about - I knew there were issues with data that we all had data silos, but I had no idea there was an issue with NHS Highland accessing GP data. – Core team member

Understanding how different stakeholders experienced the pathway enabled the group to identify key themes, such as 'Data sharing and flow'. The themes of 'Clinician knowledge and understanding' and 'Patient information and support' similarly emerged from UHI and third-sector data, revealing patient reluctance to engage with clinicians due to past negative experiences with issues like weight and smoking, affecting their respiratory health.

I think we've certainly been able to understand more about the patient experience—the non-medical side. . . A lot of what the patients have talked to us about has been emotional support. . . their feelings about getting a diagnosis, their own responsibility, or how the doctors have treated them. – Core team member

A key aspect of this learning was the recognition of the third sector's value, which transformed the collaborative dynamic. Over time, biases and misconceptions faded as participants came to appreciate the third sector's unique contributions to patient-centred care. As one third-sector participant noted:

. . .The TEC team came back to say they actually really couldn't progress it without us because our- and actually, [core team member] wrote a really good kind of supporting email. To say that the level of information coming in from myself and [another third sector participant] was invaluable and the comments that we could make gave it a real patient focus. Which they weren't going to get from anywhere else. –Core team member (third sector)

Several clinicians also described a newfound appreciation for the third-sector perspective, realizing that the third sector offers support and information not typically provided by the NHS:

In many cases, you know, doctors always assume that patients are just wanting the right treatment to get better but that's not always necessarily the case. . . Whereas people like LGOWIT, they perhaps come along and say what patients need is to know which websites they can look at to, you know, how is this going to go? How am I going to be in five years' time? Who can I talk to when I'm feeling particularly bad? And that's not necessarily information that GPs are primed to provide. – Core team member

Because for me, what [third sector org] bring and it's any third sector, but they bring to us the quality of care that we would like to give in the NHS. Not that the NHS level is bad, it's just that when folk drop to a low enough acuity that they can be left by themselves, we tend to leave them by themselves and actually if you want to stop coming back into the system, they need more support than the NHS can give them. – Core team member

This learning process built a shared understanding of each participant's role and strengthened interdependence, which allowed them to devise more holistic solutions. Through mutual and transformative learning, actors deepened their collective understanding, ultimately enhancing the collaborative innovation process.

Joint ownership

The degree to which participants saw this project as jointly owned was mixed during the first block of fieldwork but transformed by the second block. Over the course of working together, joint ownership strengthened as the core group learned from one another, discursively framed the root of the problem, shared resources, and developed a sense of mutual respect and understanding. This mutual recognition of value among the core team fostered a sense of joint ownership, providing a strong foundation and sense of accountability as they moved into the Develop stage.

However, the financial power asymmetry noted with empowered participation carried over into joint ownership. Inconsistent resource-sharing decisions intensified existing power and resource differentials between those whose expertise was seen as more legitimate due to their professional status. Inconsistent resource-sharing decisions amplified existing power and resource differentials, making it challenging to cultivate a sense of collective ownership. Actors recognized these disparities, which undermined the perception that all contributions were equally valued. This imbalance was particularly felt by third-sector participants, as one remarked:

It doesn't feel like a partnership. I don't feel like a partner at all. I'm a consultant. They come to me when they want some input. So, they're consulting with me. Core team member

As resource-sharing improved in the second block of fieldwork, joint ownership began to solidify. Third-sector actors, now resourced and recognized, moved from a consultative role to a more integral position in the project. The project evolved from one in which third-sector participants felt consulted to one in which they felt integral to its activities and thus jointly responsible for achieving its objectives.

So, it has changed and it's much better. And I think the level of respect at the meetings, that they want your opinion now. If you don't speak, they're asking you where you kind of stand with it. And I think they're listening. – Core team member (third sector)

The tension between top-down and bottom-up approaches to metagovernance was another factor initially hindering joint ownership. The national coordinators' hands-on governance approach made it challenging for core team members to feel they collectively owned the project and were responsible for enacting change. Requirements to meet performance management expectations and adhere to what they saw as strict guidelines eroded trust between the core team and national coordinators, impacting joint ownership.

On this Pathfinder project, it does feel more transactional. It definitely feels like, well, we came up with the idea. We said we want to transform this pathway, but Scottish Government are telling us how to do it. So, they are, it feels like they are in control of the process around doing it. –Core team member

By the second block of fieldwork, the national coordinators had taken a step back from their initial project management approach. Although some core team members felt there was still too much expected in terms of evaluation, there was a notable shift in the way participants spoke about the national coordinators' governance and the SAatSD more broadly.

I think it's a very uncomfortable space for a lot of people to be in and it continues to be an uncomfortable space and I don't mind being the person that gets blamed for the uncomfortable bits because then you hear wonderful things when [NHS Highland TEC team member] says, if

we hadn't done what we've done, we'd have been tackling the wrong problem. And to hear say that in a webinar recently was just like oh that's so wonderful. – National coordinator

Joint selection

The goal of joint selection is to bring convened actors to an agreement on actions to be taken – not necessarily through full consensus, but by achieving a rough majority on the proposed solutions (R. V. Livingstone 2023). For this project, the themes to be addressed and the solutions to be developed were jointly selected through a systematic ranking process based on criteria related to feasibility and stakeholder impact. The UHI research team refined these themes by engaging patients via focus groups and phone interviews. Based on the findings, the core group was divided into three working groups, each bringing together patients, GPs, researchers, respiratory care professionals, and healthcare administrators to collaboratively develop solutions aligned with the selected themes.

The systematic nature of this process, described by a core team member, provided reassurance to some actors, while others found it overly complex and challenging to understand the criteria:

So yeah, again it's very democratic and systematic and so we had criteria based on how easy something was to do, what the impact would be, would it impact on the service, would it impact on patients, what kind of resource would it take for that to happen - whether that's manpower or funding or other. – Core team member

While this process was robust and systematic for core group members, several relevant and affected actors were either underrepresented or excluded from the collaborative arena and thus from joint selection. Patients were directly involved in the joint selection of solutions within the working groups, but their engagement in earlier stages – where key decisions were made, and the problem was defined – was mediated at a distance through researchers and third-sector representatives. Additionally, adult social care was only peripherally involved through the head of community services, who was not part of the core team. The project also did not meaningfully include representatives from regional Adult Social Care, despite its integration into NHS Highland and its critical role in the care pathway. As a result, while joint selection was present to some degree, it lacked the inclusivity necessary for truly comprehensive coproduction.

Metagovernance

The Highland's TEC Pathfinder project can be viewed as having two layers of metagovernance. One level is the NHS Highland TEC team, which guided actors through the four phases of the SATSD, convened the actors initially, mediated conflicts, allocated project funding, and provided actors with decision-making structures and systems. Hierarchically above the NHS Highland TEC team were the national coordinators, who acted as another layer of metagovernance. The national coordinators assessed each of the four projects' performance, progress, and adherence to the SATSD, acting as gatekeepers for each phase's tranche of funding.

Governance tensions between the national coordinators and the NHS Highland TEC team was a recurring theme in the first block of fieldwork. The NHS Highland

TEC team perceived the national coordinators as more hands-on than expected, which conflicted with the bottom-up ethos of the SAtSD. The extra work required for SAtSD adherence and reporting was also seen as more onerous than represented during the application process.

I mean this project, I said this to somebody else just recently, this project has got more layers of oversight, you know, of checking up on what we're doing than any project I've ever worked on before.– Core team member

By the second round of interviews, this tension had eased considerably. Participants attributed this to two factors: an easing of formality and rigidity by the national coordinators in managing project performance and the realization over time by the NHS Highland TEC team of the value of the SAtSD-prescribed methodology and the role of national coordinators in advocating for its adherence. Several actors who were initially critical of the SAtSD later credited it with pushing them to involve a broader range of relevant stakeholders and adequately problematize issues before developing solutions.

The convenor role of metagovernance, which involves bringing together a diverse and relevant range of stakeholders to ensure an inclusive collaborative process (Sørensen 2016; Torfing 2016), was evident in the NHS Highland TEC team's efforts. The NHS Highland TEC team, under the guidance of the national coordinators and in alignment with the SAtSD, endeavoured to involve as many stakeholders as possible. They reached out to relevant stakeholder groups, such as Adult Social Care, which did not respond and were not contacted again. Before the project began, the national coordinators assumed NHS Highland might adopt a holistic approach, given its nationally distinct model for integrating health and adult social care. However, they soon became concerned that NHS Highland's approach was overly medicalized, failing to adequately involve patients and non-medical stakeholders like adult social care and third-sector organizations. This concern is reflected in the following quote:

The battles we had to make sure that they included the third sector... that was a heck of a struggle to get them to do that and you know, every time we said, what about housing, what about, what about, what about and they do it begrudgingly and then they realise all that was really useful. – *National coordinator*

This reluctance to integrate non-medical stakeholders underscores the critical role of the national coordinators' metagovernance in convening an appropriately diverse collaborative arena. By facilitating the inclusion of diverse voices, particularly non-medical stakeholders, the national coordinators helped to expand the scope of problem-solving beyond a narrow focus on clinical understanding and professional judgement. This broader approach enriched the team's comprehension of the care pathway, better enabling the collaborative arena to consider holistic, patient-centred care and consider broader determinants of health.

Efforts to convene a diverse range of stakeholders revealed challenges in securing the sustained involvement of key actors. These barriers carried over into another role of metagovernance, facilitation, which involved managing interactions, fostering trust, and ensuring inclusive dialogue (Sørensen 2016; Torfing 2016). The NHS Highland TEC team played a critical role in mediating conflicts and encouraging participants to voice their concerns, even when some felt hesitant or out of place. This facilitative

approach, while not always yielding neat conclusions, highlighted efforts to address power imbalances and foster inclusivity, enabling the project to move forward.

While the NHS Highland TEC team made efforts to foster inclusive dialogue and address dissent, a significant challenge in facilitation emerged around resource-sharing. Initially, third-sector groups struggled without remuneration, despite their significant contributions and the resource-sharing with other, less precariously positioned actors. A shift occurred, however, in the roughly six months following the first block of fieldwork. Resource-sharing was initiated following formal requests and the involvement of the national coordinators, who recognized the third sector's essential role in upholding the bottom-up ethos of the SATSD framework. This intervention diminished the power asymmetries that had been exacerbated by the reluctance to engage in resource sharing with third sector actors, empowering them with the resource capacity to engage more fully. Nonetheless, this shift only occurred after said earlier reluctance to cede control over resource distribution had reinforced power hierarchies and stifled empowered participation. These findings highlight the importance of addressing power asymmetries early, as unequal resource distribution and control over decision-making can undermine collaborative innovation.

Outcomes

Although fieldwork concluded before full implementation of solutions, the TEC Pathfinder project has since progressed, as documented on their website (TEC Scotland 2021), achieving the following outcomes:

- Respiratory resource hub: A website offering information for respiratory patients and carers, integrating links from trusted sources and local content.
- Your Breathing Matters: Online learning sessions covering respiratory conditions, symptoms, self-management advice, and broader non-medical information.
- Digital access: A pilot programme offering digital access to health records, improving patient engagement with their healthcare data.
- Secondary care letters: Standardized letters for patients at the time of referral and after clinic appointments, improving communication and transparency.
- Access to specialist respiratory nurses: Expanded services including early supported discharge, virtual wards, remote monitoring, and additional nursing support.
- Pulmonary rehab: Enhanced pulmonary rehabilitation services, including new classes and promotional materials.
- Embedding third sector: Active involvement of third sector organizations in solution design and development, promoting their services within the project's framework.
- Improved respiratory guidelines: Updated guidelines to aid diagnosis, management, and referral of respiratory patients.
- Clinician learning and knowledge exchange: Implementation of educational sessions for primary care, formalizing multidisciplinary team working, and mentoring.

- Secondary care systems and processes: Although some systemic changes were beyond the project's timeframe, significant groundwork was laid for future improvements.
- Clinical applications and data sharing: Addressed key issues in data sharing and clinical applications, with ongoing efforts to enhance these systems.
- Data sharing with the Scottish Ambulance Service (SAS): Successful implementation of a new COPD pathway with the SAS, facilitating better follow-up care in the community.

These outcomes underscore the value of collaborative innovation in addressing complex healthcare challenges. While some initiatives were fully implemented during the project, others laid critical groundwork for future systemic improvements. Notably, elements such as embedding third-sector organizations, fostering multidisciplinary teamwork, and iterative improvements to clinical processes demonstrate how collaboration across diverse stakeholders can produce meaningful and sustainable changes in public service delivery.

Discussion

This study explores the mechanisms underpinning collaborative innovation within public service delivery, with a particular focus on how metagovernance shapes and sustains these processes. The research question focused on identifying the factors that shape, facilitate, and constrain collaborative innovation processes. Findings indicated that metagovernance exerted the greatest influence, playing a pivotal role in overseeing the process, resolving issues, and convening relevant actors. Through the conceptual framework of collaborative innovation, the study examines how discursive problematization, empowered participation, joint ownership, joint selection, and transformative learning interact with metagovernance to shape the collaborative arena. These processes are deeply intertwined with power asymmetries, which metagovernors must navigate through strategic interventions, as shown in this case.

Power asymmetries and resource imbalances

While third-sector actors had some degree of discursive legitimacy due to their embeddedness within patient communities and their role as boundary spanners, this legitimacy was seen as relatively lower than that of academic stakeholders (scholars) or professional stakeholders (clinicians, healthcare professionals, and NHS personnel), whose expertise was often considered more institutionally legitimate. Their inclusion signalled recognition of their patient advocacy role, yet resource disparities constrained their influence and capacity for systemic change. This dynamic aligns with Purdy's (2012) framework on power, where authority, resources, and discursive legitimacy must be balanced for effective collaboration. It also echoes Milbourne and Cushma's (2010) examination of trust and power in the third sector, which highlights how resource inequalities and hierarchical relationships often marginalize third-sector organizations. That being said, the diversity within the third sector means that these organizations do not uniformly experience financial precarity, nor should all collaborations assume resource allocation is the sole mechanism for addressing disparities.

Instead, metagovernors should consider the specific contribution mix of each collaborative context and the relational dynamics at play to ensure funding decisions mitigate, rather than exacerbate, existing power inequalities within collaborative arenas.

Convening power and actor selection

Metagovernance played a critical role in shaping the collaborative arena by determining which actors were included and how they participated. In the early stages, health-centred actors dominated, while unpaid carers and patients were underrepresented, their involvement initially mediated by researchers. Though one unpaid carer was later included, the lack of sustained engagement from adult social care limited the collaboration's ability to fully address the holistic nature of the care pathway. These decisions on actor inclusion demonstrate how metagovernors shape the collaborative process not only by allocating resources but by influencing the perspectives that inform problem definition and solution development. This dynamic illustrates how metagovernors, through their process authority, shape the collaborative environment not only by managing resources but also by deciding which voices are included and at what stage (Purdy 2012).

Barriers to collaboration

Two key barriers emerged in this case: reluctance to cede power and the legacy of prior paradigms. The reluctance to cede power manifested most clearly in the control over resource distribution, where more powerful actors initially denied funding to third-sector participants. This decision perpetuated existing power hierarchies, limiting the ability of marginalized actors to participate fully. This aligns with Torfing's (2016) assertion that power dynamics in collaborative governance often favour established institutions, making it difficult for less resourced actors to influence the process.

The legacy of prior paradigms, particularly the influence of New Public Management (NPM), further entrenched these power dynamics. The national coordinators' initial managerialist approach conflicted with the project's ethos of bottom-up, patient-centred innovation, creating friction between actors embedded in hierarchical institutions and those advocating for more collaborative, holistic approaches. This tension reflects Hood's (1991) critique of NPM, which prioritizes managerial control and efficiency over inclusivity in public service innovation. It also aligns with Sørensen and Torfing's (2011) discussion of how rigid governance systems often clash with the need for more flexible, co-creative approaches in governance networks, particularly when empowering local actors is essential. Metagovernors must carefully balance institutional requirements for performance management and accountability with the need to grant collaborative arenas the autonomy and support required to empower participants to take joint ownership of their solutions. Without this dynamic balance of hands-off and hands-on, there is a risk that actors perceive the process as imposed from above, rather than emerging organically from deliberative engagement and discursive problematization with affected stakeholders.

Rebalancing power asymmetries through metagovernance

Despite these initial challenges, the case illustrates the transformative potential of collaborative innovation. Through discursive problematization, mutual learning, and resource-sharing, the power imbalances that hindered early participation were eventually addressed. Central to this transformation was the recognition of interdependency among actors, an insight that aligns with Ansell and Gash's (2008) framework, which underscores that collaboration flourishes when participants build trust, commit to shared objectives, and recognize their mutual dependence. In this case, these principles were operationalized through repeated cycles of discursive problematization and mutual learning, enabling actors to deepen their understanding of the pathway and appreciate the roles and contributions of fellow actors. This process ultimately fostered a shared recognition of interdependence as essential to holistically addressing the problem's inherent complexity.

Metagovernors were pivotal in orchestrating this evolution, particularly by creating conditions conducive to mutual adaptation and learning. While early decisions reflected a reluctance to cede power, the willingness to adapt and engage in mutual learning allowed the collaboration to gradually evolve. This highlights the iterative nature of metagovernance, where both hands-on and hands-off approaches are necessary to navigate complex dynamics and ensure inclusivity (Sørensen and Torfing 2017). By redistributing resources and actively facilitating discursive engagement – a hands-on approach – metagovernors addressed early power imbalances and fostered joint ownership. In contrast, their hands-off strategies, such as delegating decision-making authority and creating space for stakeholder-led problem-solving, were most effective once initial trust was established and actors had a shared understanding of the problem. This balance between intervention and autonomy demonstrates how metagovernors can strategically use these approaches to enable collaborative innovation to evolve beyond initial inequalities and develop into a more inclusive and effective process (Sørensen and Torfing 2017).

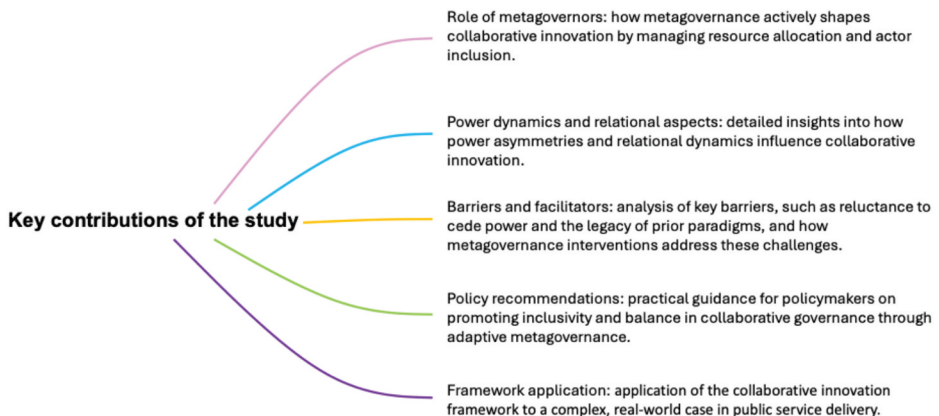


Figure 3. Key contributions of the study.

Contribution to the literature

This case contributes to the literature on collaborative innovation by demonstrating how metagovernance addresses power asymmetries not only through facilitation but also through active intervention, such as resource redistribution. While Torfing (2016) emphasizes the role of metagovernors in mediating and steering governance networks, this study extends this by showing how metagovernors can mitigate structural inequalities through both material and discursive interventions. For instance, by redistributing resources more equitably, metagovernors empowered marginalized actors, fostering a more inclusive collaboration (see Figure 3 for a visual summary of the study's key contributions).

The study also challenges the notion that conflict is inherently detrimental to collaboration. Instead, conflict and growth are integral to achieving joint ownership, as actors recognize their blind spots and interdependence. This reinforces the idea that collaborative innovation is dynamic and non-linear, requiring continuous adaptation as power relations shift and actors engage in mutual learning. By integrating these findings, this research advances the understanding of how metagovernance contributes to the rebalancing of collaborative arenas.

Practical implications

For policymakers and practitioners, this study underscores the importance of flexibility in metagovernance, particularly in addressing power asymmetries. Rather than simply facilitating discussions or redistributing resources, metagovernors must remain responsive to the changing dynamics of collaboration over time. In this case, the extended period of engagement allowed trust and interdependency to develop among actors, which proved crucial for fostering empowered participation. Additionally, hands-off strategies – such as the national coordinators' decision to ease reporting requirements – helped maintain progress without stifling the collaboration with rigid performance demands. Striking a balance between interventions like resource-sharing and providing flexibility ensures a more inclusive and resilient collaborative process.

Conclusion

This study has explored the dynamic and relational factors that shape collaborative innovation in public service delivery, with a particular focus on the role of metagovernance in managing power asymmetries and facilitating inclusive participation. Using a conceptual framework of collaborative innovation, the research highlights the critical role of discursive problematization, empowered participation, joint ownership, joint selection, and transformative learning, all of which are intertwined with metagovernance interventions that actively reshape the collaborative arena in which innovation takes place.

The findings reveal that metagovernance serves as a powerful tool for addressing power asymmetries that can hinder meaningful collaboration. By balancing hands-on interventions – such as resource-sharing – and hands-off strategies that grant autonomy, metagovernors can actively mitigate structural imbalances and foster an environment where diverse actors can engage equitably. This study contributes to the

literature by providing empirical evidence of how metagovernance techniques, especially in the management of power dynamics, play a crucial role in sustaining innovation in complex governance settings.

Additionally, the research identifies and examines several barriers to collaboration, particularly those related to resource imbalances and institutional constraints. While these barriers were not insignificant, they were effectively addressed through adaptive metagovernance strategies, illustrating the flexibility required to navigate the relational and dynamic challenges that emerge in public service innovation.

This study's contribution lies in advancing the understanding of how power relations and metagovernance interact within collaborative governance. While prior theoretical work has emphasized the importance of addressing power asymmetries, this research offers concrete insights into how these processes unfold in real-world settings. The implications for policymakers and practitioners are clear: to foster truly inclusive collaboration, attention must be given to the careful balance of governance interventions that empower marginalized actors and create an equitable space for collaboration.

However, it is important to acknowledge the limitations of this research. The case study is context-specific, and while the findings provide valuable insights, their generalizability is limited to settings with similar geographic and institutional characteristics. Future research could expand this analysis to other sectors and regions to explore how metagovernance strategies adapt across different collaborative arenas. Moreover, integrating mixed-method approaches may enhance the transferability of findings and offer a broader understanding of the role of metagovernance in collaborative innovation.

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Data availability statement

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

Ethical approval statement

Ethical approval for this research was obtained from the University of Strathclyde in July 2019 and NHS Highland in September 2019. This research was categorized as a 'service evaluation' by NHS Scotland's research ethics guidelines as patients were not sought as participants. Therefore, a patient consent statement is non-applicable.

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Appendix. Data collection questions

This appendix contains a guide used for the semi-structured interviews conducted in this study. The questions are categorized according to their relevance to the elements of the conceptual framework of collaborative innovation depicted in [Figure 1](#). This list is not exhaustive; not every question was necessarily asked, and questions were not always worded exactly the same way for each interviewee. Given the study's focus on the dynamic and relational elements of collaborative innovation, preference was given to questions pertaining to the key processes and the concept of metagovernance. Specific wording and questions varied depending on the institutional context of the project and the interviewees' roles. The same questions were used in both rounds of fieldwork; however, for the five participants who were interviewed twice, questions asked during the first interview were not repeated. Additional questions for these participants included inquiries about changes since the first block of fieldwork.

Initial Questions:

- Can you describe the project?
 - What is your organization's role in the project?
- What is your job/role in the project?
- What stakeholders are included in the collaboration?
 - Can you describe them and their role?project?
- What is the intended outcome of the project?
 - Was innovation an articulated intended outcome?
- Would you describe the project as collaborative? Why or why not?
- Would you describe the project as innovative? Why or why not?

Inputs:

- Starting Conditions
 - Incentives and constraints
 - Do you do this in addition to your 'normal' job or is this your sole focus at this time?
 - What is motivating you (and others within your organization) towards making sure this project is successful?
 - What does your organization (and/or your stakeholder group, or you individually) hope to gain from participating in this project?
 - How did your group/organization decide how much in terms of time and resources could be expended on this project? Are there factors constraining your full collaboration, in other words?
 - What was the highest level (hierarchically-speaking) of personnel included from your stakeholder group? From other groups? The lowest?
 - Are some groups involved more than others? Why?
 - Initial trust levels
 - Which stakeholders had you worked with before? How did that history affect your/the organization's trust in them (or opinion of them)?
 - Did you generally have a positive attitude towards collaboration at the start? Did others seem to share that attitude?
 - Were there stakeholders that you had to work hard to get on board?
 - How would you describe the history of your organization with each of the stakeholders? Those stakeholders with each other?
 - Who had the most power/resources out of all the stakeholders?
 - Who had the most power/resources out of all the stakeholders?
 - Who had the least?
 - Did the powerful stakeholders directly or indirectly assert their power over the rest of the collaborators?
 - Did the project coordinators make any effort to correct for this imbalance? For instance, were there any attempts to suppress the powerful or encourage the less powerful? Why or why not?
 - What do you think could have been done to better manage the imbalance of power between stakeholders?

- Drivers
 - Shared risks/costs
 - What do you think was the main reason or catalyst for this project starting – and why now?
 - What – if any- are the additional costs of collaboration?
 - Which organizers fund these activities?
 - Do you see the risk of innovation as shared between collaborators or solely on the shoulders of public administrators?
 - Urgent wicked problems
 - What would you consider to be the problem or issue that this project is aiming to be or be part of the solution to?
 - Do you think the urgency of this issue was part of the reason this project started now, or do you believe that did not really play a part?
 - Likelihood of success and substantial gains
 - Was there a sense that innovation was needed to solve this problem?
 - Was there a sense that collaboration was necessary to produce this innovation?
 - What sort of gains for your organization were expected or hoped for by participating in this collaboration?
 - What do you think the other stakeholders hoped to gain by entering into this collaborative project?
 - High levels of interdependency
 - To what degrees do the external stakeholders depend on your organization? Could the problem be solved by them without you?
 - To what degree does your organization depend on the external stakeholders? Could the problem be solved without their help/guidance?
 - Could any single stakeholder alone successfully execute this project or were others needed?
 - How did these dependencies affect the decision to collaborate? If these dependencies were not present, do you think the collaborators would have been the same?
 - If the stakeholders were more dependent on one another, how do you think the collaboration might be different?

Discursive problematization:

- What problem or issue was this project trying to address?
- What would you consider to be the problem or issue that this project is aiming to be or be part of the solution to?
- What would you consider to be the problem or issue that this project is aiming to be or be part of the solution to?
- Could there be different ways to view this problem?
 - How might a different view of this problem change the kind of solutions that were chosen?

Key processes:

- Empowered participation
 - Did the ‘team’ (collaborators/stakeholders) feel a degree of independence in taking the project forward?
 - Did they have time/resources/confidence to participate?
 - Through what mechanisms were stakeholders/participants empowered to participate?
 - How did the project address the vast imbalances of power, knowledge, and resources among participants/stakeholders?
 - Were you given an opportunity to offer your views of the problem?
 - Were you given an opportunity to offer potential solutions to the problem?
 - Were collaborators given an opportunity to voice their disagreement with others’ views/ideas?
 - If you did not feel very empowered to participate, why? What could they have done that would make you feel empowered enough to participate?
- Mutual and transformative learning
 - What have you learned from participating in the project?

- (Probe about learning/lack thereof across different networks/teams and both intra- and inter-organizational relationships)
- Did the learning seem to be one-way or more mutual? How so?
- Did participating in the project and collaborating with these stakeholders change the way you view the issue at all? How so?
- Did you notice a shift in the way any stakeholders viewed the problem or one another?
- What do you see as the barriers to stakeholders learning from one another? What do you think could be done to mitigate these barriers?
- Joint ownership
 - Who is responsible for the solution being implemented?
 - Do teams/stakeholders working together on this have:
 - Control of resources to make it happen?
 - Clear responsibility (as a collaborator) for taking this forward?
 - Autonomy and power to do stuff differently?
 - What is the role of each shareholder in implementing the innovation?
 - What resources have each stakeholder contributed to the project?
- Joint selection
 - Who or by what process was it decided what innovation/solution would be implemented?
 - Did you feel that you were included as a part of that decision? Do you feel like you should have been?
 - Do you feel like all the actors were included in major decisions surrounding the project? Do you think they should have been?
 - How do you think the innovative solution should be chosen? Who should be included in the decision?

Metagovernance:

- Who served as the metagovernor on the project? In simpler terms, the metagovernor is like the coordinator or overseer who ensures smooth collaboration among different groups or individuals. Who do you think fulfilled this role in our project?
- Convenor role
 - Who decided which stakeholders and specific organisations would be included/excluded from the collaborative innovation project (one person or a group/board)?
 - Do you know how that decision was made?
 - Did some stakeholders need to be convinced? How was that done?
 - Were there barriers to convening the participants initially? How did [identified metagovernor] overcome or mitigate these barriers?
- Facilitator role
 - Who is responsible for, and how do you go about
 - Supporting collaboration?
 - Mediating conflict?
 - Ensuring all have a chance to participate?
 - Was the problem or issue discussed in order to make sure stakeholders had a common understanding of its magnitude? Did someone seem to be guiding that?
 - Were participants challenging one another?
 - Did it seem that stakeholders were behaving strategically? How do you think that could have been mitigated?
 - How do you think the structure and the norms of the organizations involved might be shaping, supporting or constraining the collaboration among the stakeholders?
 - How do funding and governance influence, support, and/or constrain collaboration?
 - Was there a sense of shared ownership over the project? Did someone seem to be guiding the implementation and making sure collaborators adhere to their agreed responsibility to the project?
- Catalyst role
 - Was the innovation idea itself conceived collaboratively?
 - Was there a person or process to 'spice things up' when things got stale?
 - What sorts of processes were used in addition to collaboration to trigger creative thinking? (eg new venues, new people, brainstorming workshops, experimenting, prototyping)

Facilitators:

- Boundary spanners
 - Stakeholder groups/organizations/silo'd groups can make collaboration difficult. Was there a person (or role) who linked (x group) to (y group)?
 - Did they do this as part of their job, their whole job, or more informally?
 - Does it take a certain kind of person to be successful at linking these groups?
 - Do they share information between groups?
 - How much authority and resources do they have to make things happen?
 - Do you think having a person linking these organizations together is helpful? If not, what do you think would be more helpful?
- Job design
 - How much autonomy do you have in your position? How does that compare with other collaborators?
 - How secure do you and other collaborators feel in their jobs?
 - Is there any reward or recognition to be earned from participating in innovation projects?
 - Do you feel the demands of your job are realistic given the time pressure? Especially balancing it with the innovation project?
 - In your view, does the way your job is designed allow for you to have time and the mental capacity to engage in innovation?
- Communities of practice
 - Communities of practice develop among people who do things together and are mutually engaged in work-related activities whose meanings they negotiate with one another. Given that definition, do you see any examples of communities of practice that are part of facilitating this project?

Barriers:

- Socio-technical incompatibility
 - How big of a factor is IT in your collaboration?
 - Has there been any IT difficulties during the project?
 - Have you used any IT tools to enhance the collaboration?
 - Are there any IT tools that were not used but you think could have helped the collaboration?
- Reluctance to cede power
 - The stakeholder(s) with the most power in the group – did they express any signs of hesitation or reluctance to collaborate?
 - How and how effectively were challenges overcome?
- Repeat participants
 - Have you ever done a collaboration project like this before?
 - Were any of the participants of the current collaboration involved with the former one?
 - What were the benefits and problems associated with this?
 - If you engage in another collaborative innovation project, will you include the same participants or will you make some changes to the group?
 - Echoes of New Public Management/Traditional Public Administration
 - How is job performance measured in your organization?
 - Is there a strong focus on:
 - KPIs?
 - Cost reduction?
 - Lean?
 - Contracting out services?
 - Entrepreneurial leaders?
 - To what degree do these factors hinder the project?
 - Are you familiar with Lean/Green Belt/continuous improvement? Are these tools used in your workplace? To what degree?
 - Do you believe criticism of the public sector to be overly bureaucratic to have merit?
 - How risk averse is your organization?
 - How important is hierarchy in your organization?
 - Professional groups and communities of practice

- What professional groups were represented as stakeholders to the project?
- To what degree do you think professional groups/communities of practice hampered collaboration between stakeholders?
- Is silo working – due to a) political accountability; b) budget lines; c) organizational structures; or d) professional demarcation – a barrier to the project?
- Inadequate budgets
 - Would you describe the budget of your organization to carry out its mandate as adequate?
 - (If inadequate) Why is the budget inadequate? What structural mechanisms determine the budget and why are they currently ineffective?
 - What affect does this budget situation have on the organization's approach to risk?

Barriers:

- What is the intended outcome of the project?
- Do you think the outcome of the project will amount to innovation or more incremental changes?
- What has been delivered so far? How is that going?
- How will the outcome of the project be evaluated? Will user/citizen/patient feedback be collected?
- What will be done with the feedback collected from the evaluation?
- Will changes be made to the implemented solution based on feedback?
- Will staff feedback be collected? Which groups of staff?
- What determines success in regards to this innovation?
 - What could have been done differently to arrive at a more 'successful' outcome?