An exploration of neighbourhood team members experiences of the transition from traditional health and social care teams to integrated care systems, within a defined health and social care economy

Volume **1 of 1**

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Year of submission: 2020

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Acknowledgement

The completion of this thesis would not have been possible without the amazing levels of support and patience of the wonderful people I have around me. Firstly, I would like to express my sincere gratitude to my supervisor's Dr Michelle Howarth and Dr Emilie Whitaker. Their expert guidance, kindness, and encouragement has been a constant motivator and kept me going through the long hours of writing and editing this thesis. Emilie has been with me through the difficulties of this journey and I was very lucky for the chance meeting that lead to her being my supervisor thank you for all the times you listened.

I would like to acknowledge the participants who allowed me the opportunity to inhabit their space and who welcomed me with openness and generosity. This research was always a partnership with them and would not exist without their knowledge and expertise. I would also like to thank the leadership of the Integrated Care Organisation for granting me permission to conduct this thesis within their organisation and for granting me the time to share the finding with them.

In addition, I need to thank my mum, my husband and cheerleading daughter Edie with whom I have lost many hours with and who have provided me endless support and inspiration. Also, to all my family and friends near and far who have listened to hours of doctorate talk, with only a small amount of complaining and much more encouragement. I must raise a special mention to my friend and fellow professional doctorate student Hayley Bamber, who has been there every step of this journey with me and pick me up repeatedly. Without these people and others this thesis would not be here, and I am eternally grateful to all of them.

Abstract

The UK is undergoing changes in the demographics and epidemiology of the population. To tackle this, successive UK governments have introduced policies focused on transforming health and social care from its traditional forms into integrated care systems. Previous research has demonstrated that people are essential in the transformation process which is often complex and requires structural, practical, and cultural change. Despite this focus, there has been a lack of frontline research on the real-time experiences of practitioners tasked with making integration real from the outset.

This study attempts to address this gap. It presents a faithful representation of the experiences of two teams, one from health, one from social work, as they moved through the initial stages of integration. The study uses an adapted institutional ethnographic approach (Smith, 2005), which involved observing two teams as they came together to form an integrated neighbourhood team over a nine-month period. The use of this approach ensured that the reporting of the team's experience was from their perspectives and considered the wider external factors that influenced those experiences.

The analysis of the findings identifies several key factors in how teams experience integration that could influence future policy. These areas included: the imperative of a local narrative for integration; the place of hope and hopefulness in uniting teams; the importance of 'Bottom-up' action; the imperative of joint leadership. The process of integration was not a linear one but one where teams move through a process of converging and separating from each other. Based on the findings a framework has been developed to assist organisations in the development of integrated teams.

Glossary of terms

Clinical Commissioning Group (CCG)- Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services in a local area. They were created in 2013 and replaced Primary Care Trusts

Cross-sector partnerships – Partnerships that include organisations from more than one public and/or private sectors i.e. health and social care sectors

District Nurse – A registered nurse working in the community and holding a specialist qualification in District nursing (QnI, 2019)

Social worker – Registered Professionals who support adults, children, families and communities to improve their lives. They protect and promote human rights and wellbeing and have a responsibility to safeguard vulnerable people (BASW, 2019)

NHS England - NHS England oversees the budget, planning and delivery of the commissioning side of the NHS in England.

Primary care organisation - Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services until 2013

The King's Fund - Independent think tank in England, focusing on the health system in England.

World Health Organisation [WHO] – A specialized agency of the United Nations that is primarily concerned with international

Chapter 1. Introduction

1.0 Chapter Introduction

Despite the advances in health and life expectancy in recent decades, there remains more than 400 million people globally who do not have access to essential health care (World Health Organisation [WHO], 2016). In the UK, a recent update on the Marmot report, into health inequalities stated that since publication of the first review in 2010, life expectancy in England has stalled, ill health has increased, and inequalities in health have widened, especially in the north of the country (Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020; Marmot, Allen, & Goldblatt, 2010). Locally, while Greater Manchester has a rapidly growing economy, larger than both Wales and Northern Ireland, the area continues to experience high levels of health inequality and rates of cardiovascular and respiratory illnesses that are above the national averages (GMDA, 2015). The impact of health inequalities and access to health care have been further magnified through the current coronavirus pandemic, which has exposed fragility in health care systems worldwide (Lewis, Pereira, Thorlby, Warburton, 2020), leading to renewed calls for the designing of stronger and more resilient care systems which are able to respond and adapt to new challenges and crises (Lewis & Ehrenberg, 2020).

The WHO (2016) highlighted one cause of inequalities in health care provision as fragmented and siloed services. Integrated care, by contrast is seen as having the ability to rectify fragmentation in services and rebalance health and social care systems, so they are more effective, and person centred (WHO, 2016). However, Ham and Curry (2011) have warned that the benefits of integrated care will not be fully realised if clinicians are not fully engaged and able to drive through changes in

practice.

This thesis offers a unique insight and original contribution to the knowledge of neighbourhood teams' and integration. The study achieves this through an exploration of the emergent real-life experiences of team members prior to and post implementation of a neighbourhood approach. The observations lasted nine months starting in November 2017 and where contextualised within the current integrated care agenda of Greater Manchester. The findings report a narrative of these experiences from the team members' perspective, illuminating what drives and divides them in their journey toward integration. The study is able to provide this unique perspective through an institutional ethnographic [IE] approach, based on the work of Dorothy Smith (2005, 2006a, 2006b).

Using IE enabled the research to provide a deep insight into the development of integrated care through the presentation of an institutional ethnographic narrative. This narrative was developed through ethnographic field work and focuses on the early stages of the development of an integrated neighbourhood team. Building on previous research (see Chapter 3) this study provides a unique insight into how integration is experienced by local team members and how these experiences can affect the introduction of neighbourhood approaches.

This introduction details the emergence and context of the research area and sets out the rationale for the selection of the research problem, including discussion of organisational issues. A summary of the structure of the thesis follows, as well as an outline of the professional biography. To provide background for the study, this chapter

includes a conceptualisation of integrated care and an analysis of the demographics and epidemiological backdrop that have led to the current elevation of integrated care within national and international policy. Chapter 2 then provides an analysis of policy on the international, national, and regional levels in order to establish a wider understanding of how integrated care is currently being adopted within various settings.

1.1 Context of the Study

This section introduces the context of the study including how the original problem was identified, the local context and the organisational setting.

1.1.1 Identification of the Problem

The journey of this professional doctorate began with the identification of a foreshadowed problem, which Hammersley and Atkinson (2007) explain as an area of concern that can spring from a natural setting and act as a starting point of inquiry. For this study, the foreshadowed problem arose from the experience of working within an integrated transformation team and encountering potential challenges and barriers to integration, as well as opportunities. In particular, there appeared to be a disconnect between the rhetoric of integration and integrated care both internally and externally, and this disconnect was especially pronounced between the strategic vision for integration and the experiences of those implementing integration in local settings.

At a high level, there was strategic alignment between various organisational and system partners as they embarked on the development of neighbourhood teams as

part of the macro-level implementation of integrated care. This synergy was demonstrated through meetings across the local health and social care system, through policy documents ('Continuity planning team report', PWC, 2015), and in joint planning initiatives ('A Place-Based Approach to Better Prosperity, Health and Wellbeing - locality Plan,' Anon, 2015). However, while there appeared to be cooperation at the system level, frontline teams often were not included in the design of the implementation, leading to a disconnect between high-level planning and the experiences of the local teams.

1.1.2 The Local Context

As previously stated, integrated care has been promoted both nationally and internationally as a method of transforming health and social care to reduce demand and cost, to increase access, and ultimately to improve patient outcomes (WHO, 2016a; Mitchell, Howard, Tazzyman, & Hodgson, 2019; Ham, Heenan, Longley & Steel, 2013). In England, this vision is outlined in the 'Five Year Forward View' (NHS England, 2014a) and the 'Long Term Plan' (NHS England, 2019a), which set out an ambition of transforming the delivery of health and social care. These policies call for a shift in emphasis from reactionary episodic care to preventative, person-centred, and integrated care (NHS England, 2019a; Charles, 2020). Regionally, in 2016 Greater Manchester became a devolved authority and took on the management of a health and social care budget of £6 billion (GMCA, 2015). A cornerstone of that management approach was the adoption of integrated health and social care in an effort to address the health inequalities that remain present within the communities of Greater Manchester (see Chapter 2) (GMCA, 2015). The Greater Manchester Devolution agenda has brought about significant changes in services. Marmot (2020) champions

the Greater Manchester approach, stating that the region has been a pioneer in the development of system-wide, integrated public-service approaches including joint commissioning, neighbourhood based teams, and place-based approaches (all discussed in further detail in Chapter 3).

1.1.3 Organisational Context

This study adopts the stance that valuable, in-depth knowledge of the workings of institutions can be achieved through the exploration of the everyday activities of people's lives (Smith, 2005). The study explores a specific moment in time within one team in one organisation to explicate and describe the experiences of team members during integration and to draw attention to the wider institutional factors that coordinate consciousness and actions (Walby, 2007). Therefore, to enhance the credibility and relevance of the findings, the unique circumstances and context in which the inquiry was conducted have been outlined (Creswell, 2017).

At the commencement of the study, the organisation (NHS Trust) in question was experiencing a dramatic change in form and function. Several factors had driven these changes, the two most significant of which were the NHS Trust's naming in the 2013 Keogh report on hospital deaths. The report identified the need for urgent improvement due to high mortality rates, which, led to the NHS Trusts placement in special measures, and a financial deficit plan. The NHS regulator had commissioned the auditing firm Price Waterhouse Cooper as a continuity programme team [CPT]. The resulting report presented a long-term plan for the local health and social care economy and outlined actions to be taken to bring about clinical and financial

sustainability. One of the main recommendations was the implementation of an integrated care model. The new model included a joint commissioning function, transformation of acute and community services, and greater involvement by community and voluntary sector groups.

Several structural changes were intended to aid the integration. A neighbouring trust had managed the community nursing service until 2016, when the service transferred to the Integrated Care Organisation. The adult social care team was managed by the local council (same locality as the NHS trust), and the team were awaiting a type of formal transfer from one organisation to another called TUPE (Transfer of Undertakings [Protection of Employment] Regulations, 2014). By 2016, the Trust had made considerable progress towards the implementation of the new model of care, including planning for the formation of neighbourhood teams.

Neighbourhood teams are a central feature of an integrated care system, as they bring together primary, community, and social care. Integration is a structural process; however, it is also based on a set of ideas and principles that differ from traditional health and social care paradigms. Therefore, at the time of the study, the local health and social care economy were in a period of both structural and cultural change. Structural change took the form of remodelling and redesigning of services, such as the development of neighbourhood teams and the creation of intermediate-tier services. Cultural change was witnessed as professional groups within the restructured teams began to shift their modes of working. This was a pivotal time for the organisation, providing an opportunity to gain a unique real-time perspective on how teams manage the process of integration.

1.2 Conceptualising Integrated Care

Prior to commencing the study, it was important to understand the complex and nuanced nature of integrated care and to provide an understanding of why the organisation was transitioning to this model of provision. There are significant motivations for adopting integrated care, such as reduction of fragmentation, greater financial viability, improved patient outcomes, and greater efficiency (Ham, 2018). Nevertheless, a concise definition of integrated care remains elusive and, according to some studies, there are approximately 175 different definitions in use (Armitage, Suter, Oelke, and Adair, 2009; Goodwin, Smith, Davies, Perry, Rosen, Dixon, Dixon, & Ham, 2011). The lack of a definitive definition is unsurprising, as there have been multiple types, methods, and applications of integrated care programmes, all of which are context dependent (Billing, Alaszewski, & Coxon, 2003). This view is reiterated by Ham and Curry (2011), who state that there is no single best fit for integrated care or integration, and is echoed by Goodwin (2016), who has expressed similar sentiments and suggests that the variance in definitions has been driven by the many legitimate purposes, stakeholders, and requirements involved in integrated care. However, despite the lack of an established definition, proponents champion integrated care as a solution to the fragmented and siloed provision of services that has led to deficiencies in the quality, safety, and efficiency of care (Ham, 2010; Ham & Curry, 2010). Although a single definition has not yet been agreed upon, several attempts have been made to define integrated care. Notably, Shaw, Rosen, and Rumbold (2011:3) define integrated care as:

> *…. reflecting a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.*

An alternative definition was provided by National Voices (2013). National Voices is a coalition of charities that works towards people being in control of their health and care

> *I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.*

This definition from the perspective of the patient as the user of the service provides a different and important viewpoint. There are clearly aspects common to both the quoted definitions, including patient experience, fragmentation of delivery, and developing a patient-centred approach. The National Voices (2013) definition has since been used to inform policy guidance, such as 'Integrated Care and Support: Our Shared Commitment' (National Collaboration for Integrated Care and Support, 2013), and therefore has been an important and significant voice in the development of integrated care policy in the UK.

While these definitions are important for gaining an understanding of integrated care, Goodwin (2016) and Busse and Stahl (2014) emphasise that integrated care needs to

be recognised as an overarching approach with a set of guiding principles that exist across the discourse, rather than as a concept with a stringent definition. A view of such an overarching theoretical approach is reflected in the WHO's core principles of integrated care (Table 1).

Table 1. *World Health Organisation Core Principles of Integrated Care (WHO, 2016)*

Comprehensive	Care needs to be offered in a way that is responsive to the needs and aspirations of the populations and individuals
Equitable	Care provided for all and there is equity of access
Sustainable	Care should be provided in a way that promotes sustainability
Coordinated	Care should be provided in an integrated manner that wraps around the person
Continuous	Care should be provided across the life course
Holistic	All aspects of a person's life: physical, socio-economic, mental, and emotional wellbeing need to be considered
Preventative	Prevention is important and care should consider the social determinates of health and ill health
Empowerment	All aspects of care should aim to support people to have control of their own health
Respectful	Care should consider and be sensitive to people's dignity, social situation, and culture
Collaborative	Teams delivering and planning care should aim to promote collaborative practice
Co-produced	People should be considered active partners at a strategy, organisational, and individual level
Governed through shared accountability	Between care providers and local people to ensure quality care and improved health outcomes
Evidence-informed	Strategy, policy, and implementation to be informed and guided by the best evidence base and assessed through measurable outcomes
Whole-systems thinking	The health system such be considered as a whole system rather than silos
Ethical	Risk-benefit ratio is considered for all interventions—understanding that individuals have the right to make autonomous informed decisions

These principles are designed to guide the design of strategy and the implementation of integrated care, rather than to define it. The WHO (2016) later used the core principles to develop a strategy for integrated care that centres on five key areas (outlined in Table 2); this strategy has been used to develop integrated care around

the world.

***Table 2**. World Health Organisation Strategy of Integrated Care (WHO, 2016)*

Engaging and empowering people and communities	Integrated systems should provide the opportunity, skills, and resources so that people can be empowered. Unlocking individuals' and communities' resources and assets, they are partners co-producing health and wellbeing in their communities, with a focus on minorities and the disadvantaged.
Strengthening governance and accountability	Promoting transparency in decision making, creating robust systems for collective group (individual, community, and health and social care providers)—alignment of governance and accountability with incentives.
Reorientation of the model of care	Reorienting the model of care towards primary and community care services and the co-production of health.
Coordination within and across services	Coordination of services around the needs of people at every level and promotion of activities that integrate providers and develop networks across sectors.
Enabling environments (and creating them where they do not exist)	To support the implementation of the previous four strategies, environments must exist to bring stakeholders together.

The WHO (2016) explains that adopting the strategic approach provides a framework for the underpinning of a wide range of integrated care activities, such as financial realignment, development of system-wide health and social care initiatives, and implementation of a personalisation agenda.

A further complication related to terminology is that the terms 'integrated care' and 'integration' are often used interchangeably, leading to a merger of the concepts (Ham, 2018). In Shaw, Rosen, and Rumbold's (2011) explanation of the difference, 'integrated care' is a set of organising principles that underpin an integrated delivery

of care (including provision and commissioning), while 'integration' relates to the actions, models, and processes that seek to improve coordination of care to bring about integrated care.

The WHO (2016) strategy and principles make clear that integrated care is not merely a structural change but also requires a shift in the philosophical positioning of health and social care (Ham & Curry, 2011). This shift is required because integrated care seeks to address issues within current health and social care models, which are often predicated on medical and pathogenic thinking and lead to gaps in provision and poor patient experience and outcomes (Ham & Curry, 2011; Shaw, Rosen & Rumbold, 2011). Foot (2012) asserts that to tackle health inequalities, an integrated system must progress from a deficit approach to a strengths-based model, where individuals and communities develop services together. She argues that community assets and social networks have a significant impact on health and wellbeing, and maintains that there is a need to recast the relationships between statutory and community sectors in a way that aims to strengthen the health and wellbeing of whole communities and individuals. The ideas Foot presented have been widely adopted as part of the integrated care discourse, policymaking, and implementation (National Voices, 2013, NHS England, 2014a; Wood, Finnis Khan, & Ejbye, 2016). For many proponents of integrated care across the UK and Europe, a salutogenic approach is a core feature of integrated care (Foot, 2012). The term salutogenesis derives from Antonovsky's (1979) seminal works where he concluded that disease and stress occur continuously and that understanding what makes us healthy therefore should be considered equally important in understanding the reasons for disease (Eriksson & Lindstrom, 2006). The influence of Antonovsky's (1979, 1993) ideas can be observed across integrated

thinking and NHS England's policy development, most significantly in the personalisation agenda of the Long-Term Plan (NHS England, 2019a) and Greater Manchester's person-centred and community approaches (GMCA, 2017), which aim to support the development of connected and empowered communities including the expansion of initiatives such as social prescribing. Social prescribing is a way of linking patients to support within the community to help improve their health and well-being, including activities such as peer support, community groups, and voluntary organisations (Bickerdike, Booth, Wilson, Farley, & Wright, 2017).

1.3 Rationale for the Implementation of Integrated care

The preceding section introduced the concept of integrated care and its several definitions and underpinning theories. Additionally, it is important to shed light on why integrated care currently has such primacy within health and social care policy. This section outlines the demographic and epidemiological changes that have brought about the current drive for integrated care.

1.3.1 Demographic Changes

This section details the changing demographic landscape of the UK and discusses how these changes have affected the current agenda of integration. While demographic changes across the entire UK are discussed, statements about the NHS and policy refer to England only, as the devolved nations hold control over their own health and social care systems and therefore have differing health and social care policies.

The UK has an ageing population, with the Office for National Statistics [ONS] (2017) predicting that by 2024, there will be more people over age 65 than those age 15 or younger. Providing context for these changing demographics, Public Health England (2018) states that although most people in society are living longer and are healthier than in the past, the inequalities that have plagued the health of the nation persist, and these inequalities have had an impact on the provision of services. It has been estimated that there are 15 million people in England with one or more long-term conditions, including diabetes, coronary heart disease, and chronic obstructive pulmonary disease (Department of Health [DH], 2012a). People living in deprived areas are most affected by such conditions, and women in poorer areas are disproportionally impacted (Marmot, Allen, & Goldblatt, 2010; DH, 2015, 2019; Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020).

In 2010, the Marmot review (Marmot, Allen, & Goldblatt, 2010:16) stated that ‘inequalities are a matter of life and death, of health and sickness, of well-being and misery’, with people in the lowest social class having a 60% higher prevalence of long-term conditions and 30% higher severity of those conditions. In the follow-up report 10 years later (Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020), Marmot stated that health inequalities have worsened between 2010 and 2020, leading to people spending more of their lives in poor health. Alongside this change, improvements in life expectancy have stalled and have declined for the poorest 10% of women in the UK, the result being that the health gap has grown between wealthy and deprived areas.

The shift from communicable to non-communicable disease dominance has had an

impact on the health economy which is hospital focused (Antunes & Morerira, 2011). There is now an 18.6-year gap in male healthy life expectancy (the measure of mortality and morbidity data to estimate the years of good health a person has) at birth in different areas of the UK (Marshall, Finch, Cairncross, & Bibby, 2019) .Blackpool has the lowest healthy life expectancy at birth for men where boys born in 2016-18 can expect to live 53.3 years in good health. Whereas boys born in Richmond-upon-Thames, where healthy life expectancy is highest can expect to live healthy lives until they are 71.9 (The Health Foundation, 2020). A survey by the Health Foundation in 2018 found that nearly one in four people had two or more conditions and around one in twelve people have four or more long term conditions(Stafford, Steventon, Thorlby, Fisher, Turton, & Deeny, 2018). These findings align with national data, which estimate that 14.2 million people in England have two or more conditions and an estimated 4.7 million people in England have four or more conditions. The growth and prevalence of long-term conditions and their link to social inequality have become a significant concern for health and social care policymakers (Ham, 2010, 2018; George & Martin, 2016; Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020). Importantly, people with long-term conditions often have multiple physical and mental health co-morbidities, leading to significantly poorer health outcomes and reduced quality of life (Naylor, Parsonage, McDaid, Knapp, Fossey, & Galea, 2012).

The national perspective was reflected locally in the borough of Greater Manchester where this study was conducted, an area with some of the worse health outcomes in the UK. Each borough council in England must produce a locality plan that outlines their ambitions for improving the health of their residents (Mckenna & Dunn, 2015). The locality plan (Anon, 2015) for the borough of Greater Manchester where this

research was conducted stated that the healthy life expectancy in the area was 57.9 years for men and 56.8 for women, which was less than the North West and national averages. Consequently, within the local area, there were large numbers of people living in poor and deteriorating health (Public Health England [PHE], 2018).

1.3.2 Epidemiological Changes

The WHO (1948) has defined health as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity. However, there has been growing criticism of the WHO definition, and many have questioned whether health can ever be a state of complete physical, mental, and social wellbeing (Huber, Knottnerus, Green, Horst, Jadad, Kromhout, Leonard, Lorig, Loureiro, Meer, Schnabel, Smith, Weel, & Smid, 2011; Card, 2017; Charlier, Coppens, Malaurie, Brun, Kepanga, Hoang-Opermann, Correa Calfin, Nuku, Ushiga, Schor, Deo, Hassin, & Herve, 2017). The shifting rationale for defining health has been linked to epidemiological changes that have affected the nature of illness and thus the requirements placed on the health and social care system (Ham, 2018). The growth of long-term conditions, that is, has meant that health is increasingly viewed as how we maintain and adapt through life, rather than an ambition for a state of complete health. Huber et al. (2011) explained that as ageing with a chronic disease has become so prevalent, the WHO's definition of health could now be counterproductive, as it defines people with disability and chronic diseases as ill, ignoring the human capacity to cope with challenge. Barnett, Mercer, Norbury, Watt, Wyke, and Guthrie's (2012) study of multi-morbidity concluded that long-term conditions are now the main challenge facing health and social care systems. This view is supported by Ham

(2018), who stated that while multi-morbidity and co-morbidity of physical and mental health issues have become the norm, health systems remain configured for disease management, which has been challenging for both patients and services, as they often fail to draw together appropriate care.

While long-term and lifestyle diseases remain the dominant health concern, the 2020 COVID-19 pandemic highlights that there is still a need for health and social care systems to be able to manage large-scale pandemics. Even with the pandemic yet unresolved, commentators have begun to reflect on how it will influence future policy. Bruke (2020) states that the pandemic has acted as a catalyst for change, driving rapid transformation and integration, while a report for the International Foundation for Integrated Care stated that the COVID-19 crisis has highlighted the interconnected and integrated nature of people's lives and society, requiring services that are responsive, integrated, and population-focused. They state that without a move to a more integrated approach across all policy areas, countries will not be able to address the social injustice and inequalities that are contributing to the disproportionate impact of both long-term conditions and the current pandemic (Lewis & Ehrenberg, 2020).

1.3.3 Demographic and Epidemiological Influence on Societal Drivers Toward Integration

Demographic and epidemiological changes within the population should be considered as part of the wider political and societal system. Lafond, Charlesworth, and Roberts (2016) described the current health and social care economic climate as '*a perfect storm*' of pressures on NHS providers. NHS demand has grown by around 4% a year, due in part to the ageing population, but also due to rising costs, increased expectations, and the prevalence of long-term conditions. However, investment has not increased to meet the demand, resulting in many organisations struggling to maintain services under current restraints (Robertson, Wenzel, Thompson, & Charles, 2017). The UK government's austerity policy has meant significant reductions to social care budgets in England, leading the Institute for Fiscal Studies to report that fewer people over the age of 65 were receiving publicly funded social care, which has had a great impact on the NHS, contributing to the increased demands and costs (Crawford, Stoye, & Zaranko, 2018). These 'perfect storm' circumstances have drawn policymakers' attention to the potential of integrated care as a solution. Reports by the powerful health think tank The King's Fund have stated that integrated care could be an effective approach for remodelling health and social care services, as it aims to improve patient outcomes by tailoring care to specific needs, thus helping reduce costs via streamlined systems (Ham, 2018).

1.4 Thesis Overview

The previous section introduced the concept of integrated care and the demographic and epidemiological case for its introduction. This section presents the purpose and structure of this thesis and is followed by an outline of my professional biography.

1.4.1 Purpose

The purpose of this thesis is to present the experiences of team members in an integrated neighbourhood team as they moved through the initial stages of integration, exploring how they affected and were affected by the integration process.

The thesis provides a unique insight into their experience and aims to provide recommendations that support the development of more effective implementation of neighbourhood teams through learning and co-designing.

1.4.2 Structure

This thesis presents professional doctoral research and is structured in nine chapters. As an institutional ethnographic account, the thesis is organised in such a way as to allow the reader to gain an understanding of the everyday practices within an integrated neighbourhood team as team members transitioned from providing traditional services in traditional organisational structures into an integrated team.

Chapter 1 has introduced the key elements of the thesis, including the contexts in which integration has been developed and studied and the demographic and

epidemiological factors driving the adoption of integrated care approaches. It will conclude with a description of my professional background.

Chapter 2 contextualises the study within previous and current policy by providing a detailed account of political and policy developments in integrated care, from international, national, and local perspectives.

Chapter 3 presents a comprehensive scoping literature review which demonstrates what is currently known about the implementation of integrated care. Through an exploration and examination of research, evaluations, advisory papers, and government papers, the review follows an institutional ethnographic approach and collects knowledge of the topic area to support the formal fieldwork.

Chapter 4 delves more deeply into the methodology selected for this study, the institutional ethnography approach developed by Dorothy Smith (2005). The chapter demonstrates the ethical approach of the research by providing a robust and transparent account of the ontology, epistemology, and theoretical underpinnings of the study.

Chapter 5 proceeds to detail the methods applied within the thesis, the rationale for selection of those methods, and the ethical considerations of working within this field. This chapter demonstrates the application of the methodological approach and provides an account of how the research was conducted.

Chapter 6 Outlines how the finding will be presented, followed by the findings of the

first stage of the research and the location of the standpoint group (as defined in IE methodological approach).

Chapter 7 then summarises the main findings of the study through key themes; additionally, the chapter explores the links between the local setting and the wider organisational issues that control and influence it.

Chapter 8 presents a discussion of the findings and analyses them in relation to previous studies, determining the unique contribution of this thesis.

Chapter 9 provides concluding arguments and recommendations for future practice including the presentation of a framework for the preparing organisations for the implementation of neighbourhood teams.

1.5 Professional Biography

As a professional doctorate study, this research connects the world of the professional with the world of academia (Fenge, 2009). At the beginning of the study, I existed within two communities of practice which incorporated my professional self (transformation lead) and academic self (doctoral student). The development of the study enabled me to bring these worlds together to explore a problem connected with the area of practice (Wellington & Sikes, 2006). This section provides readers with insight into my professional context in order to illustrate my professional background and connection with the research area.

I completed my pre-registration nurse education at the University of Nottingham, qualifying in 2000. Since then I have worked in acute and community settings, completing my District Nurse specialist practice qualification in 2005. Later, I moved into health service governance and subsequently into service improvement, working regionally and nationally. As my career progressed, I developed an understanding of the need to support health in addition to treating illness. In recent years, I have worked as an integration and transformation programmes lead, leading both programmes that support people in maintaining their own health as well as organisational transformations and workforce developments. Working in the field of integration changed my thinking about how health care should be viewed and implemented. In 2017, I moved to work in a university setting and now work as a Senior Lecturer with a focus on Integrated Care and Specialist Practice. My current publications and conference presentations are outlined in Appendix 1.

I commenced my professional doctorate studies whilst working as an integration lead within the National Health Service. My interest in pursuing a doctorate developed through my experiences of implementing integration programmes and a desire to better understand how the ambitions of integrated care become organisational realities. My interest in the development of integrated care teams grew from observing the complexity, challenges, and opportunities that integrated care offered. In my transformation roles, I observed that there was a disparity between the rhetoric of change and the experience and voices of those implementing change. These observations and my professional background drove my selection of research topic and methodology.

1.6 Chapter Summary

While it remains challenging to define integrated care, there are clear principles that underpin the approach, including empowering people, transforming governance, and removing barriers that create siloed systems. The analysis of recent demographic and epidemiological changes presented in this chapter demonstrates the need for more integrated approaches to health care. This thesis provides a unique insight into integration and partnerships in the context of the current integrated care agenda, through research conducted using an institutional ethnographic approach based on the work of Smith (2005, 2006a, 2006b). This method has ensured a faithful representation of the experiences of an integrated neighbourhood team, enabling the development of an understanding of the influences on the team from the wider organisation. The work that follows represents an original contribution to the knowledge base around integrated care.

Chapter 2 Policy Review

2.0 Chapter Introduction

The preceding chapter outlined the foreshadowed problem, the concept of integrated care, the rationale behind its current primacy, and the overarching purpose and structure of this thesis. This chapter will now detail the policy background of integrated care in the UK, referencing other international integrated health and social care systems and their influences on policy in the UK. The review tracks the development of integrated care and integration against the wider history of health and social care systems and explores key areas of policy and legislation.

2.1 Political and Policy Background

The political drivers outlined within this section demonstrate how integrated care has become a dominant health and social care policy. This exploration of policy is important in placing the study within its wider context, as well as in drawing attention to the political and policy changes that influence the local space in which the study was conducted. Such an exploration is crucial since, as Smith (2005) explains, the local experience of people is influenced and controlled by trans-local 'relations of ruling' and controlling text. Smith (2005) describes controlling text as documents that coordinate and excerpt influence on local spaces through their enactment by local actors.

2.1.1 International Perspective

The WHO (2016) highlights a crisis in the provision of and access to high quality health and social care across the world, stating that currently health care systems are

straining under the cumulative effects of socio-demographic, economic, and environmental changes (WHO, 2016, 2018). The Astana Declaration of 2018 (WHO, 2018) outlined a commitment by WHO member nations to the development of primary health care and health services that are high quality, safe, comprehensive, integrated, and accessible. The declaration also focused on the need to create and develop health- enabling environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and wellbeing. The importance of the declaration is that the countries that committed to implementing it viewed the achievement of the highest standard of primary health care as a fundamental human right.

The Astana Declaration focused on primary care and the delivery of universally accessible health care. The drive for more integrated care is often linked to the need to move health care to the community and improve its provision and quality (Curry & Ham, 2010). There are several notable international examples of the development of integrated care, such as the population-based models of Kaiser Permanente (WHO, 2016), the commissioner/provider models of the Geisinger Health System (Curry & Ham, 2010), and the person-need-led models of Buurtzorg (De Blok, 2011). Many of these models have influenced the design of integrated care in the UK and have formed part of a narrative developed by advisory organisations (such as the King's Fund) that champion the development of integrated and population-health driven policy (NHS England, 2019a).

2.1.2 European Perspective

Since the 1990s, most European countries have been transitioning away from traditionally positioned health systems which were almost exclusively oriented to the treatment of illness through high-tech, hospital-based services (Antunes & Morerira,

2011). Antunes and Morerira (2011) further this observation, stating that there was a consensus in the European studies they reviewed that hospital-based care systems are insufficient in the management of chronic diseases which require multi-organisational, integrated, and system-wide approaches. The intergovernmental organisation The European Centre for Social Welfare Policy and Research (or simple the European Centre) in 2002 developed a programme called Providing Integrated Health and Social Care for Older Persons [PROCARE]. The aim of this programme was to develop a concept of integrated health and social care for older people by highlighting a number of areas of good practice from across Europe (Billing, Alaszewski, & Coxon, 2003).

One of the earliest examples of an integrated care model highlighted by PROCARE was the Danish system of applied integrated home care based on self-care theory, developed in the Skaevinge Municipality in 1984 (Wagner, 2001; Robertson, 2011). This model predates much of the modern literature on integrated care, but the principles (as defined by WHO, 2016) are clearly visible within its design and application. These principles can be observed in the goals of the project, which centred on availability of support, especially within a person's own home. In a 10-year review of the Skaevinge municipality, Wagner (2001) found that more older people in 1997 (40.8%) assessed their own health as better in comparison with those of the same age in 1985 (28.9%). There was also a reduction in cost of service even with the increase in older people in the municipality.

Another example of integration of care can be observed in the Buurtzorg model in the Netherlands, which emphasises the need for prevention, self-management, and out-of-hospital care (De Blok, 2011). The Buurtzorg model started in 2007 (English translation - 'neighbourhood') was founded from a grassroots movement in nursing in

the Netherlands and was a reaction to a system that was highly bureaucratic and highly regulated (De Blok, 2011). Buurtzorg, in contrast, focused on person-centred and personalised care approaches (Monsen & De Blok, 2013). The model included the formation of self-directed teams that supported patients in maintaining their independence and self-care in the least restrictive environment. The approach has been highly influential in the UK, as can be seen in the work of Drennan, Ross, Calestani, Saunders, and West (2018), which reports on a Buurtzorg development within London, and that of Maybin (2019), who discusses a similar development in West Suffolk.

The European approaches highlighted here demonstrate several consistent themes and concepts, including person-centred care (Monsen & De Blok, 2013), social inclusion (Curry & Ham, 2010), continuity of care (Ham, Heenan, Longley, & Steel, 2013), needs approaches (Robertson, 2011), and harm minimisation (Curry & Ham, 2010). These early European interventions have continued to be reflected within integrated care policy in the UK today, as discussed further in the scoping review (Chapter 3).

2.1.3 North American Perspective

There have been several notable examples of integrated health care systems within North America, particularly the United States and Canada, a number of which have influenced the development of policy in the UK (Curry & Ham, 2010). Comparisons between systems in the UK and the US is difficult due to the complexity of health and social care systems and contexts, including socio-political situations and cultural expectations (Rosen, Mountford, Lewis, Lewis, Shand, & Shaw, 2011; Ham, 2005).

Rosen et al (2011) reviewed international integration implementation, including in the United States, to identify generalisable features that could be of use to the NHS. One area they highlighted was payment mechanisms in the UK, arguing that existing mechanisms did not support integrated care or provide high quality and efficiency. Rosen et al. (2011) cite the introduction of accountable care organisations in the US as a mechanism for developing financial incentives for integration. Accountable care organisations operate on the basic premise that different organisations from the health and care system should work together to improve the health of a population (Charles, 2020). However, there are various types of delivery organisations, including multi-specialty groups, physician-hospital organisations, and virtual physician organisations. Many of these are in the early stages of development, with evidence not yet supporting significant reductions in health care spending or improvements (Shortell, Addicott, Walsh, & Ham, 2014). It is also noteworthy that accountable care organisations remain controversial, as stated by Pollock and Roderick (2018), who highlight the difference between US insurance-based health care systems and the NHS in terms of universal coverage. They also raise uncertainty about the cultural transferability and application of accountable care organisations in the UK.

Curry and Ham's (2010) review of Kaiser Permanente stated that it was a health care system that had developed a successful vision and application of integrated health care. Kaiser is the largest integrated care system in America and is considered an exemplar in the delivery of quality services that support patients in maintaining health and wellbeing (McHugh, Aiken, Eckenhoff, Lawton, & Burns, 2016). Kaiser's population health and chronic care approach has been emphasised as best practice, as it empowers the population through prevention, self-management, and case management. Some advocate for this approach because it removes the artificial

constructs of primary and secondary care (McHugh, Aiken, Eckenhoff, Lawton, & Burns, 2016; Goodwin, Dixon, Anderson, & Wodchis, 2014).

Another North American system viewed as best practice in integration is the PRISMA research project established in Quebec in 1999 (MacAdam, 2015). The programme aimed to implement a consistent integrated service that would improve the health, wellbeing, empowerment, and satisfaction of the frail elderly population. While this programme shared many basic features with integration programmes (e.g., care coordination, self-care, single point of entry), it was its approach to governance and leadership that garnered international attention, as it did not use either vertical or horizontal mergers, instead opting to adopt a coordination approach (Leutz, 1999; Hébert, Raîche, Dubois, Gueye, Dubuc, Tousignant, & Prisma Group, 2010). Evaluation of the approach provided clear evidence for the role of leadership and strategic direction within integrated care (MacAdam, 2015; Goodwin, Dixon, Anderson, & Wodchis, 2014).

2.1.4 The Devolved Nations

The four nations of the UK share significant challenges; however, each nation has a unique and individual culture, economic circumstances, and socio-political outlook. The 1998 devolution agreements enabled each nation to define its own health and social care strategies (Ham, Heenan, Longley, & Steel, 2013). Twenty years on, it has been reported that devolved responsibility has resulted in divergence in health and social care policy across the UK (Bevan, Karanikolos, Exley, Nolte, Connolly, & May, 2014). The following section provides examples of how the three devolved nations have approached integrated health and social care using different models.

2.1.4.1 Northern Ireland

Northern Ireland [NI], unlike the rest of the UK, has had an administratively integrated health and social care service since 1973. The NI system has been described as 'one of the most structurally integrated and comprehensive models of health and personal social services in Europe' (Heenan & Birrell, 2006:48). Heenan and Birrell (2006, 2009) and Ham, Heenan, Longley, and Steel (2013) have explained how the NI approach has enabled a more rapid development of integration within local services. Heenan and Birrell (2009) note that the closer managerial, organisational, and working arrangements between staff across disciplines provide the opportunity for patients to move more effectively from acute to community settings. Another unique element within NI is the 'purchaser—provider split' which is viewed as enabling greater cooperation between services supported by commissioners, which, unlike the English system, does not incorporate an element of competition (Donnelly & O'Neil, 2017).

2.1.4.2 Scotland

Scotland's integrated care strategy does not have the history of that of NI, however recent years have seen a commitment to the development of an integrated health and social care system (Pearson & Watson, 2018). While there have been previous attempts at integration, including the Community Health Partnerships (CHPs) from 2005 to 2015, it was the Public Bodies (Joint Working) (Scotland) Act (2014) that provided the legislation for the delegation of health and social care to joint integrated boards (Ham, Heena, Longley, & Steel, 2013), providing the system-wide structural shift required to develop integration on an organisational, local, and community level (Pearson & Watson, 2018). Since 2016, integration of health and social care services

in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 have rapidly increased. Research by Person and Watson (2018) found that while there were examples of individual innovations, Scotland remains in the early stages of structural change to facilitate integrated practice.

2.1.4.3 Wales

Wales, like the other nations of the UK, has commenced a journey to integrate its health and social care system (Ham, Heena, Longley, & Steel, 2013). Part of the Welsh approach was the introduction of an integrated care fund to act as a financial incentive for innovation in health and social care. This fund also aimed to support the implementation of the Social Services and Well-being (Wales) Act (2014) and Well-being of Future Generations (Wales) Act (2015) (Welsh Government, 2018). The fund has supported a number of initiatives, including Capital Investment, Wales Community Care Information System, and the Dementia Action Plan. Similar to Scotland and England, these programmes and plans remain in their early stages and require further research to demonstrate whether they provide fundamental improvements (Ham, Heena, Longley, & Steel, 2013).

There is a wide range of other health systems in North America (e.g., the Veterans Health Administration, the Mayo Clinic, and Geisinger Health System) and across Europe that have been highlighted as successful examples of integrated care (Ham, 2010; Ham & Curry, 2010; Robertson, 2011, Rosen et al, 2011). The examples outlined here demonstrate how high-performing integrated care approaches are reviewed, evaluated, and reported on, leading to their transference across national boundaries and their spread and adoption by other systems (Curry & Ham, 2010).

2.2 English Health and Social Care Policy: Methodology

Previously in this chapter insight has been provided into the international responses that have influenced English policy development. This section provides an assessment of health and social care policy in the English system, outlining the significant policy changes which have been defined and driven by integration and integrated care.

2.3 Rationale for Inclusion of Relevant Policy Documents

De Leeuw, Clavier, and Benton (2014) explain that the terms 'health' and 'policy' can in themselves be problematic to understand and describe. Therefore, they recommend the use of a definition. The definition of 'policy' adopted for this review is:

> *...the expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe. (De Leeuw, Clavier, & Benton, 2014:2)*

Policies included in the review were produced by or for UK government departments or arms-length government bodies charged with supporting the implementation of integrated care in England. Integrated care programmes in Scotland, Northern Ireland, and Wales were considered outside the scope of the review, as health policy in the devolved nations follows a different path (integration in the devolved nations is outlined in 2.1.4).

The following search terms were identified to refine the policies selected for review: 'adult health and social care', 'integrated care', and 'integration'. Research, evaluation, government-commissioned research and evaluations, and literature reviews were considered beyond the scope of this review, as they formed part of the wider scoping review presented in Chapter 3. The years included were 2008 to present (2020). The year 2008 was selected as the beginning point because it was the year of release of

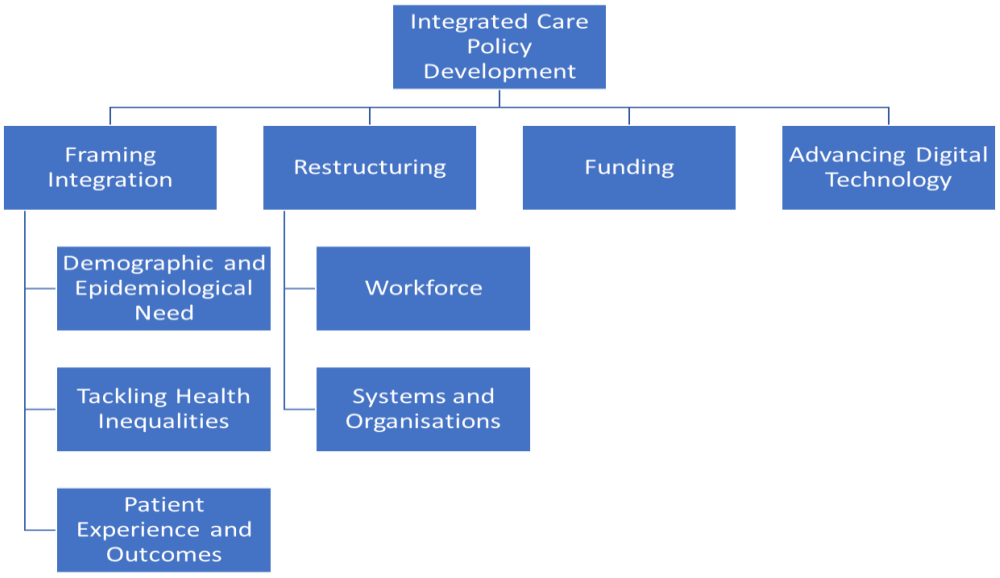
the final report 'High Quality Care for All NHS Next Stage Review' (Darzi, 2008), which marked a significant shift in governmental policy towards integrated care. It is acknowledged that there were significant changes prior to this report in 2008, and while these will not form part of the thematic analysis, they will be referred to where they provide insight into current policy. The search found 67 documents, of which 32 (Appendix 2) were included in the final section. Of the 32 policies reviewed, 25 were produced since 2012, which reflects the current increased drive for integration policy. As the focus of this study is the devolved region of Greater Manchester, this process was repeated with the primary focus on regional policy (see Appendix 3) and reported in 2.4.5.

2.3.1 Analysis

The policy documents were read, re-read, and then manually coded (n = 83 codes). The codes were then analysed to develop sub-themes and then themes, using Braun and Clark's (2006) approach. The themes are presented in Figure 1.

Figure 1 –

Themes Identified in Policy Review



2.4 Review of English Health and Social Care Policy: Findings

For many years it has been argued that health, wellbeing, and societal pressures in the UK cannot be addressed without transforming how health and social care are delivered (Baxter, Johnson, Chambers, Sutton, Goyder, & Booth, 2018). Integrated care and integration have been the cornerstone of policy for most of the past 30 years; however, in recent years there has been a renewed focus which has aimed to accelerate the spread and adoption of integrated care (NHS, England, 2014a, 2019a; Charles, 2020). The NHS Confederation, 2020 report into the future of integrated care in England highlighted that for decades the legislative framework governing health has centred around the principle of competition as a means to improve the quality of services. However, there is now a recognition that collaboration and integration is required to improve population health, deliver better quality care, and make more efficient use of resources (Das-Thompson, McQuade, Pett, & Ville, 2020). This section presents the key themes identified within health and social care policy in England since 2008.

2.4.1 Framing Integration

Analysis of English health policy documents revealed a significant alignment in the way integrated care was framed. Typically, policy initiatives refer to and include discussions of demographic and epidemiological changes, the need to address health inequalities, and patient experience and outcomes (DH, 2012a). The changing demographics and epidemiology of the UK appear to have instigated the questioning or challenging of whether traditional health and social care models are able to address the complex health and social needs of the population (NHS England, 2019a, Darzi, 2008).

Societal changes such as an ageing population and an increase in long-term conditions influenced policy drivers prior to 2008; however, the publication of the document ‘High Quality Care for All NHS Next Stage Review’ (Darzi , 2008) articulated the need to redress the balance of service provision to address gaps in safety and quality experienced by patients, shifting from episodic, reactionary care to more proactive and preventative care. During this period, there was a series of policy initiatives aimed directly at addressing the needs of an ageing population. For example, the Partnerships for Older People Project [POPP], launched by the Department of Health in 2006, was supported by £60 million in funding for 29 pilot projects. The POPP aimed to promote health, well-being, and independence and prevent and delay the need for care (Windle, Wagland, Forder, d'Amico, Janssen, & Wistow, 2009). The POPP project is an example of promotion of the role of the volunteer, community, and faith sectors, which during this period began to gain greater prominence as a means to address the health and social care needs of the population (DH, 2006).

The concept of health inequalities has been present since the 1800s, but has gained considerable traction in the past 40 years, including in publications like the ‘Black Report’ (Townsend, Davidson, Black, & Whitehead, 1988) and the ‘Marmot Review’ (Marmot, Allen, & Goldblatt, 2010). In the years after the publication of the first Marmot Review (Marmot, Allen, & Goldblatt, 2010), health inequality has gained greater prominence within policy and has been established as a rationale for the development of integrated services (Marmot, Allen, & Goldblatt, 2010; Darzi, 2008, 2018). The NHS Future Forum report on integration (DH, 2012b:16) clearly identified the need for communities to be engaged in the development of services, stating:

> We need to make it easier for patients and families to fill in their own gaps in services and support them to do so. Where this is done, communities feel empowered to make the most of their own resources, providing highly innovative solutions to plug gaps in existing services, reduce inequalities and help more people to receive care closer to home.

The need to engage, enable, and empower communities to reduce health inequalities remains an important part of English health policy, which has been borne out through policy incentives introduced in the 'Five Year Forward View' (NHS England, 2014a) and the 'Long Term Plan' (2019a). These endeavours include promoting personalised care and patient-centred care and expanding community services. These policy initiatives are supported by financially incentivised programmes such as sustainability and transformation partnerships [STPs], which bring local health and care leaders together to plan around the needs of their communities (NHS England, 2014a), and integrated care systems [ICSs], which are the next stage in the evolution of STPs (NHS England, 2019a). Similarly, the Integrated Volunteering Approaches Programme was introduced to increase community engagement in volunteering through financially supported programmes (NHS England, 2019b).

Across the policies reviewed, the introduction of integrated care was framed as a means to improve patient experience and outcomes (NHS England, 2014a, 2019a). 'Integrated Care and Support: Our Shared Commitment' (National Collaboration for Integrated Care and Support, 2013) aimed to place people at the heart of integration through the adoption of the National Voices' (2013) definition of integrated care, which frames integration from the perspective of those who use services. An example can be seen in the development of the shared commitments, which outline national and

local commitments in which national partners commit to supporting local organisations in their work towards more patient-centred care (National Collaboration for Integrated Care and Support, 2013). 'Our Shared Commitment' (National Collaboration for Integrated Care and Support, 2013) also led to the introduction of the Integrated Care and Support Pioneer Programme (NHS England, 2014b). This programme worked with a range of national partners in local areas to innovate new approaches to providing care and support which was coordinated around people's needs. The aim was to increase the knowledge base of exemplar practice that could then be spread and adopted more widely (NHS England, 2014a).

Placing people at the centre of policy development was a priority in the Care Act (2014), which embedded new local authority responsibilities in legislation, including the provision of service that prevents care needs from becoming more serious, provision of information to people that support decision making, and increased choice in services. In addition, the Care Act (2014) amended the NHS Act of 2006 to provide the legislative basis for the introduction of the Better Care Fund [BCF] (DH, 2016). The aim of this initiative was to transform local services, so they became more integrated and community focused, leading to improved patient outcomes. The fund was seen as a means of supporting health and local authorities in working closer together. Evaluation of the fund, however, has been mixed (Forder, Caiels, Harlock, Wistow, Malisauskaite, Peters, Marczak, Dimico, Fernandez, & Jones, 2018; DH, 2014, 2016).

While the Care Act (2014) attempted to address local authorities' responsibilities for provision and choice of services, in the same year the 'Five Year Forward View' (2014a) set out an integrated care agenda that aimed to address fragmentation of service delivery across health and social care. This policy ambition has been further supported in the 'Long-Term Plan' (2019a) which introduced ICSs that incorporate

both health and social care in the development of integrated systems at micro, messo and macro levels (Charles, 2020). The ambition of the 'Long-Term Plan' (NHS England, 2019a) was also reflected in 'Refreshing NHS Plans for 2018/19', which is the joint NHS England/NHS Improvement guidance that set out the expectations for commissioners and providers in updating their operational plans for 2018/19 (NHS England and NHS Improvement, 2018). The guidance reinforced the move towards working within systems in which commissioners and NHS providers, General Practitioners [GP] networks, local authorities, and other partners collaborate.

2.4.2 Restructuring Systems and Organisations

Utilising system-level structural change, such as SPTs and ICSs, to drive integration has become a part of the rhetoric of integrated care policy (NHS England, 2014a, 2019b; NHS England and NHS Improvement, 2018). Many policies now advise that system-level change is imperative if integrated care is to become a reality (Darzi, 2018). Despite the current policy appetite for integrated care, it has been argued that previous policies such as the Health and Social Care Act (2012) and Equity and Excellence: Liberating the NHS (DH, 2010) have been instrumental in creating an environment that has made the achievement of integrated care more difficult (Edwards, 2014; Darzi 2018). In 2008, the final report 'High Quality Care for All: NHS Next Stage Review' signified the commencement of a significant restructuring of community services. The subsequent 'Transforming Community Services' [TCS] policy (DH, 2011) aimed to enable community services to transform themselves to reduce inequalities and fragmentation in services; however, in reality TCS had an overly simplistic approach that focused on structural change rather than on service improvement and led to community services being transferred to acute, mental health,

or private providers, and it has been claimed that the policy failed to deliver improvements (Edwards, 2014).

In 2010, the UK coalition government implemented ‘Equity and Excellence: Liberating the NHS’ (DH, 2010) to structurally reform the NHS and public health systems. This policy was later followed by the Health and Social Care Act (2012) which brought about changes for local authorities on public health functions, introduced clinical commissioning groups [CCGs], and announced specific responsibility for reducing health inequalities. The formation of these CCGs, led by GPs and other clinicians, was a key feature of these reforms. The role of the CCGs was to oversee commissioning, to join up health and social care services, and to align these with local government responsibilities (DH, 2010: 4). Significantly, the previous commissioning bodies, NHS primary care trusts, were abolished as commissioning and provision was separated, which then led to the transference of public health and health improvement functions to local authorities (DH, 2010).

It has been argued that these changes have left a significant legacy that has affected current policy implementation by structurally changing community services into a highly complex, narrowly focused, and often poorly coordinated service, which has made the system difficult to understand and navigate, both for professionals and for those using the services (Darzi, 2018; Edwards, 2014). A major criticism of this legacy was recorded in Darzi’s (2018) ‘Review of Health and Social Care’, which argued that the Health and Social Care Act (2012) fixed institutional architecture in primary legislation, which resulted in delayed progress in the implementation of integrated care and led policymakers to use mechanisms that do not have a legal underpinning (Darzi, 2018). Darzi (2018) maintains that the most visible example of programmes without legal underpinning are SPTs, as they have no legal basis, unclear governance, and

no decision-making authority. Similarly, the Health and Social Care Act (2012) was also criticised for prioritising the expansion of competition between providers and increasing patient choice to improve quality and cost effectiveness, rather than improving the integration of services (Miller & Glasby, 2016; Kaehne, Birrell, Miller, & Petch, 2017). In contrast, it has been argued that the introduction of integrated care and integrated care systems has the potential to address challenges in funding and to enable greater local control (Ham, 2018).

2.4.3 Funding

The funding of health and social care services has remained a high-profile area of policy, as policymakers attempt to improve efficiencies and reduce costs (Curry & Ham, 2010). In this section, funding is considered in two ways: the money entering the health and care system and its impact on the development of integrated care, and the way that funding is allocated and managed through system organisation.

According to Lafond, Charlesworth, and Robert (2016) between 2009/10 and 2020/21 NHS funding only recorded a modest average increase of 1.1% a year, compared to the previous average increases of nearly 4% a year since the NHS was established. They further explain that many NHS Trusts were facing significant financial difficulties due to the perfect storm of reduced incomes and rapidly increasing costs and demand (Lafond, Charlesworth, & Robert, 2016). Within social care funding, there has been a real-term fall in provision for adult social care by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly funded social care (Lafond, Charlesworth, & Robert, 2016). Given the impact of wider social determinants on people's health, there has been significant pressure brought about because of the real-term decrease in social care funding. A study by Watkins, Wulaningsih, Da Zhou, Marshall, Sylianteng, Rosa, Miguel, Raine, King, and

Maruthappu (2017) found evidence of a substantial mortality gap due to associated spending constraints.

As a response to rising demands, changing demographics, and fiscal challenges, there has been a renewed emphasis on restructuring the health and social care system (Ham, 2011). Ham and Smith (2010) state that the introduction of integrated care initiatives have the potential to improve financial flow and management, as they remove barriers, decrease silos, and enable budgets to be more locally controlled. The move to integrated approaches can be most clearly seen in the introduction of ICSs, which aim to transform how health and care services are planned, paid for, and delivered.

These ICSs have developed from STPs, which were launched as part of Department of Health and Social Care policy in 2016. The development of Integrated care systems [ICS] represent a reversing of decades of policies that favoured organisational autonomy in favour of collaboration and the joining up of health and social care budgets in voluntary partnerships (Charles, 2020). These partnerships are viewed as an effective method of providing long-term financial stability in both the health and social care systems. However, ICSs are not without controversy, as there is no formal approach to their development, they are not statutory bodies, and their governance and decision-making processes remain unclear (Charles, 2020, Bate, 2018). There is an additional controversy relating to ICSs, as they are predicated on the principles of the American system of accountable care organisations, which has led to concerns that their introduction will lead to further privatisation (Charles, 2020).

2.4.4 Advancing Digital Technology

The Topel Review (2019) describes digital health technologies as including telemonitoring, teleconsultations, decision support, mental health, machine learning, genomics, and artificial intelligence. The implementation of these technologies is viewed in policy as an essential enabler of integrated care (NHS England, 2014a, 2019a). This is because integrated care requires higher levels of enhanced care coordination across organisations and sectors, self-management, decision-making tools, data management, risk analysis, and facilitated proactive interventions (Baltaxe, Czypionka, Kraus, Reiss, Askildsen, Grenković, Lindén, Pitter, Rutten-van Molken, Solans, & Stokes, 2019). Lewis and Ehrenberg (2020) encapsulate this idea in noting that many of the building blocks of integrated care are reliant on effective communication, which can be significantly enhanced by effective use of digital solutions. However, Murray, Hekler, Andersson, Collins, Doherty, Hollis, Rivera, West, and Wyatt (2016) highlight that the introduction of digital health care solutions is not without challenges, explaining that there needs to be greater understanding of the impact of digital interventions on patient outcomes.

Within English health policy, there has been a push for the expansion of scalable digital interventions with both the ‘Five Year Forward View’ (NHS England, 2014a) and the ‘Long-Term Plan’ advocating the widespread adoption of digital solutions at a local, organisational, and systems level. The aforementioned policies promote the adoption of digital technology in health and social care, viewing them as a means to change the way patients engage with services, to improve efficiency, and to support people in self-care (Honeyman, Dunn, & McKenna, 2016). Mahuire, Honeyman, Omojomolo, & Evans (2018) provide support to the policy-drivers, citing successful digital transformations such as the introduction of electronic patient records which have been

seen as improving patient experience because they enhance patients' access to their information.

While there are examples of successful implementations of digital technology, there have also been a number of less successful governmental initiatives. The national IT programme that ran from 2002 to 2011 attempted to implement a top-down digitisation of healthcare and cost £6.2 billion, but the programme failed to deliver its main objective of a single national electronic health record. Despite multibillion-pound investments, it was dismantled in 2011 (Tagheed, 2016). Many of the critiques concluded that an overly centralised approach had led to a failure to engage the end user and led to the system not being fit for its purpose (National Audit Office, 2013; Tagheed, 2016). A second example of an unsuccessful digital policy drive can be seen in Health Secretary Jeremey Hunt's 2013 challenge for the NHS to go paperless by 2018 as part of a digital transformation (DH, 2013). While this goal was not achieved, there have since been consistent policy aims related to greater digital technology within the NHS (Topol, 2019). The delivery of digital technology within health and social care policy is outlined in chapter 5 of the 'Long-Term Plan', which stated: 'In ten years' time, we expect the existing model of care to look markedly different. The NHS will offer a "digital first" option' (NHS England, 2019a:92).

Mahuire, Honeyman, Omojomolo, and Evans (2018) argue that there are key barriers to successful digital transformation and the realisation of policy ambitions, and that these include organisational constraints, budgets, risk-aversion in organisations, and workforce digital literacy. Topol (2019) supports this analysis, arguing that within the next 20 years, 90% of all jobs in the NHS will require the workforce to be highly digitally literate. Digitalisation is seen as both a challenge and an opportunity for the introduction of integrated care (DH, 2012c; NHS England, 2014b). However, the

COVID-19 pandemic has led to a rapid proliferation of digital solutions and has driven forward a number of local, regional, national, and international initiatives that have the potential to continue driving policy in the future (Lewis & Ehrenberg, 2020; Ehrenberg, Terris, & Marshall, 2020). It is important to note that the Topol Review (2019) does provide the caveat that while digital solutions have the potential to transform health care, they may also bring new variants in health determinants and inequalities if adequate consideration is not given to how they impact vulnerable groups.

2.4.5 Regional Perspective: Greater Manchester

In 2015, the UK government announced plans to enable the devolution of control of the £6 billion health and social care budget for Greater Manchester to the Greater Manchester Strategic Partnership, consisting of 10 local authorities (see Fig. 2), 12 clinical commissioning groups, 15 NHS trusts and foundation trusts, and NHS England (McKenna & Dunn, 2015). In April 2016, the legal transfer of power and budget was completed, and an ambitious transformation plan was commenced which aimed to reduce health inequalities and improve efficiencies, including through the expansion and rapid adoption of integrated care (Walshe, Lorne, McDonald, Coleman, & Turner, 2018).

Figure 2

The 10 Boroughs of the Greater Manchester Combined Authority (GMCA, 2015)

Devolution in Greater Manchester was not without criticism, and the original legislation was seen as leaving a number of unresolved issues, such as the tension between local and national arrangements, concerns regarding financing and the workability of the new devolved region, and tensions within local coordination (McKenna & Dunn, 2015). This criticism notwithstanding, devolution was widely accepted as an approach that could provide the Greater Manchester Devolved Authority [GMDA] (later Greater Manchester Combined Authority) and the Greater Manchester health and social care partnership with the opportunity to reshape health and social care delivery for its 2.8 million residents through the transfer of the £6 billion budget (GMCA, 2015).

The GMCA was formed from leaders of all 10 local councils, the mayor of Greater Manchester, and the chief executive of the GMCA (GMCA, 2015). The Authority provides strategic direction for the Greater Manchester Region. The GMDA has

articulated that the 10 Manchester boroughs need to work differently to achieve the ambition of a healthier Greater Manchester. This ambition was further consolidated by consultation for the Healthier Together programme (Boampong, 2014), which was reported to have received the largest public response to a regional consultation regarding health and social care services in England in the past decade (Boampong, 2014). The key finding of the consultation was that three-quarters of the Greater Manchester population were in support of NHS reform to provide services that better fit the needs of the population.

The 'Greater Manchester Health and Social Care Devolution Memorandum of Understanding' (GMCA, 2015) consolidated the new responsibilities for the region, and the 'Five-year vision for better health and social care in Greater Manchester' plan (2015) included a £450 million transformation fund to support organisations in developing more integrated and community-focused services (GMCA, 2015). The transformation funding has been used in a wide variety of ways, including the development of integration of health and social care neighbourhoods (Mitchell, Howard, Tazzyman, & Hodgson, 2019), the development of system self-care and asset-based approaches such as social prescribing (Marshall & Easton, 2018), and projects to alleviate homelessness (GMCA, 2018).

At the core of Manchester devolution was rapid expansion of integrated care in the region, through the formation of integrated care organisations, shifts to population-health approaches, and greater coordination across the region. Integrated care policy within the region has been driven by the desire to rebalance the health and social care economy and reduce health inequalities that continue to plague the population (Walshe, 2017).

2.5 Chapter Summary

The international, national, and regional policy context in which integrated care has been implemented is complex, with several complicating factors. These factors include a shift from a medical model to an integrated model that incorporates health as a partnership across several sectors, including the community and the individual. Additionally, health inequalities have led to certain populations, such as that in the North West of England, having significantly poorer outcomes and healthy life expectancy, which has increased the call for a new system. Significant shifts in the political landscape within the UK have resulted in policy reform and the promoting of integrated care as a means of meeting individual and community needs. This chapter sort to highlight a selected number of policy areas from different international, national, and regional settings to provide context for the development of the research. Next Chapter 3 expands this context setting by exploring the wider literature.

Chapter 3. Scoping Review

3.0 Chapter Introduction

This chapter presents a scoping review, which explores what is currently known in the field of integrated care. Included in the review are a contextualisation of the subject area and scrutiny of the concept of integration, providing insight into current drivers and barriers to its adoption. The chapter begins by detailing the design and methods used in conducting the scoping review, followed by presentation of the themes and findings. The scoping review expands on the policy review of the preceding chapter by placing political drivers and policies within a wider field of knowledge. Considered together, Chapters 2 and 3 draw attention to the policies and surrounding knowledge base that form the extraordinary and ordinary relations that mediate, influence, and coordinate people's lives.

3.1 Methodological Considerations: Institutional Ethnography and Literature Reviews

This section details methodological considerations involved in the scoping review, including theoretical and ontological tensions between the production of a literature review and the principles of institutional ethnography. Throughout the literature review process, a critical and suspicious position toward the literature was adopted, with attention paid to how the external factors and discursive practices of knowledge production were reinforced (Rankin, 2017; Campbell & Gregor, 2002). This was important, as Campbell and Gregor (2002) illuminate that the language of powerful outside institutions is engrained in literature and can control the local agenda through documented texts; these forces are described as the 'relations of ruling'. The seminal work of Smith (2005) describes the relations of ruling as the extraordinary and ordinary relations that mediate, influence, and coordinate people's lives through text. These

relations of ruling are considered a danger in institutional ethnographic research, as they have the potential to remove the researcher's gaze from the actualities of people's lives and to influence the findings.

3.2 Principles of Literature Review Within Institutional Ethnography

The literature review was undertaken to collect and analyse data on the current state of knowledge on integration. The research methodology used in this study is institutional ethnography, which is a distinct ethnographic approach that seeks to understand the experiences of people marginalised by institutional process (Smith, 2005). The approach of IE remains an emerging methodology , and there was little guidance provided by seminal literature on how a literature review should be conducted within an IE approach. Therefore, prior to commencing the review, key writings on IE—such as Campbell and Gregor (2002); Rankin (2017); and Smith (2005, 2006a)—were examined to develop a framework for explicating the literature.

Six principles for conducting a literature review when using an institutional ethnographic approach were identified, as they were consistent through the literature (Table 3).

Table 3 *Principles of Conducting a Literature Review with an IE Approach*

1	Literature should not be taken as facts that generate the background; the primary interest of the review is to understand the social organisation of the knowledge of the topic.
2	Literature is data, and analysis begins with an interrogation of how the relations of ruling are constructed in the literature.
3	The literature review should inform the stance the researcher takes to the research topic.
4	There is a requirement to explore how concepts and theories have been scaffolded or held up and to examine the structures of each piece of literature and the impact they have on knowledge of the topic presented.
5	Attention should be paid to how the topic is known about within the ruling relations. Discursive practices of the knowledge production should be identified.
6	Authoritative discourse should be identified.

Note. Adjusted from Campbell and Gregor, 2002; Rankin, 2017; Smith, 2005, 2006a.

These principles are reflected in the text by aligning them with the actions conducted. The methodological approach to the review process will be evidenced throughout by highlighting where these principles have been applied. The development of the principles for scoping and reviewing literature in institutional ethnographic approaches enabled the review to be conducted in a robust manner, while preventing compromise of methodological sensitivities, such as the forcing of theory on local spaces and primacy of the local actualities of people's lives.

3.3 Strategy and Methodology

The next stage in the development of the literature review was to develop the strategy. The review strategy was designed to reflect the six principles identified above and to be robust, valid, reliable, and repeatable (Xiao & Watson, 2017). A scoping review was selected as the type of review; scoping reviews are suitable when there is a need to

comprehensively review and map available literature for critical ideas (Levac, Colquhoun, & O'Brian, 2010; Anderson, Allen, Peckham, & Goodwin, 2008). Integration and integrated care research are by their very nature heavily intertwined with policy development. Therefore, a scoping review was deemed suitable for this study because it facilitated the application of the IE principles outlined in Table 3 and enabled greater flexibility and exploration of both empirical studies and the wider literature that together form the textual relations of ruling (principles 2 and 6).

To support the development of the review alongside the IE principles outlined in Table 3, Arksey and O'Malley's framework (2005) was used (further developed by Levac, Colquhoun, & O'Brian, 2010) (see Fig. 3). This framework provides a robust structure for the review and enabled a sequential, ordered, and logical approach to be followed (principle 2).

Figure 3

Overview of the Arksey and O'Malley Framework (2005) for Conducting a Scoping Study

3.3.1 Identification of the Review Question

There were three main considerations in the identification of the review question (Arksey & O'Malley, 2005; Smith, 2005):

1) The actualities of people's working lives in the context of integration (principle 3)

2) The policy reviewed in Chapter 2 (principle 4)

3) The breadth of the review: broad enough to ensure there was enough literature generated, but not so broad as to gather so much literature that the endeavour became unmanageable

The following two questions were developed as the aim of the scoping review. As part of the question development, the 'PICOS' design was applied (population, interventions, comparators, outcomes, and study). This approach has been identified as a method of ensuring a fully comprehensive search when time and resources are limited (Methley, Campbel, Chew-Graham, McNally, & Cherahi-Sohi, 2014; Centre for Reviews and Dissemination, 2009). The review questions were:

1) How has integrated care been implemented in the UK adult health and social care sector?

2) What is known about how health and social care teams respond to the implementation of integrated care models?

3.3.2 Identification of Relevant Studies

The review questions were broken into their 'concepts' which were then developed into the search terms that would be used to locate literature (Centre for Reviews and Dissemination, 2009). The terms identified were then compared with concepts and terminology that were prominent within current policy documents on health and social care integration/integrated care. Seven key terms were identified as search terms (Table 4).

Table 4 *Search Terms for Scoping Review and Their Rationale*

Term	Rationale
Integrated care	The policy term for the development of integrated systems; used particularly in international, governmental, and think-tank documents
Cross-sector partnerships	A common form and method of developing integrated systems across public, private, and voluntary sector systems
Integration	The mechanism models and modes of achieving integrated care
Health and social care	The sectors of interest within the study
Workforce in integrated care	Participant groups within the study
Asset-based development	A commonly discussed philosophical principle of integrated care (WHO, 2016)
Neighbourhood working	The research was being conducted within a neighbourhood team

The search terms were first employed individually and then in combination. The combining of terms, however, did not produce additional publications or articles. The search for relevant literature was conducted in two stages: first, an initial scan of abstracts was undertaken to screen out any documents that were outside of the scope of the review; second, inclusion and exclusion criteria were applied (Centre for Reviews and Dissemination, 2009).

3.4 Study Selection

Multiple resources were used in the selection of relevant studies, including electronic databases, internet searches, and research registers. Journals and reference lists were also checked by hand. This section describes how these resources were

employed and details the inclusion and exclusion criteria by which the studies included in the review were selected.

3.4.1 Electronic Databases, the Internet, and Research Registers

Once the key search terms were identified, a search of available databases was conducted through SOLAR, a search tool which searches in databases available to the university. The following databases were used to perform the search: MEDLINE, CINAHL, and the British Nursing Index [BNI]. These three were selected because they are a reliable source of primary studies for qualitative evidence synthesis. Brettle and Long (2001) found that repeated searches in different databases can deliver varied results; therefore, to ensure relevant documents were not missed, searches were repeated in more than one applicable database. Following the primary searches of databases, journals unavailable through SOLAR were found online through Google Scholar and the websites of individual journals, such as the Journal of Community Nursing and the International Journal of Integrated Care. These websites were searched separately, since they did not appear in the university's databases when the search was first undertaken. The NHS Trust library service and the University Library Service were used to locate journal articles that were not accessible through other means.

3.4.2 Manual Searching of Journals and Reference Lists

To expand the research yield, a manual search for articles was undertaken, and reference lists were checked for potentially relevant studies (Whittemore & Knafl, 2005). Manual searching was useful in locating documents that may not have been discovered via the search terms but were nevertheless relevant to the review (Centre for Reviews and Dissemination, 2009; Whittemore & Knafl, 2005). Manual searching involved scanning the content of journals, conference proceedings, and abstracts

page by page. Any relevant literature identified was then located using the university library search.

The government papers included in the search focused on providing an insight into the English integrated care journey, although international literature was also included to provide broader perspectives on integrated care. This approach was adopted because the devolved nations (Scotland, Northern Ireland, and Wales) have distinct and different health and social care policies.

A manual search of certain websites was also conducted to identify literature that could not have been located through the database searches. This additional search served to identify recent government papers that supported policy, evaluations within organisations that implemented integrated care, and literature developed by think tank organisations. Think tank organisations were considered an important source because of the influence these organisations have on policy development, making them important 'relations of ruling' that influence the social organisation of knowledge (principles 4, 5). Prior to the commencement of the search, consideration was given to what constituted advisory think tank papers. There is not a clear definition available, although there have been several attempts to define what such think tanks are. These include Weaver and Stares (2001), who explain that they are a form of alternative policy advisory organisation. Plehwe et al. (1998) provides further detail, explaining that these organisations are private, semi-public, and public institutions of knowledge and ideology production. More recently, Pautz (2011) has maintained that the importance of think tanks is in their ability to influence policy as state-external agents. Therefore, papers produced by these organisations were considered of importance as they represented a significant body of influential documents.

The Websites included in this search were:

- Department of Health (from 2018, Department of Health and Social Care)
- Ministry of Housing, Communities, and Local Government
- NHS England
- The King's Fund
- Nesta
- The Health Foundation

3.4.3 Sequence of Searches

The review was first conducted in February of 2016 as part of the initial development of the research. The literature search and review were then repeated midway through course of the research in March, 2018, after data had been collected, and finally the search was repeated in August, 2020, as part of the preparation of the final thesis. This was to ensure that the review reflected the current state of knowledge on integration and integrated care, since they are emergent and developing topics (Centre for Reviews and Dissemination,2009). The results presented here represent the final review of literature.

3.4.4 Inclusion Criteria

Sets of inclusion and exclusion criteria were developed to enable the final selection of the literature to be included. The inclusion criteria were developed to support the refining of the selection process, and the rationale for each criterion is outlined in Table 5. The criteria used PICOS to ensure a robust and systematic approach (Methley, Campbel, Chew-Graham, McNally, & Cherahi-Sohi, 2014; Arksey & O'Malley, 2005).

Following initial screening of abstracts, the full text of the remaining papers was scanned. The inclusion criteria (Table 5) identified characteristics deemed desirable in the papers being scanned—characteristics that made them appropriate for the review and gave them the potential to address the research questions. Each paper was reviewed against each of the inclusion criteria. Papers that met the inclusion criteria but none of the exclusion criteria were added to the final list of articles.

Table 5 *Inclusion Criteria*

Inclusion criterion	Rationale
Population: studies and evaluations that focus on adult care (age 16 and above)	The identified problematic was in adult care; therefore, research was limited to studies that were conducted in the adult care setting
Population: community services outside of hospital or care setting	The research scope is limited to out-of-hospital care and neighbourhood approaches
Population (Geography): international and national studies	While the research was conducted in England, integration and integrated care has been applied internationally
Interventions, comparators: integration and partnership, inter- and multi-sector, including public, private and voluntary sector, neighbourhood team development	Ensure that there is a board enough scope to reflect a wide range of papers that inform the current integration/integrated care agenda
Comparators: government papers and think tank papers relating to England and UK as a whole	Devolved nations from the devolved nations
Outcomes: studies and evaluations that demonstrate success or failure of integrated care and integration (including service delivery, patient outcomes, and financial outcomes)	Identify current knowledge of the enablers and challenges in integration and integrated care
Study design: policy papers and theoretical papers relating to integrated care	Policy and think tank papers inform about the relations of ruling within the local sphere. There are currently many papers being written on integration.
Study design: peer-reviewed quantitative and qualitative research studies	To gain understanding of Current knowledge base and what is already known
Time frame: studies post-2008	The time frame was selected to reflect current health and social care policy, as identified. The Darzi report (Meline, 2006; Darzi, 2008) being identified as a significant shift in policy towards the current inception of integration

The timescale for the literature review was adjusted for the August 2020 search to enable the inclusion of contemporary research. However, there are three studies that formed part of the early searches that have continued to be included although they are outside the time frame. Their inclusion was deemed important because they informed part of the early planning and development of the research.

3.4.5 Exclusion Criteria

Articles were excluded if they did not fulfil one or more inclusion criteria or they met any of the exclusion criteria listed in Table 6.

Table 6 *Exclusion Criteria*

Exclusion criterion	Rationale
Population: research that applied to children's services	Children's services are outside the scope of the research
Interventions, comparators: studies that related to public-private sector partnerships and corporate responsibility partnerships	Excluded as they sat outside of the scope of the study
Interventions, comparators: studies on accountable care development	Outside scope of the research
Interventions, comparators: studies that related to services that had a single function or worked with a single condition or disease focus	The area identified as the potential research problematic as was a generalist service
Comparators: government/think tank documents that do not have a direct reference to the English health and social care system	Research is being conducted within England
Outcomes: research that focused on one aspect of structural transformation (e.g., IT, clinical pathways, or electronic health records)	The research explores challenges within the workforce; while structural issues would form part of the finding, studies that only looked at single issues were deemed too narrow
Outcomes: research that only applied to performance measures	How integration is measured is not the area of interest of the study
Study design: non-peer reviewed papers, editorials, and comment papers	Excluded to maintain quality and reduce bias within the review
Study design: foreign-language papers without translation	Excluded because translation services unavailable to the researcher

3.5 Search Results

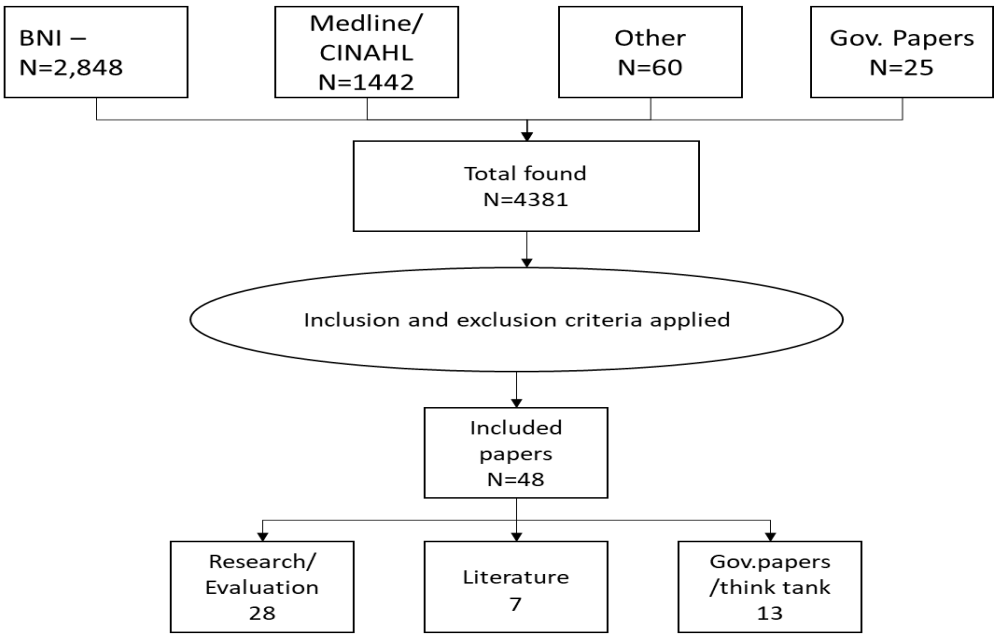
The results of the final search conducted in August, 2020, identified 4381 potential papers. An initial screening was conducted, and all abstracts were screened against the inclusion and exclusion criteria. Abstracts which met the inclusion criteria were included in the next stage (n = 66). Identified papers were then reviewed in full against

the inclusion and exclusion criteria, and about two-thirds were included (n = 41). Citation tracking (manual search) was then used to identify any other relevant papers (n = 7) (Horseley, Digwall, & Sampson, 2011). The final search results (n = 48) are outlined in Figure 4 and Table 7.

The papers identified were divided into three areas: research and evaluation, government and advisory papers developed by think tank organisations, and literature reviews. A complete list of included literature can be found in Appendix 4. The final decision for inclusion was made by reviewing the papers against the principles of the literature review to ensure that the ultimate body of literature chosen for review enabled an analysis in line with the ontological approaches that underpinned the study; such decisions were also made in discussion with the wider supervision team as part of the professional doctorate process.

Figure 4

PRISMA Flow Chart



Note. Adapted from Moher, Liberati, Tetzlaff and Altman, 2009

Table 7 *Search Results*

Search term	Database	Results	Included	Excluded
'cross-sector', 'partnerships', 'cross-sector partnerships'	BNI	102	3	99
	MEDLINE/CINAHL	137	3	134
	Gov. Papers	0	0	0
	Other	30	2	28
'integrated care'	BNI	1,077	4	1073
	MEDLINE/CINAHL	74	5	69
	Gov. papers	23	7	16
	Other	7	6	1
'asset-based development'	BNI	639		639
	MEDLINE/CINAHL	14	0	14
	Gov. papers	6	6	0
	Other	12	2	10
'integration', 'workforce', 'integrated workforce'	BNI	64	2	62
	MEDLINE/CINAHL	1160	3	1157
	Gov. papers	2	0	2
	Other	1	1	0
'neighbourhood teams'	BNI	966	2	964
	MEDLINE/CINAHL	57	1	56
	Gov. papers	0	0	0
	Other	10	1	9

In line with the review questions, the search results included a number of international studies which met the inclusion criteria. These are outlined in Table 8. The inclusion of these studies was important as they enabled the study to explore how concepts and theories have scaffolded literature across a number of settings and the impact that this has on the knowledge of the topic (principle 4); it also enables analysis of the development of authoritative discourse (principle 6).

Table 8. *Country of origin of international studies included in review*

Country	*Type*	*Number*
Canada	Randomised control trial	1
	Qualitative study	2
	Literature review	1
Netherlands	Qualitative study	1
Hong Kong	Qualitative study	1
Ireland	Qualitative study	1
Sweden	Qualitative study	1
Australia	Qualitative study	1
United States of America	Literature review	1

3.6 Extraction and Charting of Data

The diversity of the literature within the scoping review brought a level of complexity to the extraction and charting of data. For example, the wide range of methodologies and ideological approaches led to the documents not being universally comparable. The following sections discuss how these complexities were managed to ensure the

dependability of the synthesis and analysis. The approach followed aligned the analysis to the principles of the ontological approach (Table 3), and the review proceeded from the position that literature should not be taken as facts that generate the background, but instead as necessary for providing an understanding of the social organisation of the knowledge of the topic (principle 1).

3.6.1 Extraction of Data

To extract the relevant data from the included studies (n = 48) and provide a standardised approach, the critical appraisal skills programme (CASP) (2018) checklists were used. This programme was selected because it has a number of checklists and provides a succinct and effective means of covering the areas needed for critical appraisal of evidence (Nadelson & Nadleson, 2014). A number of the CASP checklists were used in order to reflect the range and type of literature included within the study (Table 9).

Table 9 *CASP Checklists Used in Extraction of Data*

Checklist	Document type	No. papers applied
Systematic review	Systematic review	3
	Other literature review	4
Qualitative	Gov. papers and think tank—research (mixed)	7
	Gov. papers and think tank—evaluation	2
	Gov. papers and think tank—other	4
	Qualitative study	21
	Evaluation	6
Randomised control trial	Randomised control trial	1

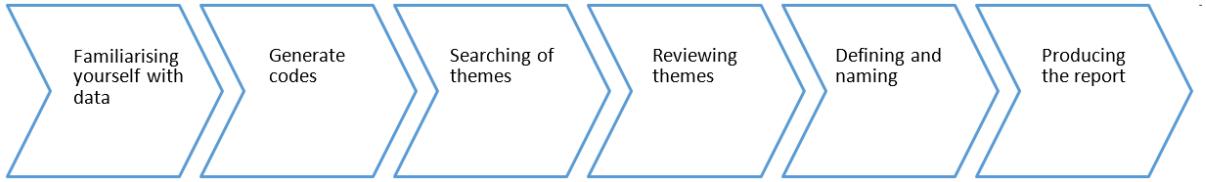
Following completion of the CASP checklists, the matrix table was added to and completed (Appendix 4) The matrix table enabled and supported the analysis of the selected studies.

3.6.2 Charting of Data: Evaluation, Analysis, and Interpretation

Arksey and O'Malley (2003) describe charting as a technique for synthesising and interpreting qualitative data through a process of sifting, charting, and sorting material according to key issues and themes. This was achieved through the application of thematic analysis using Braun and Clark's six-step thematic analysis framework (2006) (Fig. 5).

Figure 5

Braun and Clark's (2006) Six-Step Thematic Analysis



The use of this framework enabled the literature to be themed and organised using a standard approach, which adds to the dependability of the findings (Nowell, Norris, White & Moules, 2017). Each article (from each round of searchers) was re-read, and key points were cut and pasted from the articles into an Excel spreadsheet as data points. An example is illustrated in Table 10. Each data point was assigned a code (or multiple codes), and in total, 427 codes were developed (including repeated codes). The codes were then transferred onto sticky notes and analysed to look for themes and sub-themes, with reference back to the data points to ensure meaning was not lost in the theming process. This process ensured that codes, themes, and sub-themes could be traced back to their original source. Figure 6 provides an example of

the process used to record codes. Figure 7 illustrates part of the manual process of coding.

Table 10 *Example of Data Point in Spreadsheet*

Author	Data point	Code
Syson, & Bond, (2010).	One point of referral for consideration of nursing and social care needs improved benefit for citizens, users, carers and other professionals referring into the service.	Improved service delivery

Figure 6

Theme Development Process

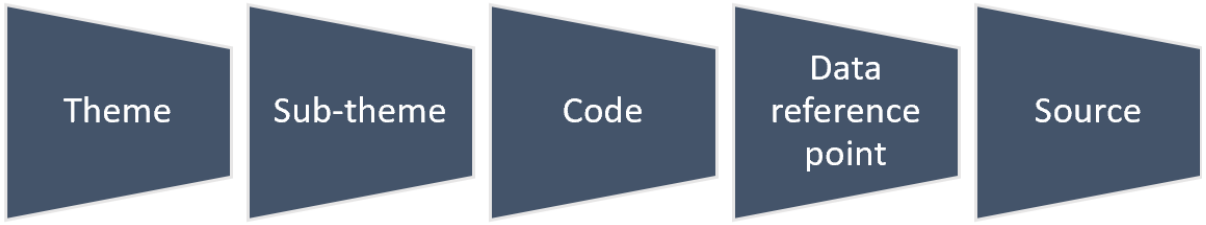


Figure 7

Use of Sticky Notes in the Process of Coding Themes

Following the thematic analysis, the papers were re-read to ensure all relevant data had been extracted. The themes and their data reference points were then collected to be summarised and reported.

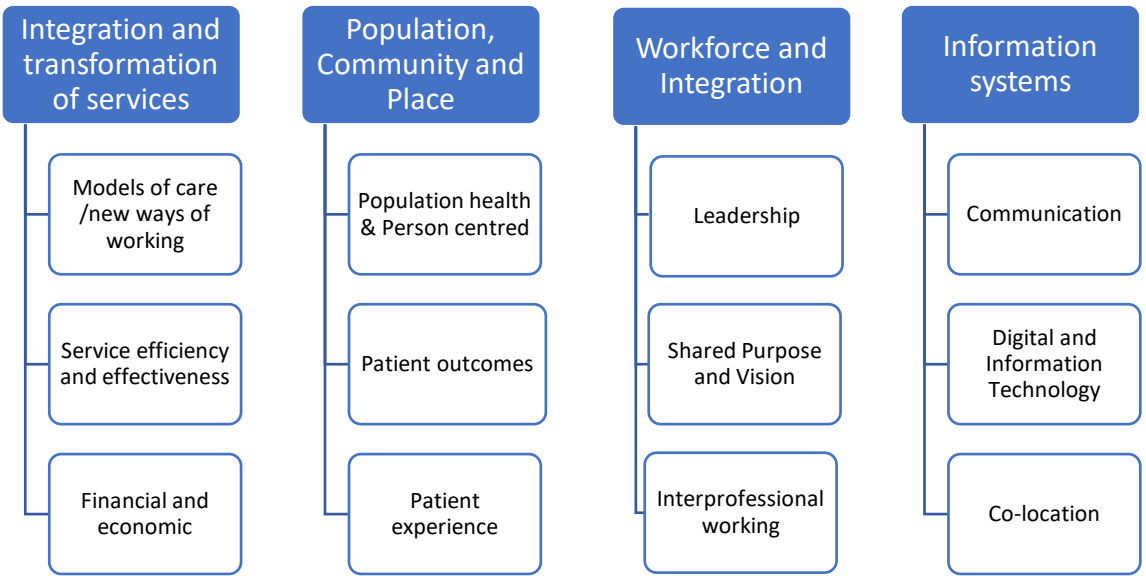
3.7 Collating and Summarising the Results

This review was designed to report on what is known about integrated care in adult health and social care services within England. It also considered implementation internationally and in devolved nations to reflect the differences, alignments, and interconnectivity within the process of integrated care.

The research and evaluation studies included one randomised control trial (Canadian), 21 qualitative studies with variable methodological quality, and six evaluations with variable methodological quality. The government and advisory papers developed by think tanks included research reports of mixed methodologies (n = 7), evaluations (n = 2), and other reviews (n = 4). The literature reviews included systematic reviews (n = 3) and literature reviews of other methodologies (n = 4). All included papers were coded and themed. Figure 8 represents the identified themes and their associated sub-themes, which will be explored and discussed in Section 3.7.1 to 3.7.5.

Figure 8

Themes and Sub-Themes Identified in Scoping Review



3.7.1 Findings

The following four sections present the results of the scoping review, centred around the four major themes identified in the review: integration and transformation of services; population, community, and place; workforce and integration; and information systems. Within each theme, several sub-themes are presented and explored.

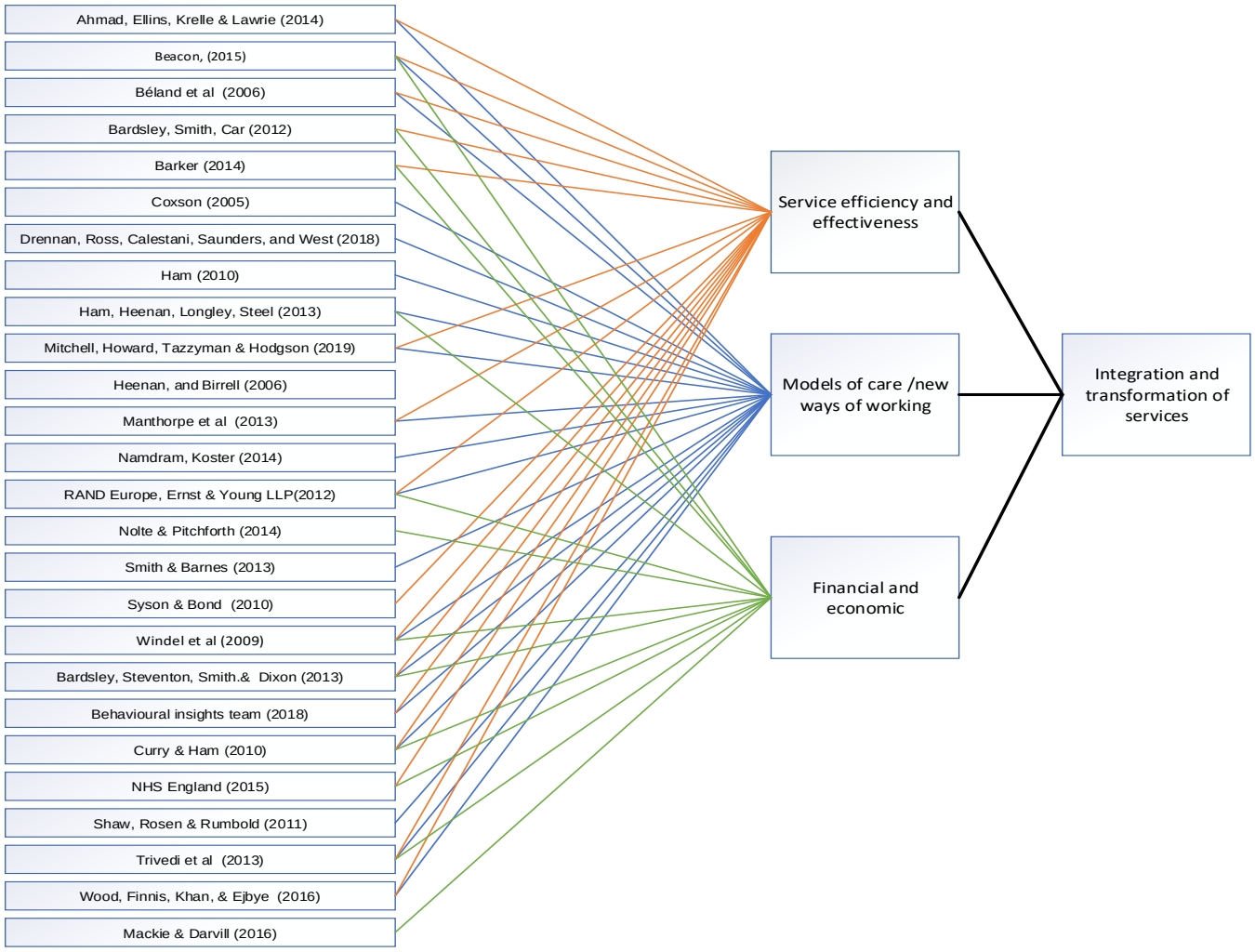
3.7.2 Integration and Transformation of Services

Twenty-six papers were included in the theme of transformation of services or a change in service provision, either as the direct topic of the paper or as part of the wider discussion of the impact of integrated care. This theme encompassed three sub-themes: new ways of working (n = 19), financial incentives and economic benefits (n

= 12), and service efficiency (n = 16). Figure 9 illustrates how the sub-themes were drawn from the 26 texts to build the overall theme.

Figure 9

Spread of Literature Within the Theme of Integration and Transformation of Services



The sub-theme of 'new ways of working' revealed a common consensus across all 19 papers that reported the need for new integrated approaches. The rationale for this was to ensure that services should be developed around people's needs, rather than the current definitional divides (Ham, 2010). Typically, the literature reported that integrating care requires changes to service provision, and that these changes have

the potential to improve processes and delivery (RAND Europe, Ernst, & Young LLP, 2012; Ham, 2010; Curry & Ham, 2010). In their advisory paper, Ham, Heenan, Longley, and Steel (2013) demonstrated the breadth of integrated care when they evaluated several programmes from across the UK, ranging from frontline programmes to whole-system integrations. Ham et al. (2013) highlighted a Scottish programme called Delivering for Health, which aimed to deliver a systematic approach to managing long-term conditions, including identifying those people at greatest risk of hospital admission, provision of earlier care to prevent deterioration, and equipping people with the skills to manage their own health (Ham, Heenan, Longley, & Steel 2013; Scottish Executive, 2005). While Delivering for Health is an example of a national programme, Syson and Bond (2010) presented a local pilot of an integrated care team within the city of Salford. Their study found that the introduction of the team led to improved services for citizens, users, carers, and other professionals, concluding that the introduction of integrated teams had led to improved access, experience, and delivery of services. Comparison of this national and local evidence identified a range of common themes but also identified an authoritative discourse that integrated care requires the development of new ways of working to deliver improvements.

Another large-scale evaluation by Bardsley, Stevenson, Smith, and Dixon (2013) presented results from 30 different integrated and community-based care sites (including integrated care pilots funded by the Department of Health). Their findings indicated that within these pilot sites, there were process improvements such as an increase in the use of care plans and the development of new roles. A national evaluation by RAND Europe and Ernst, and Young LLP (2012) provided a greater analysis of the Department of Health's integrated care pilots. The pilot sites were

implemented to develop a range of service changes and transformations to bring about more streamlined and integrated services. These changes included:

- Single point of access/referral, which simplified access for patients and provided more coordinated services;
- Key worker/case manager approaches across organisations, enabling greater coordination of services;
- Single pathways, where one assessment and plan were used by all care providers, facilitating improved communication.

The analysis concluded that while there were challenges involved in making judgements about heterogeneous and emergent activities within changing environments, the pilots demonstrated that integration was a way of managing the problems associated with specialisation, siloed working, and organisational variation.

The literature revealed how integrated care could deliver new ways of working; however, the evidence for the impact of the implementation of integrated care on the effectiveness (producing the intended or expected result) and efficiency (manner of delivery with the least waste of time and effort) was more mixed (Bardsley, Stevenson, Smith, & Dixon, 2013). A variety of measures of service efficiency in integrated care interventions were used in the various evaluations and reviews. It is noteworthy, however, that several of the measurements focused on the usage of secondary care (emergency attendance, overnight stays, and length of stay) and of primary care (GP attendance) (Bardsley, Steventon, Smith, & Dixon, 2014; Beacon, 2015; RAND Europe, Ernst, & Young LLP, 2012).

An example of changes in primary care is provided in Beacon (2015), who reported on the introduction of practice integrated care teams [PICTs] in Greater Manchester. Beacon's (2015) evaluation used a number of metrics, including emergency admissions, which saw a percentage reduction of costs of 22%, with cost savings in emergency admissions accounting for 96% of the programmes savings. Beacon's findings were also mirrored in other evaluations, such as NHS England's 2015 report on integrated care pioneer sites one year in. One pioneer site highlighted in this report was Penwith, which saw the number of people being admitted to hospital falling by nearly 50% and quality of life indicators increasing by 18%. Another example of improvements in service efficiency was provided by Windle, Wagland, Forder, D'Amico, Janssena and Wistow's (2009) review of the Partnerships for Older People Project [POPP]. The data analysed demonstrated the changing rates of service use and levels of cost. A significant finding of the review was reported in the context of older people at risk of admission, which after implementation of a POPP intervention saw a 50% reduction in the number of overnight hospital stays and visits to accident and emergency services. The evaluation estimated a mean per person cost reduction of £277 in measurements over a three-month period (Windle et al, 2009). A later report by Bardsley, Steventon, Smith and Dixon (2013) found that when comparison was made to matched control patients, there was limited evidence of a reduction in emergency hospital admissions associated with any of the four POPP interventions studied. In some cases, emergency admissions in the intervention group were higher than in the control group. These mixed findings on service improvements are also reflected in international data; Bardsley, Steventon, Smith, and Dixon (2013) assert that previous data from the US observed over several decades has shown a failure of complex social programmes to deliver an impact.

As the evidence of the impact of integrated care appears to be mixed, it is important to reflect on what is considered success and what measurements are used to define that success (Wood, Finnis, Khan, & Ejbye, 2016). Bardsley, Steventon, Smith, and Dixon (2013) report that there is no universal agreement on how to measure the impact of integrated care, but that there is a reliance on the use of key performance indicators [KPIs] such as emergency admissions, length of stay, and GP attendance. Furthering this idea, Nolte and Pitchforth (2014) highlight the difficulties in drawing conclusions about the economic outcomes of integrated care, because measurements are often hospital-focused and produce mixed findings that are not commonly quantified, making an overall assessment of the size of possible effects problematic. Mitchell, Howard, Tazzyman, and Hodgson (2019) discuss the use of KPIs and find that measures such as length of hospital stay and reduced hospital admissions may not be effective as they may not reflect what the integrated team is trying to achieve. This view is shared by Wood, Finnis, Khan, and Ejbye (2016), who assert that programmes require a commitment to the principles of person and community-centred approaches for health and wellbeing and need to demonstrate an ability to enhance the quality of people lives rather than rely on traditional outcome measures.

The focus on the cost and financial benefits of integration appears to be important in several ways, not least—as Mackie and Darvill's (2016) systematic review identified—in that NHS payment systems, such as payment by results and block contracts, do not incentivise the delivery of care in the community and therefore are barriers to the development of integrated health and social care. The significance of financial incentivisation was also highlighted by Curry and Ham (2010), who purport a requirement for alignment of financial incentives to avoid the perverse effects of fee-for-service reimbursement. There are further issues presented by Nolte and

Pitchforth's (2014) policy summary on the economic impacts of integrated care, which found that the financial impact tended to be mixed, and while there is evidence of the cost-effectiveness of selected approaches, the evidence for financial benefits remains weak and inconclusive.

While there appears to be a need to further develop the evidence base on financial impacts, the scoping review found evidence within existing research of the impact of changing financial models. Research from the Netherlands by Namdram and Koster (2014) championed a shift to the financial delivery model which enabled the Buurtzorg approach. This model included an average fee per hour and did not determine which level of staff delivered care. The study found that this payment method enabled innovation, as it freed up nurses to organise care that made sense to them and their clients. Namdram and Koster (2014) reported that this change in the financial approach enabled frontline workers to feel empowered to provide good quality, holistic care. Financial incentives and support for new integrated care projects were also cited in Bardsley, Smith, and Car (2012) in their evaluation of the first year of the Inner North West London Integrated Care Pilot, in which substantial financial and other support was made available. Financial incentivisation was viewed as a significant enabler for the pilot, as it aided investment in IT, pilot leadership, coordination of multidisciplinary groups, and project management.

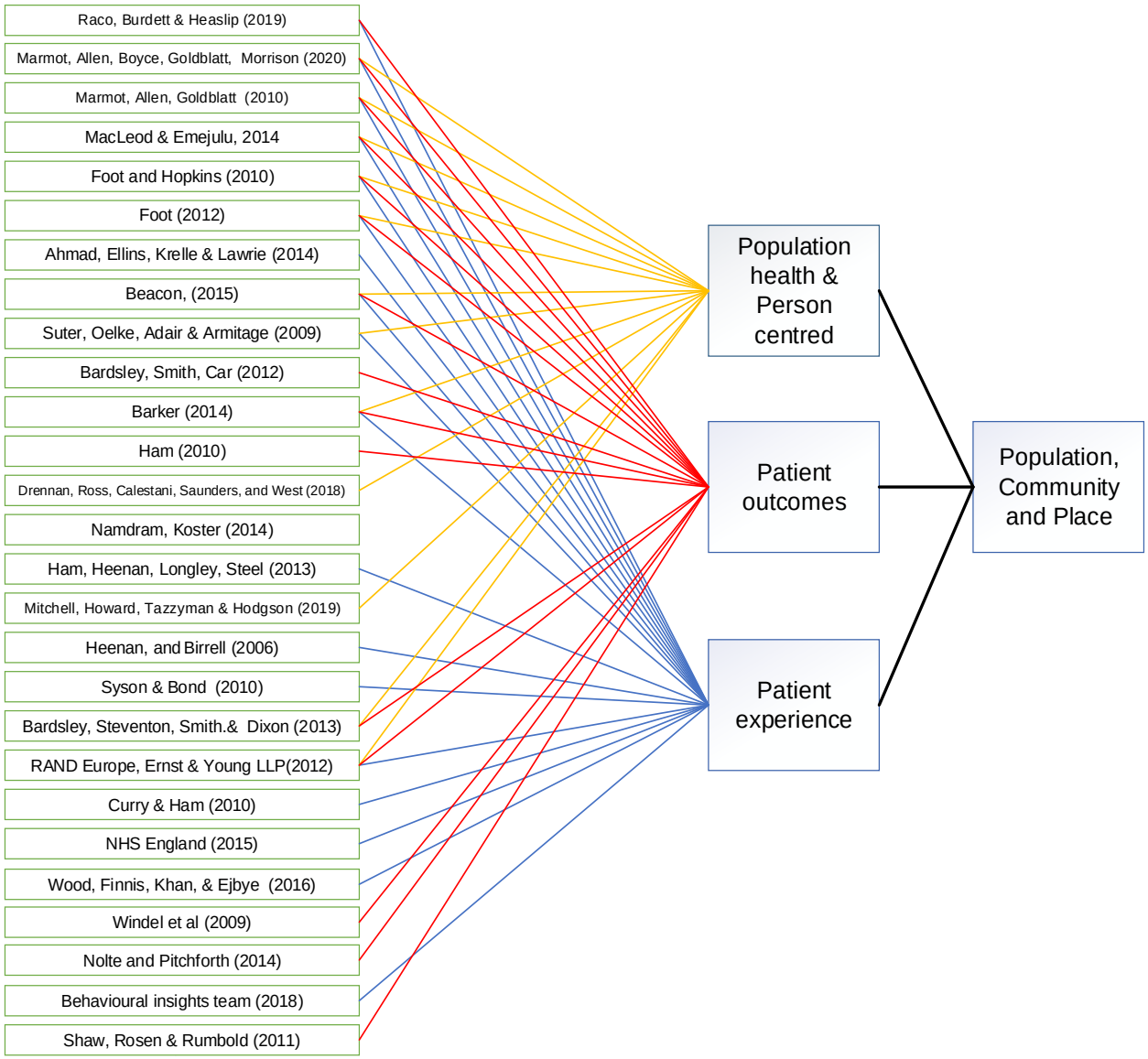
3.7.3 Population, Community, and Place

Out of the literature reviewed, a significant number of studies (n = 27) discussed population, community, and place. This theme centred on the role of integrated care in the development of services that were underpinned by the principles of population-based, community-based, and place-based health and social care (WHO, 2016). There were three main sub-themes, each represented by a substantial number of

studies: health and person-centred care (n = 17), patient experience (n = 12), and patient outcomes (n = 14). The development of this theme from its sub-themes is depicted in Figure 10.

Figure 10

Spread of Literature Within the Theme of Population, Community, and Place



The papers included within this theme were drawn from a broad spectrum of literature, including large-scale reports such as the Marmot report (Marmot, Allen, & Goldblatt,

2010), evaluations of programmes (RAND Europe, Ernst, & Young LLP, 2012), and literature reviews that focus on specific areas of care (Raco, Burdett, & Heaslip, 2019). Each paper within the sub-theme builds to provide an in-depth picture of the interlinking relationship between person-centred care and integrated care.

The Marmot Review (Marmot, Allen, & Goldblatt, 2010) and its subsequent 10-year update drew on a wide range of demographic data to outline the case for a dramatic shift in the societal perspective on health and social care. The five key findings of the 10-year examination of the original Marmot Review were that people can expect to spend more of their lives in poor health, that improvements in life expectancy have stalled, that the poorest 10% of women have seen a decline in life expectancy, that the gap between wealthy and deprived areas is increasing, and finally that place matters, with health being worse in the North East than in London, even in areas with similar levels of deprivation (Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020). Foot and Hopkins (2010) and Foot (2012) argue that the emphasis on 'deficit' models in health and social care, which focus on the problems and deficiencies in communities rather than on the assets, contribute to inequities in population health. One example provided is that deficit models lead to the designing of services to fix problems or fill gaps, rather than to empower people to be able to live healthier lives, and that this leads to communities feeling disempowered and dependent, with people becoming passive recipients of expensive services (Foot & Hopkins, 2010).

In contrast to traditional 'deficit' services, Ham, Heenan, Longley, and Steel (2013) and Suter, Oelke, Adair, and Armitage (2009) promote integrated care as a means of providing seamless care which is responsive to people's needs rather than being designed to serve providers. These papers explain that health care requires more than a simple one-size-fits-all approach. These views are reflected in Ahmad, Ellins, Krelle

and Lawrie (2014) who when discussing the need for person centred care stated that there is not one approach but rather there is a set of concepts that place the patient at the centre of their care, these include mutual agreement, self-efficacy, and unbiased information. Ham, Heenan, Longley, and Steel's (2013) advisory paper also explained that many of the integrated care programmes they reviewed sought to redress the balance between user and provider and to reimagine service delivery in a more person-centred way. This rebalancing included greater emphasis on the role of the GP, prevention programmes for obesity and smoking, and personalisation of care delivery. Another example of the shift to a more person-centred approach can be seen in Beacon (2015), who described the principles behind the practice of integrated care teams as grounded in the idea that patients should be empowered to self-manage their conditions, understand their needs, and have a key role in managing their own health and health care. Within the PICT model, there was also an added emphasis on professionals building stronger links with the community and volunteer sectors (Beacon, 2015). In addition, Raco, Burdett, and Heaslip's (2019) systematic review provided evidence of the importance of taking a person-centred care approach in integrated palliative care to enhance the experience of patients and their families at the end of life. They assert that an integrated palliative model of care is supportive of the delivery of person-centred care to older people who are dying, in a range of different settings.

Wood, Finnis, Khan, and Ejbye (2016) state that person- and community-centred approaches to health and wellbeing can potentially improve experiences and outcomes for individuals and support the development of strong and resilient communities. Barker's (2014) policy document 'A new settlement for health and social care' stated that there is already good evidence that integrating care produces better

services and a better experience for care users and patients. These findings are also reflected in the results of a pilot study on the implementation of a Dutch Buurtzorg model of district nursing in the UK. Drennan, Ross, Calestani, and West (2018) confirmed that the introduction of neighbourhood nursing that was proactive and responsive to patient needs enhanced patient experience. An evaluation by RAND Europe and Ernst, and Young LLP (2012) corroborated this in finding that staff reported positive feedback from patients through letters, phone calls, and on websites. These findings were given further validity as similar experiences were reported by NHS England (2015), which found that many pioneer sites were able to demonstrate that they had improved patient experience of care through the integration of services. Considering patient experience from an international perspective, Nandram and Koster's (2014) study in the Netherlands found that the introduction of the Buurtzorg model enhanced patient experience by changing the paradigm of nursing care from one based on targets and pre-determined time slots to a more patient-centred approach.

Alongside experience of care, there was substantial attention across the reviewed papers on the impact integrated care can have on patient outcomes. Several of the evaluations in the review were conducted when programmes were in early stages of implementation (two years or less), and therefore could not produce significant findings on patient outcomes. This limitation was observed in Bardsley, Smith, and Car's (2012) evaluation of the North West London integrated care pilot (ICP), which was designed to improve the coordination of care for people over 75 years of age and for adults living with diabetes. While the evaluation acknowledged that after only one year it was too early to explore changes to patient outcomes, they found that there was an increase in the use of care plans for patients with dementia and an increase in

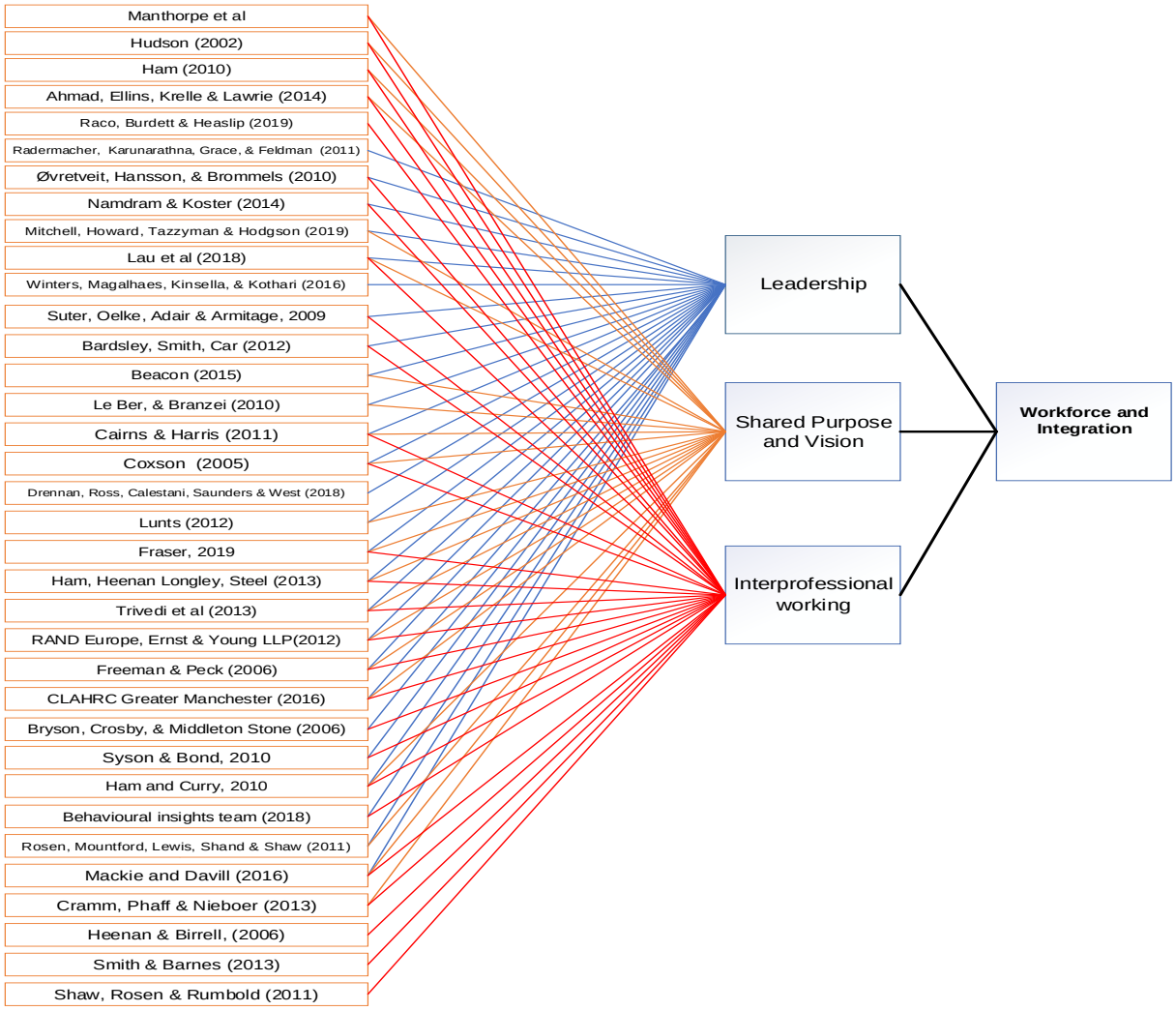
testing for people with diabetes. Syson and Bond (2010) were also able to identify process-level changes; however, they were not able to identify changes in patient outcomes such as a reduction in hospital admissions at the time their evaluation was conducted. At the time of this review, it is therefore difficult to establish the impact of integrated care on patient outcomes due to the need for more longitudinal studies within the field.

3.7.4 Workforce and Integration

The effect on the workforce was a recurrent theme in the literature reviewed, present in 35 papers. The theme was comprised of three sub-themes: leadership (n = 25), shared purpose and vision (n = 21), and interprofessional relationships (n = 27) (see Fig. 11).

Figure 11

Spread of Literature Within the Theme of Workforce and Integration



In an umbrella review, Winters, Magalhaes, Kinsella, and Kothari (2016) found that effective leadership is an integral element of cross-sector service provision, a view supported by Mackie and Darvill (2016), whose systematic review found that leaders and managers play a key role when implementing integrated care. Bryson and Middleton Stone (2006) add to this point in maintaining that cross-sector collaborations are more likely to succeed when there is one or more linking mechanism, such as powerful sponsors or high-level leadership.

While the previous studies have highlighted the general need for strong leadership, in their paper for the Nuffield trust, Rosen et al (2011) emphasised the importance of active medical leadership with a remit for developing care standards, resources, and raising awareness about expected standards of practice. Furthermore, they commented that these medical leaders also need to have the ability to 'win the hearts and minds' of frontline staff. This is a view supported by Suter, Oelke, Adair, and Armitage (2009), whose literature review found that physicians need to be effectively integrated at all levels and have leadership roles in the design, implementation, and operation of integrated health systems. While these papers highlight medics as important leaders, others have noted that the hierarchy between different professions (and within them), especially in medicine, has the potential to exacerbate difficulties in interdisciplinary work, with professions such as nurses, occupational therapists, and physiotherapists feeling inhibited in expressing their opinions and feeling that they cannot challenge doctors within integrated teams (CLAHRC Greater Manchester, 2016). In addition, Mitchell, Howard, Tazzyman, and Hodgson (2019) described the 'social care vs. health service issue', identifying a perception among social care staff that they were dominated by the much larger NHS (health) sector, and this impacted how they felt about their role in integration.

A number of researchers have examined the relationship between integrated care and organisational culture and leadership (Fraser, 2019). For example, Beacon (2016) noted that strong senior leadership had been critical throughout implementation of the PICT project, as it enabled the maintaining of momentum and the formation of trusted ongoing relationships, whereas Mitchell, Tazzyman, Howard, and Hodgson (2019) emphasised a lack of distributed leadership and an unwillingness to delegate as having a negative impact on integration. Additionally, they found that leadership was

described as requiring courage and risk-taking, since integrating health and social care represents a move into uncharted territory. Building on these perspectives, Ham (2010) considered a more international perspective in highlighting that high performing health organisations in the US, such as Kaiser Permamente, have gained successes from investment in the development of leaders in the health community.

Strongly linked to the sub-theme of leadership is the sub-theme of shared purpose and vision, which was present in 21 papers. Throughout these papers, all leaders at all levels were considered to have a role in building a shared purpose and vision within integrated teams (RAND Europe, Ernst, & Young LLP, 2012). Integrated care by its very nature brings together a range of organisations, teams, and individuals, many of whom have different histories, cultures, and professional values (Ham, Heenan, Longley, & Steel, 2013; Hudson, 2002). It has been emphasised that for integrated care projects and programmes to be successful, they need to have a coherent shared purpose and vision. Ham (2010) stated that change will only happen and be sustained through the commitment of the clinicians and managers involved in delivering the care, as they are the ones who will make the vision of an integrated system a reality. Beacon (2016) builds on the need for a shared vision by stating that it is necessary to establish a common need amongst partners, as this has been important in enabling shared risk, with a recognition of shared benefits across the system. Winters, Magalhaes, Kinsella, and Kothari (2016) support Beacon's (2016) assertion, stating that striving for a shared vision of care across sectors is integral to the success of integration, since for arrangements to be successful, there must first be a perception of a need for the integration. Mitchell, Howard, Tazzyman, and Hodgson's (2019) study found that the establishment of a shared purpose is a key enabler supporting integration. They advance this view by stating that it is vital that this common understanding remains

embedded for teams to be able to continue to progress. Heenan and Birrell (2009) and Curry and Ham (2010) both discuss the well-established integrated system in Northern Ireland as demonstrating that there are practical methods for increasing interdisciplinary trust and respect in building a shared vision. An example of the approaches adopted in Northern Ireland is that leadership roles are not limited to single professional groups. This enables managers not to be constrained by artificial boundaries between health, social care, and profession as they develop an understanding of each other's roles.

Beacon (2016) adds a cautionary note in how shared purpose is established, recognising that it is important for core professionals to develop trusted relationships and work together; however, they must also acknowledge that the role of the community and volunteer sector has been undervalued. Shaw, Rosen, and Rumbold (2011), Rosen et al (2011), and RAND Europe, Ernst, and Young LLP (2012) all shine a light on the inclusion of service users, who are integral to integrated care, emphasising that there is a need for any shared vision to include their perspective; inclusion of the service user will help build staff commitment and a strong sense that integration is doing the right thing.

Interprofessional relationships formed a strong sub-theme, appearing in 28 papers. Local-level interpersonal professional relationships, synergy, and identity were all identified as being important across the literature. Cairns and Harris (2011) assert that ensuring all partners can contribute, be valued, and bring influence is a significant component in building and maintaining successful partnerships. Integration between large public-sector organisations can be viewed as an extraordinary undertaking, involving both structural and cultural mergers and transformation (Cramm, Phaff, & Nieboer, 2013). However, as qualitative studies by Cairns and Harris (2011),

Radermacher, Karunarathna, Grace, and Feldman (2011) and Mitchell, Howard, Tazzyman, and Hodgson (2019) have found, it is often interpersonal relationships within organisations that have a substantial effect on the outcome of integration. Fraser's (2019) study on interprofessional working supports these other studies, finding that organisational integration strategies often do not lead to improved collaboration at the interface of care delivery.

The impact of professional identity within integrated services requires consideration, as observed in work by Cairns and Harris (2011) and Lunt (2012). They identified the importance of 'human factors' within integration, which were viewed by participants as pivotal to success or failure. Le Ber and Branzei's (2011) longitudinal narrative study identified that relationship challenges and conflict within cross-sector partnerships and integration are caused by the divergent expectation of value creation across the sectors. They reported that while partners depend on each other for success, they often move forward through a process of relying on each other's interpretations while retaining their own standpoint, preventing them from 'locking step'. Across the research there appears to be a consensus that supports the idea of professional identity playing a part in the building of relationships within partnerships and is often a challenge to successful implementation. This point is embodied in Mitchell, Howard, Tazzyman, and Hodgson (2019), where a core and recurrent theme in their interviews was professional identity and boundaries—viewed as a critical aspect of integration that can hinder progress.

Relationships at all levels of a partnership appear to be intrinsically linked to successful and sustainable outcomes. Cramm, Phaff, and Nieboer (2013), Cairns and Harris (2011), and Radermacher, Karunarathna, Grace, and Feldman (2011) all discussed the inherent and multiple complexities, conflicts, and contradictions within cross-sector

alliances and partnerships. One area identified was that while there is often a positive narrative of partnerships being for the 'common good' and a potential means of increasing democratisation, these actions did not always equate to the bringing together of disparate groups to create a new group.

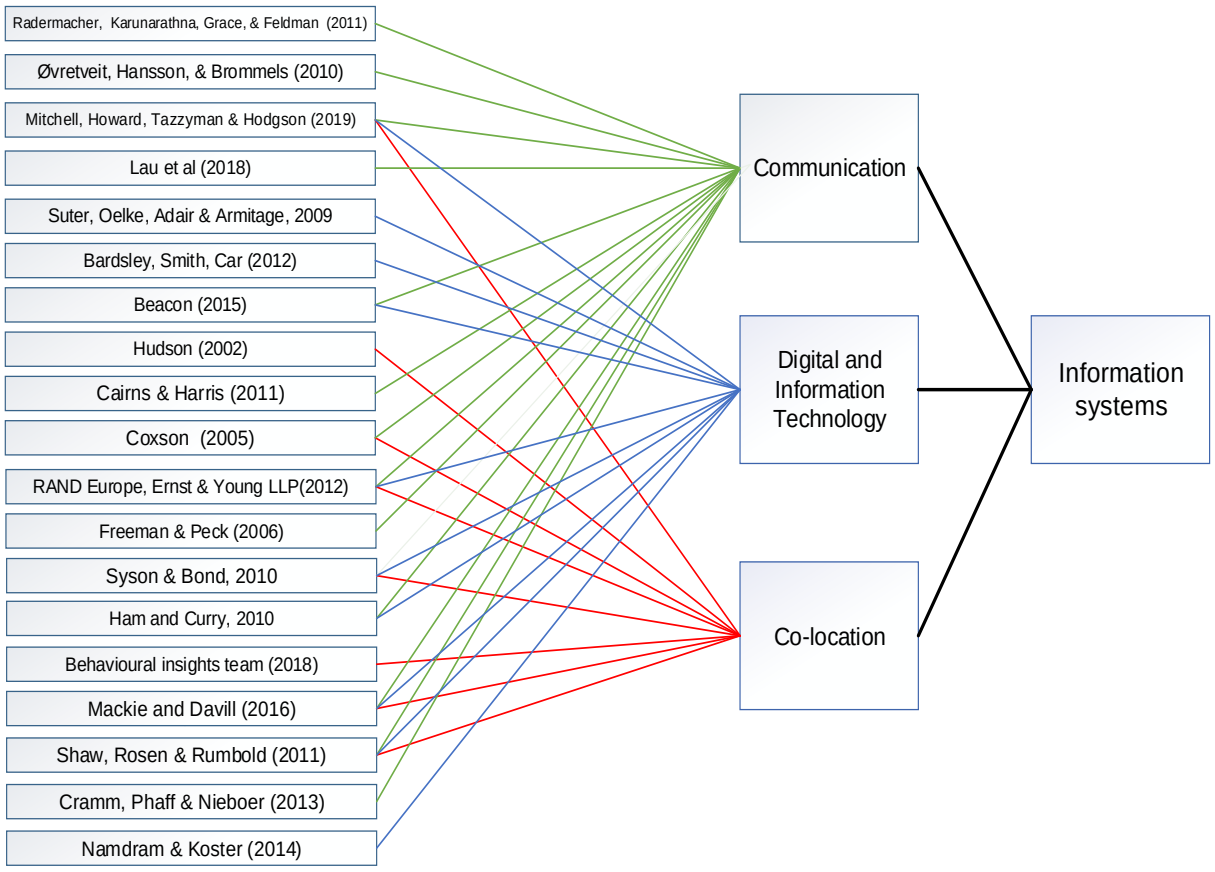
Integration could be viewed as a unique field in which the actors' relationships influence each other and the outcomes of partnerships. Several studies have shed light on the theme of relationships. Hudson (2002) found that there were 'territorial' disputes as different occupational groups vied for position within the partnership. These territorial issues are of interest when considering Smith and Barnes' study (2013), which found that the very complex nature of these partnerships makes them challenging and often leads those within the system to have a reduced understanding of the ambition of the integration or partnership. The ambiguity may then provide space for the fault lines of emergent partnerships to appear and the fragile new relationships to break down.

3.7.5 Information Systems

The theme of information systems was present in 19 papers and incorporated three sub-themes: communication (n = 14), digital IT (n = 10), and co-location (n = 8). While information systems appeared fewer times across the papers as a whole than the other three themes, this theme was a significant element of the findings in the papers in which it was discussed. Therefore, information systems developed into a relevant theme of its own (see Fig. 12).

Figure 12

Spread of Literature for Information Systems



The research analysed in this review demonstrate that communication between multi- and inter-sector partners is a complex process involving multiple negotiations and constructions (Cairns & Harris, 2011; Øvretveit, Hansson, & Brommels, 2010; Freeman & Peck, 2006). As previously discussed, power within integration is often unequal and problematic, and there can be conflict about who determines the norms of the communication, who enforces them, and how communication norms affect and influence the ability of a partnership or integration to function (Cairns & Harris, 2011). Fraser (2019) and Cairns and Harris (2011) have observed a further complication in cross-sector partnerships and integrations, which centre on individuals' and groups'

mistrust, tensions, lack of understanding of roles, and negative stereotyping of each other. Both studies concluded that these behaviours lessened the ability of a partnership to deliver successful outcomes. In contrast, Mackie and Darvill (2016) explain that communication partially contributed to the success of integrated teams where strong relationships are created. Beacon (2016) and Fraser (2019) also highlighted sharing of information as an important priority for teams in building trust and strong communication, to enable coordination and continuity of care and joint collaboration. Mitchell, Howard, Tazzyman, and Hodgson (2019) drew together the concepts of communication, shared purpose, and leadership, maintaining that often, the communication of a vision of the impact of health and social care professionals working together much more closely relies on effective leadership.

The various ways in which teams communicate is considered important in a number of studies. The role of digital and information technology tools to aid and develop communication is identified as an important contributor to successful communication (Curry & Ham 2010). Curry and Ham (2010) draw on examples from the American system to demonstrate how IT systems facilitate the timely and efficient flow of information and are an essential enabler of integrated care. Their report draws attention to the example of the Mayo Clinic, which has electronic medical records that are accessible by all clinicians at every site to enable positive working relationships and an integrated approach. In contrast Mitchell, Tazzyman, Howard and Hodgson (2019) found that a lack of coherent, integrated technical information systems covering health and social care hinders integration of teams and professional groups. Syson and Bond (2010) also found that improving staff access to shared information, knowledge of service provision, and rapid responses improved practice and avoided repetition and frustration for users/patients. Other benefits of improved IT systems

were witnessed by Bardsley, Smith, and Car (2012), who found that an IT tool allowed a pilot programme to track and capture health and social care usage improved service delivery . This was a positive development, as this had not been possible before and was vital to the new care planning approach. In similar findings, Syson and Bond (2010) noted that direct access to IT systems had significantly improved patient information, decision making, and risk management.

Alongside the digital approaches, eight papers discussed the importance of the physical location and co-location of teams as an aid for integrated care. The Behavioural Insights Team (2018) was commissioned to present a report on how best to support the introduction of integrated care services. One of the recommendations they presented pertained to the benefits of co-located teams. The report concluded that co-location supported a focus on team-building, group cohesion, and team trust, which were considered to be particularly important in integrated care teams because of their multi-professional nature. The conclusions of the Behavioural Insights Team (2018) are supported by Mackie and Darvill (2016), whose systematic literature review found that co-location of staff was one of the most common themes to emerge in their data and was identified in five of the seven studies they reviewed. Their findings confirmed that co-location is viewed as an important factor in enabling integration and is necessary for developing relationships that are required for the formation and sustainability of new teams (Mackie & Darvill, 2016). Syson and Bond (2010) and Mitchell, Tazzyman, Howard, and Hodgson (2019) both found that co-location of staff enables more timely and appropriate communication concerning patient/user's care, with proximity being reported as a core component of the new team. Furthermore, they explain, co-location also improves collegiality, creating informal networks which spread tacit knowledge across the system. The study by RAND Europe Ernst, and

Young LLP (2012) concurred that while co-location was not essential for successful integration, there were clear signs that it was advantageous to the development of integrated care.

3.8 The Importance of the Proposed Research

The scoping review highlighted a large range of documents that demonstrated what is currently known in integrated health and social care. The understanding of the state of knowledge enables the problematic to be understood within its larger context, drawing attention to wider themes existing within the literature, while maintaining an awareness of the lives and actualities of those identified as part of the problematic (Smith, 2005).

The current study was conducted within the unique situation of Greater Manchester as a first devolved province of the UK with control of its own health and social care budget. The impact of devolution within Manchester has potentially wider implications, both nationally and internationally, as it represents a new model of health and social care delivery and has also become a test case for the implementation of integrated care. While, there have been a number of evaluations conducted within the Greater Manchester area (e.g., Beacon, 2015; Mitchell, Howard, Tazzyman, & Hodgson, 2019; Syson & Bond, 2010). The methodological approach adopted within this study offers the opportunity to understand the voice and experience of those tasked with delivering integration from their own standpoint, as a group within the organisation that was marginalised by the organisational process (discussed in Chapter 4).

While the study focuses on the standpoint of one group, the importance of the proposed research and its original contribution to knowledge has broad potential, since integration is currently one of the most important and widespread health and social

care policies. Internationally, the WHO strategy for integrated care (2016) and the WHO's Declaration of Astana (2018) advocate the widespread adoption of policies that prioritise, promote, and protect people's health and wellbeing, at both population and individual levels, which requires more integrated health and social care systems. Nationally, the 'Five Year Forward View' (NHS England, 2014a) and 'Long-Term Plan' (NHS England, 2019a) lay out a consistent vision of more integrated services across health and social care systems.

This study's focus on how people achieve integration is another potential original contribution to knowledge. This is important, since the scoping review has demonstrated that people are at the core of integration, and many of the pitfalls, barriers, and successes relate to how people communicate, work, and interact together (Cains & Harris, 2012; Lunts, 2012). This study adds to the previous body of evidence but reflects the current agenda of integrated care at the time of writing.

The original research problem was grounded in the researcher's experience of working within the implementation of an integrated health and social care organisation. Undertaking this review then enabled the establishment of a wider and deeper understanding of the context and social organisation of partnerships and integration. Therefore, preceding formal fieldwork, the research aim was revisited and reflected upon, which led to development of the following problematic:

> The research intends to explore how neighbourhood team members experience the transition from traditional health and social care teams to integrated care systems, within a defined health and social care economy.

3.9 Chapter Summary

The themes developed within the scoping literature review (Chapter 3) combined with the policy review (Chapter 2) enable the concepts of integrated care to be considered within the context of the problematic. To shed light on what is already known in the area and to consider different kinds of knowing and how they impact the positionality of the researcher who sits between what is known and spoken in the literature and what is expressed, known, and experienced within local spaces (Campbell & Gregor, 2002). The scoping review as part of the wider reflective journey enabled literature to be considered as part of what Campbell and Gregor (2002) describe as the 'contested terrain of knowledge' which was an important consideration within this IE research.

Chapter 4. Methodological Approach

4.0 Chapter Introduction

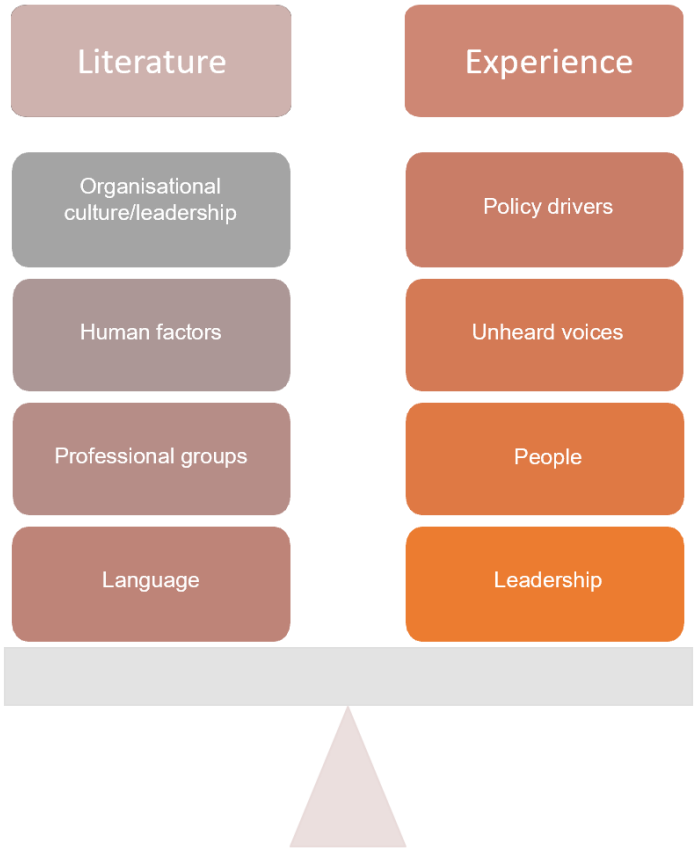
This chapter details the emergence of the research problem, the rationale behind the selection of the methodology, the theoretical underpinning of the study, and the approach to reflexivity. As part of the preparation of the research design, potential methodologies were analysed by considering their ontological and epistemological standpoints, their applicability to this study, and any adaptations that would be required. This analysis resulted in the selection of institutional ethnography as the approach adopted for the study. Following the outline of this methodological approach in this chapter, Chapter 5 details the methods as applied to this study.

4.1 Research scope and focus

The scoping review presented in Chapter 3 exposed several potential problems and influential factors within the development of integrated care systems that were considered alongside local experience in formulating the purpose of the study. Several features transverse the literature and personal experience (see Fig. 13), one of which was significantly prominent across both areas: the influence that people have on the success or failure of integrated care implementation.

Figure 13

Areas of Intersection Between Evidence from the Literature Review and Prior Experience



In its preliminary stages, the study's purpose began to coalesce around how people experience integration. The main point of interest was the transition from traditional team structures to an integrated care system and how this was enacted locally. The second area of significance was the wider factors of integration, including policy, economics, and organisational structures. These external factors were of interest as they had a considerable influence on the experience of teams and were drivers of change, highlighting the need for a methodology that incorporated people's local experience and the coordinating influences of external factors. A final consideration

was the need to ensure that the development and implementation of the research methods would result in findings which were relevant to the organisation, to external parties, and—importantly—to the participants, thus aligning the research process with the principles of a professional doctorate (Morley & Petty, 2010).

4.2 Aim and Objectives

The aim of the study was to produce a faithful representation of the experiences of an integrated neighbourhood team and to develop an understanding of the relations of ruling within the wider organisation. More specifically, the main objectives were the following:

- To describe and compare team members' experiences of the transition
- To identify and interpret how work was undertaken during the transition to an integrated neighbourhood team from the perspective of the team members
- To establish the current factors that influence the ruling relationships within integrated care systems

4.2 Setting, Field, and Case

There are three key spheres of the research to consider: the setting as the wide external institutional lens; the field in which the research took place; and the case within the organisational field (see Fig. 14). Settings are not merely naturally occurring phenomena; they are constituted, their boundaries are not fixed, and they are maintained or shifted through cultural definitions and social strategies (Hammersley & Atkinson, 2007; Sangasubana, 2011). This mutability of setting is of importance to this

study, as the integration process includes the destabilising of one setting to allow for the construction of another, encouraged by external political and social determinates. Therefore, the setting—the health and social care economy—itself was in a state of flux during the research.

The field of study, described as the organisation, sparked initial curiosity because it was where the foreshadowed problems emerged. The organisation under study was a forerunner in the development of integrated care systems within England and included the NHS Trust, council services, a clinical commissioning group, and members of the volunteer, community, and faith sectors. The amalgamation of numerous individual organisations (formally and informally) into an integrated health and social care system was complex and raised the question of how exactly integration would happen.

Since it would not be feasible to provide an exhaustive account of the organisation, a local team was selected as the case within the field to allow an in-depth exploration of the foreshadowed problem (Hammersley & Atkinson, 2007). The selection of the case arose from consideration of the field of study and the standpoint group. The design of the study recognised that a key objective of a professional doctorate is to make an impact and provide an original contribution to knowledge. To ensure this was achieved, the study was limited to the selected case (one neighbourhood team) while acknowledging the wider context.

Figure 14

The Setting, Field and Case

The integration process took place within the organisation as the field, but this process was not separate from the larger setting of the health and social care economy. Whilst considered external in many ways, the health and social care economy was never truly external, as its influence could be seen in how the organisation adopted, modified, and invoked ideas. This interplay was seen in text and documents that were guiding influences governing the direction of the transformation within the organisation and within the team selected as the case.

4.3 Selection of Methodological Approach

Following the establishment of the point of inquiry, the focus then moved to the development of the methodological approach (Creswell, 2013). Jeon (2004) asserts that a researcher should base the selection of a research methodology on the research question and the aims of the research, with attention given to the feasibility and

applicability of the methodology in relation to the phenomena of interest and the resources of the researcher. While Jeon has been more closely related to grounded theory, the assertion remains useful. Prior to the selection of the methodological approach, the ontological and epistemological assumptions were explored. This section presents various factors that influenced the selection of the research approach.

4.3.2 Time

The study commenced just prior to the co-location and formation of the new team and was interested in the experiences of the team's journey through the transitional period. Hammersley and Atkinson (2007) explain that while time may appear as an obviously important aspect of social experiences, it is often neglected. Time was particularly relevant within the selected case, since integration by its very nature brings together groups and, regardless of its perceived virtues, can often be a lengthy and convoluted journey (Cairns & Harris, 2011). The epistemological impact of viewing integration as a journey was that the selection of a methodology needed to reflect the subjective interpretations of participants as their social context was changing (Keele, 2010).

Two aspects of time were considered: the duration of the study and the time required within the organisation to gain data that reflected the temporal variation of integration. As the study formed part of a professional doctorate, there were time constraints that required mitigation through the careful selection of the methodological approach. The time available for data collection was also a factor in the selection of methodology, as any attempt to represent and bring meaning to the experiences within a specific team required adequate coverage (Hammersley & Atkinson, 2007). However, as Hammersley and Atkinson (2007) further explain, it would be impossible (and even undesirable) to conduct fieldwork 24 hours a day, and so there is necessarily an

element of sampling in data collection. They concluded that quality is enhanced by the production of high standards of fieldnotes, memoranda, and reflexive notes on selected data. The examination of time as a factor in the research approach brought further clarity to the focus of the study and assisted with the definition of the case under investigation. The research would move to focus on the specific period of early integration while acknowledging that the journey would continue after the completion of the study.

4.3.1 Context

The research problem existed within the naturalistic setting of the integrated care organisation, and the research question was interested in the experiences, social behaviours, actions, and interactions of team members within the newly integrated team. The starting point for the selection of the methodological approach was to reflect on the research paradigms and their suitability to the phenomenon of interest. The primary goal of this study was to make sense of the experience of neighbourhood teams within their natural setting, to seek understanding of their world through their shared meaning. The study, therefore, closely aligned an interpretive approach which, if adopted, would enable the social context and subjective interpretations of participants to be studied. However, the social context was potentially vast, and as Hammersley and Atkinsons (2007) assert, producing a detailed account of a whole setting is rarely possible. Therefore, a concise, manageable, and appropriate case was selected, and one neighbourhood team became the focus of the study.

4.3.3 People

The scoping review drew attention to integration of services as a human endeavour that affects and is affected by the people tasked with implementation (Bryson, Crosby, & Middleton Stone, 2006; Cairns & Harris, 2011; Coxson, 2005; Mitchell, Howard,

Tazzyman, & Hodgson,2019). Thus, team members were understood not as objects within the study but as agents who actively constructed their politics, societies, and cultures. This perspective was important to the study as people are both influenced by and influence the environmental context in which they exist (Leavy, 2014; Keele, 2010). Consequently, the selected methodology had to focus on the human nature of integration.

4.3.4 Marginalised Voices

The foreshadowed problem was that there was a disconnect between managerial rhetoric and unheard voices of team members. Standpoint epistemology, which is central to IE and places the relationship between knowledge and politics in a central position, states that different socio-political arrangements affect the production of knowledge (Harding, 1998, 2007). Smith (1987) asserted that the very systems used to create knowledge are systems of control that do not reflect or represent the voices of the marginalised. Standpoint epistemology had a direct influence on the selection of the research methodology, as the research aimed to understand and give voice to experiences of neighbourhood teams in the acknowledgement that those teams may be marginalised by the process of integration (Smith, 2005).

4.3.5 Written communication

Written communication is important in integration, as the written word enables the passing of information across multiple organisations, continuously and simultaneously (Smith, 2005). Walby (2007) described textual language as the discursive, managerial, and professional forms of governance or relations of ruling that can control and coordinate. During integration, as local groups (staff teams, community groups, and patients) were brought together, they used the written language of integration in several ways, including to rewrite, subvert, and impose their agency on to the original

message. It was, important, therefore, to use a methodology that enabled the exploration and examination of the influence of written texts on the experience of transition.

4.3.6 Selection of IE Approach

The identification of a foreshadowed problem, the scoping review, and the factors discussed in this section informed the selection of IE as the methodological approach, because it enabled an observational approach within the naturalist setting, with a focus on the voice of the participant (Smith, 2005). A unique element of this approach is that it includes exploration of the influence of texts as relations of ruling that influence the local from an external position.

4.4 Research Design and Theoretical Underpinnings

This section outlines the research design, including identifying the principal characteristics of the selected design, the ontology, epistemology, and overview of methodological adaptations made. The following section records the theoretical underpinnings of the research, making clear the key influences within the methodological approach.

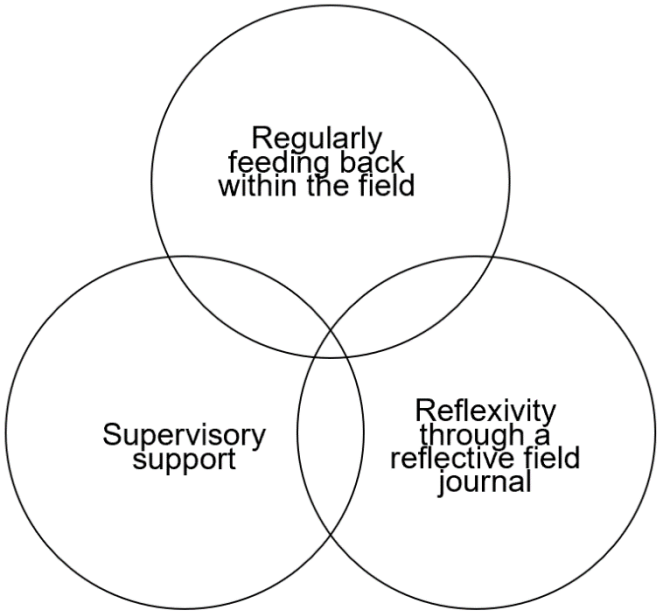
4.4.1 The Role of Conceptual Frameworks in IE

Before adopting a conceptual framework, it was important to outline the methodological challenges faced in the research. Smith (2005) argued that the ‘clamping on’ of conceptual frameworks to institutional ethnographies can lead to the framework determining how the ‘actual’ will be managed, warning that these frameworks can then constrain and dominate the selection and interpretation of the data. Hammersley and Atkinson (2007) similarly warned that while philosophical approaches are useful, it would be a mistake for a study with an ethnographic

approach to acquiesce or force itself into only one theoretical framework. However, there are also dangers associated with entering the field without an exploration of underlying concepts and theories, especially for a novice researcher. The inherent risk was misunderstanding the concepts that were at play and thus failing to faithfully represent the local area. To ensure alignment with the methodology and in acknowledgement of the positionality of the researcher, steps were put in place to ensure that the conceptual framework did not become dominant in the selection and interpretation of data (see Fig. 15).

Figure 15

Steps to Prevent the Dominance of Conceptual Framework



Implementing these three overlapping steps ensured that there was a cautious approach to the development of the conceptual framework, including a mindfulness of

and sympathy toward the overarching methodological approach of IE, but also an acknowledgement of the benefits of a supportive conceptual framework.

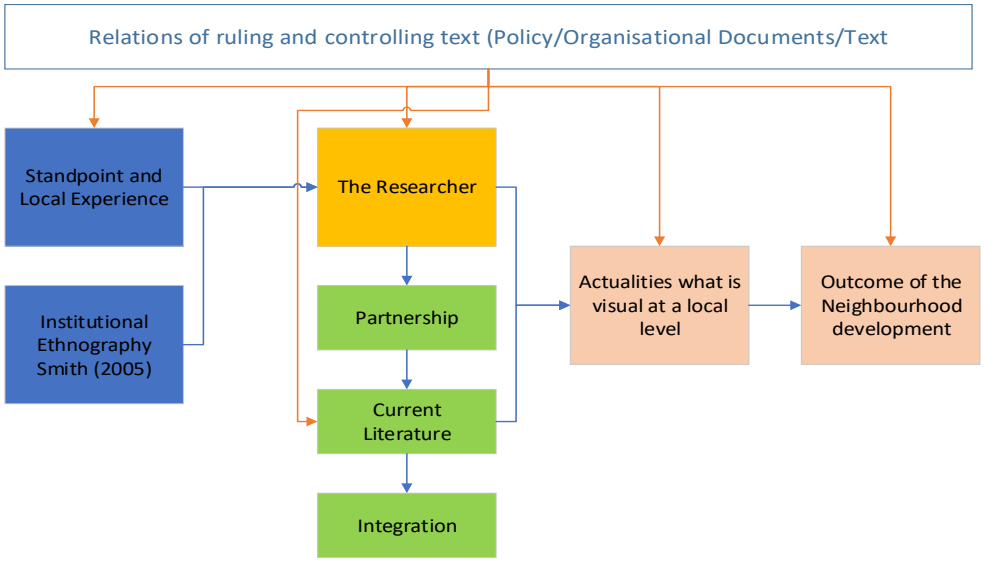
4.4.2 Conceptual Framework

The conceptual framework adopted (Fig. 16) provided a definition of the concepts within the field and framed the theoretical lens through which these concepts were viewed. The aim of the conceptual framework was to outline the theories, concepts, assumptions, and beliefs that supported and informed the research. The development of the conceptual framework began with the experience of integration. However, it was the literature that highlighted the paradoxical and complex nature of integration. During the development of the framework, concepts and theories intertwined and often appeared to mimic each other's attributes.

The framework influenced fieldwork by acting as a guide to ensure the research remained centred in the actualities of the participants, while always acknowledging the influence of the relations of ruling on the research.

Figure 16

Conceptual Framework



Spanning the whole framework is the concept of relations of ruling and textual mediation within local settings (the overarching conceptual framework should be read from left to right in Fig. 16). The framework highlights the two major theoretical influences on the study, IE (Smith, 2005, 2006a) and the standpoint group (Smith, 2005). Moving across from the theoretical lens is the researcher's perspective based on experience, interests, values, and beliefs, the literature on integration and the current knowledge base, followed by the actualities of the local area and what is visible within the ruling relations. Finally, leading to the outcomes of the integration process, the lines in the framework depict connections between each of the major concepts and draw attention to their interconnectivity.

4.4.3 Standpoint Group

The conceptual framework was developed after the literature review and prior to the commencement of data collection in the field. The framework was then revisited at the end of the first stage of data collection, and the standpoint group was added. This addition was made because the standpoint group were central to the study design and an important methodological feature.

Standpoint is the central epistemological feature of IE (Walby, 2007; Smith; 2005, 2006a). Smith (2005) explained that standpoint politic refers to the intent of creating knowledge from people's perspective to demonstrate the nature of macrosocial powers and processes that shape their lives and work. Taking the aforementioned view does not reject the principle that several predetermined groups, such as women and minorities, can be marginalised within society. Rather, it adopts the premise that within organisational structures, it is important to actively seek a standpoint, as those

marginalised by the institutional process may not traditionally form part of a predetermined group or may intersect several traditionally marginalised groups. The standpoint group for this study was developed through an interview process with a theoretically sampled group (see Fig. 17). The interview findings are discussed in depth in Chapter 6

Figure 17

Developing the Standpoint

4.5 Characteristics of Institutional Ethnography

The approach of institutional ethnography holds a distinct ontological and epistemological position (Smith, 2006a, 2006b). The institutional ethnographer at an aim to understand the external influencing factors (relations of ruling) that exist within the institution, from the standpoint of the people making up the institution (Smith, 2005, 2006a). There are several key characteristics that set the approach apart from other ethnographic designs and made it particularly suitable for this study. The characteristics presented below outline how the adoption of IE influenced the observations and fieldnotes in this research and provided a specific approach to working with participants.

4.5.1 Cultural Context

The research question required an exploration of the cultural context of the neighbourhood team. Ethnography describes and interprets culture-sharing groups as it attempts to describe people's experience of their cultural context, their interaction within that context, and their interactions with each other as part of that context

(Creswell, 2013; Hammersley & Atkinson, 2007). Institutional ethnography shares this overall aim. It differs, however, in that the cultural exploration should be grounded in and viewed from the standpoint of a group within and marginalised by the institutional processes (Smith, 2005). In this study, it was important to consider that even identification of a group as marginalised may impact the research process and how participants work with the researcher. Therefore, during the research, it was important not to objectify the participants or assume the meaning of marginalisation for them.

4.5.2 Thick Description

The study used ethnographic observations as a basis to develop thick descriptions to create an interpretative understanding of how different people, communities, or cultures experience their lives. The term 'thick description' was established in the work of Geertz (1973), who defined it as not merely a record or surface representation of what was done by a person or group, but the representation of the detail, context, and social relations of that experience so that the voices of the participants are heard. Thick descriptions in IE work to give voice to the marginalised, bring institutional discourse into view, and shed light on the relations of ruling and their effect on the actualities of people's lives.

4.5.3 Talk

Exploring how people talk and the use of language has remained an essential element of the ethnographic endeavour. In professional settings, talk exists in every action, and actions can be understood from their placement within the talk (Hammersley & Atkinson, 2007). Hammersley and Atkinson (2007) explain that talk cannot be viewed as data in isolation but is required to be contextualised and understood in unfolding patterns and events. Importantly for this study, language was the medium in which

people's actions were coordinated through the wider institution, and it was through talk that these links could be observed (Smith, 2005).

4.5.4 Local and Natural Setting

The local setting (neighbourhood) is where people work and interact, and as stated by Blumer (1969) in his seminal work, meaning and action are collectively negotiated and context dependent. Therefore, the study of human behaviour must begin with the study of human association within the local context. Jerolmack and Khan (2014) argued that researchers who rely exclusively on self-reports through processes such as interviews limit what can be understood, as these accounts hold the risk of being overly individualistic and abstracted from the lived experience.

The 'local' is a central tenant of IE, as Campbell and Gregor (2002) emphasised, explaining that knowledge must be generated by and grounded within the actualities of people's lives and work. Smith (2005) argued that the relations of ruling which control and coordinate people's lives are magnified within local settings. Subsequently, the local setting and the standpoint group are a vital lens through which to gain knowledge of the wider institution.

4.6 Reflexivity

It is acknowledged within this study that ethnographic findings are influenced by the researcher's participation in the field as much as by their reflections on the data; therefore, the understanding of 'self' is an integral part of the research process (Borbasi, Jackson, & Wilkes, 2016). Throughout the study, a process of reflexivity was adopted to support the understanding of self and the impact of self on the research. Structured methods were used to ensure that the reflexivity was robust. A key tool was a reflexive diary, which supported the development of continual internal dialogue and

critical self-evaluation (Berger, 2015). Narratives, thoughts, and notes were documented within the diary to capture developing ideas and gain an understanding of personal subjectivity (Smith, 2006a; Hammersley & Atkinson, 2007). The diary was used to systematically document feelings and thoughts at the time of data collection (pre and post-observation), to acknowledge bias, assumptions, values, influences as understood at the time. Notes made in the diary were returned to multiple times, so that changing perspectives and positionality could be better understood through internal dialogue.

Reflexivity was also used to return to the findings. The process of revisiting the findings was a continuous one which recognised that the accounts and observations were affected by assumptions, and these needed to be understood and recognised (Hammersley & Atkinson, 2007). Once data collection was completed, the findings were revisited again to revaluate initial codes (and later themes) to question and challenge initial findings and constructions. Conducting this process at each observation enabled a deeper understanding of the data through a secondary dialogue (Smith, 2006a).

Regular supervision by professional doctorate supervisors was ongoing throughout the process. The supervision process enabled an open discussion of the progress of the research and the reflexive journey. These actions ensured that there was a constant examination of self within the field and self-challenging of positionality, influence, and subjectivity. This robust approach was important, as Reid (2017) has warned that without reflexivity, there is a danger that the power of the researcher is unchecked and that the research participant becomes seen as an ‘other’ through the development of a morally questionable representation of people.

4.7 Positionality

Part of the reflexivity process is to understand the self. This thesis adopts an interpretive approach and acknowledges the subjectivity of the researcher as the interpreter of the participants' subjective experience (Hennink, Hutter, & Bailey, 2020). At the start of the research process, there was self-identification as an inside researcher with membership in the population (group) being observed (Dwyer & Buckle, 2009). This 'insider' position (group membership) was considered relevant in three distinct ways: professionally, as a nurse; organisationally, as an employee of the trust; and in 'job' role, as the integration programme lead. The initial assumption had been formed on the premise that researchers are either insiders or outsiders within the field. Bonner and Tolhurst (2002) identified the following benefits to insider researcher status: a greater cultural understanding of the group, not altering the flow of the research, and having an established closeness. Therefore, being an insider was an appealing standpoint.

However, reflexivity led to the conclusion that the identification as 'insider' was incorrect. While professional and employment history were superficially viewed as equating to 'insider status', these assumptions fell away upon deeper examination. While there was a common professional history, history was not equivalent to being a part of the participating group, particularly in the new neighbourhood setting. However, the claim of outsider researcher status could be substantiated either, as prior knowledge of the field and professional identity did not simply evaporate, but left a footprint of knowledge. It was thus concluded that there is a problem in viewing insiderness and outsiderness as binary descriptions or fixed dichotomous approaches (Hellawell, 2006). These assumptions are further dismantled when considered within the epistemological assumptions of IE, where the standpoint of the participants is

privileged. The research methodology provided an alternative understanding of the insider/outsider dichotomy, as IE subverts the insider/outsider approaches by viewing the field and the participants differently. The participants were not the subject of the study—they were the gateway to viewing the institution and relations of ruling, thus changing the relationship between observer and participant, and enabling a nonbinary approach to be acceptable or even useful to the research. The adoption of the aforementioned understanding of positionality and changing position aided a stronger analytical approach, as positionality was continually explored and revisited throughout the research process as part of the reflexive process (Berger, 2015).

4.8 Chapter Summary

The research design aimed to facilitate the understanding of the experiences of the neighbourhood teams, viewing those team members as experts within their own experience and context (Smith, 2005; Walby, 2012). Uniquely, the use of an institutional ethnographic approach enabled the study to explore the individual's experience, but also to investigate the organisational practices by using the standpoint of those marginalised by the institution. Before IE was adopted, the question and topic area were revisited to gain an understanding of the researcher's own assumptions and of the concepts within the literature.

Chapter 5. Methods

5.0 Chapter Introduction

This chapter presents the methods of the study as actually applied during fieldwork. It summarises how these research methods were constructed and details the approach taken to the application of the methodological assumptions, principles, and ethics. Where the method applied was unique or contributes differently to the research than set out in original methodological approach, the rationale has been clearly outlined, providing an honest and truthful account of the research approach.

5.1 Ethical Considerations

Firstly, it was important to consider how the research complied and aligned with research ethics. This section identifies the central ethical considerations of the study and the actions taken to ensure that any findings were ethically sound. The ethical principles presented here were interwoven through all activities undertaken within the research.

5.2 Research Ethics

It was recognised prior to the development of the study that no matter how new and interesting the findings were, they would only be of value if the research was conducted in an ethical and honest way (Walliman, 2017). The ethical requirements were defined as the ethical standards of behaviour that the researcher applied to the research from commencement to final report (Keele, 2010). The development of the ethical approach was one of the primary activities in the development of the study. The standards developed were applied to the design, values, actions, judgments, and reporting within the study (Snowden, 2014).

5.3 Ethics of the Methodology

To achieve the required ethical standards, the study context, environment, methodology, and methods were each evaluated to ensure that all ethical principles were accounted for (Campbell & Gregor, 2002). The ethical principles considered were prevention of harm, informed consent, protection of confidentiality, avoidance of deception, and the right to withdraw (Walliman, 2017). The study adopts an institutional ethnographic approach and therefore involves working to understand the experiences and concerns of a distinct group within an institution who are marginalised within the relations of ruling (Smith, 2005). Therefore, entering the field of study involves an ontological assumption of entering an environment which is coordinated by the actions of those outside of the local area. The ethical approach, therefore, centred on understanding the complex field and protecting against the objectification of the participants.

5.3.1 Confidentiality

Wilson (2012) explains that confidentiality is central to supporting an open discourse between researcher and participants. Additionally, a researcher in the field has an obligation to protect confidentiality (Parahoo, 2006). During the fieldwork, the teams identified that confidentiality was a key concern. Participants from both teams expressed anxieties about feeling that they wanted to demonstrate their positivity towards the integration process but were also concerned about being individually identified as not engaging. To address these concerns, there was a series of one-to-one meetings and group meetings where participants were encouraged to express any concerns and ask any questions. One area explored was that during the interview and observation process, participants might discuss issues that were sensitive to

themselves, patients, peers, and managers. The following actions were instigated to safeguard the confidentiality of participants:

- Only the researcher/research supervisor had access to the research recording, transcripts, and fieldnotes.
- All recordings, transcripts, and fieldnotes were kept in a locked box, which was to be maintained off the NHS Trust site.
- Once the research had been concluded, the tapes and transcripts would then be destroyed (Ritchie, Lewis, Nicholls, & Ormston, 2013).
- All data was anonymised and coded, with only the researcher having access to the codes (Wilson, 2012).
- The anonymity of the participants was protected, and any presentation or publication of findings will be done in a way that protects their identity (Wilson, 2012).

5.3.2 Consent

Holloway and Wheeler (2013) emphasise that informed consent is crucial to the ethics of research. However, the concept of consent is not without debate within the field of ethnography. Within ethnographic research, there are occasions when covert research can be legitimate; however, as the study presented here formed part of an IE, the standpoint of the participant group was key. It would have been difficult if not impossible to work with the participant group without their full knowledge and consent. Therefore, research participants (observation and interview) were provided with information on the research and the methods being deployed, and potential participants were provided with written and verbal explanations of the research,

methods, and purpose (Wilson, 2011). While the participant information sheet did not describe the three distinct phases of the study as, these were made clear to potential participants in the recruitment meetings which were held with all team members as part of the recruitment and consent process.

Participants gave consent prior to the commencement of their involvement, and, importantly, all participants were informed about their fundamental right to withdraw from the research at any point (Ryan- Nicholls, & Constance, 2009). During the observation stage, the teams consented at various points within the research. The process was quite fluid as staff varied from shift to shift, and at one point, one team member did not wish to consent. Following discussion of that person's rationale for declining, the person stated that they felt comfortable with me being in the office space, but that they preferred not to take part.

5.3.3 Ethical Approval

Ethical approval was sought and gained through the university ethics committee (Appendix 5), and the ethical approval was updated and amended prior to commencement of stage 2 of the research, due to the changes in data collection (Appendix 6). Following discussion with the Trust management team and research department, a letter of support was obtained (Appendix 7). Finally, under new NHS requirements, ethical approval through the National Research Ethics Service was not a requirement. This was confirmed using the Health Research Authority decision tool (Appendix 8, 9) and through discussion with the Trust research team. The decision tool and the Trust research department confirmed that the study was classified as a service evaluation rather than research as defined by the National Research Ethics Service.

5.3.4 Exiting the Field

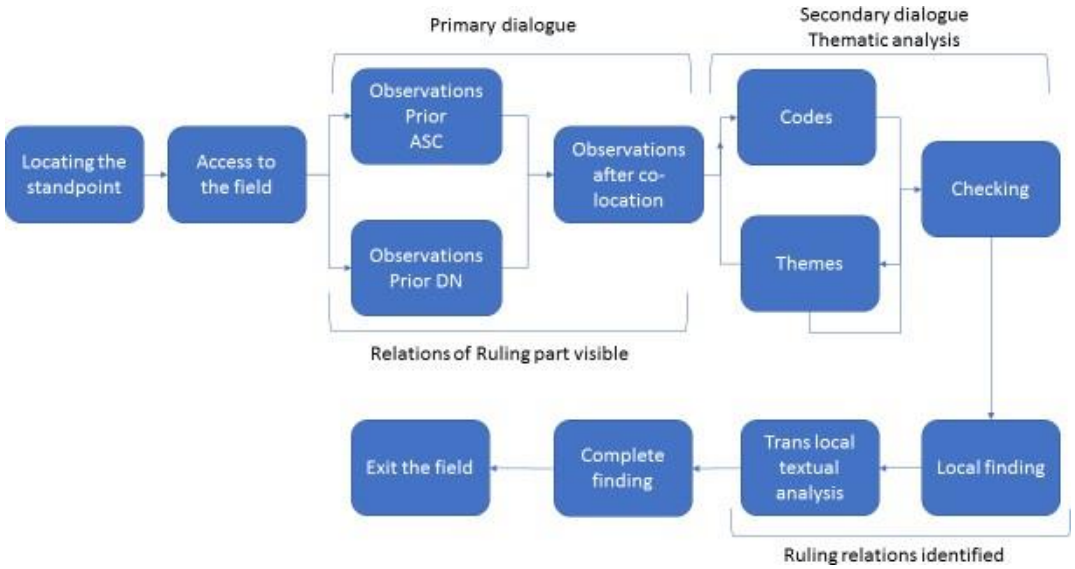
As with all research, there was a requirement to leave the field at the end of the study (Hammersley & Atkinson, 2007). Prior to leaving the field and as a signifier of the end of the data collection, a feedback meeting was held with the participants. This meeting was important, since, as previously discussed, the knowledge of the local setting was owned by the participants rather than the researcher and therefore needed to be returned to them to enable them to make use of the knowledge gained. On completion of the study, a written report was be provided to the participants and the organisation.

5.4 Research Journey

Figure 18 presents a visual representation of the research journey, from after the literature review to exiting the field, differentiating each section of the data collection and analysis process.

Figure 18

Research Journey



5.5 Data Dialogues

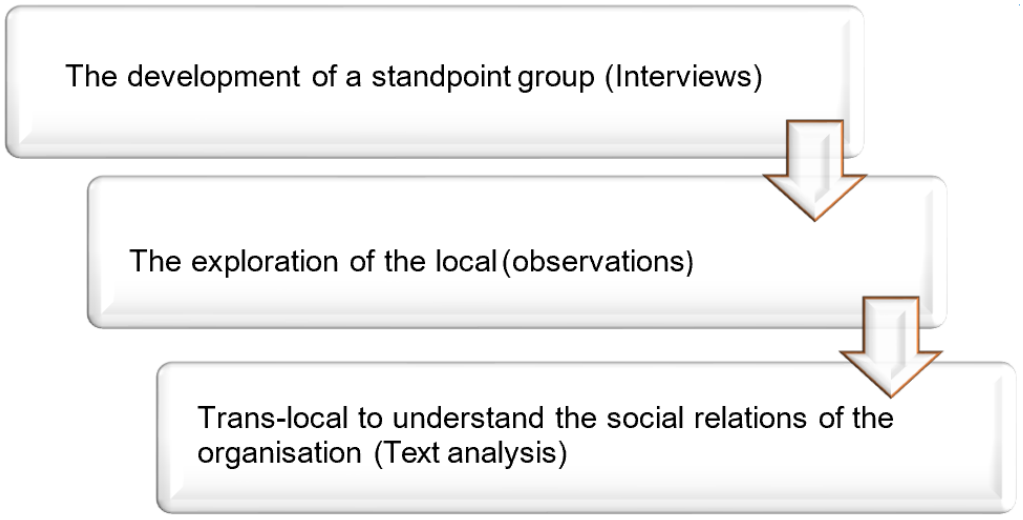
The research data collection followed the principles defined by Smith (2005) in that the creation of data happened through a sequence of steps which were consistently applied at distinct stages of the research. These steps, or 'data dialogues', are the points within the research where the researcher enters a 'dialogue' with the intention of creating data that reflects the voice and experience of the participants (Walby, 2012). Data dialogues are either primary (with participants) or secondary (with fieldnotes), and both aim to create new data (Smith, 2005).

5.6 Research Stages

The first action conducted in the planning stage was translating the ontology, epistemology, and theoretical framework into a method that enabled ethical and effective data collection and analysis (Creswell, 2013). In this study, there were three defined stages, depicted in Figure 19.

Figure 19

Stages of the Study



Definition of each stage was influenced by the purpose, required outcome, and methodological approach.

5.7 Access

Access was viewed as not merely a physical presence within the field, but as a mutual agreement between the participants and researcher to the study being conducted (Smith, 2006a, 2006b; Hammersley & Atkinson, 2007). Gaining access to the case group involved the development of respect and understanding of the rationale and purpose of the research. Part of the development of this trust was ensuring through the ethical approach that participants were always viewed as the creators of the knowledge and, therefore, viewed as equal partners.

Following, successful completion of the ethical approval (Appendix 3), the Trust was approached to finalise access arrangements. Adding complexity to the process was that services were not yet integrated, and access needed to be agreed upon with a range of stakeholders in a number of services and organisations, including GPs, the acute hospital sector, community staff, local authorities, and the adult social care team. The actions taken to obtain access are outlined in Table 11.

Table 11 *Services and Organisations Involved in Obtaining Access*

Service	Organisation	Local or trans- local	Process for access	Comments
Executive team	NHS	Trans- local	Meeting Director of Operations/medicine	Supportive of study learning
Neighbourhood managers	NHS	Trans- local	Meeting individual manager	Vital relationship link between the local and trans-local
Social work team	Local Authority	Local	Manager/ team meeting; individual discussion	Very open and keen to contribute; consent obtained for observation
Community nursing team	NHS	Local	Manager/ team meeting; individual discussion	Slight delay due to the manager being our sick; access confirmed on her return

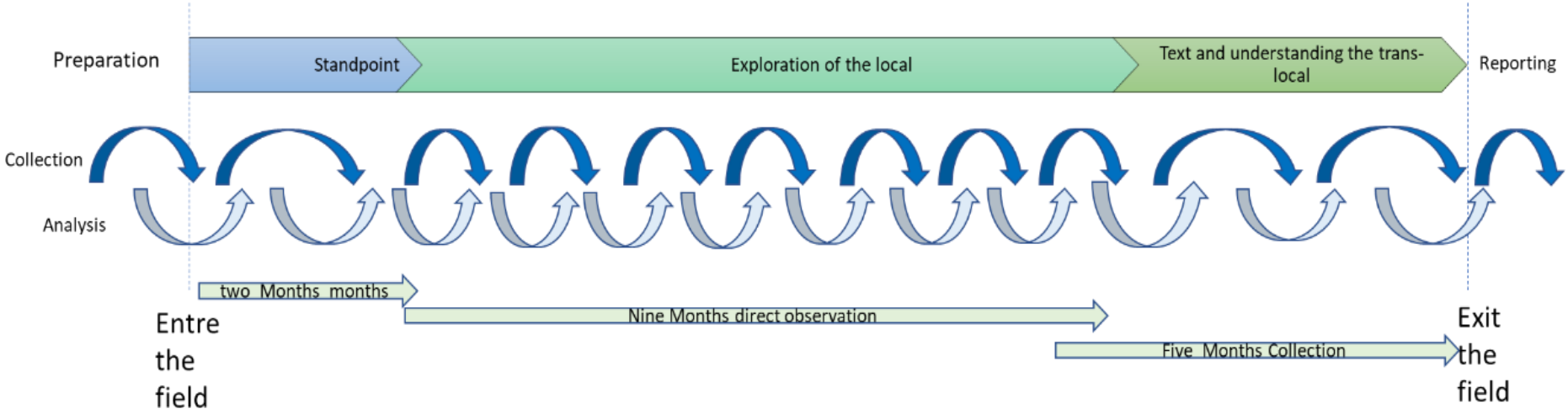
Access to the adult social care team was facilitated by the neighbourhood manager, who supported the establishment of rapport with key members of the team. Access to the community nurse team took longer to obtain, largely because their manager was on long-term sick leave and communication with the team varied as the team leads changed frequently. It was the adult social work team who facilitated access into the nursing team, through meeting invitations and introductions. Once access had been obtained in each of the areas, data collection through observation commenced.

5.8 Research Process

Data collection and analysis began pre-fieldwork and continued through to the writing of the final report (Hammersley & Atkinson, 2007). As the study progressed through the three stages, there was constant movement between data collection and analysis (see Fig. 20). The cycles repeated through each stage and intensified during the observation phase due to the substantial amount of data collected, which required analysis prior to the next observation period. Each cycle included the use of reflexivity prior to moving to the next cycle.

Figure 20

Process of the Research



The following sections outline sample selection and data collection in each stage of the research. This is followed by a description of how data analysis was conducted across all three stages of the research.

5.9 Stage 1: Locating the Standpoint

Stage 1 required the identification of a standpoint group. This is a methodological requirement of IE, as the study must be conducted through the lens of those marginalised by an institutional or organisational process. Along with the scoping review, stage 1 also acts as a confirmation point for the foreshadowed problem, ensuring the problem identification aligns with the actualities and working lives of the potential participants (Smith, 2005).

5.9.1 Sample Selection

In stage 1, purposeful sampling was used to allow the selection of ‘good’ informants who were able to inform the study, who understood the area of interest, and who were able to share their experience (Holloway and Wheeler, 2013). This approach led to a detailed contextualisation of the area of study from which the second stage was developed (Morse, 1991, Hennink, Hutter, & Baiiley, 2020).

Five interviews were conducted with team members from across the organisation, and several meetings were attended to view integration in action (see Table 12). Following the completion of these interviews and meetings, it was concluded that a saturation point had been reached, as no new themes or potential themes were being identified (Keele, 2010).

Table 12 *Stage 1 Interviews and Meetings*

Interview Participants	Employment Context
Neighbourhood manager	Working within the integrated care organisation (ICO); clinical background; physiotherapist; in post approximately 12 months; time with the Trust over 10 years
Nurse (from a community team)	Long-term conditions nurse; worked for the NHS with the Trust for over 10 years. As a long-term conditions nurse, she worked across a range of nursing and social care teams. She had also been involved in a range of projects that supported integration.
Physiotherapist	Over 10 years' experience working in the NHS Trust; experience leading a range of teams in the acute and community sector
GP	Local GP working with neighbourhood team within another borough; over 10 years of experiences as a GP; engaged in the wider neighbourhood development
Social worker	Employed by the council; worked within hospital, council services, would be joining the community nursing team
Meetings	
Neighbourhood meeting (n = 3)	Attended by a range of employees of the integrated care organisation; multi-disciplinary
GP neighbourhood meeting (n = 2)	Attended by a range of professionals, led by GPs within the neighbourhood
Community team meetings (n = 6)	Any meeting between the community nursing team and/or the social care team

5.9.2 Data Collection

The data collection tool used in stage 1 was interview. Fetterman (2010) stated that the interview was a useful ethnographic tool, as it enables the researcher to place their observations into the larger context of the field of study. Interviews were only conducted in the first stage of the research. The interview was selected as a method of data collection as it was an effective method of gaining in-depth knowledge of the subject area and assisted in the identification of the standpoint group (Campbell & Gregor, 2002).

In line with the methodological approach, the interviews were unstructured in order to access people's perceptions, attitudes, and experiences of their social reality (Zhang & Wildemuth, 2009). DeVault and McCoy (2002) described interviews in IE as a manner of talking to people to investigate widespread and discursive processes. Campbell and Gregor (2002) expand on this idea by framing interviews in a broader context, explaining that they are simply the time spent talking to people across the whole of the research journey. Importantly, unstructured interviews do not impose any a priori categorisation which would limit or guide discussion with participants. The use of interview questions and topic guides is not advised for unstructured interviews (Zhang & Wildemuth, 2009). However, to provide a consistent approach, a set of prompts were developed to act as a memory aid for the interviewer. The prompts were designed to provide discussion points to start conversations and encourage the social interaction (see Table 13).

Table 13 *Interview Prompts*

1	position/role within the organisation (length of employment, job role, other roles, profession)
2	understanding of organisational changes (since 2016, structural, managerial)
3	current issues effecting community health/social care
4	the defining characteristics of a neighbourhood
5	Involvement in neighbourhood teams (knowledge of neighbourhood teams)
6	you/your team effected by the development of neighbourhood
7	other teams effected by the development of neighbourhood
8	benefits or challenges of current changes (neighbourhood)

5.10 Stage 2: Exploring the Local Case

After the completion of stage 1 of the research, the decision was made to change from interview to observation. The rationale for the change was that while an important part of data collection, the perspectives and reports gathered during the interviews would not have provided a narrative in the same way that observations in the natural setting could (Jamshed, 2014). The decision to use observation was supported by the work of Jerolmack and Khan (2015), who argue that ethnographic observation provides a greater level of information about social action, as it directly observes events and interactions and is less likely to be limited by individualist self-reporting. Notwithstanding their limitations, interviews were not fully disregarded during stage 2, but they morphed into informal conversation that naturally occur within the field of study, and these were recorded within the fieldnotes. The approach taken is supported

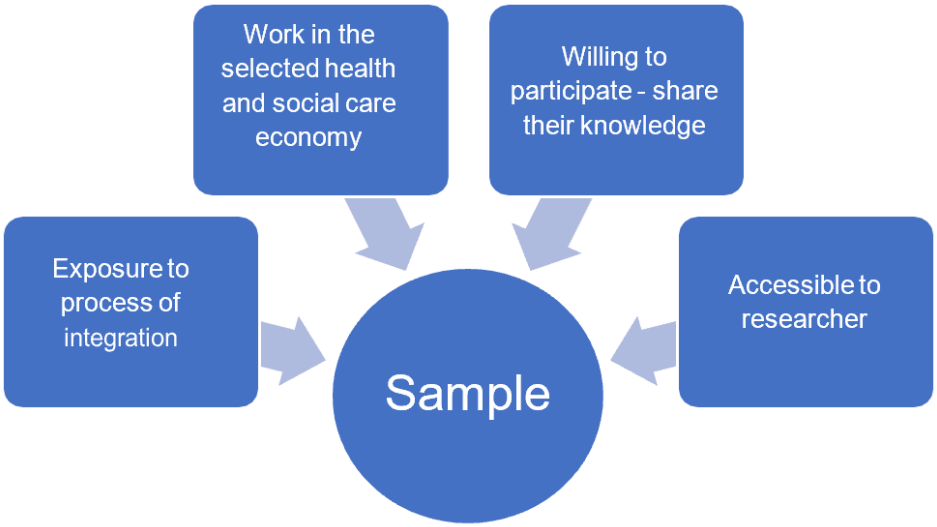
by Fetterman (2010), who asserted that it is in informal discussions that personal perspectives and views can be explored as categories of meaning that expose shared values and differences. As the study explored integration through the experience and actualities of the neighbourhood teams, it was through these discussions and observations that knowledge of their perspective was gained.

5.10.1 Sample Selection

The findings from stage 1 defined the sample selection for stage 2. The standpoint group (sample for stage 2) was the output of stage 1 of the research (see Chapter 6). To improve the credibility and confirmability in the selection of participants, a sample criterion was developed (see Fig. 21). Characteristics such as age, gender, and background were not considered as part of the sample selection, as the field encompassed a range of people who were joined by the work within the field, and it was their collective cultural experience that was being considered.

Figure 21

Sample Selection Criteria



The standpoint group identified in stage 1 then became the sample for stage 2 of the research.

5.10.2 Data Collection

In the second stage of the research, ethnographic observation of the neighbourhood team was the main source of data collection. The observations included non-participant observations and 'go-along' observations (see 5.8.3). These observations include elements of participation and observation and fitted my own positionally as both an insider and outsider within the field (Kusenbach, 2003).

The observation period lasted nine months and took place both prior to and after co-location and integration. This portion of the research adopted the institutional ethnographic approach to produce findings that are based within the everyday work of the neighbourhood team. It draws attention to institutional processes through the exploration of the nuances, stories, and experiences of the team from the members' own standpoint.

5.10.2.1 Observation

The maintenance of a strongly ethical approach is fundamental to all research and forms part of the ontological considerations of IE (Walby, 2012). The approach adopted within the study was that participants were the owners of knowledge and that creation of any new knowledge was undertaken in partnership with them. Therefore, all observations were conducted overtly—that is, the researcher's presence was announced, open, and known to all the participants within the field (Hammersley & Atkinson, 2007). As new participants entered the field, they were informed of the researcher's presence. However, it would be an oversimplification to believe that merely announcing one's presence as a researcher equates to a truly overt research practice. Therefore, to maintain an ethical approach that preserved the principle of

partnership in knowledge generation, the relationship between fieldworker and participants was further examined. One principle adopted to preserve the ethical standards of openness and transparency was what Van Maanen (1995:20) described as ‘making the familiar strange rather than the strange familiar’. The importance of making the familiar strange was to prevent over-identification or missing vital, small, and incidental acts of everyday practice. The adopted approach involved balancing necessary immersion and empathetic understanding with the need to problematise and critically explore institutions (Czarniawska-Joerges, 1992). An example from the fieldwork centred on previous roles, as previous work as a District Nurse meant a risk of over-identification with the nurses within the team due to shared identity, culture, and familiarity. As Ergun and Erdemir (2010) have explained, factors such as affinities, gender, status, and political preference build our identities, and these identities impact relationships during fieldwork. Data was recorded as a non-participant observer, without active participation within the group’s activities, such as clinical work this ensured identification in the primary role as a researcher (Creswell, 2013). Practicing reflexivity helped in remaining cognisant of positionality within the research process (O’Reilly, 2012). There was also frequent discussion of the role and the purpose of the research with the team members, so as not to become familiar.

The decision to include a ‘go-along’ approach was a pragmatic one, as the nature of the work of both social workers and community nurses was such that observations were conducted by being taken along on visits or sitting with participants while they worked through cases. Go-along observations were an opportunity to observe practices in situ, while also accessing team members’ experiences and interpretations at the same time. Moreover, a secondary advantage of the go-along approach was that it provided a spatial angle to the observations, enabling the symbolic qualities of

everyday practices in relation to individual environmental perceptions to be viewed. The observations combined a range of activities that are outlined below.

5.10.2.2 Workplace Observations

Workplace observations were undertaken once a week over a period of nine months. These observations included mapping and documenting the temporary and spatial features of the actualities of daily work (in the office and out on visits), identifying key events and activities (handovers, informal meetings), and identifying key individuals or groups (team leaders, coordinators, clinical and social care leads). Data was then brought together into a complex and rich account of the social setting.

5.10.2.3 In-Depth Informal Conversations

In-depth informal conversations have been an integral source of ethnographic data collection since the 1920s, gaining significance as a method due to their inclusion in a number of studies by sociologists from the Chicago School (Swain & Spire, 2020). To maintain the robustness of the ontological approach, it was important not to conflate qualitative interviews with ethnographic fieldwork (Driessen & Jansen, 2013). Therefore, the decision was made to use fieldwork conversations rather than interviews, as they take place in situ within the spaces that the participants naturally occupy and do not require removing people from their context (Driessen & Jansen, 2013). Gusterson (2008) explains that while these methods appear casual, they are the foundations of what embodies serious ethnographic fieldwork, and they provide a profound level of understanding of the participant. The decision to use a deep conversational approach over interview within this stage of the research also considered the work of Whitaker and Atkinson (2019), who argue that interview does not give access to the interiority or private emotions of social actors. It was these interior and private emotions that would be needed to provide an authentic narrative

within the findings. Ensuring the authentic narrative and voice of the participant within the study is core to the ontological approach adopted, the achievement of the aims of the study, and the delivery of a unique contribution to the knowledge of integration.

In this study, in-depth conversations were led by participants and took place in in-between settings and spaces; they occurred in cars, over coffee, and as debriefings after meetings. They were intentionally open and informal, because of this, participants shared vital insights into their daily routines, the highs and lows of the integration process, their frustrations, and their fears. Conversations facilitated scene setting, understanding routines, and contextualisation of local spaces. They were opportunities to listen to stories and for individuals to reveal their worlds. These encounters were the gateways to the participants' experience.

Conversations also held an important ethical function, as they were the means of building trust and rapport with participants, or, as Driessen and Jansen (2013) explain, they were a means of discovering each other's trustworthiness, enabling small talk to develop into in-depth conversations which ultimately provided the basis for the ethnographic narrative. Hammersley and Atkinson (2007) also emphasise that the importance of social interaction should not be underestimated as a method of building trust and establishing a relationship between the researcher and participant in order to gain in-depth knowledge.

As stated previously, this approach was selected deliberately, as institutional ethnography holds the central tenet that the experience of the participant has primacy. Therefore, any data created has to be through the lens and voice of the participant. The importance of the informal approach adopted here is also reflected in Hammersley and Atkinson (2007), who conclude that informal conversations enable participants to

share their stories in a more natural and less artificial way. Swain and Spire (2020) further support the use of informal conversations, stating that they produce more authentic data, as they create a greater ease of communication between researcher and informant. Smith (1999, 2005) argues that participants are not the objects from which to draw data in a controlled or mechanised manor, but they are the entry point to the social world that they experience. Therefore, it was important in the study that the researcher transcended the objectification of participants that can occur when using techniques that control the discourse and therefore the voice of the participant.

Smith's position is reflected in Spradley (1979), who maintained that while other social science research paradigms require researchers to enter the field with preconceived ideas and goals in order to confirm or disconfirm a hypothesis, this should not be the method adopted by ethnographers, who require an emergent process that enables participants and informants to define what is of importance in their own experience. Considering the ontological and ethical underpinnings, the conversations observed in this study were maintained as naturally as possible. Had these encounters been formalised or 'set up', it is unlikely that participants would have shared so freely, as artificial settings tend to create a stage for performance rather than a relationship for revealing and sharing (Whitaker & Atkinson, 2019).

Each interaction was individual to that conversation and led by the participant. To provide structure to the conversation and draw out relevant information, however, Spradley's (1980) participant observation list was used as a mental note or memory aid to ask relevant questions during interactions (see examples in Table 14). This approach aligned the recording of conversations with wider fieldnotes.

Table 14 *Example of In-Depth Conversations Recorded With Spradley's Participant Observation List (Spradley, 1980:78).*

Visits with the nurses – discussion on co-location		
1. Space	The physical place or places	Impact of co-location on daily work
2. Actor	The people involved	Two teams working together
3. Activity	A set of related acts people do	How has co-location changed interactions
4. Object	The physical things that are present	Changes because of moving to the new office
5. Act	Single actions that people do	Changes in acts conducted
6. Event	A set of related activities that people carry out	working with the other teams (joint working activities)
7. Time	The sequencing that takes over time	Changes to how time is managed by staff (car parking restrictions)
8. Goal	The things people are trying to accomplish	what has co-location achieved
9 Feeling	The emotions expressed by people	Emotional impact on person and others

5.10.2.4 Shadowing of Individuals

To develop knowledge of the roles and contributions that certain individuals or groups made to the development of the integrated care team, shadowing observations were undertaken with the following groups:

- district nurses
- community nurses
- social workers
- clerks and administrators
- occupational therapists
- wellbeing workers

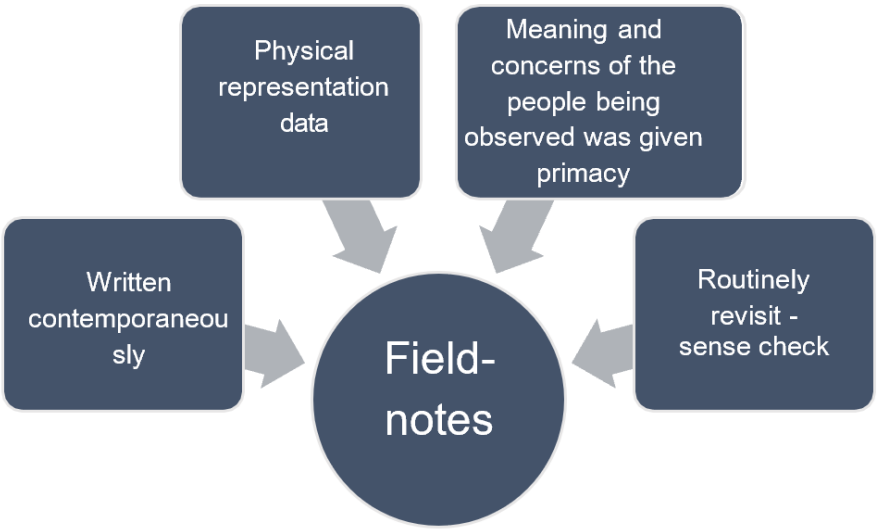
Usually, participants were shadowed opportunistically during workplace observations. However, it was required that ‘go-along’ observations with the district nurses were prearranged due to the nature of their work and early starts. These shadowing opportunities normally lasted two to three hours. There were several specific sites and contexts where these shadowing opportunities took place. These included spending time with a nurse as they conducted their visit allocation for a morning or afternoon, and spending time in the office with individual team members and members of the management team. All observations were recorded, first in handwritten field journals which included descriptions, and then in separate interpretations.

5.10.2.5 Fieldnotes

Fieldwork is the central tenet of ethnographic research and involves researchers immersing themselves in and observing natural settings for extended periods of time (Fetterman, 2009). In IE, fieldwork forms the basis for the primary dialogue between the participant, the environment, and the researcher. Within this study, fieldnotes are the product of fieldwork and represent how the primary dialogue was interpreted and recorded (Wolfinger, 2002). Figure 22 presents the principles that were adopted throughout the creation of the fieldnotes.

Figure 22

Principles of Fieldnotes Strategy



Note. Adapted from Emerson, Fretz and Shaw 2011

Throughout the observation period, fieldnotes were used to capture the salient and relevant data from the observations, and therefore a strategic approach to notetaking was adopted. The selected approach was Spradley's (1980) strategy for fieldnotes (see Table 15). Condensed notes taken in the field were typed up after the observation in greater detail (within 24 hours).

Table 15 *Field Note Strategy (Spradley, 1980:78)*

Area to consider	Description
1. Space	The physical place or places
2. Actor	The people involved
3. Activity	A set of related acts people do
4. Object	The physical things that are present
5. Act	Single actions that people do
6. Event	A set of related activities that people carry out
7. Time	The sequencing that takes over time
8. Goal	The things people are trying to accomplish
9. Feeling	The emotions expressed by people

Once completed, the fieldnotes formed the basis for what Smith (2005) describes as the secondary dialogue. During the secondary dialogue, the fieldnotes, memos, and comments made in the primary dialogue were re-examined and analysed to rediscover what was observed and to see what had not been seen in the earlier process. This process was continual throughout the research, and each cycle informed the next observations. On completion of fieldwork, writing fieldnotes gave way completely to reading and analysis, and the data analysis moved to the thematic analysis, as defined by Braun and Clarke (2006).

5.11 Stage 3: Incorporating and Understanding Institutional Text

Prior to the commencement of the study, consideration was given to how text would be identified, collected, and analysed. Smith and Turner (2014) explain that text used in IE is considered through a distinct ontological lens that differentiates it from other forms of discourse analysis and research paradigms. This study adhered to the institutional ethnographic principle that texts are material objects and are not the objects of research in themselves. During the study, the examined texts were not

considered as separate from their coordination of people's lives (Smith & Turner, 2014). The point of interest was not the text itself but how the participants activated, were influenced by, and used the text within their local spaces (Smith, 2005). The importance was not what was written in the documents, but how participants referred to the documents interactionally—how they used the controlling texts to open discussions and display different levels of knowledge, allegiance, cynicism, or hope.

Therefore, while textual analysis has been identified as a distinct stage in the research, in reality this stage ran concurrently with the fieldwork and is presented as part of the complete ethnographic narrative in line with the methodological principles (Smith, 2005; Campbell & Gregors, 2002).

5.11.1 Identification of Relevant Text

In line with the ontological and epistemological positioning of the study, identification, collection, and analysis of text was conducted throughout the data collection period. As an institutional ethnography, the study viewed texts as replicable documents that existed in the actualities of the lives of the participants and were activated in their talk, actions, and space (Smith & Turner, 2014; Campbell & Gregor, 2002; Smith, 2005). The selection of text was therefore not conducted through a formalised preset or preconceived set of criteria. In practice, the text was collected as it appeared within the local space and when its influence was visible through the participants' talk. Text selection was intentionally an emergent process which built on the observations and discussions with participants. Following each observation, the influence of text was considered, and where specific documents were conceived as having an influencing or controlling force on the local, they were selected and incorporated into the analysis of data (Smith & Turner, 2014).

The rationale for selecting text in this emergent and participant-focused manor lies within the methodological underpinning of IE (Smith, 2005). Smith and Turner (2014) assert that texts should not be viewed in isolation or as stand-alone documents, but rather texts are explored only at the point where they are observed to enter people's course of action which cannot be predetermined. In this study, the approach was translated to the texts of interest defined as those that were observed as bringing influence and control over how the participants experienced and interpreted the introduction of integration. The research problematic centred on the disconnect between the organisational rhetoric and the local experience. Therefore, texts of interest were those that mediated the actors in the field (organisationally and locally), pulling down the power of their authors and reproducing their voice multiple times in multiple locations, influencing organisational rhetoric and the local experience (Smith, 2006a). A number of other types of text could have been considered, such as local paperwork, nursing and social work assessment documents, and patient records. However, these were not discussed by participants as influencing this stage of integration. The teams were in the very early stages of co-location and had not yet explored how to bring together local-level documentation; therefore, local paperwork was considered outside the scope of this study. Table 16 identifies the types of text that were to be considered as influential to the problematic.

Table 16 *Identification of Types of Text to be Considered Within the Study*

Included text	Excluded text (outside scope of the research)
National policy documents	Team-level nursing documentation (i.e., assessment/patient records)
Regional policy documents	Team-level social work documentation
Meeting minutes (for attended meeting)	Clinical policy and procedures
Programme plans, institutional policy, and procedures	Safeguarding materials
National policy, policy statements, guidance documents	
Continuity planning team reports	

In line with the policy review and scoping review, documents from 2008 onwards were included. For documents internal to the NHS Trust, only documents that were developed post-2015 were considered, as this was the point that the community services joined the Trust and the year the continuity planning team report advised the formation of an integrated care organisation.

5.11.2 Method for Searching for Text

As previously stated, in line with the methodological approach, the process of text identification was emergent and guided by the fieldwork observations. However, throughout the development of the study, there were a number of texts that were identified as being potentially relevant to the research problematic (see Table 17). These were identified through the policy and literature review and considered as relevant if they were present in the local space, either explicitly or through repetition of their content and language (for example, if they were spoken about often in the office, identified in the standpoint stage, or discussed in team meetings).

Table 17 *Text Identified as Relevant*

Included text	Search method	Number of documents identified
National policy document	Chapter 2 policy review was used to locate the relevant text	31
Regional policy documents	Chapter 2: regional perspective Greater Manchester	4
Meeting minutes (for attended meeting)	Nursing meeting	3
	GP lead neighbourhood meeting	1
	Social care meeting	2
	Neighbourhood meeting	3
	Team leader meeting (all minutes supplied on request)	2
Programme plans, institutional policy, and procedures	Supplied on request from the organisational team	8
Continuity planning team reports	Supplied by the organisational management team	1

5.11.3 Data Extraction and Charting

In preparation for thematic analysis, the texts were charted following the process outlined in Chapter 3 (Page 65). Where charting had already been conducted on a text, this was rechecked and then merged with the charting from additional documents. While analysis of text is described as part of stage 3 data collection, the analysis of text was ongoing throughout the study and followed the same data analysis methodology as stages 1 and 2.

5.12 Data Analysis

The IE approach provides little guidance on formalising the analysis process. Rankin (2017) explains that there is often a tendency for new researchers to import theories and methods that can present challenges and strains within the ontological stance of IE, while adopting an overarching IE approach also requires careful consideration of the study's own scope and scale to ensure that the findings are open, transparent, and

reliable. Therefore, when adjustments were made to the methods as applied, all adaptations were conducted with caution and consideration for the overarching methodology. To ensure consistency in the analysis, a modified data analysis approach was developed through the adoption of the six-step framework of thematic analysis as defined by Braun and Clarke (2006) (see Fig. 23).

Figure 23

Six-Step Framework of Thematic Analysis (Braun and Clarke, 2006)

Thematic analysis was chosen because it is applicable to the type of research in question and is easy for a novice researcher to use, and because it would provide analytical consistency across the study. It was also important to align the process to the principles of IE, which was achieved by regularly returning and checking in with the participants throughout the study to ensure that the findings were aligned to the actualities of the neighbourhood team. Thematic analysis was used in all three stages of the research. The stage 1 analysis was completed first, followed by stages 2 and 3 concurrently (analysis of text followed the process outlined in Chapter 3), and fieldnotes were analysed using the manual approach identified below. The final analysis involved drawing all the themes together to develop the concluding set of themes, which are reported in Chapter 6

5.12.1 Phase 1: Familiarisation with the Data

The process of familiarisation with the data was a continuous and repeated activity. The process began in the field (interviews, observations, and text) and was followed

by the writing, reading, and re-reading of interview transcripts and memos (stage 1), fieldnotes and memos (stage 2), and text, data points, and memos (stage 3). The initial phases of analysis for each stage of the research involved scrutinising the data for patterns and incidents that were relevant to the research question.

During the early part of the analysis, formalised codes were not used, but instead ideas, patterns, and comments were collected from the data. Presented below is an example of a memo written during the secondary dialogue when revisiting fieldnotes.

Memo 01

Memo – The district nurse team leader had been discussing the space the team needed – the social worker appeared to be providing the nurse space to speak about this issue.

This conversation was more direct than pervious conversations I had with each of the teams, why was this – what had changed

Talk – The Nurses were concerned with where they fitted – Space came up a lot in talk – the practical and symbolic.

Space and loss – loss of their own space and their location as they understood it as health professionals may be important

5.12.2 Phase 2: Generating the Initial Codes

Following the process of familiarisation, the initial lists of ideas were developed into codes that complied with one or more of the following criteria: the code must have appeared regularly in the lists, appear to have common features, and/or appear interesting or different from previous studies. Negative findings or events that stood out as different were also recorded to understand the multiple stories and voices involved. The process of developing codes involved the inspection of the initial list of ideas and the merging and collating of events and observations into loose groups. As more data was analysed, some initial ideas had a greater number of associated events

and became codes, whereas others had fewer and were removed from the list or merged with other items on the list where appropriate.

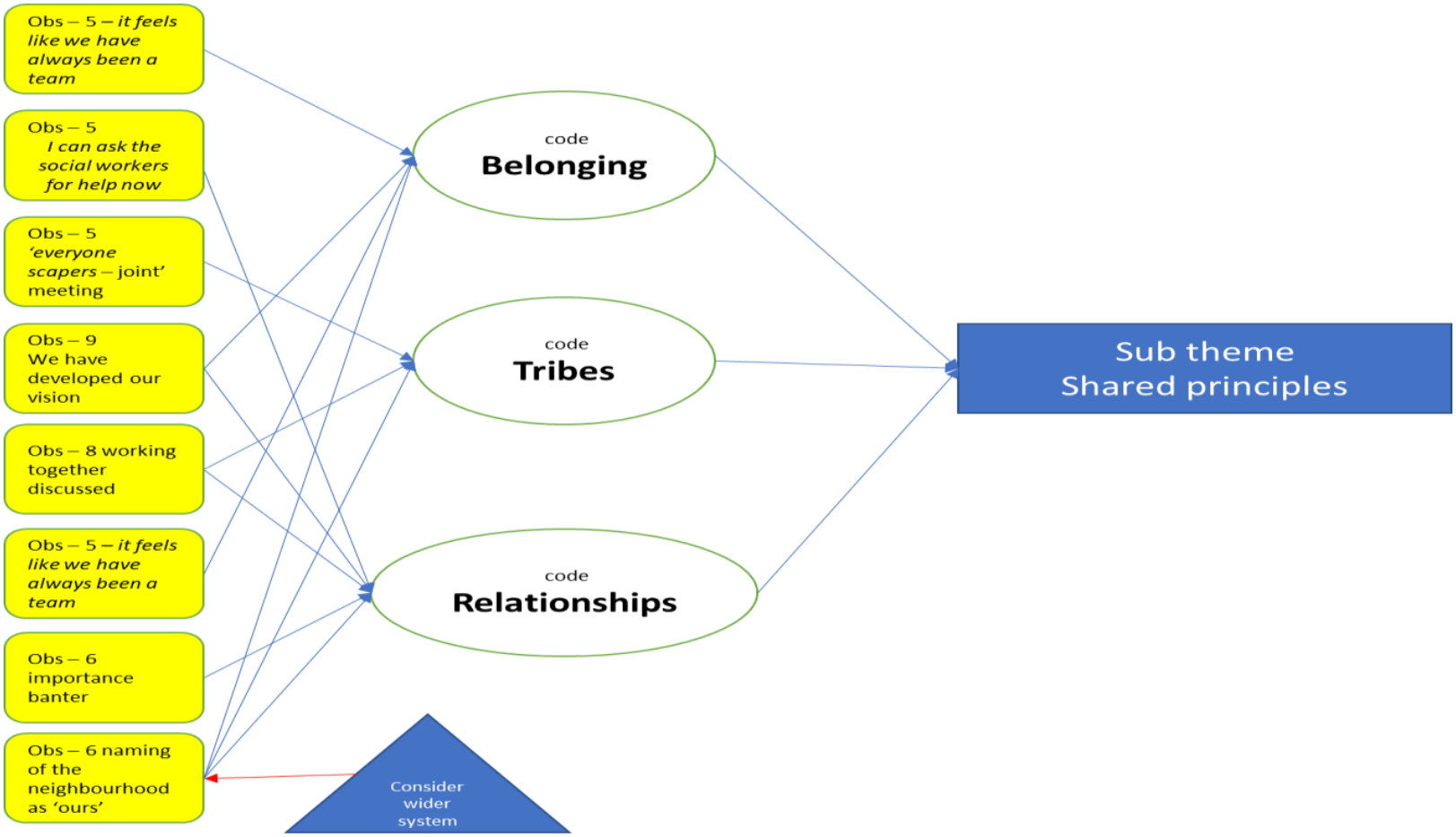
The coding process involved the initial lists being transposed onto individual sticky notes, differentiated by colour as ideas generated from the data (blue) and from the events and observations (yellow). Where ideas/events applied to more than one list item, duplicate sticky notes were made and marked as duplicate. This approach facilitated immersion within the data as the fieldnotes and memos were revisited repeatedly to draw out the relevant data. The coding process involved the reduction and organisation of the data (Creswell, 2013; Nowell, Norris, White, & Moules, 2017).

As the codes developed, they were repeatedly taken back to the field to check them with the participants. Following these checks, code lists were revised, and further memos were written to reflect the changes, which enabled tracking of where codes were selected or rejected.

Once several codes were identified, they were further analysed to look for patterns that could reveal sub-themes. The process also involved considering codes that hinted at or inferred wider relations of ruling in line with methodological assumptions. Figure 24 presents an example of the development of the sub-theme ‘shared principles’: here, one section of the notes was isolated to demonstrate how the data moved from raw data through initial coding and into sub-themes, which then contributed to the larger theme.

Figure 24

Example Sub-Theme Development



A central requirement throughout the process was careful consideration of the overarching methodological principles. To safeguard that the codes were data-driven rather than theory-driven, they were discussed regularly with participants. The adoption of this process ensured their voice remained within the findings and facilitated ongoing alignment with the principles of IE.

5.12.3 Phase 3: Selecting for Themes

The development of the codes into themes commenced after all the codes had been developed at the end of the data collection period (Braun & Clarke 2006). During the theming phase, the analysis was refocused to draw out the wider themes from the selected codes. A theme captured something important from data that was relevant to the research question and was a patterned response to a data set (Braun & Clarke, 2006). Once the sub-themes had been defined, they required further refinement to ensure that as they were developed into themes, the themes reflected the experiences of the teams (Braun & Clarke, 2006).

Alongside the themes, in this phase the relations of ruling were beginning to be identified. These partial glances within the experiences of the neighbourhood team formed the basis of the text analysis, which would move the data from the local to the trans-local (Smith 2005).

5.12.4 Phase 4: Reviewing Themes

As the review phase commenced, several potential themes had been identified. All extracts from each theme were re-examined to confirm whether they equated to a coherent pattern, and themes that did not have enough data to support them were joined with

other themes. ‘Deviant/negative cases’ that were outliers from the themes were analytically integral to the analysis, as they guarded against the cherry-picking of data and supported the revising of arguments. The negative cases were viewed as establishing comparisons with major themes and providing a greater depth of analysis and increased fidelity and credibility (Tracy, 2019).

5.12.5 Phase 5: Defining and Naming Themes

Following the completion of the identification of the themes, the process of defining and refining commenced. During this fifth phase, the thematic ‘essence’ of the themes was determined. The themes encapsulate a range of codes and data and were validated by the neighbourhood team as the key areas that have affected their work and their experience of integration. At this stage, the themes from stages 2 and 3 were brought together to develop the final themes.

5.12.6 Phase 6: Reporting Themes

Finally, once the experiences of the teams had been themed and the textual analysis had been completed, the final narrative was developed. To report the themes, the findings were presented as a narrative followed by a discussion of the findings. It was important during phase 6 to reflect on the methodological approach. Institutional ethnography does not have any set scheme for the final written report, but rather holds that at the centre of the story is the standpoint of the participants who occupy every day of the institution (Campbell & Gregor, 2002). Therefore, the final narrative presented the experience of those participants, reflected on how people brought into being what happened and how what happened was shaped through an organised process (Campbell & Gregor, 2002). Prior to completion, the findings were presented to the neighbourhood team, and their feedback was incorporated into the final narrative presentation.

5.13 Participant Sense Checking

Within this study, the researcher was the data collector and data analyst, which could open the research up to potentially unacknowledged researcher bias (Miles & Huberman,1994; Birt; Scott, Cavers, Campbel, & Walter, 2016). This view is supported by Mason (2002), who claims that without safeguards, there is a danger that researchers might impose their personal beliefs and interests on the research process, leading to the researcher's voice overshadowing that of the participant.

Smith (2006a) has emphasised that analysis in IE research should always be vested in the actual happenings in people's lives, tying their experiences together over time in order to build an account of how people's work is socially organised from outside their local space. In this study, observations captured individual moments in time, and it was the threading together of these individual episodes that enabled the emergence of a collective narrative. The narrative was then capable of unveiling the team's journey and the influence of external factors. To ensure that the participants' voices remained central, a process of participant 'sense checking' was included (Lincoln & Guba, 1985).

The participant sense checking was a core and sustained activity throughout the research journey. A deliberate and consistent approach throughout the observation period centred on ideas, analysis, and insights being returned to the participants in a number of informal encounters. Discussions occurred at opportune moments on car ride, in team meetings, and during lunch breaks, and draft summaries of findings were shared with participants. This approach was emergent, rather than structured, in line with the ontological and epistemological positioning of the research. It was important that this process was not governed by strict guidelines and procedures, as this would risk changing the gaze of the researcher and leading to departure from the task of

explicating the problematic, thus forcing the findings, rather than enabling their emergence (Rankin, 2017; Smith, 2005).

Participant sense checking ensured alignment with the participants' experience, which improves the dependability, trustworthiness, and credibility of the findings (Rashid, Hodgson, & Luig, 2019). However, it is important to note that the accounts of the standpoint group were not considered as a singular perspective, and the resulting findings were not obliged to describe or accommodate their perspectives alone. There was an acknowledgement that the researcher would organise the knowledge differently from those within the standpoint group, and that it was within these contrasting descriptions that the insights into the social organisation would be found (Rankin, 2017). Therefore, the process of returning the data to the participants was not only a process of checking data and analysis but also a process of providing insight into the contrasting perspectives of the researcher and the standpoint group in order to explore the social organisation of the selected case (Rankin, 2017).

5.14 Storing the Data

Institutional ethnographic approaches require a melding of data from the macro (text) and the micro (individual, team) levels to gain an understanding of the institutional processes that influence the experiences of people within a local setting (Walby, 2012). The adoption of this approach acknowledges the complexity of people's experiences within institutions and the insight people's experiences bring to understanding those same institutions. To enable the complexity and volume of data to be effectively managed, NVivo software was used to as store all transcribed interviews, typed fieldnotes, memos, and texts. For an individual researcher with a complex data set working from three different bases, it was vital to maintain good research governance.

5.15 Reflexivity in Analysis

Throughout the study, the understanding of the presence of self was significant, as the study cannot exist separately from the self, nor can the influence of the self with its own unique perspectives, pre-existing thoughts, beliefs, and values be ignored (Nowell, Norris, White, & Moules, 2017). During the course of the research, it was necessary to engage with the analysis as trustworthy a witness to the accounts in the data, being honest and vigilant about how themes were selected and developed (Starks & Brown Trinidad, 2007). The knowledge of the local space and actions was interpreted, and what was seen, what was selected and what was written were all influenced by the researcher's socio-historic location (Hammersley & Atkinson, 2007).

Through a reflexive approach, analytical attention was given to the locality and influence of the researcher, which enhanced trustworthiness in the research analysis, as it provided an evaluation of how the interpretation of data happened and exposed the positionality of the researcher (Creswell, 2013). The researcher does not enter or leave the field unchanged, and that change influences how the knowledge of the local can be extrapolated and understood (Palaganas, Sanchez, Molintas, & Caricativo 2017). Reflexivity also enabled the tracking of the influence of the research and the local on the researcher. Examples of reflexivity are provided within the presentation of the findings in Chapters 6 and 7 .

5.16 Chapter Summary

As presented in detail in this chapter, the methods applied to this research were based on the work of Smith (2005, 2006a, 2006b) and followed an institutional ethnographic approach. The approach was adapted to support the specifics circumstances of this study, including the incorporation of thematic analysis. At the core of all activities within

the study was the maintenance of high ethical standards to ensure that the final report was an honest and trustworthy account of the participants' experiences.

Chapter 6. Findings of Stage 1: Standpoint Group Selection

6.0 Chapter Introduction

This chapter reports the findings of stage 1 of the study and includes the presentation of adult social care and adult community nurses as the choice of standpoint group. Following thematic analysis of the interviews, the following themes were identified: 'institutional maintenance', 'leadership', 'presence', and 'vision and strategy' (see Fig. 25)

Figure 25

Themes of stage one

The adult social care and community nursing (District Nursing) teams were selected as a suitable standpoint group because they were central to the organisational integration but were marginalised by the process. The following sections present the analysis of the interviews, and the chapter concludes with the rationale for the selection of the adult social care and adult community nurses as the standpoint group.

6.1 Theme 1: Institutional Maintenance

Institutional maintenance was a substantial theme and was observed across all interviews and observations. The term 'institutional maintenance' is used here to describe the several actions and behaviours that were aimed at maintaining institutional norms and structures. The reporting of these behaviours by participants appeared to confirm the foreshadowed problem, as they revealed a disconnect between the narrative and reality of integration. This disconnect can be seen in excerpt 1.1 and is presented Figure 26

Excerpt 1.1 (Interview)

> *'…..it's going to be a positive change, they (management) talk the talk….. but I cannot see it in action yet…' (community nurse).*

The participants expressed that while there was a strong narrative around integration, there was a belief that little had changed, and institutional norms continued despite the organisational rhetoric, as identified in excerpts 1.2 and 1.3.

Excerpt 1.2 (Interview)

> *'I think it was a kind of vision that would be a move towards community services and away from the acute trust so that people only needed to go into the acute trust when they're acutely unwell and we would keep a lot of people at home and that would be the drift' (physiotherapist)*

Excerpt 1.3 demonstrates that the participants were aware that there was a practical reality that was potentially different from the vision:

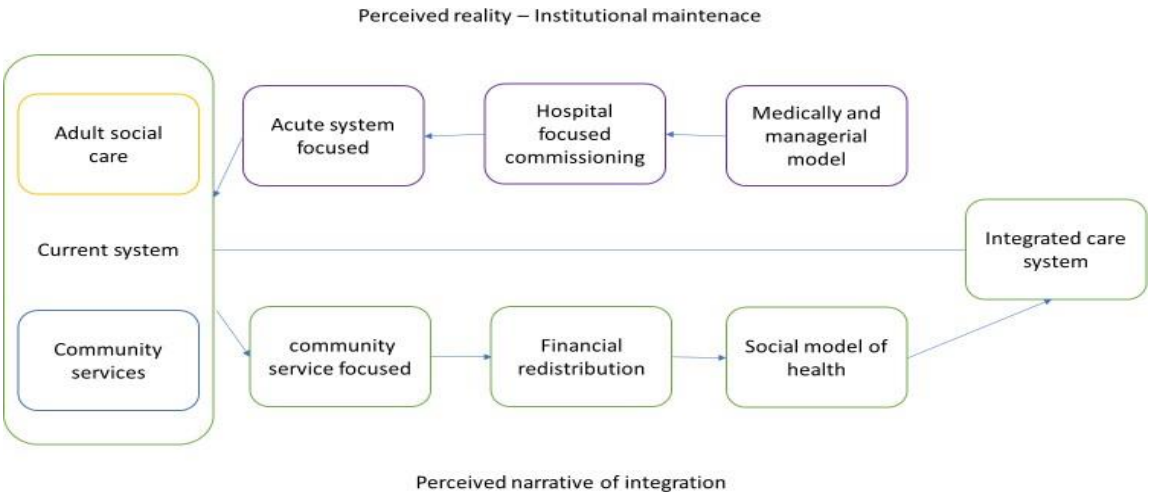
Excerpt 1.3 (Interview)

> '*I just need to see the vision of where the money is going. My worry is the money will go to the most acute need – Clarification request – the acute need in the hospital because that is where the money is needed ….It might lead to a shift away from the community to the hospital' (community nurse)*

The divergent views between the 'community-focused' narrative and the reality of finances which it was felt would remain in the acute hospital sector were common across the interviews and are summarised in Figure 26. The figure illustrates that while there was a strong change narrative, the interviewees felt that the narrative did not match the actualities of integration, which focused on maintaining traditional models.

Figure 26

Perceived narrative and reality



Participants identified that the goal of integration was to transfer services into community settings; however, there was a perception across participants that the

financial requirements of the hospital would be prioritised over the transition, as expressed in interview excerpt 1.4.

Excerpt 1.4 (Interview)

> '*Community services don't get the same budget ….the hospital requires a lot of financial support... we are not a big Trust it's hard to see how the budget will move and if it doesn't …..it's hard to see changes happening' (physiotherapist)*

This disconnect was echoed in the observations of meetings, as in excerpt 1.5.

Excerpt 1.5 (Fieldnotes)

> *'The meeting included staff from a number of the teams they were discussing the challenges of the move (integrating the teams) – these challenged were described in both practical terms – computer systems, desks, and locations and cultural terms including the differences between the cultures of the organisations – these differences were seen as being organisational rather than local' meeting notes, neighbourhood development meeting, June 2017*

A further example of the maintaining of institutional norms was that the neighbourhood meetings were held at the GP health centres and chaired by either the neighbourhood manager and/or GP, revealing a traditional institutional power structure. Participants across all interviews highlighted similar examples of the maintenance of the traditional power balance between the acute hospital services (high power) and community (outside of a hospital—low power) and primary care (GP—high and low power). However, in contrast, interviewees also viewed integration as a method of changing

and shifting power bases with more focus on empowerment of the community as illustrated by the following participant quote:

Excerpt 1.6 (Interview)

> *'We are the poor relations; the hospital is important – it's just bigger and its where the money goes. But that must change, we need to prevent people needing the hospital and that should mean that integration will, put more…. emphasis on the community.' (community nurse)*

The interviewees perceived that integration was a potential tool for shifting institutional power, but also expressed that there was an imbalance between the hospital and community.

The participants identified adult social care and community (district) nursing teams as core to the formation of the neighbourhood team. These teams were perceived as essential to the integrated care offer, which aimed to provide a more integrated service to patient/service users, as the neighbourhood manager explained:

Excerpt 1.7 (Interview)

> *'Once formed the new neighbourhood team will have responsibility for managing some of the most vulnerable people in the community, who have complex health and social care needs.' (neighbourhood manager)*

The analysis revealed that while the adult social care and adult community nursing team were deemed essential, they were also perceived as having a minimal voice in the decision-making process. In observations, the absence of community nurses and social workers from meetings was noticeable. Often the community (district) nursing

staff were not in attendance, the reason given for non-attendance was workload commitments. In these initial stages of integration, there was an 'institutional maintenance' which presented as a lack of transition in the balance of power and was visible in the lack of a voice and presence of the adult social care and adult community nursing team.

6.2 Theme 2: Presence

The interviewees discussed presence or 'the act of being together with others' across all the interviews, which was also reflected and reinforced in observations of the neighbourhood meetings. The interviewees expressed that the lack of presence was an outward symbol of exclusionary behaviours that prevented certain groups (particularly community nurses) from being able to interact with the integration process. The following interview excerpt (1.8) with a member of the management team reiterated the position of the community nurses as lacking a presence within the process of integration and within the wider organisation:

Excerpt 1.8 (Interview)

> *'Because of time they (community nursing) don't know who to ring-. I think sometimes they are anxious that everyone else is 'can-do' but they are perceived as not being 'can do' because there isn't an awful lot of well if you do this for me, I can do this for you – there isn't that bargaining.' (neighbourhood manager)*

Conversely, it was expressed that co-location and integration would provide an opportunity for the teams to be present with each other. The expression of a need for

and perceived benefit of being together as teams is explained by a social work participant in excerpt 1.9:

Excerpt 1.9 (Interview)

> *'A major challenge is – speaking to people (nurses) ….That does not always happen because of their work…..if you have a (patient) need that, requires a discussion – I have had a difficult case, her environment has broken down if the nurses were here, we could have a 5-min discussion. How do we work together? That 5 min will make all the difference…' (social worker)*

The statement was not isolated, and other interviewees also expressed the challenges of not being able to work together. Excerpt 1.10 illuminates the effect that this lack of presence had on the team and their views and engagement with integration:

Excerpt 1.10 (Interview)

> *'What they really want - co-location the nurses and social care want to be located together, which for us is sensible – it is how you get to have conversations, and how you get to work effectively, talking and getting together.' (community nurse)*

There was a perception in the interviews that integration was a positive shift to a 'more sensible' way of working. The view of integration as positive re-emerges in stage 2 of the study and is presented in Chapter 7.

6.3 Theme 3: Vision and Strategy

The theme of vision and strategy describes how interviewees perceived and were influenced by a range of visions of integration, as well as how they interpreted the organisational strategy. The interview data revealed that the vision of integration was

important, with all interviewees commenting that community services (health and social care) were central to the delivery of an integrated approach, as exemplified in interview 1.11

Excerpt 1.11 (Interview)

> *'Integration is important to us in the community – it's our time, integration will help us improve care especially as we can all work together and use each other's skills.' (community nurse)*

Interviewees stated that integration would improve the work of those community teams, as they could pool resources and skills, as mentioned in excerpt 1.11. In contrast, excerpt 1.12 demonstrates a wider acknowledgement that integration was a concept and part of a vision, rather than an actuality within their workplaces:

Excerpt 1.12 (Interview)

> *'Integration is……. a concept, as a lot hasn't happened yet – we can see the value of it but it's how we get from here to here.' (social worker)*

This statement revealed positive attitudes towards the concept of integration, but there were also statements that revealed potential concerns about the construction of the neighbourhood team and the underpinning organisational vision, as described in excerpt 1.13.

Excerpt 1.13 (Interview)

> *'Integration, is there a vision? – District nurses are not the only health professionals we have contact with, so how do we integrate better with them as well. Looking at GP practices, looking at Community mental*

health (not part of the formal integration) how do we work with a range of people not just nurses how do we integrate with them.' (social worker)

This statement reveals a potential divide between the organisation and the adult social care team, suggesting that there may be a marginalisation of the adult social care team, as their voice was not present within the decision-making processes or the vision of the new integrated service.

The interviewees described support for integration, but this was coupled with concerns about the organisational vision, as articulated in excerpt 1.14, which demonstrates the uncertainty felt by the practitioners.

Excerpt 1.14 (Interview)

'So, they're in the neighbourhoods and they're all being brought together co- location etc. so they're clearly integrating us, but then us in this intermediate tier we're still separate. The therapy thing is - you've got us that are working in the neighbourhoods and you've got those of us that are working in the acute trust and I don't get it, really, I don't get the…. I don't really understand I don't get that vertical integration.' (physiotherapist)

The participants and observation revealed a divide between the vision and strategy of the organisation and the local team members. There was an expression of the wider narrative of integrated care within the interview group; however, there were concerns about how this vision would become a reality. This divide again demonstrated an alignment with the foreshadowed problem and provided confirmation that in the period prior to co-location, there was a disconnect between what was being said organisationally and peoples' experiences in local spaces.

6.4 Theme 4: Leadership

During interviews, participants discussed the importance of clear leadership, as seen in excerpt 1.15.

Excerpt 1.15 (Interview)

> *'Leadership is the key… if we provide good positive leadership this will support the teams through the transition.' (neighbourhood manager)*

A leader identified as significant was the neighbourhood manager. The neighbourhood manager was viewed by participants as the key coordinator who translated between the diverse groups across the organisations involved in integration, as seen in excerpt 1.16.

Excerpt 1.16 (Interview)

> *'Neighbourhood manager…The manager comes here quite often; she tells us what's happened she keeps us informed.' (social worker)*

In both excerpts 1.16 and 1.17, the interviewees expressed that the teams viewed the neighbourhood manager as the conduit for information across organisations.

Excerpt 1.17 (Interview)

> *'We get a lot of information from the neighbourhood manager. They are new I think it's an important bit of their job' (community nurse)*

The importance of this identification was that many of those interviewed felt there was a separation between the local and organisational level. The neighbourhood manager expressed a similar view herself, as she describes the pivotal and central positioning of the role in excerpt 1.18.

Excerpt 1.18 (Interview)

> *'By the nature of my role as a neighbourhood manager, I am right at the heart of it …. right in the middle of it, in terms of trying to drive agendas and transformation forward, but making sure we keep the staff engaged, updated.' (neighbourhood manager)*

Significantly, the neighbourhood manager acted as a bridge between many of the professional groups and the wider organisation, providing a two-way communication channel, as seen in interview excerpts 1.13 and 1.14. The manager acted in a way as to mediate potential rifts or divergences between professional groups. While their official role was to lead and transform the service, interviewees ascribed the role more of a broker function, working across the system, managing the diverse groups, and influencing change. The neighbourhood manager was an external leader to the teams, and therefore the weight of importance and leadership that interviewees placed in her role was noteworthy (excerpt 1.16):

Excerpt 1.16 (Interview)

> *'The neighbourhood manager is important to us, she tells us what is happening out there ….in the Trust and can tell them what we need.' (community nurse)*

While there was discussion of leadership in all the interviews, these statements related to the neighbourhood manager or Trust leadership, and it was of note that there was little talk of internal team leadership.

6.5 Identification of the standpoint group

After five interviews, it was concluded that saturation of the data had been reached, as no new codes where being uncovered (Holloway and Wheeler, 2013). The analysis

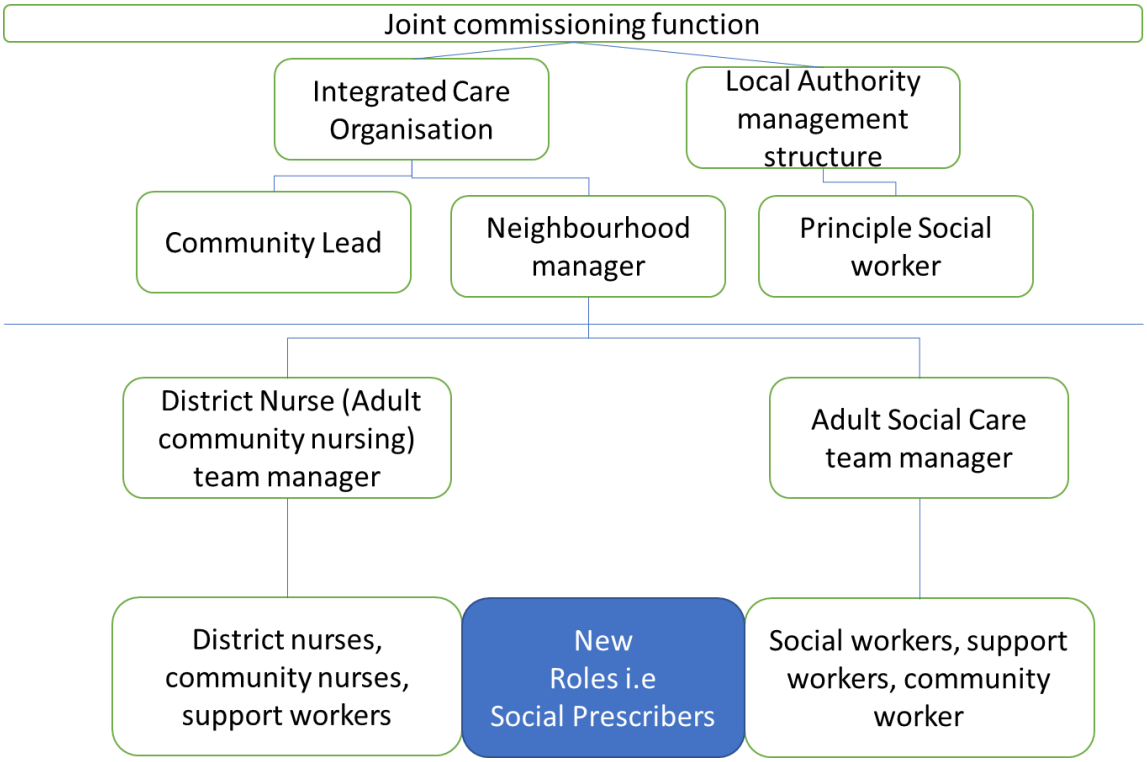
of the findings identified the adult social care and community nursing (District Nursing) team as a suitable standpoint group, because they were central to the organisational integration but were felt by interviewees to be marginalised by the process.

6.6 The Standpoint Group

Selection of the standpoint group established the neighbourhood team members (adult social care and community nursing team) as the case for the study. Figure 27 presents the position of the teams within the organisational structure.

Figure 27

Neighbourhood Management Structure



As can be seen in Figure 27, the organisational structure led to the teams feeding two different management groups within two different organisations. By the end of the study, the transfer process had begun which would see the whole team becoming part of the integrated care organisation. After the standpoint group was identified, the process of meeting the teams commenced. These early meetings were important as they linked to the core ontological assumptions of the methodology that the findings should be through the voice and lens of the participants (Nichols, Griffith, & McLarnon, 2017).

6.6.1 Adult Social Care Team

The adult social care team offered services that were focused on preventing people from becoming dependant on others for their care and support needs and managing the assessment of individuals for home care and residential care. The team holds several statuary responsibilities such as safeguarding, leading, and implementing standards (Anon council, 2018). Table 18 presents the key roles within the adult care team. At the time of the research, there were approximately 33 staff within the team. However, there was use of temporary agency and locum staff during the period to cover vacancies and sickness. There was also recruitment and departures of staff that varied the numbers during the course of the study.

Table 18 *The Adult Social Care Team Structure*

Adult social care team – Local Authority – Commissioned by the joint commissioning function	
Neighbourhood manager (n = 1)	Joint manager with the integrated care organisation [ICO] leads on transformation and the transition
Team manager (n = 1)	Operational lead
Assistant team manager (n = 2)	Team management
Social workers (n = 10)	Qualified social workers
Adult social care assessors (n = 10)	Working in the field of social work but not qualified social workers
Occupational therapists (n = 2)	Qualified occupational therapy provided practical support to people to overcome barriers preventing them from doing the activities (or occupations) that mattered to them. Support to increase people's independence (RCOT, 2018).
Moving and handling (n = 1)	Assessment and management of moving and handling within the community
Direct payment leads (n = 3)	Direct payments were introduced to enable people who have been assessed as needing social care support to pay for their own care directly from care providers. The direct payment leads assess suitability and support transition.
Community support worker (n = 1)	The community support worker works one-to-one with clients to organise a range of short-term support, such as meal packages. They also have a role in linking people to community groups.
Administrator (n = 1)	Provides administrative support across the team
Link worker (n = 2)	Health and wellbeing, assisted technology, re- enablement, intermediate care.

The adult social care team were situated in an old council building, which retained some of the grand features and facade of the area's past industrial prosperity. However, the building's interior had been made generic and plain.

The first challenge on arrival was parking, as the adult social care office was situated in the town centre of an old mill town. Like many such towns, there was a small-town

centre, which was designed before the reliance on cars, and therefore there was little parking available (and what parking there was had time restrictions). The building had a small free car park, designed for about 10 cars. However, on most days, there were approximately 20 cars in the car park, squashed together and blocking each other in.

The building itself had little signage about the team's location, but the team's office was light and lively with staff involved in discussions within small groups across the space. The desks were set up as pods of four to six, and there were staff sat at most of them.

Within the team there were several distinct roles, including social workers, social work assessors, community welfare workers, a manual handling lead, and occupational therapists. Despite the variety of roles, the team did not have many outward symbols that identified different professions. The placement and seating of the staff within the office was not delineated, although managers sat in a separate pod in the same room. Team structures and hierarchy were not identifiable, as there were no symbols, signs, or uniforms in the team. The work of the team was case-based and involved both deskwork (referrals, safeguarding, documentation, and commissioning of care) and visits to their clients out in the community. The team ran a duty system for allocation of daily work, where one worker takes and assesses referrals for the wider team on a specific day and allocates cases to other team members.

6.6.2 District Nurse Team (Adult Community Nurse Team)

The community (district) nursing service provided clinical interventions for people in their own homes or community clinic settings. The team worked closely with GPs, specialist-nursing teams, and advanced practitioners. The main function within the team was providing treatments for patients who are housebound. However, they also

worked in health centres. The team had an open referral system. The main areas of care provided were palliative care/end of life care, wound care, acute care and assessment, ear care, long-term conditions, post-operative care and support, continence care, and bowel care.

The community nursing team reflected wider issues within community nursing, which have been reported by the Queens Nursing Institute (2009, 2014). While the community nursing services strive to deliver a holistic service, organisational developments over the last 20 years have led to a reductionist view of the role, and to nurses being predominantly viewed through the tasks they conduct. Table 19 presents the key roles within the community nursing team. At the time of the research, there were approximately 20 staff, but as with the social work team, there was variance in team numbers over the course the study.

Table 19 *Community Nursing Team Structure*

Community Nursing (District Nursing) Team – Integrated Care NHS Foundation Trust	
Neighbourhood manager – (as above)	Joint manager with the ICO leads on transformation and the transition
District nurse team leader (n = 1)	Operational leader for the team
District nurse (n = 4)	Caseload holder (holding a specialist practitioner qualification), provides specialist and generalist support to people within their own home
Community staff nurse (n = 10)	Registered nurses working in the community
Health care support workers (n = 4)	Non-registered support workers, provide practical and clinical support
Administrators (n = 1)	Provides administrative support across the team

The community nursing team was housed in a health centre, which was located out of the town, a few miles from the centrally located adult social care team. The building was a 1960s flat-roof structure that looked functional but lacked architectural character. The nurse's office was through several locked doors and corridors, and rather than pods, the desks were benches along the walls. Each wall donned several whiteboards, each containing information pertaining to patients or team activities such as enhanced care or training, which reflected the task-based nature of community nursing. In the middle of the room, there was a large conference room table, scattered with papers, information leaflets, and the printed workload of visits for each team member. The morning routine involved team members collecting daily allocation of visits before leaving the office. Unlike in the adult social care team, here members' positions and roles were identifiable, as the team all wore uniforms that identified their role and position within the team.

6.7 Chapter Summary

The analysis of stage 1 revealed that the neighbourhood team were a significant employee group which lacked a substantial or influential voice. Importantly, integration would significantly affect their daily working lives, but they appeared to be marginalised from the process. Therefore, neighbourhood teams were identified as a suitable standpoint group for the research. It is important to note that the selection of a neighbourhood team did not diminish or discount the feeling of or actual marginalisation of other groups, but that it reflected the data analysis at the time. Following completion of stage 1, the study moved to stages 2 and 3 of data collection.

Chapter 7. Findings of Stages 2 and 3

7.0 Chapter Introduction

This chapter presents the main body of the findings, including the text analysis, as an ethnographic narrative overview of the observations, fieldnotes, and memos taken within the local neighbourhood setting. The narrative presented here does not claim to be the whole story of integration for the neighbourhood team. Their journey was still in its initial stages, and even during the analysis, the team continued to develop, move, and change. The findings reflect a segment of an ongoing journey, laying bare the institutional challenges and external influences that existed in the pivotal period just prior to and during the initial stages of the team's transition.

7.1 Commencement of Data Collection

Data collection commenced just prior to the formation of the first neighbourhood team and their co-location. Excerpt 2.1 describes the first observation with the adult care team in October, 2017:

Excerpt 2.1 (Fieldnotes)

> The neighbourhood manager introduced the Adult social care team. In the room there were approximately 20 staff members, they consisted of social workers, social work assistants, direct payment workers and a community welfare worker.
>
> This first meeting took place in the large open plan office. The office was quite generic for a council office. There were few notice boards or personal items.

> The team asked questions about the study – they asked about if I was employed by the Trust, what the research was for. After discussion, the team members completed consent forms for observations.
>
> The team shared their ideas and stories of integration, they engaged in open discussion and were positive about the integration and engagement in the research. The team were familiar with a range of research activities and raised questions on my role, types of data collection, and feedback. The team expressed that the study should provide an opportunity for the team and the organisation to reflect on the integration journey they were commencing. (Adult Social Care – October 2017)

The first meeting was significant to the study process, as it established the fundamental principle that the observations were intrinsically a two-way democratic process that generated knowledge through the actions and being of the teams (Smith, 2005). The establishment of this principle was important as it rooted within the study the epistemological assumptions that participants are both the creators and owners of knowledge. As part of the data analysis, three core themes were developed, each of which included three additional sub-themes. Figure 28 represents the final theme map.

Figure 28

Theme Map

7.2 Theme 1: Convergence and Separation in the Creation of the Integrated Team

During the nine months of observations, there was a process of convergence and separation in which both teams moved from their traditional team structures into the integrated neighbourhood team. The process involved practical, functional, and structural changes alongside shifts in culture, vision, and team identity. Figure 29 maps the process of convergence and separation that took place during the study.

Figure 29

Journey to Integration

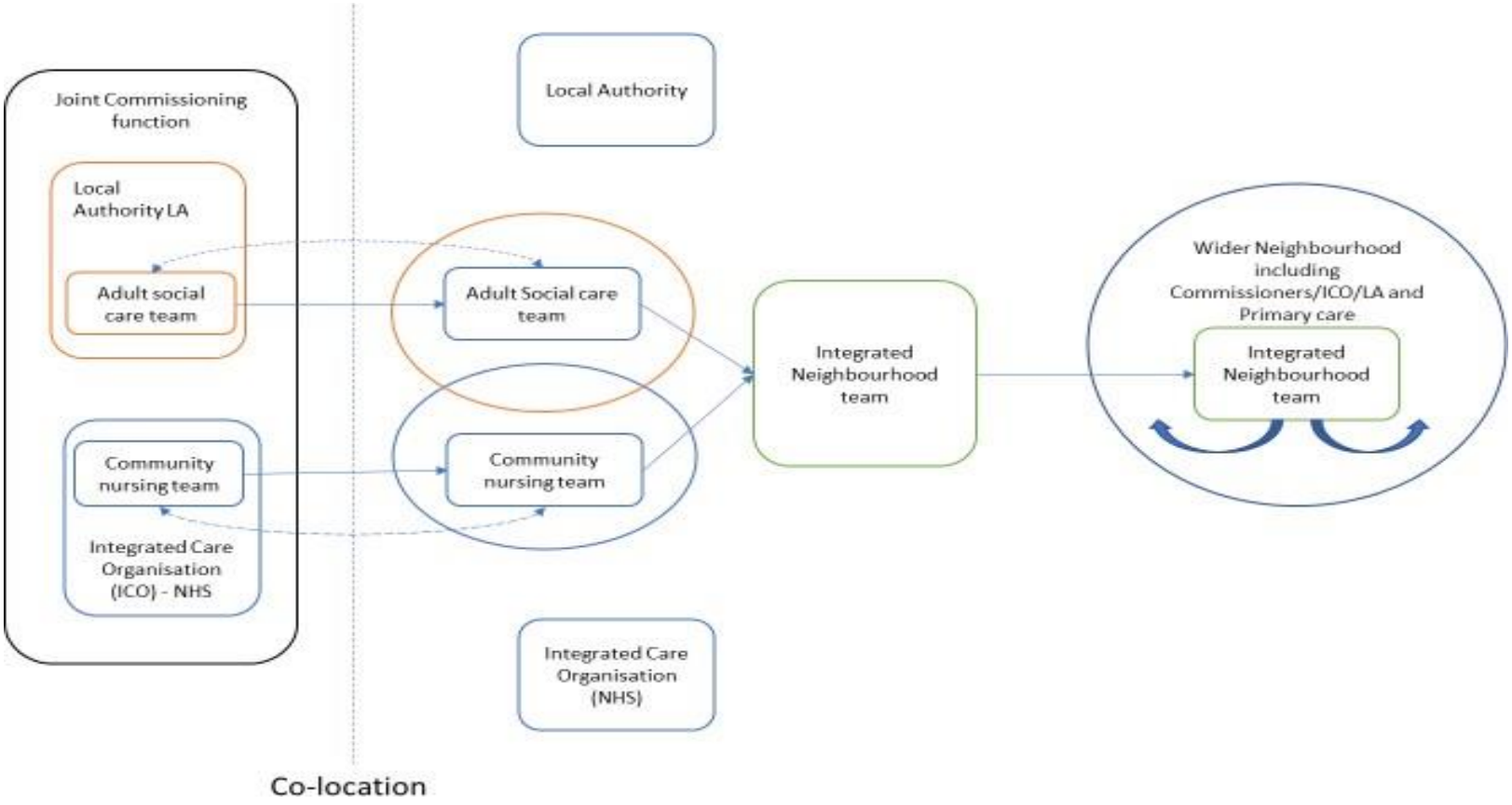


Figure 29 illustrates that prior to co-location, each team resided within its own organisation linked by the recently formed joint commissioning function (the overarching commissioner for NHS and local authority services). The co-location involved both teams being moved from their office spaces into a new joint space within the council building. The manager explained at the time that the joint space was intended to enable the teams to work closely together and form the basis for the integration into one neighbourhood team. Once the teams had co-located, there was a period of convergence as the team moved closer together symbolically and geographically whilst simultaneously separating from their traditional organisational status and identity.

The presentation of this process in Figure 29 is linear, but the process as described by the teams was not linear—there was a repeated movement forward and backwards. The movement between positions was a process of testing, as individuals and groups tentatively moved forward towards the new identity and then returned to a place of safety within their traditional structures until they gained confidence in that new identity. This movement was observed a number of times and is depicted in excerpt 2.2, which demonstrates the tentative steps the teams were making toward integration, while remaining part of their individual team identity.

Excerpt 2.2 (fieldnotes)

> …the two staff members were sat together, they were discussing a visit – both discussed the others role in the patients care, making sure that they were clear on which part of the care would be provided by each profession, they discussed how to conduct the visit expressing a desire to be together and present as one team (Fieldnotes– February, 2020)

The new identity was not exhibited as a final predetermined destination; it was instead constructed and changed over time as the team tested different ideas. For example, as the teams began working together on shared cases, from the outset team members from all professional groups would provide advice, while maintaining a professional distance. As team members tested each other's responses, the tentative advice grew into increased shared visits and the adoption of each other's professional language. Fieldnotes excerpt 2.3 recaps a discussion with a nurse as she considered the social isolation of a patient.

Excerpt 2.3 (Fieldnotes)

> As we travelled between patients the nurse explained that she had been working with a social worker on a case where a patient needed more input. The patient had been on the district nurse caseload for a long time. Their physical health had deteriorated over time and there was consideration whether the patient needed a residential home placement – the nurse was pleased that by working with the social worker they had set up a care package that would enable the patient to stay within their home setting - she explained the importance of developing community links for the person and social engagement. The person was socially isolated, and this was affecting their health.
>
> This linking of health and social need felt like a significant shift in language and focus to an integrated way of thinking – Noteworthy the nurse used terms such as community support and social isolation (social work language). Discussion during observation with (nursing team – Feb., 2018)

The case discussed here was like others observed over the nine-month period. These examples demonstrated the practical ways in which nursing changed, as social workers were changing their practice internally within the team without a mandate from the external organisation. Of interest was the nurse's use of language, with terms such as 'social isolation' and 'community assets', which are more associated with social work than with the heavily medicalised language of nursing.

Over time these examples of new ways of working increased, and the teams began to form a stronger neighbourhood team structure and culture. It was observed that the teams appeared to separate more permanently from their more traditional team structures and identities. Observations in the final period of the study revealed that the teams had developed an internal team identity, which included the blurring of traditional working practices, language, and values. These practical actions led to the forming of a hybrid team identity, which encouraged the sharing of values while also leaving space for individuals to maintain their professional identity (see excerpt 2.4).

Excerpt 2.4 (Fieldnotes)

> 'We work together now…we have gained a trust and understanding of each other - this makes it easier to support people….and ensure that they have the patients, people get the right level of support.' (social worker – feedback meeting, June, 2018)

One sign of the team's confidence in their new identity was that they increasingly brought their vision of neighbourhood team working to the wider organisation through meetings and presentations. Their vision concentrated on a person-centred, integrated approach to case managing their patients and clients. The shift to a new structure and identity was also reflected in the way the neighbourhood team members discussed the

wider organisation. During the final period of the study, there appeared to be a shift away from talking about being separate to being part of one wider organisation. The following sections outline how the process of convergence and separation presented itself within the team.

7.2.1 Reimagining the Team and Creating Team Vision

There were the three conceptualisations of vision observed as being enacted within the teams. Firstly, the received vision, which was the vision that was given to the teams from those external to them (the organisation and policy documents). Secondly, the constructed vision, which was internally built by the team as they subverted and changed the received vision to match their own ideas and beliefs. Finally, the lived vision, which was the vision that the team lived in the actuality of their daily work—how they interacted with each other and worked together in an integrated way. It was observed that there was an interplay between the written visions and the lived (experienced) vision in the early development of the team. Figure 30 demonstrates how the team moved through phases of separation and convergence, with their organisations, historical teams, and new team, finally reaching a lived vision that reflected their experience.

An example of how vision was threaded through the team from the received to the lived was seen in the way that the team embraced the social prescribers. Social prescribers support referred patients/clients to engage with a range of community activities. The introduction of the role aligned very closely with the place-based community focus of the organisational vision (Box 1). However, for the new role to be effective, it required the neighbourhood team to embrace the concept. As the team deconstructed and rebuilt their concepts of the organisational vision, they moved closer to the concepts of community and place-based approaches. The lived display

of this vision was the cautious willingness to engage with the social prescriber and refer their patients to the service, as can be seen in excerpt 2.5.

Excerpt 2.5 (Fieldnotes)

> The community support worker (adult social care) explained the role of the social prescriber – she was cautious about this role unsure how it differed from her own, stating 'I think they do the same as me, but they work for the voluntary people so I guess they are very linked in there' she went on to explain how the voluntary sector were important in supporting families and frail people. (neighbourhood team observations, February 2018)

Figure 30

Construction of Lived Vision

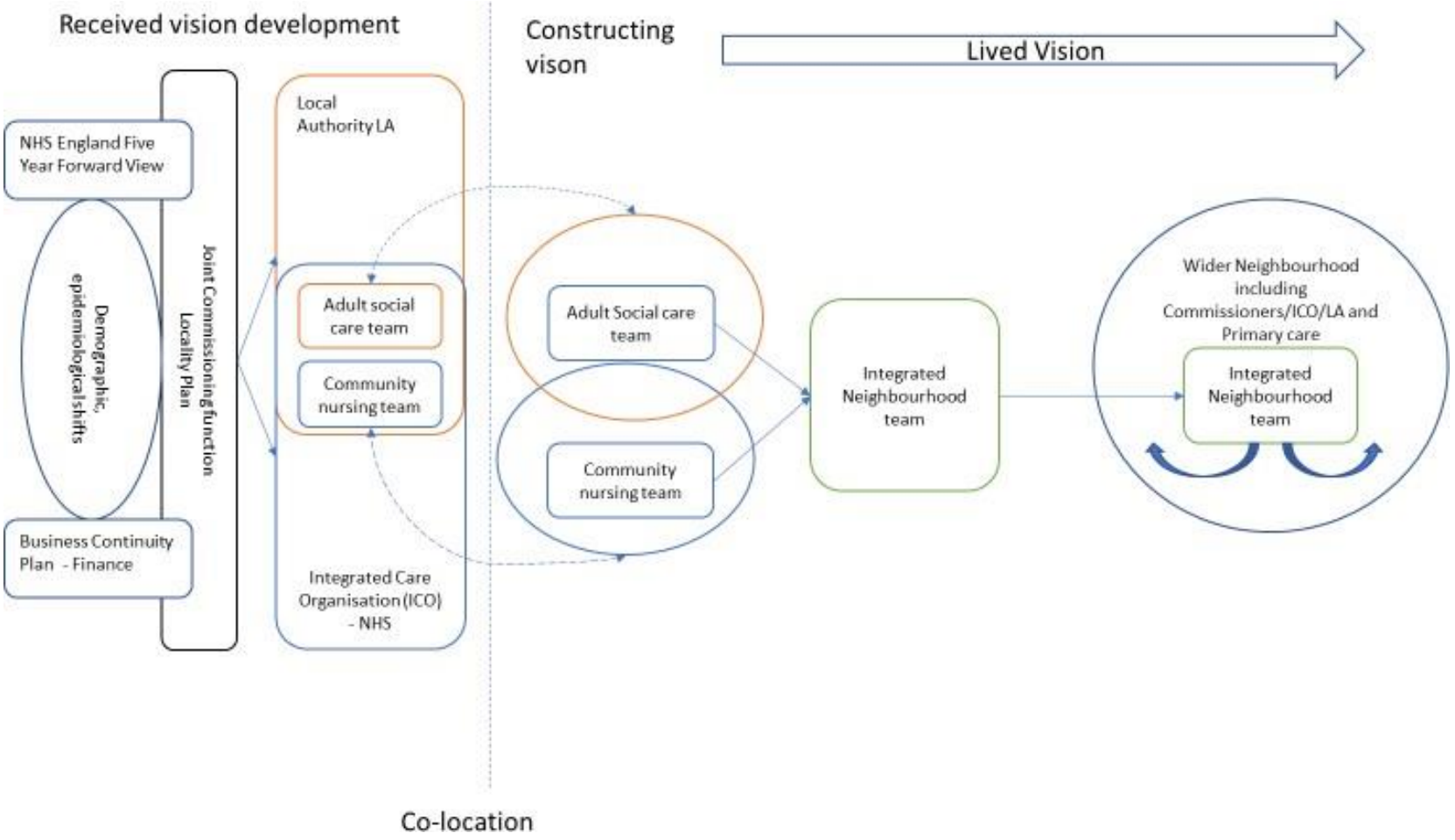


Figure 31 illustrates the key drivers for integration that influenced the developing local vision (left to right), beginning with the demographic and epidemiological shifts within the community which formed the contextual driver for change. Alongside the drivers are the controlling texts such as the 'Five Year Forward View' (NHS England, 2014a) and the 'Business Continuity Plan' (PWC, 2016). These documents were directors of change and influenced the joint commissioning board's locality plan (Text Box 1), which set out the overarching vision for the development of the local health and social care economy. The locality plan suggests the influence of wider controlling texts, such as the WHO principles (2016a) (see Table 1, above). The texts' influence can be observed as their language, concepts, and values move through a number of documents from national and international to the local level.

Text Box 1

The Locality Plan's Vision.

> To significantly raise healthy life expectancy through a place-based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable local health and social care economy within five years. Single Commissioning Group (2016)

The movement of the received vision of integration from the trans-local into the local space is represented in Figure 31. The neighbourhood team then moved through several cycles of testing and developing visions locally, and once developed, these visions were then pushed out to the wider organisation.

Figure 31

The Movement of Vision From Trans-Local to Local

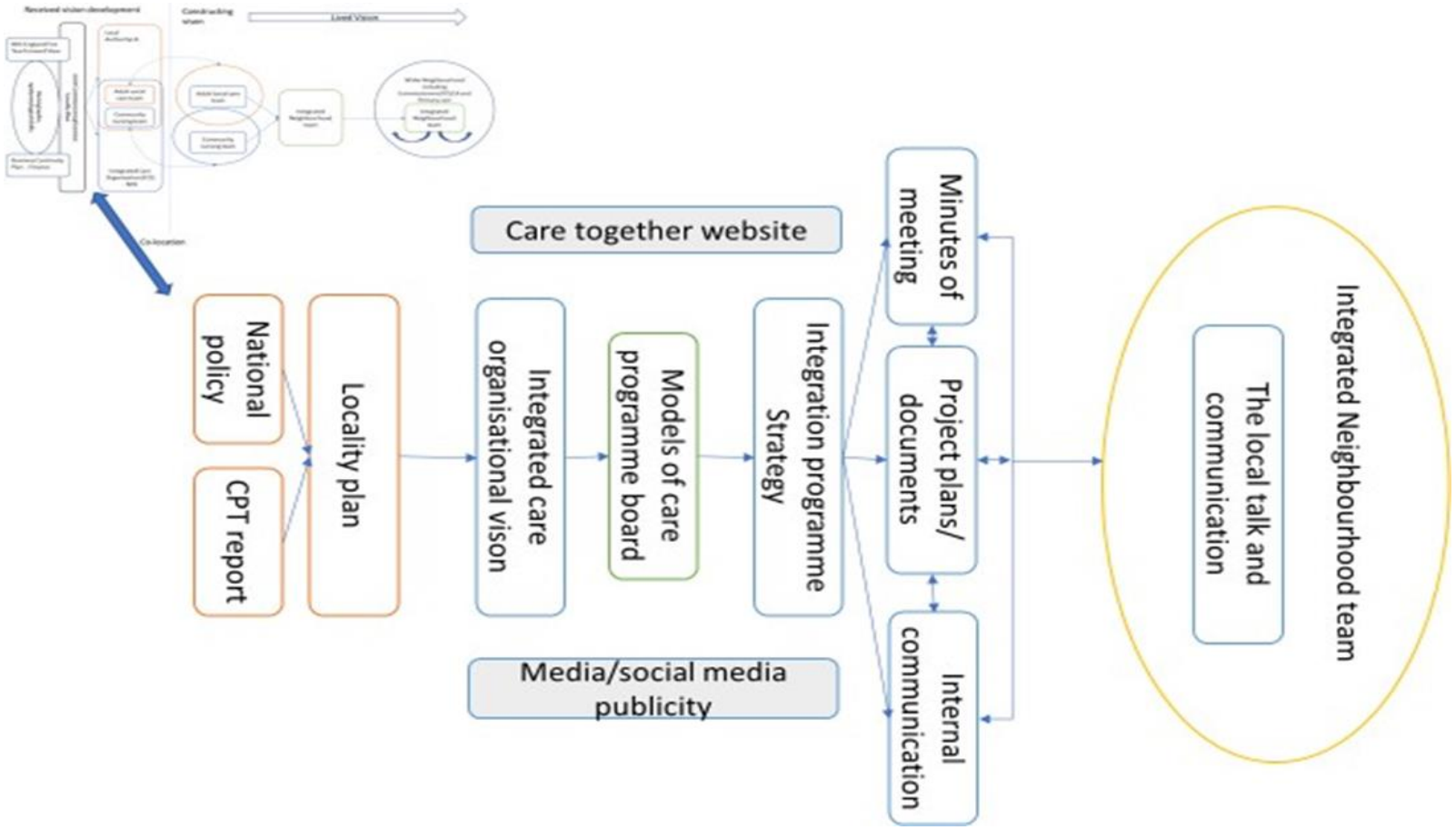


Figure 31 demonstrates the transposing of the locality plan vision into the integrated care organisation's vision, which then influenced the design of the new model of care, and in turn dictated the strategies for the development of the new services. These strategies included a move to digital health care, the development of the neighbourhood teams, and a system-wide self-care approach. The strategy documents guided the development of each project, and through this guidance, the language and essence of the locality plan became embedded within talk at a local level. However, the vision itself became less directly visible; there were no written references within the team area, and the organisational vision was rarely spoken about. This team vision was created by the teams as they deciphered, interpreted, and deconstructed the received vision (locality plan vision) and attempted to place the external text vision within the practical actualities of the new team as demonstrated in the following fieldnotes:

Excerpt 2.6 (Fieldnotes)

> …. sat with a member district nurse team and a member of the social care team at lunch, they were discussing the practical issues that had arisen since the co-location. They made jokes about car parking and the IT system. The tone was light-hearted and supportive of each other's issues.
>
> They both concluded that these issues had arisen because of the lack of understanding of their role…we are close to the patients…part of the community, they (the integrated care organisation) in the hospital, well they just don't get what we do…(observation, integrated team - March, 2018).

The interaction described in excerpt 2.6 was not unusual and was repeated frequently during the observation period. The professional groups that made up the integrated care team identified a divide between themselves as a ‘frontline, people-focused staff group’ and a distant and disconnected organisation that employed them. The observational data revealed how the teams did not reject the received organisational vision, rather they appeared to subvert, metamorphose, and develop the essence of the vision to form a co-created lived vision that reflected their unique actualities, as expressed in the excerpt 2.7

Excerpt 2.7 (Fieldnotes)

> The district nurse team leader explained a meeting she had attended earlier that day. It was noticeable that when discussing the meeting she referred to the organisation as ‘them’ or ‘the Trust’ outlining the difference between the organisation and neighbourhood. (discussion during observation, integrated team – Feb., 2018)

An influencing factor in the development of the team’s vision may have been the neighbourhood team’s position as the vanguard of frontline integrated practice within the Trust. They were the first team to co-locate and therefore had no previous team within the organisation to consult for guidance. Even though the teams were forerunners in the Trust, their decisions and views reveal the influence of the meta-narrative of integration. This could be seen in how they used similar language to that

which was stated in the controlling texts such as the 'Five Year Forward View' (NHS England, 2014a).

The documents analysed were important as controlling text that influenced the local neighbourhood setting, because they created the narrative that supported integration. For example, the move towards a more social model of health care is a clear thread across all the documents, alongside the need to change the structure and form of organisations. An example can be seen here in the opening pages 'Taking Charge of Our Health' (GMCA, 2016:2) (see also Table 20):

> *"In order to achieve this, we know we need a radical change in how we build resilience in people and communities, as well as providing safe, consistent and affordable health and social care. We need to strike a new deal with people in Greater Manchester."*

These documents were not discussed within the neighbourhood team. However, the narratives of empowering people and enabling communities appeared particularly powerful and were present within the local discussions between team members as for example during a discussion with a district nurse early in the integration, excerpt 2.8.

Excerpt 2.8 (Fieldnotes)

> '….We are all about the patient – that's what community nursing is….we work with a lot of patients for a long time, we are not just about…doing to the patient…we want to make sure they are involved in their care…' (discussion with community nurse, March, 2018)

The language used by the teams locally reflected that used within international, national, regional, and organisational strategies. Importantly, language used was

consistent and repeated many times across a wide range of documents. Table 20 presents an example of textual analysis that draws out some sample language on empowering people.

Table 20 *Textual Analysis: Empowering People*

Geography	Document	Statement
International	Framework on integrated, people-centred health services (WHO, 2016:5)	'It aims to empower individuals to make effective decisions about their own health and to enable communities to become actively engaged in co-producing healthy environments, and to provide informal carers with the necessary education to optimise their performance and support in order to continue in their role'
National	Five Year Forward View (NHS England, 2014:9)	'As a result, we have not fully harnessed the renewable energy represented by patients and communities'
Regional	Greater Manchester Combined Authority Taking Charge Implementation and Delivery Plan (GMCA, 2017:4)	'Person and community-centred approaches mean putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active' involvement in their care
Organisational	Locality Plan (Anon, 2015:6)	'We will strive to empower local residents, build community resilience by developing and delivering place-based services and early intervention and prevention to keep people healthy and independent'

Within the context of the neighbourhood team, one reason that empowering people was such an influential narrative was that it formed part of the core principles of nursing and social work, as can be observed in excerpt 2.8. Importantly, the same language is echoed in codes of conduct for both professional bodies, as demonstrated in the following section from the Nursing and Midwifery Council [NMC] Code of Conduct (2018) and in the definition of social work from the British Association of Social Workers [BASW] code of ethics (2017) (Text Boxes 2, 3).

Text Box 2

NMC Code of Conduct (2018)

2.3 'encourage and empower people to share in decisions about their treatment and care' (NMC, 2018)

Text Box 3

BASW Code of Ethics (2017)

'Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.' (BASW, 2014)

During the observations, it was noted that team members linked their professional core values to the narrative of integration; for example, nurses and social workers stated that they felt that integration was a method of being able to work closer to the ethical grounding of their professions, as recognised in excerpt 2.9.

Excerpt 2.9 (Fieldnotes)

> The district nurse team leader discussed with me why she moved to the community, stating, 'We are different to hospital nurses…. We do not have walls. Community nursing is about people's lives…we have nursing tasks but it more than that…'(Community nurse, March, 2018)

While it could be seen that there was a link between the text from the trans-local to the local, within the local setting there had also been a delay in the organisational change management programme aimed to support the development of the team. This delay caused a disconnect between the strategic vision and the newly formed team, which manifested in diverse ways (see Fig. 33).

Figure 32

Impact of Clarity of Vision on Neighbourhood Team Development

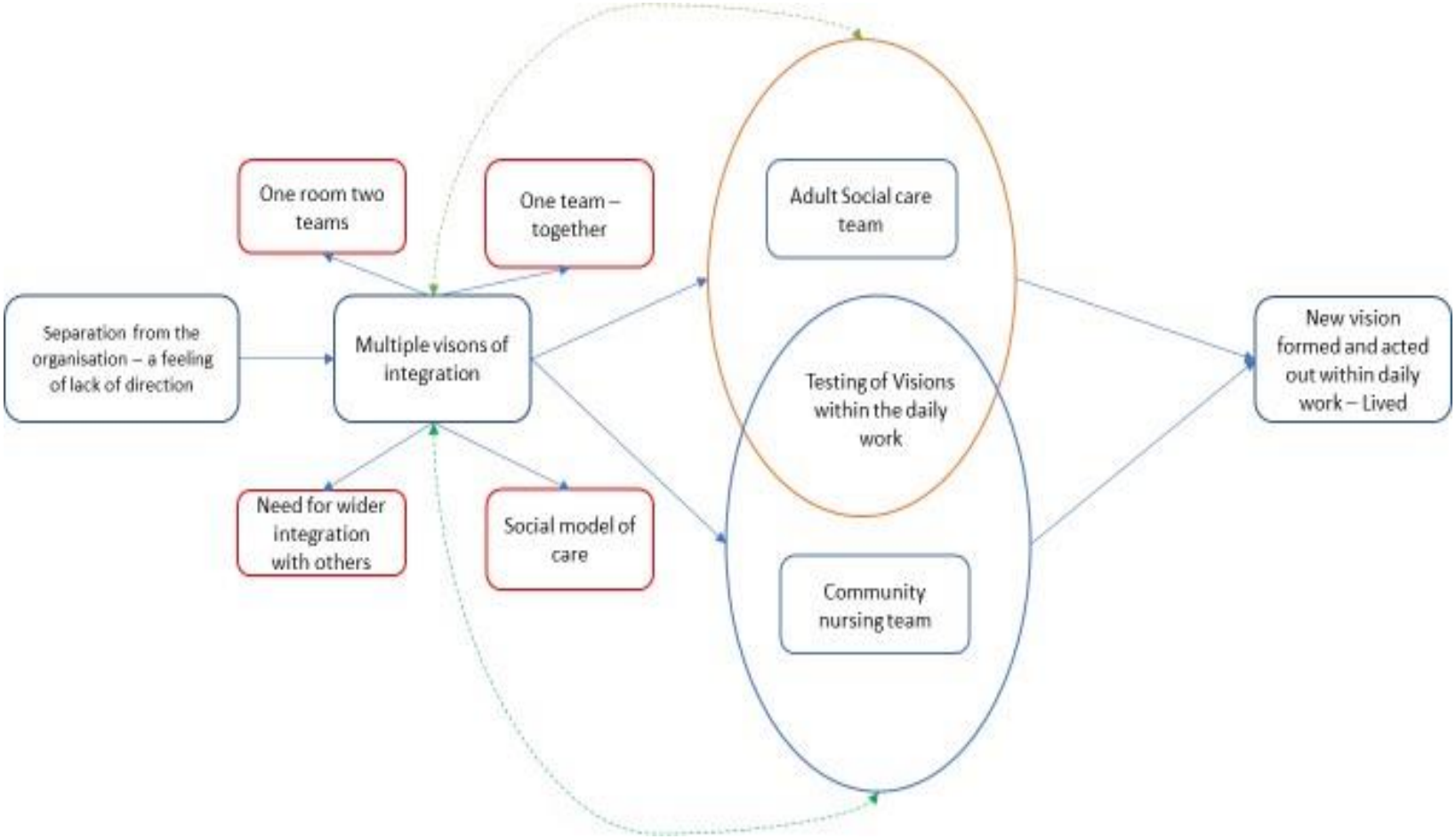


Figure 32 illustrates the conflict that arose as the wider organisation simultaneously influenced the local through the controlling texts (such as national, regional, and local policy documents) but did not provide direction, due to the delays in organisational support. The team leaders regularly discussed within joint meetings and informally within the working day their desire to make integration a success. However, they were apprehensive regarding what they perceived as a lack of guidance and vision from the 'integrated care organisation' (the NHS Trust). One manager explained that there had been a Trust organisational development programme 12 months previously, but that there had been little follow up on how to apply the programme. One output of the programme had been the development of a vision statement (Text Box 4).

Text Box 4

> 'The integrated neighbourhood vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support self-care and have improved outcomes, prosperity, and wellbeing.'

There was an influence and strategic alignment between the team vision and the locality plan, as it has similarity in the content and language used. Throughout the observation period, the team did not speak of the vision, and there was no visual signalling within the office. The neighbourhood manager expressed disappointment that the team rarely referred to the statement in their daily interactions. At a superficial level, this suggests that the team were not influenced by the wider vision. However, the daily actions of the team appeared to demonstrate that they had adopted the essence or spirit of the vision in their talk and actions. An example from shortly after the co-location was when team members described how they made proactive attempts

to work together to support patients and service users. They cited the holism of health and social care as a common ground where they could bring their professional skills together to support people, as demonstrated in the following fieldnote:

Excerpt 2.10 (Fieldnotes)

> A nurse was discussing a missed visit from the morning, she had been trying to locate the patient, a social worker came over to join the nurses. She explained that the patient was in hospital and they were trying to discharge them, the social worker was worried about this, she felt there wasn't the support and was unsure about the patient's management of her long-term condition – they had a short discussion expressing frustration that the hospital did not communicate effectively with the district nurses. Then they sat down and moved to discussing a plan for the patient's discharge and agreed on a set of concerns to take to the multi-disciplinary meeting in the hospital…(observation, integrated team – April, 2018)

The interaction described in excerpt 2.10 was not unusual and demonstrated that the teams aligned to the vision through acts of spontaneous changes to working practices that matched the sentiment of the vision. These were important actual acts of convergence that established common ground and principles between individual team members. The delay in the organisational change programme appeared at this stage to present an opportunity and freedom for the teams to create and lead the change themselves.

The organic development of a lived vision was not without challenges for the team, and although common ground was established between individuals, there were also

different ideas of integration developing in the team (see Figure 32). An example of how the vision manifested in the practical could be seen in desk allocation. The adult social care team had a desire to develop a shared space by mixing the teams in desk hubs, whereas the community nursing team with their more cautious approach argued for sitting together as a professional group. It appeared there were two visions of integration: ‘two teams - one-room’ or ‘one integrated team’. In several discussions between the team leaders, the two developing visions did not appear to be reconcilable. However, in January, 2018, just prior to the co-location, the teams held a meeting which affected both teams’ positions. The social work team leader expressed the importance of the meeting, stating that it was to build relationships (excerpt 2.11).

Excerpt 2.11 (Fieldnotes)

> The manager explained that the District nurses were coming…the team manager was excited as she felt it would make them feel like they are part of the changes. She is keen they are involved as she feels they might not have had as much opportunity and she wanted them to be included. (discussion during observation, adult social care office - Jan., 2018)

Even though the teams had been meeting for some time, the co-location was becoming a reality at this stage, and several key areas remained unresolved. These areas included seating, IT, storage, and car parking. The adult social care team used the meeting to test discussions about the new team, as illustrated in the following fieldnote excerpt (2.12)

Excerpt 2.12 (Fieldnotes)

> The meeting was held around the small table where the team had lunch. The nurses (all in navy uniforms) sat together. The conversation was friendly but did not have the informal flow or 'banter' that both teams stated as important to their working relationships. The District Nurse was discussing the need for space in the office; she felt that consideration had not been given to the needs of the team. She talked quickly and continuously, metaphorically taking the space in the meeting as she explained the need for space within the room, there was little storage space for the nursing supplies and the space that had been given was unsuitable as it was under stairs and had little actual access. There was frustration from the nurses that the needs of their team were not being considered. The ASC [adult social care] managers yielded and enabled the nurses to have space and time - they listened. After a while the conversation and tension subsided, from both the nurses and ASC managers. At this stage, they had not solved any of the issues, but they had been spoken. The conversation quickly became animated by the advantages of the move and this led to enthusiastic debate on the vision of what integration could be. Each team shared their ideas and principles regarding integration. (observation – team meeting prior to co-location – Nov., 2017)

The meeting described appeared to present a convergence of the two teams into one integrated team, as it represented a changed dialogue between the teams from a

distant to a shared experience. The discussions were also an important example of the significance of space. In the meeting, the teams drew on their everyday considerations and experiences as symbols and ways of understanding. An example of this was demonstrated by the nurses who explained that they move substantial amounts of supplies from their cars to the office, and so the lack of suitable parking was a problem. During the discussion, there was a transformation through talk of parking from a practical issue into a symbol of the organisation not understanding the needs of the team. The meeting (excerpt 2.12) was also a point of convergence for the newly forming team, resulting in the adult social care team providing support to the nursing team, offering to park off-site so that the nurses could have more spaces. The adult social care team's act of support changed the nature of the conversation between the nursing team and the social work team and created a common set of values from which to build a common vision. Therefore, car parking became both a symbol of a disconnected wider organisation and solidarity within the neighbourhood team.

7.2.2 Metamorphosis of Role and Task

The theme of metamorphosis of role and task describes the method of change that occurred within the forming team. The choice of the term 'metamorphosis' reflects the organic nature of the change. The following example (excerpt 2.13) demonstrates how these changes happened over time, as an evolution rather than a revolution. The example relates to patients within the community nursing caseload who were socially isolated. There were three important moments within the example, starting with the frustration felt by the nurses, moving to a realisation of the potential and real benefits, to, finally, empowerment to strive forward together through the convergence of the team and metaphorising of the roles within the team.

Excerpt 2.13 (Fieldnotes)

> Early in the observations, a nurse expressed her opinions on how she felt integration could support practice. The nurse had explained that community nursing teams hold caseloads of patients, many of the patients on the caseloads are socially isolated.
>
> 'You see social isolation at lot now, older people living alone with no family.'
>
> The nurse expanded stating that the management of social isolation was difficult, due to the working practices of community nurses. Which, due to the high caseloads and low staffing levels, had become more task driven. The nurse explained that, traditionally community nursing roles had been wider and had encompassed social elements. The nurse felt a loss of role and frustration at wanting to do more for individuals identified as socially isolated at assessment, she stated that, 'it wasn't viewed as part of their job' and she felt 'powerless'. The conversation reflected several interactions with the community nurses, who shared the view that their role had become task driven. (fieldnotes, community nursing team, Nov., 2017).

The nurse's remarks expressed that she felt that there has been a loss of the core mission, a view equally expressed in excerpt 2.14.

Excerpt 2.14 (Fieldnotes)

> As we travelled between visits the nurse explained why she had moved into the community. She talked about the holistic nature of the role, how it wasn't just about medical care, but working with people and families. She felt this had been lost recently. (observations - community nursing - Nov., 2017)

A secondary narrative underpinning these conversations was that nurses felt that the loss of role was not merely about the demand on the service, but reflected how the community nurse's role was viewed, defined, and controlled organisationally. These perspectives, stories, and expressions of frustration were important to the story of integration, as they provide a glimpse into how the community nurses felt at the time of co-location. Not only did they express a sense of loss of the core values that underpinned their work, they placed the cause of the loss at the door of the organisation. It could be argued that under these conditions, the meta-narrative of integration was appealing, as it spoke to the core values of community nursing and provided a means to move away from a set of working practices that caused frustration. An example of the nurses linking the meta-narrative of integration to their daily work can be seen in how the nurses related to the controlling texts of integration. The teams openly discussed and engaged with the themes of empowering people and creating enabling environments, as these matched their values. However, the governance and accountability and reorganising of models of care principles, which were a thread running through the literature from the international to local level, was viewed sceptically, which reflected the reduced trust they felt in the wider organisation. This scepticism can be seen in the following statement from a nurse commenting on the transfer of teams into the Integrated Care Trust:

Excerpt 2.15 (Fieldnotes)

> 'I think the move back to this Trust was good ……the other Trust …well they didn't really understand us, they were distant, nowhere, with the integration, if they really do it…. community will be more…but we will see.' (community nurse, Feb., 2018)

Important documents such as 'Taking Charge Together' (GMCA, 2016) outlined the transformation of organisational governance and accountability within integrated care systems. The CPT report (PWC, 2016), which was commissioned to develop an improvement plan post the trust being placed in special measures, recommended the formation of the neighbourhood team, yet within the local setting, the controlling text was little spoken about. Its influence and the influence of powerful external organisations such as the financial regulator 'Monitor' remained only partly visible to the teams.

Returning to the management of socially isolated patients, some months later, after the teams had co-located, a group of nurses in the office area were discussing social prescribing. Social prescribing was a new role within the team, employed via the voluntary sector to provide navigation to a range of services in the community. One of the team leaders was informing a group of nurses about the social prescribers in this fieldnote:

Excerpt 2.16 (Fieldnotes)

> ….. One of the nurses was making a referral for a patient, who was socially isolated. The nurse was excited about what the social prescriber could do to support the patient. She also wanted to use the teams 'team talk' to tell the other nurses about

> the social prescribers. [Team talk is the nurse's main point of communication it is partly a handover and partly information giving]. (observation, integrated care team - April, 2018)

The significance of the conversation was that a few months earlier the same nurse had spoken about being powerless in the face of a growing number of socially isolated patients. Yet, after only a brief period, the nurses were able to utilise the new role of the social prescriber to address this issue. This demonstrates that the nurses were proactively changing their working practices to work within an integrated approach.

Reflecting on the fieldnotes prior to co-location, the community nursing team often discussed the change to integration in terms of the structural shift or physical space change. However, since co-location, the teams had tested out integration through converging working practices in areas such as the management of people who were socially isolated. The teams demonstrated a deeper understanding of their own position within the new team and of the role of the adult social care team, which incorporated a shift in working culture and practices alongside the structural move.

Members of both the community nursing team and the adult social care team often stated that as an integrated service they could do more for the health and wellbeing of the community (a key element of the hope they had for integration). This view is demonstrated in the following fieldnote from the final meeting, where a member of the adult social care team reflected on how integration had changed practice:

Excerpt 2.17 (Fieldnotes)

> 'We trust each other now…. The nurses inform my practice and I inform theirs…. we trust each other's assessments.'(Quote from a social worker, fieldnotes, – June 2018)

This statement was significant because it highlights a change, or ‘metamorphosis’, in culture, as practitioners had begun to ‘inform’ each other’s practice in areas like assessments. The adoption of integrated working is illustrated in excerpt 2.18, which reflects a discussion between the team leaders regarding the implementation of a new way of working.

Excerpt 2.18 (Fieldnotes)

> Towards the end of the observations, in a meeting in which the community nurse team leader was explaining an integration plan with the team. The plan involved the nurses instigating a named nurse system within the local care homes, to support the improvement of care provision. The adult social care team leader then stated that she believed the nurse’s plan would improve care and together they decided to include the social workers going forward. Together the team leaders discussed convincing the GPs to do the same. The social care team leader explained a potential to involve the neighbourhood team into the residential homes to work with homes to improve care. (observations, integrated care team - June, 2018)

The meeting illustrated two significant points: firstly, the joint decision making highlighted the change in the actuality of the working practices of the teams. They had begun as two teams who had a distant awareness of each other and moved to one integrated team that was actively redesigning from within, without an external (organisational) mandate. Secondly, these actions demonstrated the convergence of the team vision from the multiple visions at the start of integration into a singular vision

acted out through joint working and collaborative actions. The following fieldnote records a conversation with the community nursing team leader later the same day.

Excerpt 2.19 (Fieldnotes)

> District Nurse Team Leader explained they (the neighbourhood team) were designing a project, where social care, community nurses and others would not only have a link role but also there would be home rounds (like a ward round), educational programme, community support and community response involvement. 'I'm leading this project and the chief nurse is involved, I think we are doing really well as an integrated team and we should be shouting about it' as a nurse I could not help being enthused by her excitement and pride in the project. She explained her team had now joined with the social workers to be involved in frailty project and reducing social isolation and they were developing an outside funding bid. (observations, integrated team – June, 2018)

The importance of role and task within the formation of the integrated neighbourhood team was in participants' ability to subvert, challenge, and transform their working practice. While the teams could be viewed as marginalised within the organisation, rather than being weakened by their position, they used the integration process to facilitate separation from the traditional, convergence, testing of the new, and finally, reimagining of their daily working.

7.2.3 ‘We are the Neighbourhood’: Space and Integration

The process of the creation of a neighbourhood team involved a shift in the space in which the team existed. Throughout the observations, space was considered in the following ways, corresponding with the seminal work of Lefebvre (1991) which identifies space not merely as geographical but also as a social construct: as lived/physical space, a conceived or conceptualised space, and the perceived space.

Practically, the co-location of the two teams required a new larger office, which was a structural and functional change. The office move was a cause of several delays in the co-location of the teams. In November, 2017, there was a final agreement on the office the team would move into. The office was a large space within the council building, close to where the adult social care team were based. The change of office required the community nursing team to move from their office in a health centre to a council building. While there was a slight difference in the functionality and superficial appearance of the old and new office, there was a significant symbolic change for the community nursing team. The previous community nursing office in a health centre symbolically linked the nurses to their wider ‘health service’ identity, which the new office within the council building did not. The significance of the change was observed in the different reactions of the teams; for example, the adult social care team moved into the office over one weekend, and there seemed little concern or resistance to the move. However, the team leader recounted that she had intervened as some of the adult social team members began labelling parts of the office as ‘social care team’ spaces. An example included sectioning off the kitchen, denoting designated spaces for nurses and for social care staff. This act demonstrated that while the move was in many ways not viewed as significant, the perceived ‘intrusion’ of health staff into the

‘social care space’ was affecting the team. They displayed their dissatisfaction through small acts of resistance to the perceived intrusion of the new team.

There was a more clearly defined response from the community nursing team (excerpt 2.20). Prior to co-location, the community nurses expressed frustration at the new location and the lack of engagement with their team regarding their requirements. They felt there had been no consideration of desk space, storage space, and car parking, and these were cited as being significant issues. Excerpt 2.20 demonstrates how space was a concern for the actuality of integration, in a real and present way, and hints at the interplay of the physical, lived, and conceived space.

Excerpt 2.20 (Fieldnotes)

> I observed the team leader and the neighbourhood manager discussing the move for the nurses, the team leader was concerned about the impact the move might have on the nursing team. Parking was an issue and the seating plan had still not been agreed. This concerned the team leader she felt that the social care team were moving within their building while the nurses were losing their building. (observation, adult social care team – Jan., 2018)

Excerpt 2.20 was taken from observations of the adult social care team, but it was reflective of the conversations happening within the community nursing team. On a visit to the nursing team, they explained their frustration that issues such as car parking had not been addressed (excerpt 2.21).

Excerpt 2.21 (Fieldnotes)

> The health care support workers and some of the nurses were sat at the table in the centre of the room they were arranging the

> days allocation – talk came to the new office the group expressed frustration at the parking - making statements such as – ‘there is nowhere at all, how do we get our equipment we can’t it carry across the road. (Observation, community nursing team, Jan., 2018)

Although there had been several meetings between the teams, the nurses expressed multiple times that they felt they had not been engaged in the planning of the space. The most common way the nursing team discussed the move to the new office was through the objects within the physical space (desks, computers) and the lack of physical space (storage and car parking), as illustrated in excerpt 2.22

Excerpt 2.22 (Fieldnotes)

> ‘The community nursing team were discussing some of the frustrations, even asking if I was there to help sort things out. The main concern was the move they did not feel they know what was going on. Nevertheless, they were very clear parking was going to be a huge issue. The nurses didn’t appear to have any great connection to the office there were very little personal effects and the desks were hot desks, however they were frustrated by a range of practical issues, that they felt were not being considered.’ (observations, community nursing team - Nov., 2017)

The nurses used these common issues to illustrate and represent what they felt was a lack of consideration for the needs of their team by the wider organisation. Several

of the nursing discussions centred on the perception that locating the neighbourhood team within the council building reinforced and reproduced the social relations of the social care team while disrupting and minimising the nursing team. These conversations were significant, as they represented the starting point of separation from the organisation, as several of the nurses expressed a sense of loss and marginalisation, as seen in excerpt 2.23.

Excerpt 2.23 (Fieldnotes)

> The nurse pointed to the fax and the printer and stated they didn't work, and the Trust had not sorted it. 'They don't understand these are important…' (conversation with community nurse – March, 2018)

Similar to the issue with the fax machine, car parking was raised as an issue and represented the most acute sense of loss of space, as it brought together the physical space and lived experience of space. The physical space was represented by the lack of enough parking, and the experience of space was the actual impact of having to park within a local supermarket, when the nurse's role requires them to conduct home visits throughout the day and return to the base two to three times during the day. Beyond the need to access their cars frequently, the nurses also carry substantial amounts of equipment from their office space to their car. The new office space only had a few parking spaces, and the cars were often double and triple parked. One of the nurses explained that she felt that the fact that parking had not been considered 'showed the organisation didn't understand the role of the community nurse' (nurse, observation, Nov. 2017). During the observation period, there was no resolution to the parking situation; however, post-co-location there was a change in how the teams

managed, in part because the social care team had supported the nurses in using the car park. The adult social care team's symbolic act of solidarity shifted the relationships, and the talk in the office became more relaxed and included the teams joking about how bad the parking was, as can be seen excerpt 2.24.

Excerpt 2.24 (Fieldnotes)

> The team leader was walking around the office looking for owner of a car…She was laughing with a few of the social workers about being stuck again….Once she found the owner of the car she joked with them and they apologised…. Unlike early exchanges their walk was light-hearted in nature, seeing the car park as an issue they jointly endured. (observations – May, 2018)

During these initial stages of co-location, the teams moved towards a new team identity. Tajfel (1974) explains that social identity is a person's sense of who they are, based on their group membership. The stories the team members told after the co-location revealed a focus on relaying and reinforcing group membership, in the formal work, talk, and the social aspect of the group. Excerpt 2.25 illustrates how the social worker felt her work had been enhanced by working as part of an integrated team.

Excerpt 2.25 (Fieldnotes)

> A social care client that had been on the caseload for some time and had several health issues was re-assessed as part of a joint visit. The social worker explained that by attending the assessment meeting together the nurse and adult social care team were able to ensure that the client was not admitted to

> hospital, as they jointly carry out continuing care health care assessment, which led to more care being provided quickly and the nurse could have reviewed wider health issues. (observation, social worker – March, 2018)

Excerpt 2.25 highlights the developing working practices of the integrated team. It is noteworthy that prior to integration, joint visits such as the one discussed in the excerpt were rare. The new team also depicted their changing idea of integration through how they interacted with each other socially. For example, one of the social workers and one of the nurses described how they had celebrated a team member's birthday (excerpt 2.26), which suggested that the team were engaging with each other not only at a task level but also at a social level, which both teams had previously stated as important.

Excerpt 2.26 (Fieldnotes)

> 'It was his birthday so me (social worker) and my new friend (the nurse) got together to play decorate the desk we got bits from the office and created a big display on the desk, it was really fun and great to do this together, we know each other better now.' (discussion with social worker during observations – May, 2018)

The observation illustrates how the idea of a team identity was described as both professional and social. Excerpt 2.27 further demonstrates how the telling of stories appeared as a significant method of sharing, learning, and gaining acceptance.

Excerpt 2.27 (Fieldnotes)

> The operational change manager organised a lunch, each team member brought some food in homemade cakes, curries and sandwiches the team all sat together in the big hall, chatting sharing stories talking about the families and the area. The meeting was informal and felt more like an evening get together or social event…The Team Leader (Nursing) spoke to me she explained that this was the neighbourhood, 'we know each other now there is a lot of banter…I couldn't imagine this before.' (observation, integrated team - March, 2018)

The stories told by the team members had different contexts, including what Gabriel (1998) describes as the comic, the tragic, and the epic. These stories had different purposes. Firstly, the symbolic reconstruction of events, illustrated in the stories of parking and the methods used to manage the disruption. Practically, team members talked about the lack of space in the car park being caused by the decision making of the organisational management. However, through the retelling of the stories, the car parking came to symbolise a lack of the understanding between the organisation and the neighbourhood, the result being increased cohesion in the burgeoning team and the creation of the organisation as an 'other'. Secondly, these stories were used as outward displays of cohesion, bonding, and signalling the emergence of their neighbourhood team to each other.

Team members would share stories about changes they had tested, and where the change was successful, the stories led to wider adoption. Equally, if the change was deemed as unsuccessful, the stories acted as a warning. An example of this was the

sharing of a story regarding hospital discharge. A social worker shared that she had managed to advocate more successfully for a patient who was awaiting discharge because she worked closely with the nurses and together they were able to present a united neighbourhood approach which included supporting the social and physical needs of the person and using a range of community assets. The social worker stated that the ability to refer to the medical terminology alongside a person-centred social approach gave the neighbourhood team a strong voice when advocating for people in an acute hospital setting.

Another example was the inter-professional working observed in the adoption of joint safeguarding work by the early adopters. This involved nurses and social workers having multiple meetings within the office setting to discuss patient/service users they considered at risk. This was a change in working patterns, as previously these conversations would have been conducted largely via email or phone and were often delayed because of those communication methods. The team anecdotally reported improved outcomes of the service users/patients involved, as they could speed up interventions due to the closeness of their working arrangements. At the same time as the neighbourhood team was coming together, the discourse around the wider organisation was also changing; for example, the team were expressing an internal vision that placed the organisation as an outsider, as documented in the following quote (excerpt 2.28)

Excerpt 2.28 (Fieldnotes)

> ‘They have a different agenda and their own set of outcomes, whereas we are closer to the service user the patients, and this means we can work together, they are distant….bureaucratic.’
>
> (Quote from social worker, observation - March, 2018)

The shift towards a team’s own idea or vision of integration and separation from the organisational idea was part of the process of the team creating their social identity. The actions seen in the study are reflective of Tajfel’s (1974) seminal work which explains that to increase status and self-image within a group, the group will amplify the negatives of those groups considered outside, creating an ‘us’ and a ‘them’. Excerpt 2.28 illustrates how social categorisation was at play during the process of integration.

7.3 Theme 2: The Complexity of Hopefulness in Reimagining the Integrated Space

There were many emotions expressed by participants during the observation period of the study, and analysis identified that the idea, vision, and motivation for integration changed depending on the group, profession, or individual. However, no emotion was more often repeated or articulated by the team than the expression of hope. The teams' personal accounts of change were powerful sense-making devices (Maitlis & Christianson, 2014) in which the participants as organisational actors made the transition to integrated care meaningful to themselves and each other. Many of the team’s discussions highlighted how the teams ‘hoped’ that integration would lead to improvements in patient care and their daily work. Excerpt 2.29 illustrates the point through the expression that the work situation had to be improved by closer working.

Excerpt 2.29 (Fieldnotes)

> The nurse seemed frustrated when discussing her role – 'it's got to be better…than now, working together, that will be better for patients…quicker and more appropriate – I hope it gets better.' (observation, community nursing – Jan. 2018)

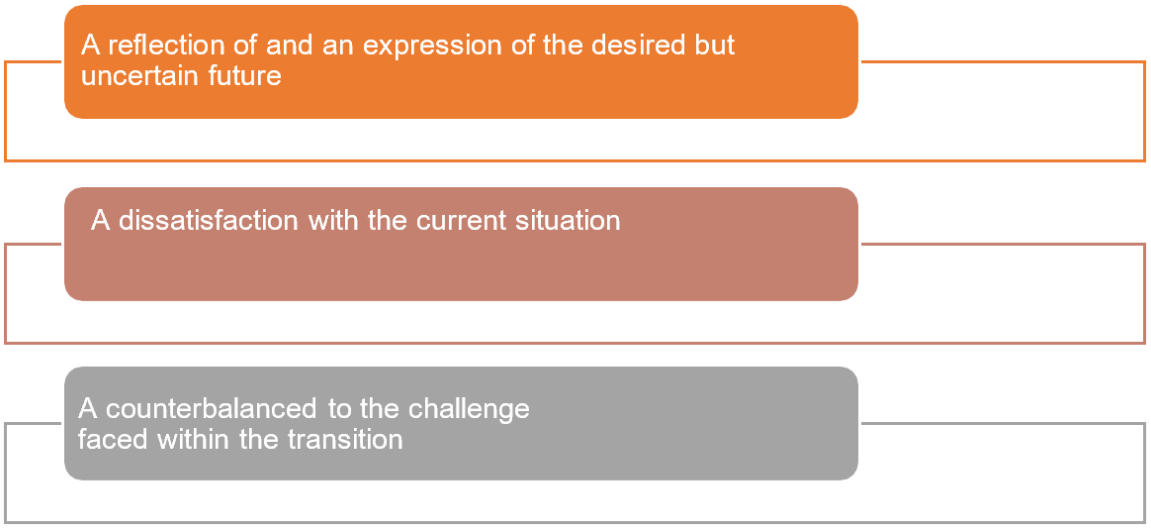
The terms 'hope' and 'hopefulness' were frequently used within the team members' discussions. There was, however, ambiguity about what was being actioned and expressed through the word 'hope'. For the team, hope was a driver for change; however, it also acted to shield the changes from criticism. This was illustrated many times as team members discussed challenges, where they would explain issues that were fundamentally making their working lives more difficult. One such issue was IT not working correctly. The two IT systems (nursing and adult social care) were not compatible with each other, and basic tools such as the fax machine had not been included in the planning. These practical elements led to the teams being unable to share information or conduct joint care planning, which they felt were fundamental to the process of integration. But these discussions were always counterbalanced with statements such as '…but it (neighbourhood) will improve things' therefore shielding the idea of neighbourhood working from the reality of the practical implementation. The shielding did not prevent the teams from being critical of elements of implementation, but it enabled them to continue to move forward despite their critique.

When reflecting on neighbourhood team members' expressions of hope, it was important not to overlook their expressions and actions as merely optimism or a feeling that everything was going to turn out well. Rather, it was important to view their actions and words as exposing a complex and varied set of responses to the transition. The

three different expressions of hope identified from the thematic examination of the fieldnotes (see Fig. 33) are discussed in depth below.

Figure 33

Three Expressions of Hope Identified From Thematic Analysis



7.3.1 Expression of the Desired but Uncertain Future

At the beginning of the observations, team members repeatedly recalled a story of a charity event coffee morning that occurred two years previously. The team explained that the event was the first time the integrated neighbourhood team concept had been discussed with them. The coffee morning story was significant as the team used it as a symbol of the lack of actual movement towards integration. The teams made links between the time passed since the coffee morning and the perception of the organisational management of integration, which they viewed as having not moved, as one team member indicated in excerpt 2.30.

Excerpt 2.30 (Fieldnotes)

> ‘Oh, integration yep that was talked about at the coffee morning, but no we haven’t really gone anywhere, maybe we should have another coffee morning.’ (social work manager - Oct., 2017)

The coffee morning was a charity event which had the secondary intention of being an introduction for the teams who would later become the neighbourhood team. However, the ‘coffee morning’ became an early collective memory for the burgeoning team, and echoes Nissley and Casey’s (2002) statement that ‘what is remembered or what is forgotten shapes an organization’s identity and image’. Equally, Reissner (2011) asserted that organisational actors use change stories for different purposes, one of which is the challenging of official accounts of change. In early observations of the teams, the institutional actors (team members) used the memory of the coffee morning to assert their perspective on the development of integration.

While the story was used as a method to demonstrate frustration at the lack of movement, it also engendered enthusiasm for integration. Team members expressed that they were frustrated at the time passed, but still excited about becoming an integrated team. Significantly, the positivity expressed towards the idea of integration did not equate to not being critical; rather, there was a belief that integration would lead to improvements in patient care. This was reflected in almost all conversations about progress between the team members, who would segment their conversations and criticism with statements that demonstrated improvements they had made, as seen in excerpt 2.31.

Excerpt 2.31 (Fieldnotes)

> Talking about the IT system one nurse gave a lengthy list of the difficulties 'the systems don't integrate so we cannot do joint assessment online', while simultaneously reinforcing that she felt there had been significant improvements 'we talk more now – in the team we are good at sharing what we know.' (observations, neighbourhood team - March, 2018)

These conversations demonstrated that even though there was no agreement on the process and there was frustration at the lack of implementation, there were drivers for the team that enabled them to manage the disappointment, demonstrating that team members were not simply optimistic. They were involved in a dialogue about a potential future that they saw as positive, but, placed in the context of their current actualities, was by no means certain. The hope they expressed acted as a powerful driving force enabling the teams to support and engage in the move to integration, even when faced with issues and problems within the process of becoming integrated. These feelings are reflected in the excerpt below, where doubts were expressed by a member of the social care team about the teams selected for the integrated neighbourhood team.

Excerpt 2.32 (Fieldnotes)

> …he did not feel there was a connection between social work and district nurses, as he stated that, he did not see nurses as having a role in the identification of finance issues or safeguarding issues or being particularly engaged with social issues, rather they just dealt with someone's clinical need. However, he did explain that integration was a good idea, for service users and, maybe with mental health could be included. (observation, social work team - Oct., 2017)

In excerpt 2.32, the social worker described the work of the teams and concluded that there was little overlap in the role. However, despite this conclusion, he also expressed positivity about integration. The view expressed here was representative of several conversations with the adult social care team prior to the co-location of teams. Excerpt 2.33 reveals how the staff nurse expressed similar hope that integration would be a positive change, while simultaneously expressing uncertainty.

Excerpt 2.33 (Fieldnotes)

> Conversation with staff nurse driving between patient visits, the nurse told me that their understanding was that they will move the teams together, but they will not become one team, rather two teams in the same office. They felt this was a good thing, but they saw this as co-location rather than integration. She was happy they would co-locate but not sure this would actually lead to actual integration. (observations, nursing team - Oct., 2017)

These interactions illustrate that during the early phases of integrated care, there appeared to be multiple ideas and visions of integration developing within each team. During lunchtime of the same observation, the concept of hope was raised by a group of nurses and health care support workers. They expressed that the ‘move’ was a functional and structural change, but at this point they did not see the shift as one of culture or role. Akin to the earlier observation, the staff expressed hope that integration would provide a positive change. The team talked of integration in practical terms, such as talking, sharing information, and joint assessment. Excerpt 2.34 illustrates how the community nurses perceived the integration in its initial stages.

Excerpt 2.34 (Fieldnotes)

> The nurses moved from talking about the process of integration to their ideas of what it could be, they talked about the crossover of the role and how working closely with social care could really improve things for their patient group. ‘a lot of our patients have a lot of social needs, but we are not connected with how that works’ and ‘it would be good to understand the assessment process to get things moving quicker.’ (observations, community nursing – Oct., 2017)

These observations revealed that both teams expressed a ‘hope’ that the integration would lead to better care. The findings suggest that while there was a strong meta-narrative of integration through the relations of ruling and controlling text, there may not have been an organisational narrative from which the team could mould their interpretation of integration.

7.3.2 Hope as a Reflection of Dissatisfaction with the Current Situation

The second expression of hope was in dissatisfaction with the current situation. In the second observation with the adult social care team, the team leader described a list of disappointments and failed attempts at moving forward with integration. She disclosed that the attempts to co-locate had been plagued for several months by delays and setbacks. The room selected for the move had been unsuitable, IT systems were incompatible, and it proved difficult to achieve agreement on the formation of the team membership. Despite these issues, the team leader explained that she remained positive about the integrated care model and 'hoped' that it would improve care. She furthered the view, explaining:

Excerpt 2.35 (Fieldnotes)

> 'It's not insurmountable, I'm sure we can find a way through, we all want things to be better for the service users… so we can find a way and once we are all together it will be better…yeh I think we can make it work.' (observation, adult social care team – Nov., 2017)

The above early conversation demonstrated that improvement in patient care was a key motivational driver for integration within the teams. Despite the several disappointments and setbacks, the team leader remained 'hopeful' the change would lead to improvement and that they could 'make it happen'. The team leader's determination reflected Snyder's (2002) definition of hope as reasoning regarding a person's ability to attain goals. Different from optimism, Snyder (2002) explains that hope includes a determination to achieve those goals through a person's agency. The distinction between hope and optimism was important. The teams were not simply

putting their faith in the outcome being a positive one (optimism). They were active players in the changes, and they felt they had the agency to act within the space of the integrated neighbourhood team, although they also were aware of the limitations of the social, organisational, and professional structures. They could not change the car park, but they found positive ways of dealing with it, creating mobile phone lists with car regs, locating alternative spaces for people to park, and finding humour and solidarity with each other when trying to manage the situation.

In a later observation with the community nursing team, they articulated their views on the potential of the neighbourhood team to solve longstanding problems and expressed that the change was an imperative rather than a choice (excerpt 2.36).

Excerpt 2.36 (Fieldnotes)

> Members sat together at the large table in the centre of the room. I asked how they felt about the prospect of becoming a neighbourhood team. The team discussed how community nursing had changed over the years. The caseloads had grown, and number of staff had reduced. They felt they had become more involved in tasks and lost the holistic nature of the role. There was high sickness across the service and stress levels were high. However, they did see the bringing together of the team as positive. They felt they could do more of the work they viewed as community nursing. The social care team leader had been coming over to meet the team leaders and discuss cases and they saw this as a beneficial way of working that could be increased in an integrated team. (observations, community nursing – Nov. 2017)

Excerpt 2.36 demonstrated how integration enabled community nurses to reframe their standpoint. At the start of the research, they had often framed themselves in a position of low agency and isolation. However, there was increasing evidence of an emerging sense that the goal of integration was a catalyst for positive change. Conversely, the social work team language and discussions in the early stages of the research identified that they believed that they had the agency to deliver the goal they hoped for. The social work team took the lead on much of the early planning, including setting out the desk plan for the new office.

An explanation for these different experiences of the two teams was noted during the first observation of the adult social care team. The assistant team leader explained that the community nursing team leader had been off for some time and she was worried that the nurses may not have had as much input, which might affect how they felt about integration. This view dovetailed with later observations which demonstrated that after increased engagement with the community nurses in the process of change, they were able to reframe their sense of agency, as seen in excerpt 2.37.

Excerpt 2.37 (Fieldnotes)

> Informal feedback meeting with District Nurse team leader – She explained how she felt she had changed – she felt she had grown as a leader and that she was more confident leading change, she explained that many of the team were now leading on small projects' (observation, district nurse team leader, May, 2018)

Significantly, these interactions highlighted how the teams engaged with and benefited from the move to integration. Each team felt they had a different level of agency to control the change, but they did share a dissatisfaction with the current situation. It was this sense of dissatisfaction that drove a sense of hope that the future integrated neighbourhood team would bring about improvements in working and patient/service user care provision. Over time there was a shifting in the agency they felt and a building of ‘confidence’.

7.3.3 The Counterbalancing of Challenges Faced Within the Transition

Throughout the research, the teams expressed that integration was a method of bringing about a positive change. The teams’ discussions reflected that they viewed this change as an imperative in meeting the requirements of the changing populations that they worked with. The discussions often mirrored the narrative of the controlling policy documents (NHS England, 2014a; WHO, 2016a; GMCA, 2015). It was this narrative that enabled hope to become the counterbalance to the challenges they faced. As the teams moved towards the point of co-location, the practical issues of physically moving the teams together came to the fore of conversations. It was during the co-location period that the teams were able to utilise hope to counterbalance the challenge of transition and maintain positivity toward the integration programme. The teams were frustrated by several issues that arose in the early stages; IT systems, car parking, and storage were repeatedly discussed. As the neighbourhood team developed, the teams created solutions (or partial solutions) to these issues, and even where solutions could not be found, the teams expressed hope for improvement—or, as in excerpt 2.38, the team found a positive impact from the difficulty they had encountered.

Excerpt 2.38 (Fieldnotes)

> ‘Car parking, yep its rubbish, but it made us get to know each other, you have to when are having to play guess whose car it is. I think we all know each other’s cars now.’ (community nurse team leader, observation – June, 2018)

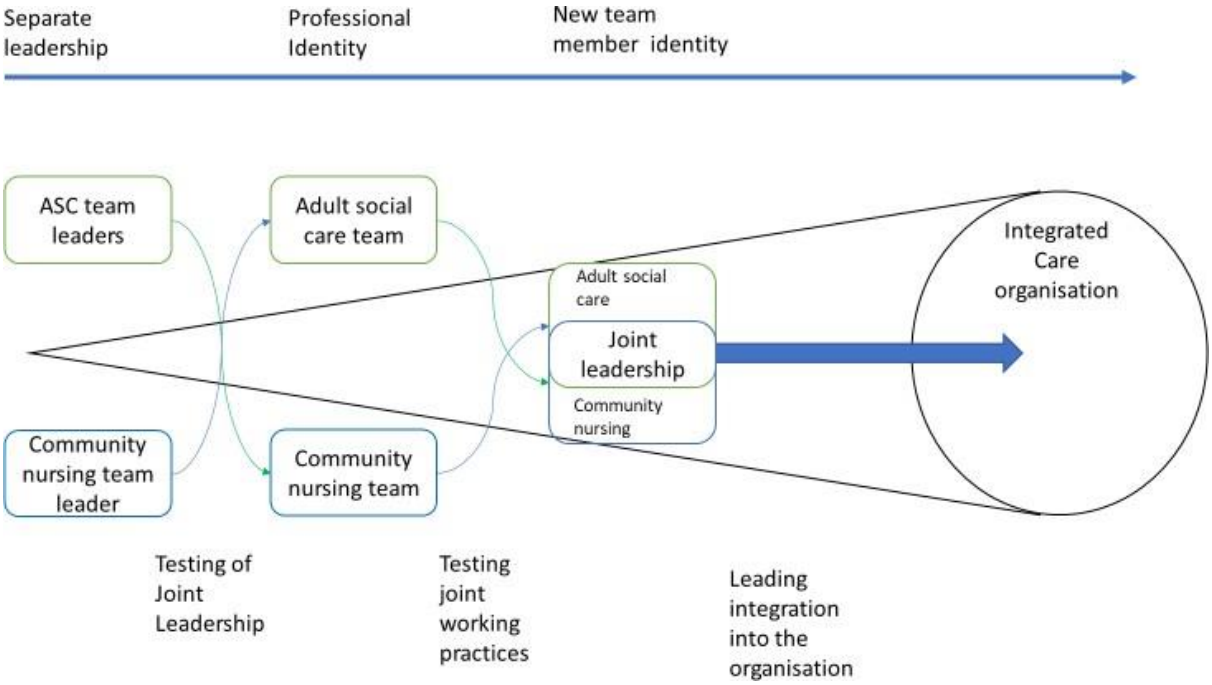
Counterbalancing the challenges with hope provided the emerging team with a positive narrative that supported the development of integration.

7.4 Theme 3: Continuity and Change in the Making of an Integrated Team Member

The analysis of the fieldnotes identified a third theme in how the team members forged a distinct neighbourhood identity. There were three sub-themes that collectively informed the development of the main theme. Figure 34 represents visually the journey of the team from two distinct isolated teams in the preliminary stages of the study to a cohesive neighbourhood team.

Figure 34

The Development of the Integrated Team Member



The journey outlined above began prior to co-location when the two teams were separate from each other and communicating via emails and referrals, rather than face-to-face. After co-location and integration, the leadership of the teams collaborated, engaging with each other in sharing work, attending joint meetings, and making joint decisions. The leadership behaviours were then mirrored across the teams, resulting in joint leadership becoming viewed as a core facet of the developing team identity. Importantly, each team maintained a sense of their own professional identity. The different identities co-existed within the burgeoning team. In one observation between a community nurse and a social worker, the nurse and the social worker referred to each other's specific professional identity: '….you are the nurse so shall you complete this section….', 'Can you help as you are the social worker and this is your field….' They were working closely together but maintaining a sense of what they felt was the skill set each profession brought to the table.

At the end of the study, the team leaders stated that they perceived the team to be forerunners in neighbourhood working. The new team used their collective knowledge of what they had experienced to influence the wider integrated care organisation. They did this in a formal and informal way, through presenting and promoting their journey at the change management meetings, and through talking to other teams in operational meetings. The positioning of themselves as forerunners, innovators, and champions of the 'integrated' model had a profound effect on how the integrated team felt about their position in the organisation. They talked of increased confidence, being heard, and being noticed by the organisation, moving them from a position of marginalisation to leaders and influencers in integrated working. The team members used integrated care and the formation of a new team to transcend their previous marginalised social identities and create a new identity centred on being leaders and innovators. The teams created a categorisation of the new group and then used the wider organisation as a comparison, placing themselves as the forerunners, and therefore elevating the position of the group and reducing the feeling of being marginalised. This shift in positionality is witnessed in except 2.39, which was documented during a neighbourhood meeting where the nurses were presenting to other neighbourhood nurses.

Excerpt 2.39 (Fieldnotes)

> The nurses had stated they were excited to share their work at the meeting – on the table there were nurses from 3 of the neighbourhoods – the team leader explained about the co-location and barriers and what they had achieved she then asked if the other nurses wanted to visit and see what they had achieved (meeting observation – May, 2018)

7.4.1 Marginalised Professional Groups and Collective Endeavour

Adult social care and the community nursing team were selected as the standpoint group due to their marginalised position within the organisation. Exploration with the teams over the duration of the project revealed several reasons why the teams believed that they had become marginalised. The integrated care organisation was managed by the hospital management team, and at the time of the study, there were no community staff in executive-level positions within the organisation, which was significant as both teams stated that they did not feel connected to the organisation and that the organisation did not understand the community. These concerns are portrayed in excerpt 2.40.

Excerpt 2.40 (Fieldnotes)

> ... Belonging was an issue for the nurse, they felt it had been a bit silly and confusing for the patients when they were managed by the other NHS Trust, in a different geographical location, they didn't really feel accepted yet, within this NHS Trust. There had been some changes – for example uniforms. However, they felt the Trust needed to learn more about how the community was

different, because it was a hospital Trust (observation, community nurse - Jan., 2018)

Excerpt 2.40 highlights that the nurses felt that they did not belong to and were not part of the wider organisation. The observation revealed the sense of exclusion and subsequent ‘lack of a sense of belonging’. This may relate to the fact that both the community nursing service and adult social care teams had recently become part of the integrated care organisation, an organisation which was previously predominantly hospital-centric. This position is reflected in excerpt 2.41.

Excerpt 2.41 (Fieldnotes)

The nurse explained that they were in one organisation and then moved and then moved back – he thought it was better but was concerned the organisation didn’t really understand what happened in the community and how different it was to the hospital. (discussion during observations, community nursing team – Nov., 2017)

Similar anxiety of a disjunction between team and organisation can be seen in excerpt 2.42 from a meeting with the adult social care team, as they reflected on the integration journey.

Excerpt 2.42 (Fieldnotes)

During the feedback meeting the team members present (both social workers and nurses) talked about the team working and how coming together as an integrated care team had improved working practices. However, there was a sense that while they understood their ‘vision’ for the neighbourhood team, there was a nervousness expressed that council and NHS trust did not

> share the same vision as they had had and more worryingly for the team they felt the two organisations did not always share the same vision as each other. A social care member of the team expressed the concern that the team could be destabilised. They felt the 'organisation' did not always understand what had been achieved in creating the neighbourhood team.' (notes from feedback meeting, July, 2018

Excerpts 2.41 and 2.42 provide an overview of the team's perspective at the start of the integration process, when they perceived that they were separate, different, and misunderstood. The finding here is significant as it contrasts with the emergent narrative of belonging at a team level—'we are the neighbourhood'—and apparent marginalisation at an organisational level. While marginalisation could have been a barrier to integration, the teams used their position to enable and construct the neighbourhood identity, by creating a sense of belonging within the team that was independent of wider organisational identity, as seen in excerpt 2.43.

Excerpt 2.43 (fieldnotes)

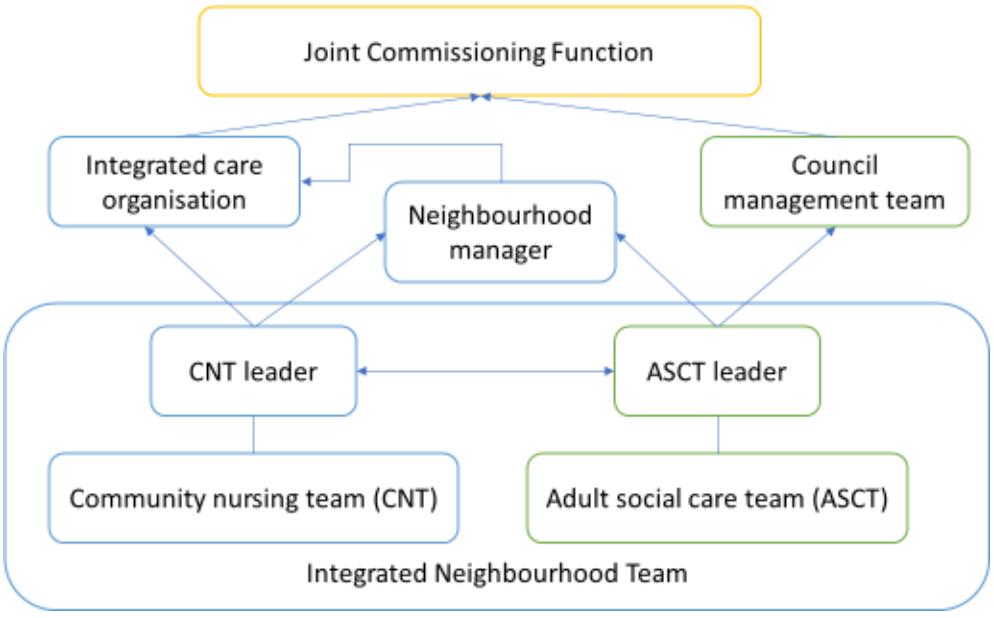
> On returning from an external meeting the team leader (DN) explained that that the management team wished to introduce a change that they didn't think would work for the neighbourhood: 'We are the neighbourhood – we know our team we know what works they need to listen to us….we can help.' (discussion with neighbourhood team - June, 2018)

7.4.2 Organic Development of Integrated Leadership

A crucial part of the development of the neighbourhood was the leadership activities within the team. The team developed an integrated approach to leadership through the organic development of joint leadership. The co-location process commenced with the recruitment of a joint neighbourhood manager, who was employed by the integrated care organisation and tasked with the development of the neighbourhood approach across three neighbourhoods. However, there was little structural change to the managerial system outside of that single appointment, and each team reported to a different organisation, as illustrated in Figure 35.

Figure 35

Management Structure at the Commencement of the Study



Consequently, early in the integration process, the vision received from the organisation did not direct how leadership would develop in the new team. Both team leaders at the point of co-location felt there would be benefits to closer managerial and

leadership structures. However, they chose not to propose a joint managerial structure, in favour of informal joint working. Several months into the research, the transition to a joint leadership approach was observed in the everyday practice of the neighbourhood team, as described in the following excerpt.

Excerpt 2.44 (Fieldnotes)

> The adult social care team leader provided the following information, stating that she and the District Nurse manager were now attending meetings together and they felt they had developed a joint vision for the neighbourhood. They both felt it was important that they had a strong relationship. She explained through working together they had developed where they felt the team needed to go and a new direction. (observation, integrated team - June, 2018)

It is important to acknowledge that the development of joint leadership may simply have reflected the leadership styles of the team leaders. Both team leaders had expressed the desire to foster joint leadership and had actively sought out ways of working together. Active examples of the approach were observed in deputising informally, co-chairing team meetings, and providing advice and guidance across the team. In the absence of formal change management, the team leaders tested out ways of working and progressed to a point of trusting each other. The leadership approach was important in the fostering of the team identity, as it exemplified joint working while enabling maintenance of professional identity.

7.4.3 Professional me', 'Team me'

The team leaders selected and modelled a collaborative style of leadership. These actions were then replicated by team members during the transition to neighbourhood working. The modelling of collaborative leadership styles was a core component of how the teams created a strong and defined team identity, while still maintaining their individual professional personas. This attitude was identified in a comment made during the final feedback meeting with the team, where the importance of individual professional identity was summed up in the following way:

Excerpt 2.45 (Fieldnotes)

> 'we all bring something different to the neighbourhood…we respect what each other brings.' (feedback meeting, occupational therapist – July, 2018).

The findings indicate that the team viewed the neighbourhood as a collective or collaborative of unique disciplines. These individual disciplines were then able to consolidate their contribution to the community through their work as a neighbourhood team, rather than through combining or merging those disciplines. Figure 36 illustrates how the approach was applied to hospital discharge.

Figure 36

Changes to Hospital Discharge

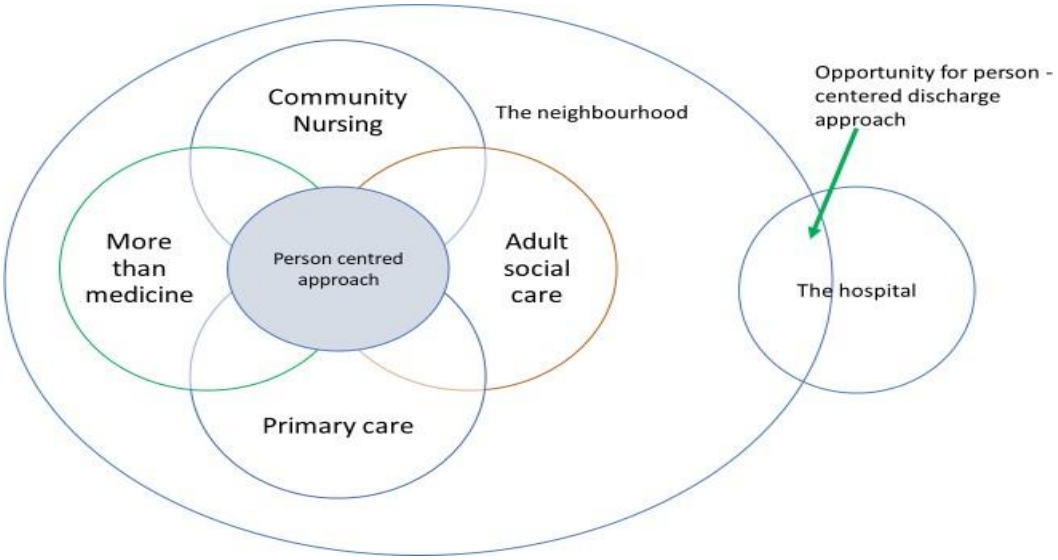


Figure 36 explains how the team viewed the neighbourhood approach as person-centred, including team members (adult social care and community nurses), the wider neighbourhood teams within primary care (GPs), and newer 'more than medicine' teams such as link workers and social prescribers. They described how new approaches enabled them to combine individual professional skill sets when planning discharge. Importantly, the hospital was not excluded from the approach, and the team stated that by using the neighbourhood they had the potential to work with the hospital to support discharge more effectively. This change was important, as during the interviews in stage 1 of the study, the interviewees spoke of institutional maintenance whereas here there appeared to be a shift in the status and power dynamics of the teams, from hospital to community.

The neighbourhood approach to working alongside the hospital was still in its infancy at the end of the study. However, the team cited several cases where they had used

their neighbourhood, person-centred approach to facilitate successful discharges. Prior to the integration, the two teams worked very separately, and it was not usual for them to make contact until a patient had been discharged from the hospital. One change the team instigated was that if there was a person who was on the caseload of both the social care team and the community nurse team, prior to the multi-disciplinary meeting at the hospital they would meet to discuss the patient /client so that whichever team attended, they had a full understanding of the community requirements. For both teams, the meetings were a positive change that assisted them in working with the patient and hospital staff when planning discharge. The change also demonstrated more effective use of resources through more effective communication. The changes in approach to hospital discharge demonstrate how the team skilfully manoeuvred the integration process. As an integrated collective, they enabled change to occur in working behaviours that they felt were beneficial, while simultaneously maintaining consistency in their deep-rooted professional identities.

A further significant change observed during data collection and discussed by the team related to the increase in joint visits. Both teams recounted that these visits did not happen prior to integration, and while they had not been mandated through the integration process, they had become part of the practice, as seen in the following observation:

Excerpt 2.46 (Fieldnotes)

> The social worker and community nurse were sat together in the office having returned from a joint visit. They discussed and completed the continuing health care funding form; this form was required to apply for funding for ongoing NHS care to manage a

> person's health needs in the community. They debated the priorities for need from a social and health care perspective coming to a consensus on the final version of the assessment. (observation, integrated care team – June, 2018)

During the data collection, there had been a delay in the organisational development programme, which had led to more organic changes in the development of the team. Rather than a formalised process managed through the organisation, the members identified areas of practice they could develop and then worked collaboratively to implement the new practices. There were only a few meetings to plan how these changes were to be achieved; they appeared to evolve through the team co-existing within the same geographical and social space. The team tested ideas such as joint visits and then continued them if they were deemed to be beneficial to the team and the patient/service user or disregarded the change if it did not support the desired outcomes, values, and principles of the team. The observations revealed that change happened and spread across the team through discussion and modelling of practice and behaviours, rather than a formalised process. The teams were able to experiment and try out a variety of changes that they had designed themselves. Excerpt 2.47 highlights one example where the team members developed their integrated working practices.

Excerpt 2.47 (Fieldnotes)

> The social worker explained 'I have so much more confidence now, I can ask the nurses about medical conditions and pool expertise to inform my assessment. I was talking to a consultant in the hospital and I felt confident to argue my case, because I knew the client's medical condition. It really makes a difference

> and we can be much more holistic' - another attendee at the meeting simply put it, 'when the medical and social work together we provide better care.' (feedback meeting, July 2018)

In the situation described in this excerpt, the social worker practically applied the shared knowledge they had developed to defend their decision making in a highly medical environment. The social worker was able to adapt and use the medical language to achieve the required outcomes, thus subverting previous medical dominance. The social worker suggested that working together was successful, which influenced the implementation of the approach by other team members. The nurses and social workers integrated, learned, and utilised each other's knowledge through gradually evolving their working practices and team cultures. Early in the research, the professionals had misconceptions about each other, and while the teams had worked in parallel for many years, there had been little crossover in their daily work. A significant factor in the method of change that the team members embraced was that both teams drew their value from the closeness they had to the patient. Throughout the observations and over time, the teams talked more frequently about integration as a positive move for the people in their care.

Another example of how the team members developed a team approach while maintaining their professional roles was the assessment of people awaiting continuing health care (CHC). In a meeting between the community nurses and adult social care team prior to co-location, there appeared to be tension between members. A social worker asked why assessments had not been completed, and the nurse responded that the time scales provided were unrealistic. The conversation created some tension, and both the social worker and the nurse expressed frustration that they did not fully understand the role of the other. There was an acknowledgement by the district nurse

the assessment could not move forward without both parts; however, previous miscommunication and misunderstanding had caused frustration. By the end of the conversation, the professionals reached an agreement that the two roles brought separate and different, yet valuable, skill sets. The conversation illustrated how each team grappled with integration, not as sublimation but complementation, as they attempted to understand each other's positioning. While there were differences in priorities, both team's members demonstrated a shared principle that placed the person at the centre of the care they wished to deliver. It was from this shared principle that the process of testing new ways of working played out. In the following statement, the same social worker described how integration had brought about a different relationship within the team.

Excerpt 2.48 (Fieldnotes)

> 'Joint working daily with our District Nurses has enhanced my role, we appreciate each other's roles more. They understand my role and can respond better to requests. I have developed friendships with the nurses.' (feedback meeting, June, 2018).

This statement represents the development of closer personal and professional relationships. At the start of the study, the two teams rarely spoke and communicated instead through email and referrals, an area of much frustration. These comments indicated that there had been a change in the way that professional groups were working together, as they now had regular face-to-face contact.

The participants were provided with the opportunity to question and challenge interpretations and validate that the findings were a representation of their experience of integration. Excerpt 2.49 provides an account of how the team had moved from a

cautious early hopefulness in the initial stages of co-location to the development of their internal team vision and joint leadership approach.

Excerpt 2.49 (Fieldnotes)

> It was explained to me at the meeting that as a team they knew at the start that not everyone wanted integration, but over time the idea of integration as a good thing had grown, and people had a vision now of what they wanted for the team and how they could all enhance each other's work. One social worker wrote a sticky note and handed to me 'single twig breaks but a bundle of twigs is strong' this statement reflected several comments by others in the room. A final comment from a team leader was 'sitting here with everyone I realise the power we have in this room, it's our power to lead this and do it our way for our people.' (feedback meeting - July, 2018)

Excerpt 2.49 demonstrated the interplay between individual experience and the development of a team vision and approach to integration. Other members reflected the sentiment expressed as they shared individual stories which demonstrated their journey to a collective vision. The team used stories of their individual experience to illustrate and draw attention to the wider endeavour of integration. However, it is important to note that there were a number of smaller professions within the neighbourhood team, that sometimes were not part of the larger discussions and conversations as these centred on the two larger professional groups of adult community nursing and adult social care.

7.5 Chapter Summary

The findings presented in this chapter highlight that the team valued the space they had developed as an integrated neighbourhood team. Through a process of convergence and separation, the team reimagined the received vision to create a meaningful set of behaviours, which included actions such as building solidarity over areas such as car parking. The teams changed working practices by linking their professional values to each other's roles, to enable activities such as joint assessment. At the core of the motivation for change within the team was a sense of hope that integration could influence a fundamental shift to improve outcomes for their patients and service users.

Text in the form of policy documents influenced the daily working lives of the teams through the integration process. There was a clear delineation between national and regional policy and the narrative of integration discussed within the teams. The strong narrative provided hope that integration would improve care. However, the narrative within the policy was not merely accepted but was also subverted, used, and manipulated to enhance the changes the team were making to their working practices.

Chapter 8. Discussion

8.0 Chapter Introduction

This chapter contextualises the findings presented in the preceding two chapters within the wider evidence base and explores how the experiences of the neighbourhood team reflect or contrast with the findings in other literature. This perspective was achieved through the extrapolation of core findings and comparison of those findings against previous research studies and policy. A recap of the research question and the aim and objectives of the study is followed by discussion of the key findings.

8.1 Research Question

This study began with the problematic that there was a disconnect between the rhetoric of integration and the experiences of those implementing integration in local settings. This observation led to the point of enquiry, which was to explore how the neighbourhood team members experienced the transition from traditional health and social care teams to integrated care systems, within a defined health and social care economy.

8.2 Aim and Objectives

The aim of the study was to produce a faithful representation of the experiences of an integrated neighbourhood team from the perspective of the team and to develop an understanding of the relations of ruling within the wider organisation. This aim was underpinned by three objectives:

- To describe neighbourhood team members' experiences of the transition to an integrated team
- To identify and interpret how work is conducted during the transition to an

integrated neighbourhood team, from the perspective of the team members

- To establish the current factors that influence the ruling relationships within integrated care systems

The findings of the study accomplished these aims and revealed a unique insight into how integration happens in local settings. The study provides a detailed account of the experiences of teams transitioning to an integrated care approach, which has implications for the team, the organisation, and the wider health and social care system. An overview of these implications is provided in the next two sections, and they are discussed in greater detail in Chapter 9.

8.3 Discussion of Findings

The following sections extrapolate the core patterns within the study, discuss the findings, and compare them with previous studies, reflecting on where this study supported previous work and where different insights were gained. The discussion of the findings refined the research results and enabled the recommendations and conclusions presented in Chapter 9 to be compiled.

8.3.1 Positivity and Integration

The concept of hope was a significant part of the experience of team members. The neighbourhood team demonstrated what they described as ‘hope’ in their talk, action, and interactions with each other. Given the compulsory nature of the structural change and the period of time without formal organisational development, the team demonstrated overwhelming positivity towards the introduction of integrated care, which they expressed as ‘hope’. As a concept, ‘hope’ could suggest a sense of general positivity about the future; however, it could also imply a passiveness to the participants’ role, which was contrary to what was observed in the study. Team

members (from each of the different organisations) were dynamic actors in building the feelings of positivity towards integration. Integration was not viewed as an external entity or concept that would be brought into the team and imposed, but rather the team considered integration as something that required construction from within. This study supports previous findings which state that frontline team members often share a commitment and enthusiasm for integrated care, although this enthusiasm is often measured and hesitant due to the barriers and challenges faced during implementation (Beacon, 2015; Syson & Bond, 2010). What this study adds is the linking of the 'hope' expressed by teams not only to the vision but also to an ongoing narrative that underpins integrated care.

The findings demonstrate the importance of external text in the development of narrative, linking narrative to the core values of teams. Shaw, Rosen, and Rumbold (2011), Wood, Finnis, Khan, and Ejbye (2016), Foot (2012), Foot and Hopkins (2010), and GMCA (2015) all support the creation of strategic narratives that privilege empowering people and communities. The influence of these text was important as the adult social care team and the community nursing team both expressed improving patient and service user outcomes as motivational drivers for integration. The findings of this study support previous studies, such as RAND Europe, Ernst, and Young LLP (2012), which found that staff believed it was important that integrated care should be about improving patient experience and access to services, and Coxon (2016), who stated that there was a relative consensus on the benefits of integrated working and that these benefits are connected to improved care. The importance of a positive narrative, which can engage and motivate team members during the early transition to integrated working, was therefore a significant finding in this study.

In addition, this study found that the teams locate their narrative from several external sources; they do not merely adopt these visions, however, but destabilise the collected visions and reconstruct them for the purpose of their local setting. These findings are supported by Namdram and Koster (2014), who reported on the implementation of Buurtzorg in the Netherlands and found that clinicians were strongly self-motivated to develop visions and make changes that result in improved care. Mitchell, Howard, Tazzyman, and Hodgson (2019) also found that for transformation plans to be successful, there needs to be clarity of vision and purpose which reflects frontline teams' values and aspirations for patient care. These findings demonstrate that the development of a sense of hope can be a powerful tool in overcoming the challenges and barriers faced during integration.

Ginter, Duncan, and Swayne (2018) found that organisational visions act as powerful beacons and controls, as they inspire members to identify with the ideals and goals of the organisation. However, during the period of this study, the neighbourhood team was being formed without a clear beacon to help establish common objectives, which, although a cause of divide between the local and the wider organisation, also enabled a more organic process of vision development through local actions. The teams worked together to reimagine the team identity, vision, and purpose. The autonomy and opportunity for self-determination of the team identity were in part due to a delay in the organisational change programme, which led to the team having around six months without formal organisational change interventions. Here the study provides a unique perspective, as several studies have previously identified that professional and organisational identity can act as barriers to integration (Cairns & Harris, 2011; Radermacher, Karunarathna, Grace, & Feldman, 2011; Smith & Barnes, 2011; Michelle, Howard, & Hodgson; 2019; Beacon, 2016).

Cairns and Harris (2011) also identified that negative assumptions and stereotypes held by groups about each other can act as barriers. Øvretveit, Hansson, and Brommels (2010) found that collaboration between health and social services can be difficult to achieve. While these barriers were significant and were observed in the pre-co-located teams, the barriers appeared to dissipate quickly after co-location. While the organisation may not have intended to implement integration with such a light touch, the space that they provided the team carried with it dividends for the team's development. Cooperation and team cohesiveness developed quickly, and new team practices such as joint visits and assessments developed in an emergent way rather than being mandated. The adoption of these activities may have contributed to the development of cohesiveness in the team, as seen in Fraser's study (2019), which found that joint assessments have the potential to build collaboration across professional roles and help to better identify the health and care needs of the most complex service users.

Subsequently, these new team practices brought about a greater understanding of each other's roles and responsibilities, which in turn increased the team's cohesiveness. The overarching result for the team was that there was space to explore and create the new landscape, which led to a sense of positivity that in turn created further action and trust within the team. These findings echo previous work by Edgren and Barnard (2012), who promoted the complex adaptive systems methodology [CAS] as a model for integration, as it enables organisational structures that are not rigid or supervised. As a methodology CAS challenges assumptions of cause and effect, seeing healthcare as a dynamic process, where interactions and relationships simultaneously affect and are shaped by each other and the system (Barnard, 2012).

In addition, Radermacher, Karunarathna, Grace, and Feldman (2011) stated that stringent top-down implementation preserves the notion that there is one model of partnership, which could potentially impose unnecessary restrictions, hindering creativity and leading to disempowerment.

There are potential limitations to the overall findings due to the relatively short time in the field. During the nine months of the study, considerable managerial and operational changes had not yet commenced. Notwithstanding the potential limitations, the following implications for practice were identified:

- The ability to self-determine the new team identity should be considered, as it appeared important to the team members
- Integration should be viewed as a creation of the team rather than a model imposed upon them
- Opportunity to construct team identity within a team has potential to reduce the barriers identified in previous studies

8.3.2 Joint Leadership Approaches

This study found that while organisations can bring about integration structurally, cultural integration happens within the local spaces where teams interact with each other. This finding is supportive of previous studies by Mitchell, Howard, Tazzyman and Hodgson (2019) and Bryson, Crosby and, Middleton Stone (2006), which also emphasised the need for local cultural changes.

Previous studies by Ham (2010), Beacon, (2016), Curry and Ham (2010), Rosen, Mountford, Lewis, Shand, and Shaw (2011), Coxon (2005), Lunts (2012), and Mackie and Darvill (2016) identify the importance of leadership in integrated care. The

importance of leadership was also supported by this study: during the period of transition, the team members used a range of leadership styles to support the development of the neighbourhood team and each other. Examples of leadership were not confined to the leadership team, nor did team members exhibit a single leadership style. The findings of this study identified four key leadership features that had a significant influence on the team's experience:

- Leadership language
- A joint leadership approaches
- Local leadership activities
- Neighbourhood-level leadership (neighbourhood manager) acting as a conduit and role model

A distinctive feature of the team transition was the leadership approach adopted by the team leaders and their deputies. Joint team leadership was not a predetermined result of the integration process, as can be seen in previous studies such as Cairns and Harris (2011), Michelle, Howard, and Hodgson (2019), and Lunts (2012), who have identified that professional protectionism could be a significant barrier to integration. The significance of the findings of this study was that the team leadership adopted behaviours and actions that presented a joint and consistent leadership approach that supported the team's values and aspirations. This supports findings by Mitchell, Howard, Tazzyman, and Hodgson (2019) Bardsley, Steventon, Smith, and Dixon (2013) who found leadership behaviours to be vital in the development of integrated teams.

The neighbourhood leadership team acted as role models throughout the transition, by demonstrating effective collaboration with each other, encouraging teams to interact professionally and socially, and presenting a consistent message to external stakeholders. The approach used by the team leaders reflected Edgren and Barnard's (2012) study into complex adaptive systems in integrated care, which stated that the capability for self-organisation, the ability to improvise, and the flexibility of approaches were prominent features of successful integration. These actions led to positive outcomes for the team through the development of trust and pride. This was demonstrated in a shift in how the teams worked together, since at the start of the study both teams expressed reservations about the impact of joint management. However, in the later months, it was observed that team members felt confident in approaching any member of the leadership team from any discipline for advice and guidance. Importantly, the findings represented a self-merging of the leadership function rather than a formal restructure.

The local leadership took the concept of 'joint team leadership' and empowered other team members, widening the scope across the team and encouraging the whole team to engage with each other in a joint and collaborative manner. There were several 'influencers' within the team who became informal leaders. These influencers promoted integration through their working practice rather than their formal positions. They actively sought opportunities to work with other professional groups and promote their success. This was observed in the findings in the way some team members activity sought to move the team through the early stages of integration. These acts were often simple or small but highly symbolic, and included things such as ensuring a space in the car park, organising joint socials, and sharing of information and assessments.

Similar findings can be observed in Windle, Wagland, Forder, d'Amico, Janssen, and Wistow (2009), RAND Europe, Ernst, and Young LLP (2013), and Bardsley, Steventon, Smith, and Dixon (2013), who found that leadership was an important factor in successful integration and identified styles such as shared leadership, distributed leadership, and authentic leadership as keys to success. These findings reflect the seminal work of Rodger's (1962) and the concept of diffusion of innovation that stated that early adopters of change will proactively take up change and promote it to others. One mechanism adopted by influencers was the use of stories to elicit responses and shape action. Bolman and Deal (2017) state that stories are a key part of the development of successful organisational cultures, as they develop and extend group lore, keep traditions alive, and locate shared values. The stories told by the local leaders were powerful influencing factors, as they were the start of the development of group identity 'lore', and they brought real examples to integration that in turn influenced others. The use of stories within change processes has been long established, as stories are one of the prime means from which people construct their social reality and are a powerful catalyst for action (Reissner, Pagan, & Smith, 2011). Throughout the research, stories remained a key feature of how the team navigated the changes brought about through the integration process.

The findings presented in Chapter 7 highlighted the position of the neighbourhood manager in the provision of neighbourhood-level leadership. The role supported 'team leadership' by being a communication point between the wider organisation and the team, ensuring and promoting purpose, and working with the team leaders to develop a collaborative culture. The neighbourhood manager also acted as a critical friend, supporter, and cheerleader for the team. Importantly, the role was strategic and did not include imposing or dictating operational activities during the transition period. As

with the other leadership features identified, the findings demonstrated that the leadership approach was flexible and supportive. The neighbourhood manager provided a flexible framework approach rather than imposing a predetermined vision, which provided an environment where team members felt confident to critique the changes whilst simultaneously remaining positive.

When considering the findings of this study in line with previous studies, the implications for practice are significant, as this research demonstrates that leadership significantly affected how the team experienced the transition to an integrated neighbourhood team (Windle, Wagland, Forder, d'Amico, Janssen, & Wistow, 2009; RAND Europe, Ernst, & Young LLP, 2013; Bardsley, Steventon, Smith, and Dixon, 2013; Mitchell, Howard, Tazzyman, & Hodgson, 2019; Michelle, Howard, & Hodgson, 2019). Leadership was observed to be interwoven across the team, and each level of leadership had a role to play in the development of the team. These findings suggest that it is important to develop skills in leadership across integrated teams as part of the strategic and operational implementation of an integration programme.

8.3.3 Professional Identity

The transition from a traditional team to an integrated system provided practitioners with the opportunity to explore their traditional identity, interact with other professional groups, and adopt and develop different professional roles. While it was not unexpected that the teams explored changes in their professional identity, it was surprising that the exploration of their roles and testing of new roles happened with little of the negative impact discussed in previous research. For example, Cairn and Harris (2011) found that protectionism was a major barrier in cross-sector working, and Lau et al. (2018) similarly reported that perceptual barriers between professionals affected attitudes and created mistrust and interprofessional stereotypes. Other

studies have also identified barriers due to professional identity, concluding that the process of integration can act as a mechanism to challenge and change previous ways of working (Beacon, 2016; Michelle, Howard, & Hodgson 2019).

A significant example of the exploration of professional identity in this study was presented through an observation of the distinct change in the work and professional identity of the community nursing team. Team members used the opportunity to explore their current role and the potential to adopt different ways of working. A drift towards task-orientated nursing has been reported due to increased caseloads as the demographics of the country change. This drift in role has had a negative impact on nurses' experiences and job satisfaction (Drew, 2018; Fanning, 2016; Maybin, Charles, & Honeyman, 2016).

During the integration process studied here, the nurses commented on how exposure to other services within the team, such as the introduction of social prescribers, had enhanced their ability to provide holistic care. The community nurses also stated that the changes had reduced the feeling of professional isolation. In the later stages of the research, the community nursing team expressed that integration had enabled them to challenge working practices that they felt did not connect with their core values, and to move 'back' to a way of working which they felt better reflected their future aspirations. They were able to shift the professional knowledge base of community and district nursing from simply treating the sick and the medical (pathogenetic) model to a more social (salutogenic) approach. The practical application of these findings is that while previous studies have identified professional identity as a barrier to integration, this should not be considered a foregone conclusion within an integration journey. This study demonstrates that, given the right context, integration can act as a

powerful enabler and catalyst for professional groups to explore their own identity and contrast and compare their identity against other professional groups.

8.3.4 Working Together

Findings from this study indicate that team relationships are important to how teams experience integration. These findings were not unexpected, as Cairn and Harris (2011) Michelle, Howard, and Hodgson (2019), and Lau et al. (2018) have explained that there can be many misunderstandings and negative perceptions between groups from different sectors. However, the findings also identified how co-location enabled the development of new understandings from what the team manager described as a 'distant knowing' to 'professional understanding', indicating that knowledge was gained not only of the tasks and duties but also of each group's professional identity as they had moved from a structural change to cultural and practical change which 'wrapped' care around people and their needs.

The findings of this study indicate that how the teams build their understanding of each other is important to the integration process. Le Ber and Branzei (2011) similarly found that frame fusion, or how each group frames each other in order to move closer, can build gradual recognition for each other's roles and create value that supersedes embedded institutional behaviours. Equally, Cramm, Phaff, and Nieboer (2013) reported that strong relationships between groups built connected partnerships, synergy, and sustainability. Intricately connected with the building of relationships is the effect of co-location. This study supports the finding of several other studies indicating that co-location is a facilitator for integration of teams, as it enables the building of relationships through informal conversations and actions (Mackie & Darvill, 2016; Syson & Bond, 2010; Behavioural insights team, 2018; Michelle, Howard, & Hodgson, 2019).

An interesting finding from this study was the ability of the teams to subvert what Currie, Finn, and Martin (2012) described as the underlying cultural artefacts of the dominant medical talk. In the adoption of each other's languages, the team were able to use language as a unifier and a practical tool, not only internally but also in their external interactions. These findings offer a unique perspective on the experience of teams, as there appeared to be no professional tribalism or protectionism over language. This finding contrasts with the conclusion of Cairns and Harris (2011) that language is a significant barrier which solidifies mistrust in cross-sector partnerships.

8.3.5 Marginalised Professional Groups

A key experience described by the teams related to a sense of gaining parity of professional position within the wider organisation. The experience of gaining parity was closely linked to the wider external narrative and principles of integration; for example, each team felt that they had a stronger positioning and parity when working with the hospital staff once they were integrated. The principles of integrated care state that meeting the complex health and social needs of people requires interaction among numerous sectors, with a lack of such interaction linked to reduced quality of care and outcomes for the community (Lau et al., 2018). In the findings, the teams acknowledged and supported integrated care as an effective response to increased demand and the changing demographics of the population. The views expressed by the participants often reflected the 'Five Year Forward View' (NHS England, 2014a), the 'Long-Term Plan' (2019a), and a range of other advisory papers (e.g., Wood, Finnis, Khan, & Ejbye, 2016; Ham & Curry, 2011). The talk of the participants as presented in the findings illustrates the strength of the narrative of integrated care: while team members did not often discuss the policies directly, the principles and sentiments were often mirrored in their talk. These policies can therefore be seen as texts that were only partially

visible in the local setting, but nevertheless influential in people's actions and talk (Smith, 2005). The newly forming integrated neighbourhood team perceived that the agenda for community-focused care presented an opportunity to equalise the sectors. Interestingly, this demonstrated how the text of integration permeated the local actualities of the team and their local experience, using what Smith (2006a, 2006b) described as controlling texts.

Early findings in this study demonstrated that at the commencement of the research, the teams did not feel they had a strong professional voice or position within the organisation. The community nursing team discussed their concerns of 'not being seen' and 'being misunderstood', concerns which were mirrored by the social care team, who discussed being a 'hidden service'. These expressions of not having professional parity were supported in the wider literature, such as Radermacher, Karunarathna, Grace, and Feldman (2011) and CLAHRC Greater Manchester (2019), which relate that during the decision-making process, individuals and organisations may experience inequalities and power differentials. These views were expressed in discussions but were also visible within the work and actions of the teams. Community nursing teams and adult social care teams work in an autonomous manner, often working alone with patients and service users, using handovers and team discussion to bring their individual work into the team. The findings demonstrated how the team metamorphosed their roles through the integration process, drawing on joint working practices and utilising each profession's skill set in order to enhance care delivery. This is a finding substantiated by Le Ber and Branzei (2011), who found that partners often move forward through a process of trying on each other's interpretations while retaining their identity, which could bring about positive changes but also has the danger of preventing them from 'locking step' and integrating.

This research revealed that all the professional groups joining the neighbourhood team had a feeling of being a ‘marginalised profession’ that was to a greater or lesser extent subservient to the privileged medical model, an assertion also present within previous studies (Fraser, 2019; Mitchell, Howard, Tazzyman, & Hodgson, 2019) . However, the larger groups found a voice and support within each other. The findings also highlight the need to consider smaller groups within the neighbourhood team, such as occupational therapists and the voluntary sector. There may be a case to be made that these groups also were in danger of being marginalised in the process, as Radermacher, Karunarathna, Grace, and Feldman (2011) found that these groups often were subject to perceived or real power differentials that could act as deterrents to working with larger, more established professional groups.

8.3.6 Practical Elements of Integration

The team experienced integration in different ways, but most participants talked about practical elements of the change as being contentious issues. For example, in the early co-location period, the team framed the success of the integration process on the effect of the practical elements of the change, such as computer networks not working, car parking, and storage. The teams also interpreted the practical elements as symbols of organisational attitude towards the integration process. Skogland and Hansen (2017) stated that people’s workspaces are visible and central structures that act to define organisations. Therefore, implementation of a new environment influences how change is accepted, experienced, and understood within organisations. Similar findings were reported in Inalhan and Finch (2012), who asserted that spatial change can act as a forceful catalyst for effecting organisational change.

In this study, both teams expressed that the ability to work in the same ‘space’ impacted ‘how work was carried out’, and that it increased informal joint working. These findings were supported by Freeman and Peck (2006), who identified that co-location of teams increases the informal contact between team members, typically enhancing working relationships and reducing the isolation of siloed working arrangements. The implication for practice is that the physical and practical elements of change are powerful symbols of the organisational approach and require consideration as part of the integration planning process.

8.4 Implications for the Team

The institutional ethnographic approach enabled all knowledge created to be grounded in the participants' experiences of integration. Throughout the study, the participants were recognised as the owners of not only their experience but also the associated knowledge. Therefore, as new knowledge was created through the research process, it was important to return that knowledge to participants.

The knowledge developed supported the teams in understanding their journey and reflecting on their next stages and progress to date (Campbell & Gregor, 2002). The newly formed integrated team also used their experience and knowledge to support other teams within the organisation. In the findings, these actions were described as part of the process of the team reconnecting with the organisation and presenting their version of integration.

8.5 Implications for the Organisation

Following team feedback, the Trust board and the joint management committee were provided with a feedback meeting. The feedback was given jointly by the team leaders for the neighbourhood team and the researcher. The feedback enabled the

organisation to discuss the implications of the research for their transformation programme. Importantly, the participants were there as the experts of their experience. This enabled the development of a respectful and trusting relationship between the senior managers and the team. The organisational feedback process enabled the standpoint group's previously marginalised voice to be heard at the most senior level of the organisation.

8.6 Chapter Summary

Core to the experience of transition to a neighbourhood team is the use of narrative, both internally and externally. Externally (trans-locally), the presentation of a positive strategic narrative acts as a powerful influencer. Internally, team members use stories to promote, subvert, and instigate required changes. In this study, the use of narrative was further amplified due to the space the teams were provided to form the neighbourhood team. The delay in the change management programme created a space which enabled team members to be autonomous, self-determined, and creative, with the results of their actions creating a further internal narrative and resulting in the creation of an internal vision.

Through discussion of the findings, it became apparent that elements such as professional identity and language that had previously been considered a barrier to integration were more complex. The findings of this study demonstrate that teams have an ability to use a range of leadership behaviours to enhance and coordinate their professional and individual skills to overcome practical challenges and work together effectively.

Chapter 9. Conclusions and recommendations

9.0 Chapter Introductions

This study presented an institutional ethnographic account of the experiences of teams as they transitioned from traditional team structures into an integrated neighbourhood team. The findings of this study have implications for the participants, the organisation, and wider policy development. Recommendations based on the findings are presented as a framework for preparedness for integration and recommendations for policy.

Essential to the research process was the continued use of reflexivity throughout the study. Application of reflexivity was important to ensure that there was an awareness of the effect of the researcher's subjectivity. To increase the robustness of the research, there has been reflection on the process, quality, and self in the research. These reflections are presented as part of this concluding chapter and form part of the entire reflexive journey. The chapter begins with reflections on the study relating to the original problematic, in line with the methodological approach, then proceeds to the recommendations and concludes by summarising the professional doctorate process.

9.1 Reflections on the Analytical Process

Having the privilege to research neighbourhood teams has been a personal and professional journey. The research has generated new knowledge and an original contribution within the area of study and enabled personal and professional growth as a researcher. Fundamental to understanding the problematic of the subject area was the adoption of a naturalistic methodology that was based in people's actual experience and gave a voice to those marginalised by the institutional processes. This was achieved through the adoption of an institutional ethnographic approach, which provided the opportunity to develop knowledge with the participants. The use of this

approach enabled the exploration of the team's transition to an integrated neighbourhood team through the lens of a standpoint group. This study was the first time an institutional ethnographic approach has formed the basis for a study on the formation of integrated teams. Therefore, the use of the methodology presented an opportunity to develop a new perspective and knowledge within the field. The standpoint group were central to the study and acted as the lens through which to view the wider institution and relations of ruling.

The standpoint group were selected through an analysis of interview data. The use of interview in the research allowed for the collection of a range of viewpoints that shed light upon groups that were marginalised via the process of integration. The standpoint group were observed over a nine-month period, with observation as the main data collection method. The use of observation was important to the study, as Bryman (2012) explained that observation entails an immersive approach, enabling the development of understanding through observing how people experience their world in a natural setting as events unfold. Observation enabled the consideration of the nuances of events as the researcher looked for the small everyday actions that brought meaning to the changes within the setting.

9.2 Study Quality

For research to be considered as advancing the knowledge base and providing an original contribution to a field, it must meet a threshold of quality (Treharne & Riggs, 2015). A widely accepted framework for ensuring quality in qualitative studies was developed by Lincoln and Guba (1985), who advocated that the following five key concepts should be considered: transferability, credibility, dependability, authenticity, and confirmability. Therefore, these factors were considered in the quality assurance

process. The following sections articulate how quality in the research was achieved, including the mitigation of factors that may limit the findings.

9.2.1 Transferability

Quality of the study in relation to its wider impact was assessed in line with Lincoln and Guba's (1985) assertion that in qualitative research, it is transferability—not generalisability—that defines usefulness. Specifically, in the field of IE, Smith (2005) and Campbell and Gregor (2002) both argued that it is not the aim of an institutional ethnography to produce traditionally generalisable results as defined in positivist approaches. As the study adopted the IE approach, its usefulness lies in its ability to make visible and demonstrate how relations of ruling exist across local settings, how these external influences affected the experiences of the participants, and how the local experience informed wider institutions. Viewing transferability in these terms enabled the study to consider the implications for the participants, the organisation, and the field of health and social care. The requirements for future research have also been identified from the findings of the study.

Transferability was further enhanced by reporting on the context in which the research was conducted, including background, history, people, cultures, and political circumstances in the field at the time of the research (Seale, Gobo, Gubrium & Silverman, 2004). The importance of context was that the natural setting was the focus of the research outcomes. Therefore, for the reader to be able to make use of the findings and transfer recommendations to alternate settings, the findings and discussion were written in such a way as to convey the observations, the context, and the presence of the researcher.

9.2.2 Credibility

Holloway and Wheeler (2013) defined credibility as how confident the reader can be that there is truth within the research findings. Throughout the research journey, attention was paid to the plausibility of the information being drawn out of the observations and to the extent to which the findings could be considered believable and trustworthy.

In this research, the process of ensuring credibility started with the methodological design, data collection, analysis, and reporting. In Chapter 4 and 5 there was an explicit and transparent account of the research methodology and methods. A research information sheet and consent forms (Appendixes 7–11) were provided to participants to ensure that there was clear and open information.

9.2.3 Dependability

Dependability was assured through the validation of findings by the participants. The process of validation was continual and involved the sharing of findings in formal and informal meetings. During these meetings, feedback was recorded as part of the fieldnotes. Participants were encouraged to discuss and comment on the believability of the findings as they were being developed. The adopted approach supports Anney's (2014) view that dependability is the measure of the stability of findings over time and requires participants to actively evaluate the findings of a study to ensure that they were all supported by the data received. In addition, since the study is an IE, the participants were required to legitimise the results, as they remained the owners of the knowledge of their experiences (Rankin, 2018; Smith, 2005, 2006a, 2006b). The legitimising of the results was achieved by continual returning of the findings as they developed, a final feedback meeting, and the joint presentation of findings to the wider organisation.

9.2.4 Authenticity

The research strove to present the findings of the study in a way that was fair and represented the different experiences of the team members. To achieve the aim, the analysis and presentation of the findings included the dissenting voices and negative cases, the importance of which was to magnify the voice of the marginalised and unheard standpoint group through the research process. For example, during the coding process and the development of the theme of hope, a process of returning to the data was undertaken to seek out alternative views. Through this revisiting process, the concept and theme of hope was advanced. Returning to the data enabled alternative perspectives to be explored. The process brought about a distinction between expressions of optimism and expressions of hope. In the early stages, it was perceived that the teams were optimistic and that was a sign of hope. However, seeking an alternative view enabled these concepts to be viewed as distinct and different, which in turn led to a deeper exploration of agency within the teams, leading to a deeper analysis of the theme.

9.2.5 Confirmability

Confirmability, or the researcher's confidence that the voice of participants was presented, was assured by compliance with Smith's (2005) assertion that an important distinction of IE is that participants are not the object of the research, but rather the lens through which the institution is viewed. During the analysis of the data, reflexivity was used to continually challenge the interpretation of the findings to ensure that the experiences and the institution were being viewed through the lens of the standpoint group.

9.3 Enhancing Research Quality

Several additional factors contributed to enhancing the overall quality of the research: the selection of the standpoint group as the sample, the period of the study, the assumption of marginalisation, and the researcher's status as a research tool.

9.3.1 Sample

The methodological and ethical approach defined the selection of the standpoint group. The selection of the standpoint group was appropriate for this study, as the group were defined as marginalised by the process of integration in stage 1 of the study. The selection of a standpoint group provided the study with a unique perspective on the effect of the implementation of integration. As Smith (2005) explains, institutional processes and controls are often played out in local spaces. The use of a thick description of the experiences of the neighbourhood team enhanced the transferability of the study because participants' experience provides the lens for viewing how integration was enacted, implemented, and controlled within the organisation.

9.3.2 The Research Period

An influential factor in the study was the context and time of the data collection. Data collection commenced just prior to the co-location of the teams and continued through the first seven months after co-location, which provided a unique perspective. There were advantages to the timing of the study as part of the team's evolution, as it enabled the exploration of the early transition. It is acknowledged, however, that the journey of integration remained within its initial stages, and several significant changes had not yet come to pass for the team. For example, the formal management structure had not changed at the time that the study closed. Therefore, the presented findings should

be read as a perspective of the experiences of the team during early stages of integration, rather than during the entire integration process.

9.3.3 Assumption of Marginalisation

A tenet of the institutional ethnographic approach is the requirement to identify a group that has been marginalised by the institutional processes (Campbell & Gregor, 2002). Smith (2005) argues that using the lens of the actualities of marginalised groups provides a unique insight into organisational behaviour and relations of ruling, giving a voice to the seldom heard. However, defining a group as marginalised involves a risk that the agency of that group may not be recognised. Such a lack of recognition of agency could lead to the active role the participants take in subverting, challenging, and manipulating the relations of ruling being missed or discounted (Lukes, 2005; O'Mahoney & Sturdy, 2015).

9.3.4 The Researcher as a Research Tool

The self was an important consideration, as Hammersley and Atkinson (2007) argued that the researcher is an active force within the research process. Furthermore, Whitaker and Atkinson (2019) have asserted that reflexivity is not to be seen as a virtue or option within social research, but as an inescapable imperative. Within this study, the researcher was viewed as a 'research tool' and consideration was given to the influence of subjectivity on the field and the analysis of data. To support the understanding of self throughout the study and ensure an ethical approach was taken, reflexivity (self) and reflection (events) were employed and recorded in a reflective journal. To further strengthen the approach, regular research supervision was conducted monthly, and regular feedback and checking in with participants took place informally throughout the study and formally at the end of data collection.

9.4 Contributions

The unique contribution of this study is that it provides an account of the actualities of implementing integrated teams, from the perspective of team members tasked with the adoption of the new models of health and social care. This is important, as there are strong policy drivers toward integration and integrated care internationally, nationally, and locally. Therefore, it is important to understand how teams enact these policies in real terms to support wider spread and adoption of these approaches.

Internationally, the WHO strategy for integrated care (2016a) and the WHO Declaration of Astana (2018) advocate the widespread adoption of policies that prioritise, promote, and protect people's health and wellbeing, at both population and individual levels. These documents hold that a key enabler for these transformations is the development of health professionals who are well-trained, skilled, motivated, and committed to supporting individuals, families, and communities. The imperatives to integration and integrated care nationally are outlined in the 'Long-Term Plan' (NHS England, 2019a), which states that there is a requirement to move to more integrated models of care to ensure the NHS will reduce the growth in demand for care and support people in improving their health and wellbeing. Locally, there was a further driver of integration, as it was viewed as a means to reduce the health inequalities for the most vulnerable within the community.

This study demonstrates the practical implications of the enactment of this vision, as transformation may be guided by policy but exists and happens in the local spaces where people work, live, and interact. This research builds on previous studies and demonstrates that the transition to integrated models of care relies on the people working within the services to change their culture, working practices, and professional identity. Therefore, this study is of importance as it focuses its attention on the local

environments where change happens and sheds light on how team members experience change.

To date, there have been only a small number of studies which directly focus on the human factors of integration. Additionally, due to the emerging status of the integrated care agenda within the UK context, there has been limited analysis of the current iteration of integrated care. This study adds to the previous evidence but is reflective of the integrated care agenda at the time of writing. Finally, the study uses a methodology—institutional ethnography—not previously used in the research of neighbourhood teams.

Institutional ethnography is a distinct methodology which requires the establishment and maintenance of an ontological shift (Rankin, 2017). Studies adopting an IE approach recognise and promote the real and lived experiences of people, linking them to external controlling forces (relations of ruling). Importantly, institutional ethnographic approaches assertively seek out groups marginalised within institutional processes and aim to bring their voice into the fore of the study. The importance of a standpoint group is that it provides a unique perspective—in this case, on how integration was experienced by those tasked with its adoption. This perspective is important, since previous research has found that the success or failure of partnerships and integrations depend on the human elements involved. An institutional ethnographic approach had not previously been adopted in the exploration of integration.

The institutional ethnographic approach was supported by the addition of thematic analysis. The approach adopted was outside of the normal analytical approach used within institutional ethnography and therefore provided a unique methodological

framework. The combination of these two approaches was not without challenges and required ontological and epistemological considerations, which were outlined in Chapter 4. The analysis of data using thematic analysis ensured a transparent and robust account of the findings.

9.5 Recommendations

Recommendations for practice are considered in the context of UK government policy, with the understanding that the NHS is not unified across the UK and that there are policy differences across the devolved nations. The publication of the 'Long-Term Plan' (NHS England, 2019a) reiterated the drive towards integrated care systems, stating that integrated care systems were essential to the delivery of the plan and transformation of the health service. The plan considers integration across three areas: primary and specialist; physical and mental health; and health and social care. This research was of direct relevance to the integration of health and social care; however, comparisons may be made with other cross-sector integration processes. The 'Long-Term Plan' (NHS England, 2019a) provides strategic guidance to health and social care economies. What this research adds is an account of the realities of integration within the current climate, the importance of which is that there can often be a disconnect between policy and reality and, as several previous studies have found, integration is influenced by people within local contexts.

9.6 Framework for Preparing Teams for Integration

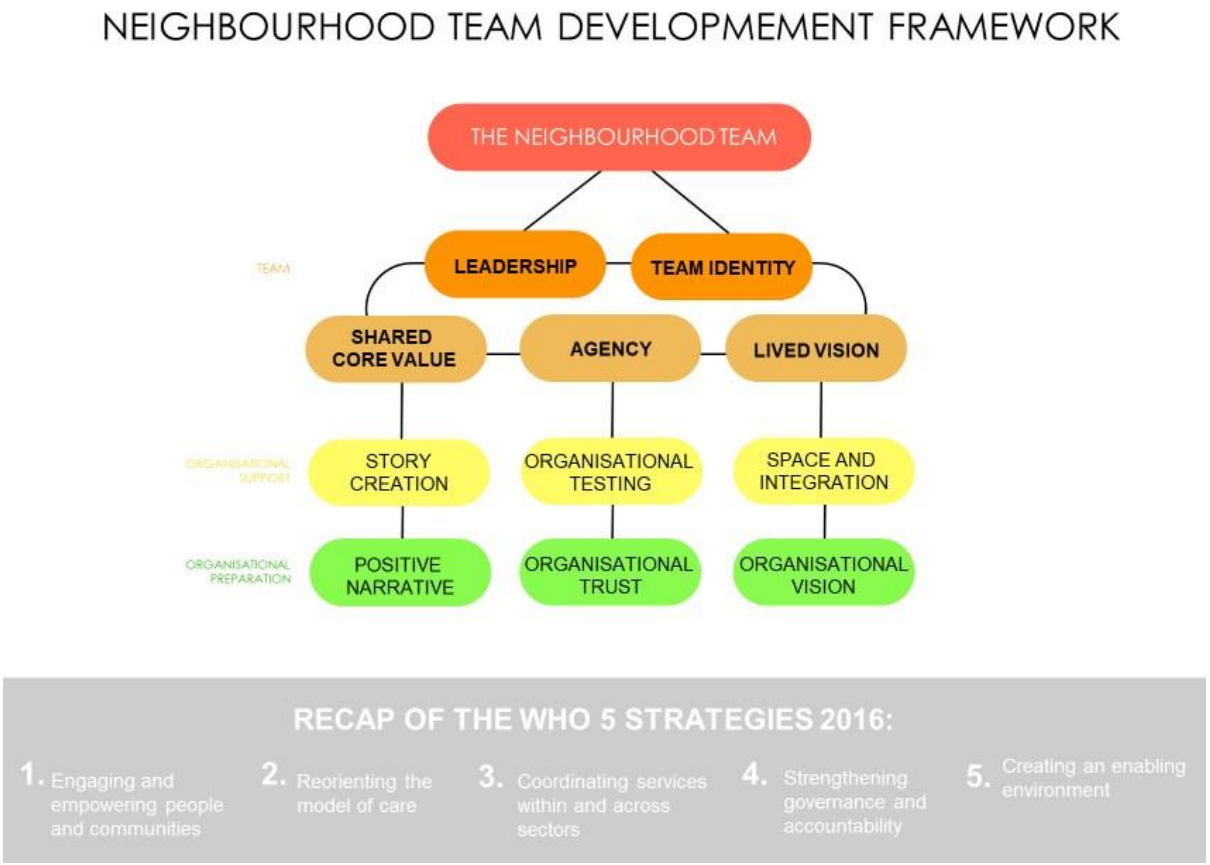
A unique contribution of this thesis has been the development of a framework for neighbourhood team development (Figure 37). The framework has implications for practice and was based directly on the experiences and accounts of the teams as described in the findings. The aim of the framework is to support organisations in developing a strategic approach to the implementation of integrated neighbourhood

teams. It is acknowledged that the findings themselves are not generalisable, and the framework will require further study to validate its use. However, the framework provides guidance on preparedness for the development of neighbourhood teams based on the experience of the teams observed within this study.

The framework describes key activities to be considered prior to the commencement of developing the neighbourhood teams and includes organisation-level and team-level requirements. The five strategic approaches of integrated care as described by the WHO (2016a) underpin the approach. The framework considers the requirements at each organisational level, but also clearly demonstrates how these requirements move through an organisation. For example, organisationally, attention needs to be given to the creation of a positive narrative on integration that is strengthened by stories created and heard from within and links to the new team's shared core values. The framework attempts to capture the complex set of dynamics that were experienced during the study in a way that can be useful to a range of organisations preparing to implement integrated teams.

Figure 37

Framework for the Development of Integrated Teams



9.6.1 Organisational Preparedness

Organisational preparedness relates to preparing the organisation and the teams developing an environment in which to transition to integrated neighbourhood teams.

Positive Narrative

Prior to the introduction of neighbourhood teams, organisations need to consider how to foster a positive narrative of integrated care. The narrative needs to be authentic and link the values of the team members to the principles of integrated care (WHO, 2016a). The importance of narrative is that, if successful, it will reflect the core value set and align these to the integration agenda, fostering hopefulness within the team.

The findings suggest that the presence of hopefulness and strong connections with a narrative are powerful drivers for change in the implementation of integration. In the creation of the narrative, the organisation should be open and transparent to prevent the narrative from becoming a controlling text. The narrative should inspire rather than control and manipulate the local setting. Inclusion of the local and vanguard areas in the development of the narrative will provide validation for the narrative by linking policy to reality.

Organisational Trust

The findings suggest that when teams are provided with a strong and positive narrative, they can use the narrative to create rapid change through local testing of ideas. However, the approach requires the organisation to place trust in teams, providing them with a framework rather than predetermined and controlling change management approaches. This approach is supported by previous work by Edgren and Barnard (2012), who asserted that in the development of integrated care, it is important to foster the capacity for self-organisation, improvisation, and flexibility. However, it is important to recognise that the findings of this study suggest that the ability to test and create change within a team requires all elements of the framework to be present. However, the organisation is a vital catalyst in the process, as they are required to provide permission (trust) to teams and relinquish centrally held power.

Importantly, organisations need to be able to deliver trust in a consistent manner during the transition. The findings suggest that the team's journey of transition involves a series of separating and converging activities, which at specific points involve the othering of the organisation to provide space for the development of a strong internal identity and testing of new ways of working. Within this study, such space arose when there was a delay in the implementation of the organisational development

programme. The team reported that they valued the time and the feeling of being trusted. Trust can be an important motivating factor which enables teams to work more proactively with change programmes.

One way an organisation can demonstrate trust is by the inclusion of key leadership roles within the neighbourhood team. The neighbourhood manager is a successful example of the approach adopted. The role of the manager is to provide strategic leadership across the teams, translating organisational vision and providing two-way communication between the team and the wider organisation. In this study, the role was key in the provision of the narrative, but importantly the manager did not operationalise the changes; the manager's role was seen as encouraging the team to take ownership of the change within the organisational framework, guiding and inspiring the team towards achieving integration.

Organisational Vision

Ginter, Duncan, and Swayne (2018) state that organisational vision acts as a powerful beacon and control—vision inspires organisational members towards ideals and goals. Adding to this idea, Drennan et al. (2005) state that when there is a lack of a shared vision, even teams that are enthusiastic and committed to a partnership may struggle with the complexity of turning divergent agendas, aspirations, and knowledge into operational reality.

The findings of this study suggest that although team members may not appear to discuss the organisational vision or interact closely with it, there may be evidence of the vision being combined within a strong supportive narrative by team members. The team used the organisational vision to construct internal team visions with meaning to them. The constructed internal vision then influenced the day-to-day working, as team

members applied their vision to practice. Therefore, it is important to develop an organisational vision that is clear and concise but enables flexibility to include individual team constructs.

9.6.2 Organisational Support

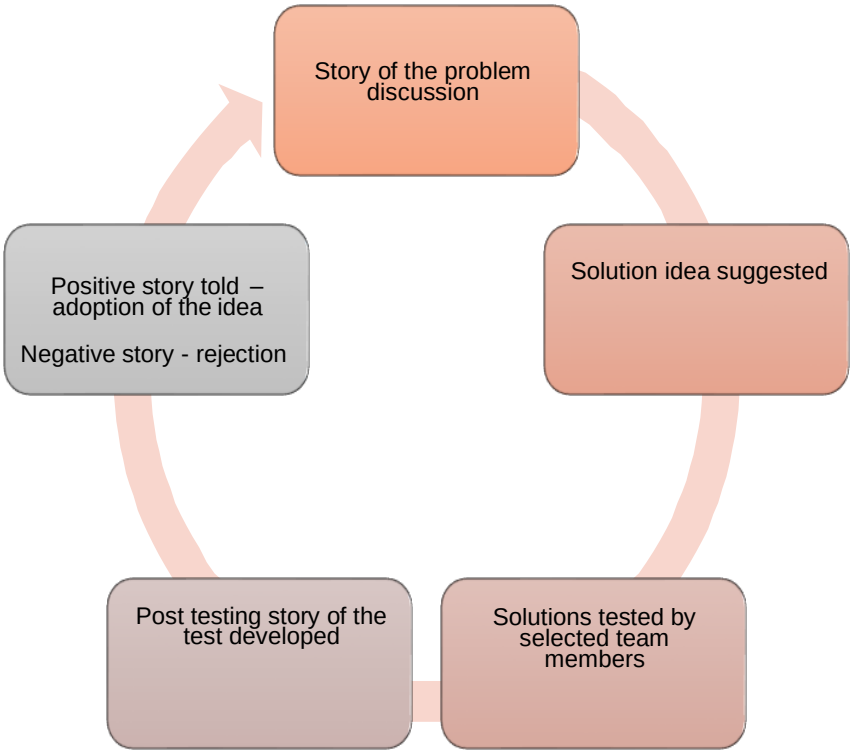
Organisational support relates to equipping the organisation and the teams with the skills to develop integrated neighbourhood teams.

Story Creation

Change stories within teams have the potential to support the growth of integrated neighbourhood teams, and organisations should explore and develop mechanisms that value and support the use of these stories. The neighbourhood team members in this study used stories as powerful change-making devices, adopting change that was supported by positive stories and rejecting change that had negative stories. The findings of this study suggest that stories support rapid spread and adoption of team-level change. Figure 38 demonstrates a typical cycle of story-guided change.

Figure 38

Cycle of Change Through Stories



Through history, storytelling has acted as a means of passing on culture (Sole & Wilson, 2002). This study identified that stories can harness learning and be used as a mechanism for sharing knowledge within organisations. Using stories as part of the change process can lead to creative solutions, in line with bottom-up change management theories (Duffield & Whitty, 2016).

Organisational Testing

Within the study, the process of testing developed organically within the space provided by the organisation. Rapid testing approaches are common within product development and fast-developing services such as information technology (Chang & Taylor, 2016). However, the findings here suggest that the approach can also be used in the development of integration. The teams in this study organically developed a

method of testing their ideas and using stories to spread changes and encourage adoption of successful change and rejection of change that did not provide positive outcomes.

Space and Integration.

Integration requires a change in space, and the shift may be geographical, cultural, conceptual, or all three. The transition of space is important, as this study demonstrated: if insufficient attention is paid to practical factors, then issues such as parking, desks, IT, and storage can become powerful symbols of dissatisfaction that can potentially derail the integration process, as individuals and teams disengage with the organisation.

9.6.3 Team

The team relates to key facets that need to be present with the teams as they come together to integrate into neighbourhood teams.

Shared Core Values

Attention must be paid to the promotion of the values of individuals and professions during integration. The findings of this study demonstrate that a team's acceptance of the narrative of integration may be linked to how closely it aligns with the shared values they hold as professionals, including empowerment of people, community- and person-centred care, and promotion of independence. Shared values enable professionals to work closely together and across professional barriers, therefore reducing challenges and encouraging transition.

Agency

The organisational narrative and vision received and lived are crucial to the development of hopefulness for change. The findings suggest that these are key motivating factors in the development of integrated teams. However, even if teams are

hopeful about the changes that integration may bring, they also require the agency to act. Snyder (2002) explains that hope needs to include a determination to achieve goals through a person's agency. Therefore, this framework recommends exploration of agency within teams as they move to integrated working.

Lived Vision

The ability of the organisation to set a positive narrative and clear vision for the integration is matched by the teams being provided with the space to transform that vision into something that is lived within their actualities, since it is through the living of the vision of integration within everyday actions that the required change takes place.

Leadership

Manning and Curtis (2007) stated that leadership provides social influence, which leaves its mark by initiating and guiding, with the result being change. Within operational environments, leadership is necessary at all levels from personal through to team (Day, Gronn & Salas, 2004). The development of integrated teams requires not only the promotion of formal leadership roles but also the fostering of self-determined leadership at all levels. The development of leadership across the team interlinks with the creation of agency within the team (Mitchell, Boyle, Parker, Giles, Chiang, & Joyce, 2015).

Team Identity

The sociologist Freidson (1973) stated that professions have distinctive conventions and institutions which differentiate them from other types of occupations and from each other. These distinctions must be recognised as having an influence on the ability of teams to form integrated teams. This is because the integration of teams requires the creation of a new identity; however, the creation of new team identity is a complex and multi-faceted process that does not follow a linear path. Team members will converge

and separate from each other while they test out the new identity and use their own identity either as a barrier to integration, as seen in studies such as Cairns and Harris (2011), or as a means to develop a strong link through their shared identity, as in this study.

9.6.4 Summary of the Framework for Preparedness for Integration

The framework presented aims to act as a guide for organisations as they consider their positionality and preparedness for neighbourhood team integration. The limitation of the framework is that it is based on the findings of one institutional ethnographic study and requires further testing to validate its application.

9.7 Implications for Policy

The implementation of integrated care is an international undertaking, as health and social care systems attempt to overcome and manage the shifting demographics and epidemiology of populations. The principles of integrated care as set out by the World Health Organisation (2016a) require a shift in the models of health and social care provision. At the heart of many of these models is the development of neighbourhood approaches that reorganise care around people and place rather than around organisations such as hospitals.

This study contributes to this knowledge base in supporting previous studies on partnerships in that it found that core to the development of neighbourhood teams is how team members are able to adapt and transition through change. A unique contribution lies in its findings of how team members are able to overcome potential professional barriers to change through a strong narrative that relates to their core value set. This is important for policymakers to understand, as they need to consider how policy can be written in a way that reflects the values and beliefs of all groups

involved in integrated care, especially those values that cut across professions, such as notions of empowering people, community and person-focused care, and independence. Framing policy in these terms will build a positive narrative that prompts a message of hope and acts as a counterbalance to the challenges of transition.

9.8 Implications and Recommendation for Further Research

Integrated care internationally and within the UK remains within its preliminary stages. Greater Manchester has been an early adopter due to the opportunities provided by devolution. Currently, there is little research that reflects the impact of the implementation of integration in its current form, and, therefore, there are a number of areas for further research, including but not limited to:

- Testing of the framework developed within this study
- Multi-site research (locally, regionally, nationally, and internationally) comparing the development of neighbourhood teams to demonstrate transferability of findings
- Measuring the outcomes for people and communities of the introduction of neighbourhood teams

9.9 Final Reflections and the Professional Doctorate

In concluding the professional doctorate process, it was important to reflect on the intellectual journey. As acknowledged throughout the research process, as an agent and researcher within the field, the researcher affects the field and the field affects the researcher (Hamersley & Atkinson, 2007). Conducting reflexive activities throughout and at the conclusion of the study enabled deep analysis of self and led to a shifting of my discursive position and assumptions about integration, how teams work together, and myself. At the start of the study, I was working within the field of

integration as a transformation lead. In March, 2017 I was appointed to the post of adult nurse lecturer. The professional change challenged my original assumptions of being an insider researcher and forced a re-examination of my positionality within the field. Reflecting on my position led me to the conclusion that the view of insider/outsider status as a binary concept did not address the complex nature of the issues involved (Hellawell, 2006). The adoption of the IE approach provided important learning opportunities as it disrupted the insider/outsider binary by positioning the participants as the gateway for viewing the institution and relations of ruling, not as the subjects of the study, thus changing the relationship between observer and participant (Smith, 2005).

As I developed my understanding of self and positionality, I reflected on how my personal journey reflected that of team members. Team members did not simply see themselves with simple professional identities—a nurse or a social worker—but rather, their identity was a complex matrix that included their values and beliefs as well as their professional status. As my position as a researcher was neither an insider nor outsider but a mix of both, my positionality was based on the values I placed in the research as the story of those who participated and shared their knowledge.

Within the doctorate programme, there was a two-year taught element. This element equipped me with a range of tools and theoretical knowledge from which to design the study. During this taught component I was able to explore my understanding of my personal epistemological assumptions and ontological standpoint. However, it was within the practical application of this knowledge during data collection and analysis that I gained a greater understanding of myself as a researcher and my positionality. For example, the methodological approach states that the research should be conducted from the standpoint of the marginalised, but data collection and analysis

challenged my assumptions on what it is to be marginalised within an institution. Despite being identified as marginalised, the members of the neighbourhood team did not act from a place of disenfranchisement; rather, they used their agency to subvert, challenge, and create anew.

The professional doctorate has been a six-year journey, and as with all doctoral journeys, has been a significant part of my life for those years. For myself, this journey has been challenging in a number of ways professionally, personally, and academically, forcing me to confront my own insecurities, values, and beliefs. I arrive at the end of this journey a different person than when I started. The journey has enabled me to contribute to the growing field of research into integrated practice and, importantly, to do this in a way that gave voice to those seldom heard within institutional change, using their experience to benefit them, the organisation, and the wider field of health and social care.

9.10 Conclusion

This study has its origins in the shifting demographics and epidemiological landscape of the UK. An ageing population and an increase in the prevalence and incidence of long-term conditions have focused political attention on the transformation of health and social care (Ham, 2018). Integrated care systems and integration of service delivery have become the preferred method of delivering health and social care (NHS England, 2014a, 2019a). However, despite the popularity and dominance of the integrated care agenda, there has been only a small amount of research focused on how integration comes into being and how teams transition structurally and culturally.

This study sought to explore the experience of team members moving from traditional health and social care teams to integrated team structures. The study findings

presented a narrative of the experience of one neighbourhood team over a nine-month period, centring on three key themes: the convergence and separation in the creation of integration, which tracked how the teams reimagined and created their unique vision for integration and how they used this vision to guide them through a process of converging into a newly integrated team; the dichotomy of hopefulness, which explored how hope acted as a driver for change and how team members expressed hope in diverse ways through the change process; and finally, the making of the integrated team and the team's experience of leadership and collective endeavour in the creation of the new neighbourhood. The findings and discussion informed the recommendations for policy, research, and practice and the development of a framework for preparing teams for integration.

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Appendix 1 – Contribution to the Knowledge base (Publications and Conferences)

Ehrenberg, Terris, & Marshall, (2020)	A Rapid Review of the Health Care Home Model in Capital and Coast District Health Board	https://www.ccdhb.org.nz/about-us/integrated-care-collaborative-alliance/health-care-home/.
Marshall, K., & Easton, C.(2018).	The role of asset-based approaches in community nursing.	Primary Health Care, 28(5), 35-38.doi:10.7748/phc.2018.e1339.
Utrecht University of Applied Science Virtual international week	UK perspectives on Covid	International Conference
Nordic Conference on Advances in Health Sciences (2020)	Phd poster presentation. An exploration of neighbourhood team members experiences of the transition to integrated care systems	International Conference
International seminar at Turku University of Applied Sciences, Faculty of Health and Well-being (virtual) (2020)	Person Centred Care Digital health care - COVID and beyond	International Conference with conference publication
20th International integrated care conference Virtual (2020)	Advancing educational approaches to developing a health and social care workforce (Workshop) Development of a framework for preparing organisations and teams for neighbourhood working (Oral paper).	International Conference with conference publication
19th International integrated care conference (2019)	An exploration of how neighbourhood team members experience the transition from traditional health and social care teams to integrated care systems, within a defined health and social care economy (Oral paper).	International Conference with conference publication
18th International integrated care conference (2018)	System Wide Self Care in Tameside and Glossop (Presentation),	International Conference with conference publication
Queens Nursing Institute annual conference (2018)	Integrated Neighbourhood Teams – Improving Experience and Practice (Poster presentation)	Conference
Researching Integration in Tameside Research Development Conference, (2017)	Tameside and Glossop Integrated Care NHS Foundation Trust - Presentation of Professional Doctorate research on integration within Tameside	Trust feedback /conference (local)
Queens Nursing Institute National Conference (2016)	Asset Based Community Development and Community Nursing	Conference

Appendix 2 – Policy review England

	Document	Department	Year
1	The Care Act		2014
2	Health and Social Care Act 2012		2012
3	The NHS's Recommendations to Government and Parliament for an NHS Bill	NHS England and NHS Improvement Strategy and Innovation Directorate	2019
4	Personalised Health and Care 2020, Using Data and Technology to Transform Outcomes for Patients and Citizens: A Framework for Action	NHS England	2014b
5	Digital Strategy: Leading the Culture Change in Health and Care	Department of Health	2012
6	House of Commons Select Committee Social Care 14th Report of Session 2010-12	Health and Social Care Committee	2012
7	Integration: A Report from the NHS Future Forum	Department of Health	2012b
8	Fairer Care Funding: The Report of the Commission on Funding of Care and Support	Dilnot, A.	2011
9	Long Term Plan	NHS England	2019a
10	Refreshing NHS Plans for 2018/19	NHS England and NHS Improvement	2018
11	Lord Darzi – Review of Health and Care	Lord Darzi	2018
12	Five Year Forward Plan	NHS England	2014a
13	Integrated Care and Support: Our Shared Commitment		2013
14	Long Term Conditions Compendium of Information: Third Edition	Department of Health	2012a

15	Equity and Excellence: Liberating the NHS	Department of Health	2010
16	Transforming Community Services: Ambition, Action, Achievement Transforming Services for Acute Care Closer to Home	Department of Health	2009
17	High Quality Care for All NHS Next Stage Review Final Report NHS Next Stage - Review Final Report	Lord Darzi	2008
18	Topol Review – Preparing the Health Care Workforce to Deliver the Digital Future	Topol,	2019
19	Facing the Facts, Shaping the Future	Public Health England	2017
20	A Narrative for Person-Centred Coordinated Care	National voices	2013
21	NHS Operating Planning and Contracting Guidance 2020/21	NHS England	2020
22	STP/ICS Integrated Volunteering Approaches Programme 2019	NHS England	2019b
23	The 2019 Spending Review - How to run it well	Audit Commission	2019
24	Accountable Care Organisations - BRIEFING PAPER	Bate, A house of commons library	2018
25	Integrating Care: Contracting for Accountable Models	NHS England	201
26	Health and Social Care Integration	National audit office	2017
28	Joining up Health and Social Care: Improving Value for Money Across the Interface	Audit Commission	2011
28	Department of Health Partnership for Older People Projects 2006 – 2009	PSSRU evaluation	2006
29	Department of Health integrated Care Pilots	Department of health	2009-11
30	Better Care Fund, Policy Framework 2016/17	Department of health	2013
31	Integrated Care and Support Pioneers	NHS England	2014c

Appendix 3 - Greater Manchester search results

	Document	Department	Year
1	Cities and Local Government Devolution Act 2016 (c. 1)		2016
2	Taking Charge of Our Health	GMDA	2016
3	Five-Year Vision for Better Health and Social Care in Greater Manchester	GMDA	2018
4	Locality Plan	LA -	

Appendix 4 - Included Literature

Research and Evaluation

No.	Author	Title	Methodology	Sample	Key Finding
R1	Bardsley, Smith, & Car (2012) UK	Evaluation of the First Year of the Inner North West London Integrated Care Pilot	**Evaluation** of the first year of operation of the new integrated care programme	Pilot is a large-scale programme	incorporating a range of organisations. In its initial stages work has focused on developing new forms of care coordination and planning for two key groups; people with diabetes, and those who are over 75 years of age Positive outcomes Patients • service design • enhanced IT • financial incentives provided • financial outcomes
R2	Beacon (2015) UK	Practice-Integrated Care Teams – Learning for a Better Future	**Evaluation**	PICT project from 2012 to 2014	The integrated teams which have been established in Central Manchester are designed to deliver a coordinated, patient-centred model of care to some of the most vulnerable people in Central Manchester. Evaluation – including insight into improved patient outcomes changes in culture

No.	Author	Title	Methodology	Sample	Key Finding
					not much on finances
R3	Béland., Bergman, Lebel, Clarfield, Tousignant, Contandriopoulos & Dallaire (2006) International Canada	A System of Integrated Care for Older Persons with Disabilities in Canada Results from a Randomized Controlled Trial	**Randomized controlled trial**		Accessibility was increased for health and social home care Increased intensification of home health care. 50% reduction in hospital alternate level inpatient stays There were no significant differences in utilization and costs of the emergency department, hospital acute
R4	Cairns & Harris (2011) UK	Local Cross-Sector Partnerships, Tackling the Challenges Collaboratively	**Qualitative** Research workshops	13 local study areas	Benefits Improved relationships and working *Challenges* Lack of capacity Time, skills Power imbalance third sector governance of cross-sector partnerships
R5	Coxson (2005) UK	Common Experiences of Staff Working in Integrated Health and Social Care Organisations a European Perspective	PROCARE study of integrated health and social care **Comparative study**	134 staff were interviewed, and another 153 respondents took part in 24 focus groups across the 18 projects	Advantages – Job satisfaction was very clearly linked to meeting the needs of clients. Importance of shared culture Disadvantages - Medical-social care boundaries Boundaries between

No.	Author	Title	Methodology	Sample	Key Finding
					organisation Lack of training Lack of real collaboration
R6	Cramm, Phaff and Nieboer (2013). International Netherlands	The Role of Partnership Functioning and Synergy in Achieving Sustainability of Innovation Programmes in Community Care	**Cross-sectional study** The Partnership Self-assessment tool: Short version (PSAT-S)	106 (across 21 partnerships	Suggested that the sustainability of innovative programmes in community care is achieved more readily when synergy is created between partners.
R7	Drennan, Ross, Calestani, Saunders, and West (2018) UK	Learning from an Early Pilot of the Dutch Buurtzorg Model of District Nursing in England. Primary Health Care	**Evaluation** of the early pilot	Interviews	A different way of working from the patient and carer perspective nursing practice the NN team nursing practice was very different Positive care outcomes were reported by General Practitioners (GPs) Positive feedback they had received from patients and family Recording care and outcomes
R8	Fraser (2019) UK	Elephant in the Room.	**Cross-sectional questionnaire**	(N=38) (76% response rate).	Joint assessment supports closer working relationships
R9	Freeman & Peck (2006)	Evaluating Partnerships: a Case Study of Integrated Specialist Mental Health Services	**Case study**	Focus group – user and carer New specialist team	Pressures for fragmentation and integration Segmented services resulted in legitimate disagreements

No.	Author	Title	Methodology	Sample	Key Finding
				Generalist team managers	between clinical professionals over what to do Team approaches were supportive Co-location of teams increases the potential for informal 'water cooler' contact, Service users viewed integrated care groups as positive
R10	Ham (2010a) UK	Working Together for Health: Achievements and Challenges in the Kaiser NHS Beacon Sites Programme	**Pilot programme** to adapt the experience of Kaiser in three areas of England Evaluation	Three areas – Birmingham and Solihull, Northumbria and Torbay	review of Kaiser Perminate's model within 3 UK areas positive and challenges defined
R11	Ham, Heenan Longley & Steel (2013) UK	Integrated care in Northern Ireland, Scotland and Wales Lessons for England	**Review of evidence fi**		NI – held up as best practice – however lack of evaluation and data makes it difficult to assess Scotland – high level policy and shifts at a strategic and organisational level Wales - The proposed system of care – a 'pull system' locality'-based model, led by multi-sector locality leadership teams

No.	Author	Title	Methodology	Sample	Key Finding
R12	Mitchell, Howard, Tazzyman & Hodgson (2019) UK	Understanding and Supporting the Integration of Health and Social Care at a Neighbourhood Level in the City of Manchester	thematic analysis of semi-structured interviews rapid scoping review of the literature around integration of health and social care **Qualitative**	Interviews were conducted with 24 individuals (comprising 6 strategic leads; 18 operational staff	There are a number of key enablers and Challenges that require consideration during integration areas covered Definition and vison of integration org. factors Professional identity Impact of IT Day to day delivery Impact of integration on delivery of health and social care services
R13	Heenan & Birrell (2006). Uk	The Integration of Health and Social Care: the Lessons from Northern Ireland	**Qualitative** research – semi-structured interviews	N = 24	Identifies and discusses integration within NI. It concludes that research identified some tensions between the professionals, but there was no evidence of any lack of commitment to working together the 'culture of integration' that existed in Northern Ireland was constantly stressed

No.	Author	Title	Methodology	Sample	Key Finding
R14	Hudson (2002) UK	Interprofessional in Health and Social Care: The Achilles' heel of Partnership	**Qualitative study**	N = 81 Interviews Focus groups	An investigation into professional relationships between practitioners in health and social care working with frail older people across three localities in northern England There are opportunities to have a more positive approach to interprofessional working
R15	Lau, Wong, Chung, Law, Threapleton, Kiang, Chau, Wong, Woo, Yeoh & Eng-Kiong (2018) International Hong Kong	Collaborate Across Silos: Perceived Barriers to Integration of Care for the Elderly from the Perspectives of Service Providers	**Qualitative study**	Interviews with 7 key informants (n = 42) 22 focus groups(n = 117)	Health care and social care service wish to collaborative work to enhance continuity of care and ageing. Efforts are hindered by a range of barriers that need to be dealt with in practical terms
R16	Le Ber & Branzei (2010). International Canada	Value Frame Fusion in Cross-Sector Interactions	**Longitudinal narratives** of four dyads		Show that partners initially contrast their sector- embedded frames, but they can work together to develop partnership frames
R17	Lunts (2012) UK	Change Management in Integrated Care – What Helps and hat Hinders Middle Manager – A Case Sudy	**Grounded theory**	8	Middle managers possess good project management and staff engagement skills Time and capacity, and lack of role clarity were a significant issue.

No.	Author	Title	Methodology	Sample	Key Finding
R18	MacLeod & Emejulu, (2014) UK.	Neoliberalism with a Community Face? A Critical Analysis of Asset-Based Community	**Feminist interpretive methodology**. critical inquiry and reflection	N/A	the application of ABCD generates tensions within an existing Scottish social democratic framework for community development
R19	Manthorpe , Goodman, Drennan Davies, Masey, Gage, Scott, Brearley & Iliffe, Steve (2013) UK	Nurse-led Case Management in the National Health Service: Bridging Clinical and Social Worlds.	**case study approach**	Three sites participated with differing socioeconomic characteristics. The study took place between 2008 and 2009.	Nurses role enlargement by undertaking work covering social care needs / Prentive roles / The implications of nurse case management roles shaping them where possible.
R20	Murphy, Hugman, Bowen, Parsell, Gabe-Walters, Newson & Jordan, (2017) International Ireland	Health Benefits for Health and Social Care Clients Attending an Integrated Health and Social Care Day Unit (IHSCDU): A before- and-after pilot study with a comparator group	A before-and-after **pilot study** with a comparator group -	48 service users	The comparator group were less well than the unit attendees and the background population, indicating that future work to determine the effectiveness and efficacy of integrated care requires a randomised design.
R21	Namdram, Koster (2014) International Netherlands	Organizational Innovation and Integrated Care: Lessons from Buurtzorg	**Case study** 38 respondents		
R22	Øvretveit, Hansson, & Brommels. (2010) International Sweden	An Integrated Health and Social Care Organisation in Sweden: Creation and Structure of a Unique	**Case study** design	Data sources were administrative document plans for the	Changes in the macro- structure make it easier for operational managers to make clinical level micro- changes

No.	Author	Title	Methodology	Sample	Key Finding
		Local Public Health and Social Care System		new organisation, documents describing its legal form and the working procedures, and interviews with a cross-section of informants 1st interviews n=13 2nd interviews n = 17	Coordinated care projects were weak in public health and social services Management underestimate the time and resource required
R23	Radermacher, Karunarathna, Grace & Feldman (2011) International Australian	Partner or Perish? Exploring Inter-Organisational Partnerships.	**The qualitative study** comprised semi-structured face to face interviews	14 employed in the sector	Participants felt partnerships were necessary Limited resources restrict the opportunity to partner There was a need to provide support and guidance Smaller partners were unequal in their influence and power
R24	RAND Europe, Ernst & Young LLP UK	National Evaluation of the Department of Health's Integrated Care Pilot	**Mixed methods – quantitative data/ Qualitative date** and cost data	16 pilot sites	

No.	Author	Title	Methodology	Sample	Key Finding
R25	Nolte, Pitchforth, (2014) UK	What is the Evidence on the Economic Impacts of-Integrated Care? RAND Europe - European Observatory on Health Systems and Policy	**Mixed**	19 studies	There is evidence that integrated care improves care – however there are a number of issues with economic evaluation
R26	Smith & Barnes (2013) UK	New jobs Old Roles – Working for Prevention in a Whole System Model of Health and Social Care for Older People	2-year period national **evaluation** – Theories of Change	Users 358 QoL baseline questionnaires n = 93 (26%) QoL follow-up questionnaires 21 returned (45%) 44 baseline interviews, sixteen 6-month follow-up interviews Networks 29 baseline interviews 15 follow up interviews Community engagement Five baseline workshops Stakeholders N=12 baseline and	Staff felt that the whole- system approach had been ambitious and challenging, but that it offered a good model for prevention work. Communication was a challenge for interprofessional working The competitive tendering process between the local authority and voluntary organisations also created problems as it had a negative impact on the voluntary sector. Awareness emerged on all sides Improvements in experience patients co-location a positive

No.	Author	Title	Methodology	Sample	Key Finding
				12month follow up.	challenges with new ways of working early evaluation
R27	Syson & Bond (2010). UK	Integrating Health and Social Care Teams in Salford.	Pilot **evaluation**	Integrating Health and Social Care Teams in Salford	pilot of integrated care
R28	Windle, Wagland, Forder, d'Amico, Janssen, & Wistow (2009). UK	National Evaluation of Partnerships for Older People Projects	**Evaluation**	29 pilot sites implemented 146 core local projects and 530 lower-level or upstream projects	Approaches, demonstrated that prevention and early intervention can 'work' for older people. As has been detailed, preventative projects can help to reduce demand on secondary care services. However, their cost-effectiveness gains cannot be fully realised unless cashable savings can be released and re-invested.

Research Studies/ Evaluations for government/think tank reports

No.	Author	Title	Methodology	Sample	Key Finding
REG 1	Ahmad, Ellins, Krelle & Lawrie (2014) UK	Person-Centred Care: from Ideas to Action	Think tank research – Health Foundation	N/A	Shared decision making was a collaborative process Self-management support enables people to live with their health and ill-health

No.	Author	Title	Methodology	Sample	Key Finding
REG 2	Bardsley, Steventon, Smith.& Dixon (2013) UK	Evaluating Integrated and Community-Based Care How do we know what works?	Evaluation	30 different sites. Outline the main community-based interventions we have evaluated and their impact	Identified nine points that may help those designing, implementing, and evaluating such interventions in future. Evaluates and adds to previous studies
REG 3	Barker (2014)	A New Settlement for Health and Social Care	Commission on the Future of Health and Social Care in England		
REG 4	Behavioural insights team (2018) UK	Applying Behavioural Insights to Health and Social Care Integration in Greater Manchester	fieldwork in four other areas of GM.	interviewed over 50 staff and observed a range of different meetings. We also reviewed relevant academic literature	Set of recommendations to support the implementation of integrated care teams
REG 5	Curry & Ham (2010)	Clinical and Service Integration: The Route to	Kings fund (think tank)	N/A	Integrated care improves outcomes

No.	Author	Title	Methodology	Sample	Key Finding
	UK	improved outcomes			Integration happens at a micro, Meso and macro level
REG 6	Foot (2012) UK	What Healthy? Makes the us asset approach in practice: evidence, action, evaluation	Commissioned Report - research	N/A	**Key messages** Asset principles help people understand what keeps them healthy Asset-based approaches have positive impacts Health-enhancing assets have not only to focus on psychosocial assets but also on the social, economic and environmental factors that influence inequalities in health and wellbeing. Assets require both the whole system and the whole community working
REG 7	Foot & Hopkins, (2010) UK	A Glass Half-Full, how an Asset Approach can Improve Community Health and Well-Being I&DeA	The Improvement and Development Agency's (IDeA) Healthy Communities Programme. Commissioned Report - Research		The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, We currently have a deficit model – which needs to shift Professional staff and councillors need to be able to share power with people

No.	Author	Title	Methodology	Sample	Key Finding
					The asset approach does not replace investment in improving services or tackling the structural causes of health inequality There was a need to be more place-based
REG 8	Marmot, (2010) UK	Clinical and Service Integration: The Route to Improved Outcomes	Government-commissioned report	N/A	Influential multi-agency report that reported on the wide spread health inequalities in the country
REG 9	Marmot, Allen, Boyce, Goldblatt, Morrison (2020) UK	Health Equity in England: The Marmot Review 10 Years On	The Health Foundation commissioned report	N/A	10 year review after the original report People can expect to spend more of their lives in poor health improvements to life expectancy have stalled, and declined for the poorest 10% of women The health gap has grown between wealthy and deprived areas Living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

No.	Author	Title	Methodology	Sample	Key Finding
REG 10	NHS England (2015) UK	Integrated Care Pioneers: One Year On	review of case studies and pioneer evaluations	14 pilot sites	This report provided a summary of the Pioneer programme in the first year. Highlight the lessons learned and challenges faced by the 14 Pioneer sites
REG 11	Rosen, Mountford, Lewis, Shand & Shaw (2011) UK review of International	Integration in Action: Four International-Case Studies	Nuffield Trust	Case study analysis	
REG 12	Shaw, Rosen & Rumbold (2011) UK	What is Integrated Care? An Overview of Integrated Care in the NHS	Nuffield (think tank)	N/A	Integrated care was an organising principle for care delivery There was an aim to improve patient care and experience through improved coordination. Integration was a combined set of methods, processes and models that seek to bring about. Integrated care requires planning, financing and providing services to have a shared vision
REG 13	Wood, Finnis, Khan, & Ejbye	At the Heart of Health - Realising the Value of People and Communities	Commissioned research	N/A	People and communities need to be at the heart of health and wellbeing which, will require a

No.	Author	Title	Methodology	Sample	Key Finding
	(2016) UK		NESTA		systematic change in the way people access, interact with and experience health and care services and wider support. Provides examples of approaches that support person-centred care.

Literature reviews

No.	Author	Title	Methodology	Sample	Key Finding
L1	Bryson, Crosby & Middleton Stone (2006) International USA	The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature	Systematic Literature Review		Make sure collaborators can gain something significant together that they could not achieve alone. View collaborations as complex, dynamic, multilevel systems. Collaborating parties should take a design approach to cross-sector collaboration. Make sure that committed sponsors, champions, and facilitators are involved throughout. Use inclusive processes to develop inclusive structures, Adopt flexible governance structures that can adjust to different requirements across the life cycle of the collaboration
L2	Mackie & Darvil (2016) UK	Factors Enabling Implementation of Integrated Health and Social Care: a Systematic Review	Literature review	seven studies	factors that support integration are Co-location of staff, Communication including information technology, limited amount of evidence regarding integrated health and social care teams.

No.	Author	Title	Methodology	Sample	Key Finding
L3	CLAHRC Greater Manchester (2016) UK	Understanding and Supporting the Integration of Health and Social Care at a Neighbourhood Level in The City of Manchester Community: a Systematic Review	Rapid scoping review …	158 article/ grey literature etc	Clear communication of the vision of integration Professional identity and the boundaries of work –
L4	Raco, Burdett & Heaslip (2019)	Exploring an Integrated Palliative Care Model for Older People: an Integrative Review	Preferred Reporting Items for Systematic reviews and Meta-Analyses	9 studies	3 themes were identified: Person-centred care, Co-ordination of care, Education and training. Integrated palliative care requires co-ordinated techniques focus upon the quality of life, individual needs awareness of vulnerability
L5	Suter, Oelke, Adair & Armitage (2009). International Canada	Ten Key Principles for Successful Health Systems Integration	systematic literature review of peer-reviewed literature		Despite a large number of articles discussing integration, significant gaps in the research literature exist The review demonstrated a lack of standardized, validated tools

No.	Author	Title	Methodology	Sample	Key Finding
L6	Trivedi, Goodman, Gage, Baron, Scheibl, Iliffe, Manthorpe, Bunn & Drennan (2013) UK	The Effectiveness of Inter-Professional Working for Older People Living in the Community	Literature review	3211 records and included 37 RCTs	Health service supports intra-professional working There was a lack of links between
L7	Winters, Magalhaes, Kinsella & Kothari (2016) UK	Cross-Sector Service Provision in Health and Social Care: An Umbrella Review	Umbrella Literature Review	16 reviews	Seven themes • Focusing on the consumer, • Developing a shared vision of care, • Leadership involvement, Service provision across the boundaries • Adequately resourcing the arrangement • Developing novel arrangements • Aligning with existing relationships ▪ strengthening connections between sectors • Need for further research

Appendix 5 - Ethics approval

University of Salford MANCHESTER

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

23 March 2017

Dear Kirsty,

RE: ETHICS APPLICATION–HSR1617-83–'An exploration of the experiences of stakeholders involved in the transition from traditional health and social care service to integrated care system, within defined health and social care economy.'

Based on the information you provided I am pleased to inform you that application HSR1617-83 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

Appendix 6 – Amended Ethics form

Health Research Ethical Approval Panel

Amendment Notification Form

Please complete this form and submit it to the Health Research Ethics Panel that reviewed the original proposal: Health-ResearchEthics@Salford.ac.uk

Title of Project: An exploration of the experiences of stakeholders involved in the transition from traditional health and social care teams to integrated care systems, within defined health and social care economy.

Name of Lead Applicant:
Kirsty Marshall

School: Health and Society

Date when original approval was obtained:
23rd March 2017

Reference No: HSR1617-83

Please outline the proposed changes to the project. NB. If the changes require any amendments to the PIS, Consent Form(s) or recruitment material, then please submit these with this form highlighting where the changes have been made:

The Title, Aims, Objectives, and Rational remain the same as previously approved Ethics form.

Minor changes to methodology - The preparation phase has now been completed and the secondary phase of data collection is ready for commencement. The stand point group has been identified as the community nursing and social worker team who are being collocated in neighbourhood hubs. Therefore, the second phase of data collection will focus on this group – this has been identified in section 5.

Minor changes – For the second phase of data collection the following methods have been identified observations and focus groups. Text is used as a secondary data source.

A change from previous ethics form is the addition Nvivo as a data analysis tool.

Section 6 – the time line for data collection remains the same.

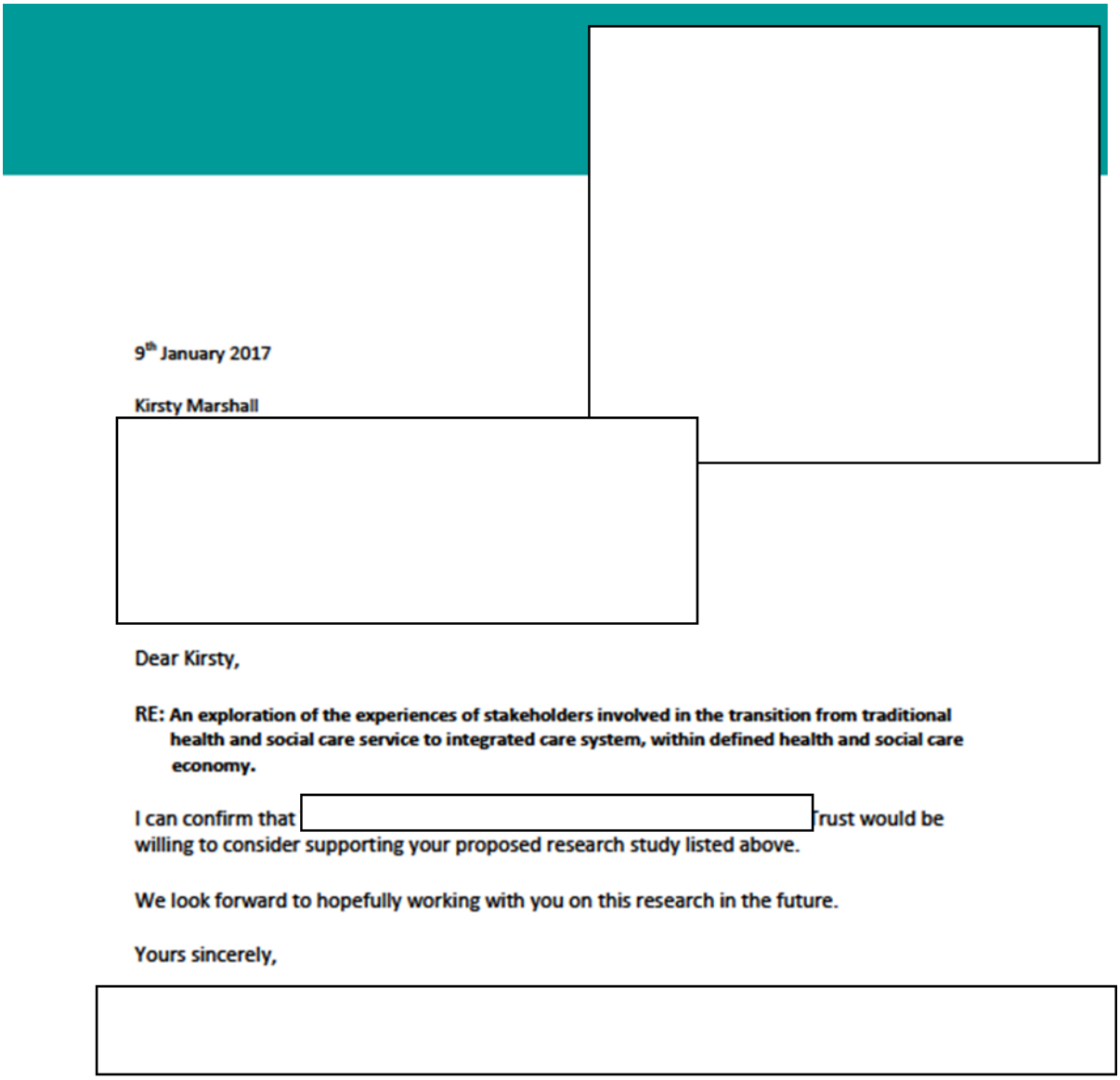
Please say whether the proposed changes present any new ethical issues or changes to ethical issues that were identified in the original ethics review, and provide details of how these will be addressed:

No new ethical issues have been identified as due the changes.

Deputy Chair's Signature:  Approved: 27/11/2017 X

Version 1.0 – 19 June 2017

Appendix 7 - Letter from Trust Support – Anonymised



9th January 2017

Kirsty Marshall

Dear Kirsty,

RE: **An exploration of the experiences of stakeholders involved in the transition from traditional health and social care service to integrated care system, within defined health and social care economy.**

I can confirm that [redacted] Trust would be willing to consider supporting your proposed research study listed above.

We look forward to hopefully working with you on this research in the future.

Yours sincerely,

[redacted]

Appendix 8 – Service Evaluation statement - Anonymised

[redacted]

Mrs Kirsty Marshall

[redacted]

Dear Kirsty,

RE: An exploration of the experiences of stakeholders involved in the transition from traditional health and social care service to integrated care system, within defined health and social care economy

From all the information I have been provided with regarding the above project, the opinion of the Research Department a[redacted]is that the project is classed as a service evaluation. Under the National Research Ethics Service 'Defining Research' guidance (December 2009), Service evaluation projects do not require ethics approval. Therefore, the project does not come under the research remit and does not require a full local research governance review. As the project is not classed as research, this will be exempt from HRA approval.

You must ensure that you gain the approval from appropriate department managers, prior to carrying out your project and adhere to all relevant Trust policies.

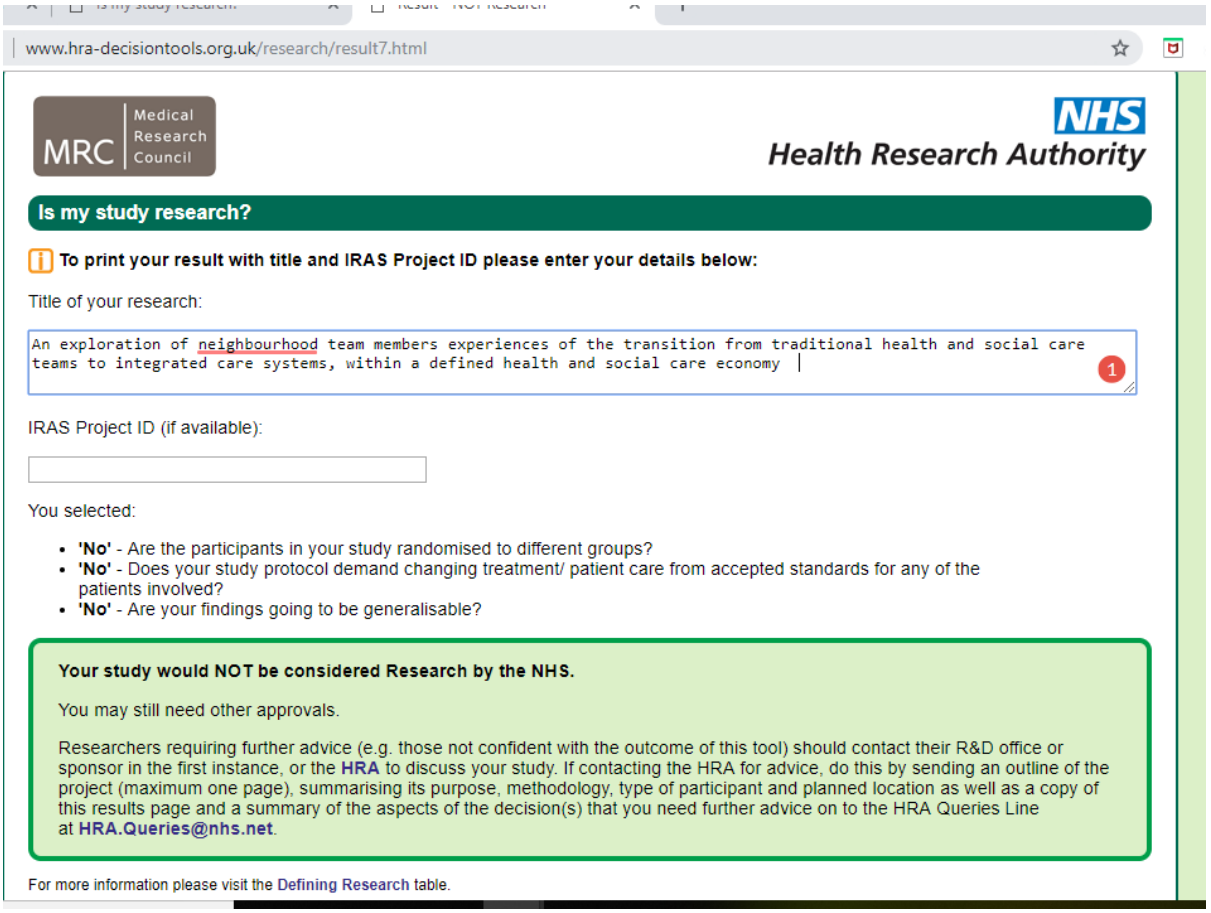
Please be aware that your employing department will be responsible for all activities associated with this evaluation, including costs.

Please note, this letter is not confirmation from the Research Ethics Committee, but the opinion of the local research department a[redacted]. Should confirmation from the Ethics committee be required, please contact the Research Ethics Committee coordinator via http://www.hra.nhs.uk/

Yours Sincerely

[redacted]

Appendix 9 - HRA Questionnaire form



www.hra-decisiontools.org.uk/research/result7.html

MRC Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

An exploration of neighbourhood team members experiences of the transition from traditional health and social care teams to integrated care systems, within a defined health and social care economy

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the **HRA** to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **HRA.Queries@nhs.net**.

For more information please visit the Defining Research table.

Appendix 10 - Participant information sheet

PARTICIPANT INFORMATION SHEET

Title of study:
An exploration of the effect of the transition from traditional health and social care models to integrated care systems on a range of stakeholders, within defined health and social care economy.

Name of Researcher:

I would like to invite you to take part in a research study, which forms part of a professional doctorate, being undertaken at the University of Salford. Before you decide it is vital that I provide you with sufficient information so you can understand why the research is being done and what your participation will involve. Please take time to read the following information carefully, talk to others about the study if you wish, and ask questions if you are unclear on any aspect of the study or would like any more information. Contact details for the researcher and supervisors can be found at the end of the form.

What is the purpose of the study?

The study will explore the experiences of stakeholders (Staff members from across the health and social care system) during the transition from traditional health and social care organisations into an integrated care system, i.e. from the previous health and social care teams into the new neighbourhood structure. The purpose of this project will be gain a greater knowledge of how integration impacts on those involved within the transition, to better predict and plan future programmes of work.

The study employs an approach that uses a number of different data collection methods including observations, focus groups, and one-to-one interviews. You may be invited to partake in some all or none of these activities.

The study lasts for 18 months and there will be a number of repeat interventions during this time period, which involve the researcher attending a number of meetings and repeating interviews and possibly focus groups. The number and frequency of these activate will depend on the outcomes of the initial interventions. If you are involved in more than one intervention your continuing consent will be requested each time. It is important for you to understand that your involvement in the study is totally voluntary and you can refuse to take part in any or of the interventions.

Why have I been invited to take part?

You have been asked to participate in the study because you have the first-hand

experience of working both in tradition services and are currently taking part in the transition process to an integrated care system.

Do I have to take part?

No, your decision to take part in completely voluntary and you are not obliged to take part. You can withdraw your consent at any point during the study.

If you wish to withdraw from the study you can do so by emailing the researcher at Kirsty.marshall1@edu.salford.ac.uk

What will happen to me if I take part?

As part of the study and you may be asked to be interviewed or attend a focus group. You may be involved in any or all of the following: a meeting I am observing or you could be asked to take part in a focus that could last up to an hour or a one- to-one interview for approximately 30 minutes.

Each time you are asked to be involved in any aspect of the study you will be asked to give your consent. You can partake in some all or none of these activities and there is no expectation that if you consent to partake in one activity (for example observation) that you would consent to partake in another (for example interview)

The research study will develop over time as the data is collected therefore you may be asked to partake in follow up interviews, you will be re-consented for any follow up and you are not obliged to partake in follow up interviews or focus groups.

The study will involve audio-taping, all recordings Interviews and focus groups will be recorded (after consent has been obtained). The transcripts will be stored on a password-protected computer that will be kept away from the research location (Holloway & Wheeler 2013). Data stored electronically will be on a password-protected computer, accessed only by the researcher, no data will be stored on clouds or internet storage system (Creswell 2013). The researcher will be transcribing all audio recording and actual recordings will not be shared within the field of research.

If the results are published in any format all data, including names and places will be anonymised.

Expenses and payments?

There is no payment for involvement within the study.

What are the possible disadvantages and risks of taking part?
You may not feel comfortable discussing issues relating to your working environment and experiences. You can ask to stop the interview at any point or decline to answer individual questions that you do not feel comfortable answering.

What are the possible benefits of taking part?

You may find the project interesting and it may give you an opportunity to reflect on your experiences during the integration journey. The information gained in the study will be used to inform the Trust of how integration impacts on those involved in the process.

What if there is a problem?

If you have any concerns please contact my supervisor's details at the end of this form

If you wish to make a complaint please contact

Anish Kurien chsc-engagement@salford.ac.uk or on 0161 295 7012 /2280

Will my taking part in the study be kept confidential?

Yes, if you consent to take part in the study your details will be kept confidential and will not be disclosed to anyone.

All data including recordings and transcripts will be stored on a password-protected computer that will be kept away from the research location.

All data collected such as questionnaires, interview recordings, transcripts, will be anonymised and coded, hard paper copies of data, including consent forms, will be stored in a locked filing cabinet within a locked room, accessed only by the researcher.

It is important to understand that if you reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher will have to share that information with the appropriate authorities in including relevant professional

bodies.

What will happen if I don't carry on with the study?

Involvement in the study is entirely voluntary and you are not required to be involved, non-involvement will not be documented or reported if you consent and change your mind you are able to withdraw from the study at any time.

What will happen to the results of the research study?

The study will be reported in a number of ways:

- As doctoral thesis at the University of Salford
- Publication within academic journals
- Reported to the Trust to inform future learning and development opportunities

Who is organising or sponsoring the research?

The Study is being conducted as part of the PhD programme, by a student at the University of Salford.

Further information and contact details:

Researcher
Kirsty Marshal- Kirsty.marshall1@edu.salford.ac.uk

Supervisor

Appendix 11 - Consent form interview

CONSENT FORM – Interview

Title of study: An exploration of the experiences of stakeholders involved in the transition from traditional health and social care teams to integrated care systems, within defined health and social care economy.

Name of Researcher:

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right-hand side.

1	I confirm that I have read and understood the study information sheet Version 2, dated, for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	**YES**	**NO**
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	**YES**	**NO**
3	If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is immediate	**YES**	**NO**
4	I agree to participate in interviews	**YES**	**NO**
5	I understand that my personal details will be kept confidential and not revealed to people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher will have to share that information with the appropriate authorities	**YES**	**NO**
6	I understand that my anonymised data will be used in the (researcher's thesis/research report) other academic publications and conferences presentations.	**YES**	**NO**
7	I agree to the interview being audio recorded	**YES**	**NO**
8	I agree to partake in the study	**YES**	**NO**

Name of participant Date Signature

Name of person taking consent Date Signature

Appendix 9 – Consent form – Observations

CONSENT FORM – Observation

Title of study: An exploration of the experiences of stakeholders involved in the transition from traditional health and social care teams to integrated care systems, within defined health and social care economy.

Name of Researcher:

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right-hand side.

1	I confirm that I have read and understood the study information sheet Version 2, dated, for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	**YES**	**NO**
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	**YES**	**NO**
3	If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is immediate	**YES**	**NO**
4	I agree to participate in observations within the meeting	**YES**	**NO**
5	I understand that my personal details will be kept confidential and not revealed to people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher will have to share that information with the appropriate authorities	**YES**	**NO**
6	I understand that my anonymised data will be used in the (researcher's thesis/research report) other academic publications and conferences presentations.	**YES**	**NO**
7	I agree to partake in the study	**YES**	**NO**

Name of participant Date Signature

Name of person taking consent Date Signature

Appendix 10 – Consent form – Focus Group

CONSENT FORM – Focus Group

Title of study: An exploration of the experiences of stakeholders involved in the transition from traditional health and social care teams to integrated care systems, within defined health and social care economy.

Name of Researcher:

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right hand side.

1	I confirm that I have read and understand the study information sheet Version 2, dated, for the above study. I have had opportunity to consider the information and ask questions which have been answered satisfactorily	**YES**	**NO**
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected	**YES**	**NO**
3	If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is immediate	**YES**	**NO**
4	I agree to participate in a focus groups	**YES**	**NO**
5	I understand that my personal details will be kept confidential and not revealed to people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or other, the researcher will have to share that information with the appropriate authorities	**YES**	**NO**
6	I understand that my anonymised data will be used in the (researcher's thesis/research report) other academic publications and conferences presentations	**YES**	**NO**
7	I agree to keep what is discussed in the focus group confidential	**YES**	**NO**
8	I agree to being audio recorded during the focus group	**YES**	**NO**
9	I agree to take part in the study	**YES**	**NO**

Name of participant	**Date**	**Signature**

Name of person taking consent **Date** **Signature**

Appendix 11 – Invitation letter

Invitation letter

Invitation letter

{ name}
{ address}

Dear {*name*},

I am writing to you to enquire if you would be interested in participating in a piece of research, which will be being conducted across a number of organisations involved in the development of integrated neighbourhood teams within Tameside and Glossop. This is a student study and forms part of a professional doctorate in health and social care at the University of Salford

The study aims to explore of the experiences of stakeholders involved in the transition from traditional health and social care teams to integrated care systems, within defined health and social care economy.

As a member of the developing neighbourhood teams your experiences are really important to this study. Your involvement will assist in the development of an understanding of the impact of integration on those involved in the day to day delivery of services.

We understand that you might have questions about your involvement, please read all the enclosed documents, which should answer many of your questions. However please discuss any questions or concerns you have with me.

Thank you. Yours sincerely,

Kirsty Marshall

Student – Professional Doctorate in Health and Social Care University of Salford