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Protocol for a process-oriented qualitative evaluation of the Waltham Forest and East London Collaborative (WELC) integrated care pioneer programme using the Researcher-in-Residence model

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ABSTRACT

Introduction: The integration of health and social care in England is widely accepted as the answer to fragmentation, financial concerns and system inefficiencies, in the context of growing and ageing populations with increasingly complex needs. Despite an expanding body of literature, there is little evidence yet to suggest that integrated care can achieve the benefits that its advocates claim for it. Researchers have often adopted rationalist and technocratic approaches to evaluation, treating integration as an intervention rather than a process. Results have usually been of limited use to practitioners responsible for health and social care integration. There is, therefore, a need to broaden the evidence base, exploring not only *what* works but also *how* integrated care can most successfully be implemented and delivered. For this reason, we are carrying out a formative evaluation of the Waltham Forest and East London Collaborative (WELC) integrated care pioneer programme. Our expectation is that this will add value to the literature by focusing on the processes by which the vision and objectives of integrated care are translated through phases of development, implementation and delivery from a central to a local perspective, and from a strategic to an operational perspective.

Methods and analysis: The qualitative and process-oriented evaluation uses an innovative participative approach—the Researcher-in-Residence model. The evaluation is underpinned by a critical ontology, an interpretive epistemology and a critical discourse analysis methodology. Data will be generated using interviews, observations and documentary gathering.

Ethics and dissemination: Emerging findings will be interpreted and disseminated collaboratively with stakeholders, to enable the research to influence and optimise the effective implementation of integrated care across WELC. Presentations and publications will ensure that learning is shared as widely as possible. The study has received ethical approval from University College London's Research Ethics Committee and has all appropriate NHS governance clearances.

Strengths and limitations of this study

- The study offers participative and formative evaluation of a complex, large scale health and social care integration programme.
- The inquiry works directly with the programme that is being evaluated to maximise opportunities to use evidence to optimise effectiveness of programme objectives.
- There is systematic analysis of language, social practices and contextual elements underpinned by a robust theoretical framework—able to engage with the complexities inherent to health and social care integration.
- A case study design means that it is difficult to generalise findings.
- The scale of the programme evaluation makes it difficult to evaluate one specific organisation in great detail—the focus is on the implementation of integrated care across Waltham Forest and East London Collaborative (WELC).

INTRODUCTION

The integration of health and social care has been central to the thinking of policymakers in the UK since the 1960s.[1] Today, integration is widely accepted as 'a demand-driven response to what generally ails modern day healthcare: access concerns, fragmented services, disjointed care, less than optimal quality, system inefficiencies, and difficult to control costs'.[2] As more people are living for longer they are progressively more likely to be living with complex comorbidities, disability and frailty, and are subsequently more likely to require care from a number of different health and social care services over a longer period of time. In England, health and social care services are commissioned by

different systems: healthcare is commissioned by the National Health Service (NHS); and social care is commissioned by Local Government Authorities (LGAs). Health and social care services are also delivered by different systems and within those systems, by a variety of different provider organisations—public, private and voluntary. This fragmentation also extends to *within* the NHS; there is generally a perceived lack of integration between primary, community, secondary and tertiary health sectors, as well as between mental and physical health. Fragmentation means that patients are often forced to navigate a myriad of health and social care teams, travelling to different places for different appointments, and repeating their stories to many different health and social care professionals.

There are also significant financial concerns relating to the health and social care systems in England. People over 65 years of age account for 51% of gross local authority spending on adult social care[3] and two-thirds of the primary care prescribing budget, while 70% of health and social care spend is on people with long-term conditions.[4] In a context of financial austerity in the UK, local government authorities have faced unprecedented cuts over the past 5 years, which have impacted heavily on adult social care and its capacity to deliver services for its population. With regard to healthcare, it has been calculated that 'a combination of growing demand, if met by no further annual efficiencies and flat real terms funding, would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/2021'.[5] The estimated funding gap for adult social care over the same period is £4.3 billion.[6] In the context of these financial concerns, the NHS 5-Year Forward View[5] has stated that action is needed on three fronts —'demand, efficiency and funding'.

In the quests to both enhance efficiency and reduce fragmentation within, and across, health and social care services, integration is seen as 'a principle driver of reform'.[2] In May 2013, localities were invited by NHS England along with national partners to express their interest in becoming integrated care 'pioneers'. Fourteen localities were successful in their applications to become pioneers for integrated care; they were tasked with leading the development and thinking on the successful integration of health and social care 'at scale and pace'[7] to inform national policy development.

Despite the clear and urgent focus on integrating health and social care in national policy terms, there remains uncertainty as to the precise definition of integration.[2] [8] [9] In 2013, NHS England commissioned National Voices—a coalition of 130 health and social care charities—to develop a statement of integrated care from the perspective of service users:[10]

> 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.

The statement was endorsed by UK government Ministers in the foreword to 'Integrated Care and Support: Our Shared Commitment',[7] and underpins many of the integrated care programmes in progress across the UK, including the Waltham Forest and East London Collaborative (WELC) integrated care pioneer programme—the focus of the research for which this protocol has been designed.

Integrated care: evidence and evaluation

The international body of literature in the field of integrated care is growing, and there has been a recent proliferation of publications relating to integration in the English health and social care systems.[1] [11–19] These publications suggest a number of benefits associated with the integration of health and social care, including early access to preventive services and improved self-care, shorter lengths of hospital stay and reduced readmissions, improved patient outcomes and experience, and reduced costs brought about by more efficient use of resources.

While evaluations in the UK have resulted in some useful learning about the implementation and delivery of integrated health and social care,[20–22] there is little strong empirical evidence yet to suggest that integrated care can achieve the benefits associated with it, for example, reduction in emergency hospital admissions or cost savings.[18] [23] [24] Much of the research and evaluation undertaken to date assumes that integration is a discreet intervention, has adopted relatively rationalist and technocratic approaches to evaluation, and seems to have been of limited use to practitioners responsible for the implementation and delivery of integrated care. As Tsasis *et al*[25] suggest, there is 'a growing movement away from mechanistic conceptions of healthcare management and delivery, and an increasing recognition of the value of understanding integration as an agent-based, nonlinear, emergent, self-organising and coevolving phenomenon'. This movement is welcome; understanding the processes by which integration is (or is not) achieved across a system must require as much attention as the outcomes of integration if integrated care is to 'become the norm in the next 5 years'.[7] There is a need to explore not only *what* works in the integration of health and social care, but also *how* integrated care can most successfully be implemented and delivered. This is where we propose that this formative evaluation will add value to the currently available literature—by focusing on the processes by which the vision and objectives of integrated care are translated linguistically, and in practice, through phases of development, implementation and delivery from a central to a local perspective, and from a strategic to an operational perspective. To do this, the project uses the Researcher-in-Residence model[26]—a participatory and embedded approach to research—within a critical and interpretive epistemology, drawing on a critical discourse analysis (CDA) methodology.

The WELC integrated care programme

The WELC integrated care programme began in 2012 and was 1 of 14 successful programmes to achieve pioneer status for integrated care in May 2013. The programme involves nine different health and social care organisations (see figure 1) across the area served by Barts Health NHS Trust—the largest NHS trust in the UK. The geography covers three boroughs in East London—Newham, Tower Hamlets and Waltham Forest.

The partners have come together to build a model of integrated care that looks at the whole person—their physical health, mental health and social care needs. The focus is on empowering individuals by providing responsive, coordinated and proactive care, and ensuring consistency and efficiency across physical and mental health and social care. The vision is for people to live well for longer; leading more socially active independent lives, reducing admissions to hospital and enabling access to treatment more quickly. The programme focuses on the top 20% of patients most at risk of hospital admission in the next 12 months. In 2012, the WELC case for change demonstrated that these patients are responsible for approximately 80% of the activity and costs across health and social care in all three boroughs. The programme is targeting this group in a phased approach, beginning with those at very high risk of hospital admission and working downwards to cover the full 20% over a 5-year period. The aim is to provide nine key interventions for this population, underpinned by five components and enablers (see figure 2). The enablers include system-wide changes such as reforming financial incentives, payment for services based on outcomes and the development of provider collaboratives.

The programme is supported by a WELC-wide Programme Management Office (PMO). The WELC PMO are responsible for the work streams which lend themselves to a 'do once and share' approach across WELC, specifically contracting and reimbursement, and evaluation. They also support the local implementation of integrated care within the three boroughs. Integrated care boards or committees and management teams in Newham, Tower Hamlets and Waltham Forest, are responsible for the design and delivery of the interventions within their local programmes, and the

- Newham Clinical Commissioning Group
- Tower Hamlets Clinical Commissioning Group
- Waltham Forest Clinical Commissioning Group
- London Borough of Newham
- London Borough of Tower Hamlets
- London Borough of Waltham Forest
- Barts Health NHS Trust
- East London Foundation Trust
- North East London Foundation Trust
- UCLPartners

Figure 1 WELC partner organisations. WELC, Waltham Forest and East London Collaborative.

development of provider collaboratives. Members of the integrated care boards or committees include health service commissioners, local authority representatives, public health representatives, voluntary and community sector representatives and representatives from the locality's provider organisations. Regular WELC-wide meetings and events provide opportunities for partners to come together to share progress and learning across the collaborative.

As an integrated care pioneer, WELC are committed to evaluating both the processes of implementation and the outcomes of the programme across the localities. The project detailed in this protocol fulfils the requirements for a formative, qualitative and process-oriented evaluation. Requirements for quantitative elements of evaluation are fulfilled by regular reporting on agreed metrics and key performance indicators through the WELC metrics working group with support from the North East London Commissioning Support Unit, and in a developing partnership with the Health Foundation. Each element should complement the other to provide a comprehensive evaluation of the programme.

METHODS AND ANALYSIS

We are carrying out a qualitative and process-oriented evaluation that adopts a participative approach and uses an innovative model placing the researcher as a core member of the programme team—the Researcher-in-Residence model. The evaluation is underpinned by a critical ontology, an interpretive epistemology and uses a CDA methodology.

The Researcher in Residence model

The Researcher in Residence model is an emerging model of participative research, particularly in the context of healthcare quality and service improvement. In response to an increasingly recognised and accepted concern that 'established approaches to getting health services research into practice are not radically changing the extent to which management decisions are influenced by scientific evidence',[26] the model embraces the concept of 'co-creating' knowledge between researchers and practitioners. Co-creation—collaborative knowledge generation by academic researchers working in partnership with stakeholders—is promoted widely as a means of 'increasing research impact' and 'adding value', particularly in 'real life' settings or the 'swampy lowlands' of frontline practice.[27] Co-creation is often constructed as an answer to the apparently persistent problem of a 'disconnect' between academics and practitioners.[28–31] Its growing popularity reflects a shift from knowledge translation (a linear process in which research is produced by academics and then packed for, and distributed to, its audiences) to collaborative knowledge production—and, some have argued, a democratisation of the relationship between universities and society.[32–34] Co-creation

WELC will provide nine key interventions for its population, underpinned by five components and enablers
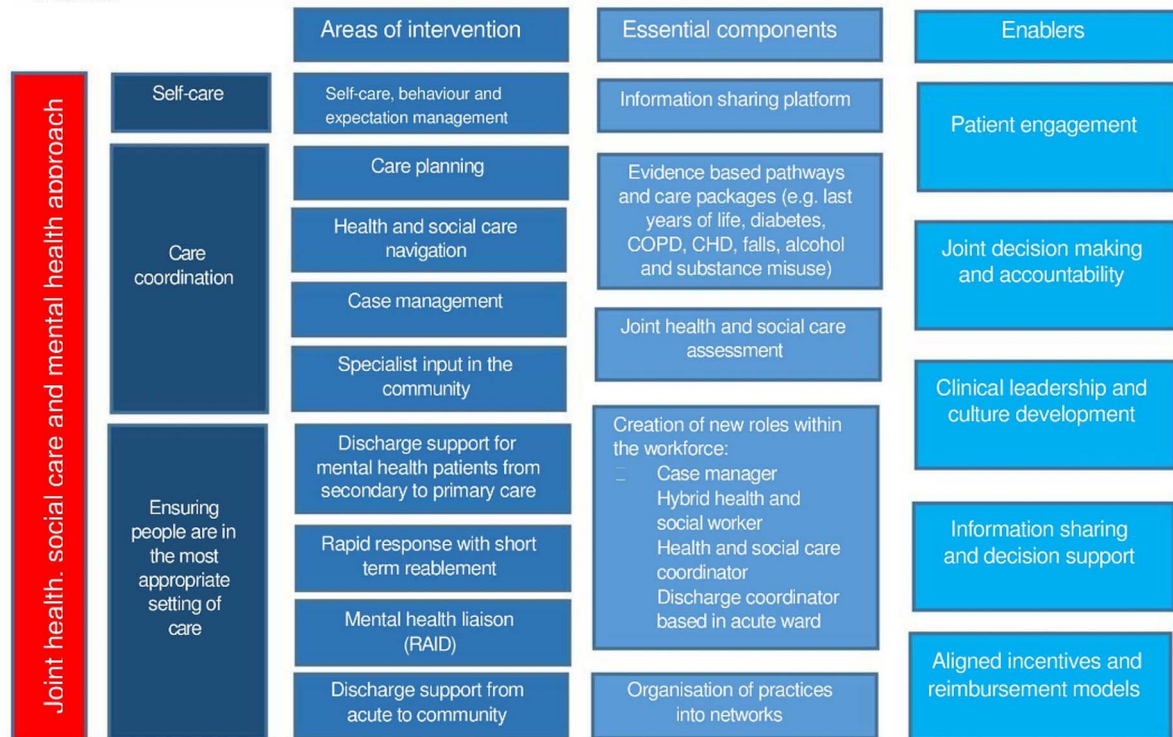

Figure 2 WELC programme interventions, components and enablers. CHD, chronic obstructive pulmonary disease; COPD, chronic obstructive pulmonary disease; WELC, Waltham Forest and East London Collaborative.

research emerged independently in numerous disciplinary fields including business studies ('value co-creation'), design science ('experience-based co-design'), computer science ('technology co-design') and community development ('participatory action research'). Across these diverse models, common features include: (1) a systems perspective (assuming emergence, local adaptation and non-linearity); (2) framing of research as a creative enterprise with human experience at its core; and (3) an emphasis on process (especially relationships, interactions, sense-making and dialogue) as much as products. The collaborative and democratic generation of research knowledge in its context of application means there is less need for a separate 'implementation phase', and encourages the assumption that the impact of co-created research is more direct and enduring.

With its origins in participative research, the Researcher-in-Residence model embodies values of collaboration, a desire to solve practical problems, a focus on initiating change through greater understanding and shared learning, an emphasis on reflection and collective inquiry, and a willingness to find common ground through negotiation and compromise. In practical terms, the researcher works with and is embedded in a programme team. The researcher is employed by UCL but has attained a research passport in collaboration with WELC organisations to enable their position within the programme. Owing to the intent of the WELC programme as well as its size and scale, the researcher is not embedded in any one specific team or organisation, but across the whole WELC programme. The academic knowledge and expertise that the researcher brings to the programme is an understanding of the broader literature in the field, skills in evaluation, experience in applying critical and interpretive approaches to policy analysis, and methodologies grounded in linguistic analysis. The researcher will work to communicate and negotiate the value of this knowledge with stakeholders rather than imposing particular forms of knowledge, epistemologies or methodologies on them.

The role of the researcher in residence within WELC is to undertake a participative and process-oriented local evaluation that will focus less on whether the programme 'works' and more on how to use established research evidence and local findings to optimise delivery of the programme objectives. Every phase of the research process (eg, project planning, data generation, analysis and interpretation of data, dissemination of findings) is negotiated collaboratively with stakeholders. The WELC Evaluation Steering Group and local integrated care boards, committees and steering groups are the main forums in which discussions and negotiations will take place, though they will also happen informally through conversations and via email, for instance.

Critical discourse analysis

CDA, associated as it mainly is with the names of Fairclough,[35–39] Wodak,[40] [41] van Dijk[42–44] and Chouliaraki,[45] has been developed in recent decades as a way of understanding 'how societies work and produce both beneficial and detrimental effects, and of how the detrimental effects can be mitigated if not eliminated'.[38] This evaluation does not adhere to a pure version of CDA, but instead draws on key concepts from particular CDA methodologies to achieve its aim.

The evaluation understands discourse—language use in speech and writing—as a form of 'social practice'. This implies 'a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s), which frame it…(discourse) helps to sustain and reproduce the status quo and…it contributes to transforming it'.[46] The implication for seeing 'language as discourse and as social practice' is a commitment not just to analysing texts but also to analysing the processes of production and interpretation of texts, and the relationship between texts, processes and contextual, institutional and structural factors.

Using CDA within this evaluation enables the systematic negotiation of a critical understanding of the ways that stakeholders in WELC both organise and are organised by their use of language in relation to integrated care. Arguably, integrated care is an idea that has been conceptualised as the answer to many of the problems relating to health and social care in England. This conceptualisation has been driven largely, though not exclusively, by senior strategists, managers and commissioners, as well as central government rhetoric, policy and intent. As such, integrated care is based largely on the values, beliefs and assumptions of those people who act within related structures and practices. Within the social practices of local provider organisations and service delivery teams, discursive moments representing integrated care have the potential to either reproduce or transform the structures in which they are situated. Similarly, discursive moments representing aspects of society specific to Newham, Tower Hamlets, or Waltham Forest have the potential to either reproduce or transform understandings of integrated care for their locality and, consequently, the development, implementation and delivery of integrated care in that locality.

This research follows Wodak and Fairclough's[47] integrated approach to CDA. This approach draws heavily on CDA as theorised by Fairclough.[35–39] [47] [48] Events in the form of meetings, actions and strategies are prevalent throughout the processes of development, implementation, delivery and monitoring, all of which take place within specific structures ('especially social practices as an intermediate level of structuring')[39] and within particular organisations (eg, Newham Clinical Commissioning Group). This methodology allows for the interpretation of the complex relations between events, processes and structures, as they progress and develop throughout the WELC integrated care programme, and simultaneously focuses on contexts,[33] and the linking or chaining of events and texts across time and space.

With a focus largely on the mediation of integrated care in Newham, Tower Hamlets and Waltham Forest, and with 'the processes and relations of mediation' largely being 'processes and relations of recontextualisation',[38] recontextualisation is thus a key analytic concept for this evaluation. The project uses the concept to address both the 'transference' of discourses relating to integrated care through political spheres, from one institution to another, and from strategy to delivery, and the progression, development or recurrence of discourses relating to integrated care throughout the project.

Research aim

The aim of the evaluation is to understand and describe the processes by which the WELC integrated care programme is being implemented by its various stakeholders, and to use these understandings to optimise delivery of the programme objectives. The specific objectives of the evaluation are set out in figure 3. It is intended that the evaluation will produce local knowledge of relevance to the participants and to the programme as well as generalisable knowledge of broader interest to those leading and evaluating integrated care initiatives.

Research design

This is a 3-year project that began in September 2014. The evaluation uses a multiple-embedded case study design[48] with a longitudinal element. The longitudinal element enables the investigation and interpretation of changes over time, and developments in the implementation of integrated care across WELC. The project includes one primary case study and four 'embedded units of analysis',[48] reflecting the structure of the WELC integrated care pioneer programme (see figure 4).

The project can be thought of as a series of iterative and participative phases including data generation, data analysis, interpretation and dissemination of emerging findings, and the application of evidence to influence

a) Develop an understanding of the objectives of the WELC integrated care programme and of the local integrated care programmes in Newham, Waltham Forest and Tower Hamlets;
b) Develop an understanding of the organisations, structures and work streams within the WELC integrated care programme and the relationships between them;
c) Develop an understanding of the contextual factors that facilitate or impede the delivery of the WELC integrated care programme objectives;
d) Develop an understanding of the processes by which the objectives of the WELC integrated care programme and the local integrated care programmes are being implemented across WELC;
e) Explore the consistencies and inconsistencies between the objectives of the integrated care programmes and their implementation 'on the ground';
f) Share and facilitate the assimilation of these understandings with implementation and delivery teams across WELC in order that they impact positively on the effectiveness of the delivery of programme objectives; and
g) Develop an understanding of the impact that the evidence, generated and shared by and with key stakeholders, has had on the development and implementation of the WELC integrated care programme.

Figure 3 Evaluation objectives. WELC, Waltham Forest and East London Collaborative.

the development and implementation of the programme. Each phase depends on and influences the design and undertaking of each of the others and, in line with a participative approach, each phase will be negotiated with the stakeholder organisations, using a mixture of formal (eg, presentations and discussions at local integrated care boards and WELC-wide meetings) and informal (eg, one to one conversations, emails, telephone calls) methods. Specific and formalised periods of reflection, discussion and action planning will also be built into the project to enable collaborative interpretation of emerging findings with stakeholders and to consider how the evidence can be used across WELC to optimise delivery of the programme objectives. These interpretive sessions will take place regularly throughout the evaluation and will also feed into the development of the evaluation as it progresses.

Data generation

Data will be generated iteratively using three complementary qualitative methods: documentary gathering; participant and non-participant observations; and individual and group, semistructured interviews.

Documentary gathering

Documents will be gathered if they are pertinent to any of the case studies, for example, the WELC Case for Change, which underpins the integrated care programme, and meeting agendas and minutes. Other relevant documents will be identified and accessed collaboratively, through conversations and negotiations with stakeholders. Documents may also be identified and accessed during the course of meetings relevant to the development and implementation of integrated care. Publicly available national and government documents relating to integrated care at a national and/ or policy level will inform the contextual component of analysis.

Observations

An initial period of unstructured observation will be combined with a further, much longer period of what will gradually become semistructured observation. The unstructured observations will inform the development and planning of the evaluation by informing the researcher's understanding of the WELC programme. The semistructured observations will begin with relatively specific questions or areas of inquiry, but will stop short of generating data in a systematic or predetermined way.[49] These stages of observation have been referred to as a 'funnel',[50] because of the gradual narrowing and directing of the researchers' attention more deeply into those elements that are emerging as important, interesting or essential.

The researcher will carry out participant observations (observations where the researcher may also have an active role in the meeting) of meetings and events that stakeholders consider relevant to the WELC and borough-based integrated care programmes. Meetings are likely to include local integrated care boards as well as WELC-wide meetings such as the fortnightly meeting of the WELC operations group. There are a large number of relevant meetings, so the researcher will not regularly attend all meetings but will prioritise attendance based on scoping work, ongoing analysis and negotiations with stakeholders. Some non-participant observations (observations where the researcher does not have an active role in the meeting) may also be carried out, either by the researcher or by programme stakeholders. Instances of non-participant observation may include multidisciplinary team meetings and shadowing of community health or mental health liaison teams. These instances of non-participant observation will inform the researcher's understanding of specific services and working practices of teams involved in delivering integrated care.

Notes will be made during participant as well as non-participant observations. These will provide information on the physical setting, the individuals who are present or absent, any materials or objects involved, behaviours, interactions and conversations.[51] Notes will not include any patient information. The notes will be written in a factual manner and contain as near to verbatim descriptions of verbal interactions as possible. These notes will be supplemented by an expanded set of notes typed up as soon as possible after each period of observation, a fieldwork diary in which any problems or ideas that arise will be recorded, and a provisional and continuous record of analysis and interpretation.[51–54]

Interviews

The researcher will conduct semistructured interviews on an individual or group basis with participants at
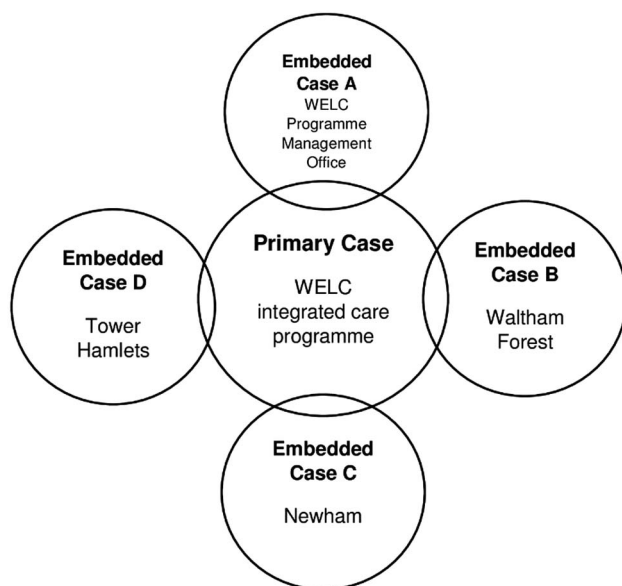

Figure 4 Multiple-embedded case study design. WELC, Waltham Forest and East London Collaborative.

three points during the evaluation. Interviews will take place at intervals of 5–6 months to enable a longitudinal exploration of the implementation and delivery of integrated care across WELC. Interviews will be conducted face-to-face wherever possible, and at a location most convenient and comfortable for interviewees. Interviews will be recorded using a digital recorder and transcribed by a professional transcription service.

Interview participants, identified using a broadly purposive sampling strategy[55] in collaboration with stakeholders, will be staff involved in the implementation or delivery of integrated care within the WELC pioneer programme. The researchers will communicate their intention to begin recruiting interview participants to stakeholders at meetings and in one to one conversations. Potential participants will then be approached and invited to take part in interviews by the researcher via email.

A semi-structured interview design is one in which 'the interviewer provides guidance and direction (hence '-structured'), but where the interviewer is also keen to follow-up interesting developments and to let the interviewee elaborate on certain issues (hence 'semi-')'.[56] This is consistent with the participative approach and emphasises the 'meaningmaking activities' of partners.[57] The interview process will focus on 'how the interviewee frames and understands issues and events'.[55] Interview protocols will be informed by observation data, documentary analysis and previous interview data.

Data analysis

The researcher will initially conduct a short thematic analysis based on areas of focus agreed with stakeholders prior to each phase of interviews. Analysis will then focus within each theme specifically on the representations and recontextualisations of discourses relating to integrated care. Discourses are understood by Fairclough[36] as 'the linguistic way in which part of the world is represented and construed in a text, for example social relations, objects or places'. The conceptualisation of discourses as not only representing but also construing hints at the critical realist sense in which discourses are real; that is, they have effects on social practices and thus on the world. Although discourses will be examined in isolation in an analytical sense, discourses are, in fact, inseparable from social practices.

As well as being representations of 'how things are and have been', discourses can also be 'imaginaries—representations of how things might or could or should be'.[38] Integrated care is an imaginary in this sense—a projection of a utopian vision for a future NHS that works in harmony with social care around the needs of individuals. Discourses representing integrated care in the Case for Change and in government policy documents 'imagine possible social practices and networks of social practices—possible syntheses of activities, subjects, social relations, instruments, objects, space-times, values, forms of consciousness' (ibid). The potential

incompatibilities between these imagined discourses (the objectives of the programme) and discourses representing local 'realities' across WELC as the programme is interpreted and implemented in Newham, Tower Hamlets and Waltham Forest, constitute the focus for analysis. More specifically analysis will focus on who is imagined to do what within specific contexts and circumstances. Analysis will therefore follow Fairclough[38] and van Leeuwen[58–61] in taking the categories of discourses to be social actors and actions. These analytic categories will be combined with an analysis of context, following Wodak's DHA approach to CDA.[40 41 62]

The analytical categories will be the representations of social actors and actions in discourses identified;[61] interdiscursive and intertextual analysis of the shifting combinations of discourses within and between texts; and the application of the 'four levels of context'[41] in order to situate these discourses within, and between, social structures/practices and social event/strategies:

1. The immediate, language or text-internal co-text and co-discourse (eg, the specific documents that set out the objectives of the WELC integrated care programme)
2. The intertextual and interdiscursive relationship between utterances, texts, genres and discourses (eg, between WELC documents, local documents, interviews with staff members and meetings)
3. The extralinguistic social variables and institutional frames of a specific 'context of situation' (eg, London Borough of Newham; Tower Hamlets CCG, Barts Health NHS Trust)
4. The broader sociopolitical and historical context that discursive practices are embedded in and related to (eg, the Transforming Services Together Programme, the Better Care Fund, the general election, austerity).

The iterative stages of analysis are summarised in table 1.

ETHICS AND DISSEMINATION

The nature of ethical approval for participative inquiries is contested, particularly given the strong focus of participatory research on what ethics committees often call 'service improvement'. We decided, within the context of this evaluation, that seeking formal ethical approval would be beneficial. The study did not satisfy the criteria for Medical Research Ethics Committee approval or Social Care Research Ethics Committee approval, therefore we sought approval from University College London's Research Ethics Committee. We made a formal application to the committee and Chair's approval was granted.

The participative nature of the evaluation and the embedded role of the researcher in the programme are overt and communicated clearly to all of the stakeholders. In relation to observations, agreement will be sought from meeting Chairs and organisers prior to the researcher's attendance at meetings. Introductions,

Table 1 Stages of analysis

Stage	Action
1	Subdivide data into case studies: A. Primary case study: WELC integrated care programme B. Embedded case A: WELC PMO C. Embedded case B: Waltham Forest D. Embedded case C: Newham E. Embedded case D: Tower Hamlets
2	Categorise data into major comparison groups: A. Programme objectives (conceptual and practical) B. Programme implementation and delivery
3	Initial thematic coding of implementation and delivery data based on areas of focus agreed with stakeholders prior to each phase of interviews
4	Mark social actors, social actions and levels of context in programme objectives
5	Categorise social actors and social actions in programme objectives using van Leeuwen's categories[61]
6	Apply 'four levels of context'[41] to programme objectives
7	Mark social actors, social actions and levels of context, in initially coded implementation and delivery data
8	Categorise social actors and social actions in implementation and delivery data using van Leeuwen's categories[61]
9	Apply 'four levels of context'[41] to implementation and delivery data
10	Compare analyses across: A. Programme objectives and programme implementation and delivery B. Newham/Tower Hamlets/Waltham Forest C. PMO and Newham/Tower Hamlets/Waltham Forest D. Health and social care E. Commissioners and providers (strategy and delivery) F. Time

PMO, Programme Management Office; WELC, Waltham Forest and East London Collaborative.

which are routinely made at the beginning of meetings, will be used to further consolidate attendees' knowledge of the presence of a researcher at the meeting and the use of observation notes to inform the evaluation. If meeting attendees object to the presence of the researcher in meetings, then the researcher will leave the meeting. Note-taking strategies will mirror those of meeting attendees. Given the usually transactional and professional nature of the meetings, minute-taking is not only customary but necessary, and most of the participants in attendance will be well accustomed to note taking during the course of the meetings. If meeting attendees do not wish for specific conversations to be noted, then it is usual practice that they request them not to be minuted, and the researcher will fully adhere to these requests. The researcher will never intentionally

hear patient-specific data, and patient data will never be recorded in any observations. If it is considered necessary for observations of frontline staff to be carried out, for example, in multidisciplinary team meetings, then, wherever possible, observations will be carried out by frontline staff and clinicians using an observation tool developed by the researcher.

Participation in qualitative interviewing, as with any form of social research, is voluntary and gaining consent from participants should be recognised as 'ongoing, requiring renegotiation and enabling participants to be aware of their right to withdraw throughout'.[63] The fully informed consent of participants will be sought before they are interviewed for the first time, and consent will be revisited prior to each subsequent interview. Participants will also be ensured of their anonymity—all data will be anonymised and separated from as much identifying information as possible. Pseudonyms will be used in transcriptions, where necessary. If, for any reason, participants are unavoidably identifiable in any of the interview data, further consent will be sought, so that the data might still be used for analysis in its current state or whether further means of anonymisation are required before an agreement is reached regarding its inclusion in the final study. Where it may be appropriate for a participant's identity to be disclosed in relation to learning and development across WELC, this will only be carried out with the participant's prior agreement. A confidentiality agreement is in place with the professional transcription company to ensure participants' confidentiality and anonymity.

Any information relating to serious breaches in the quality of care that is disclosed during an interview, will be discussed in the first instance with the principal researcher. The issue will then be escalated, if necessary, to the appropriate organisation. Sensitive or confidential discussions, such as discussions relating to contract negotiations, will not be disclosed outside of the interview, group, organisation or network in which it is appropriate to do so.

In line with the participative approach, emerging findings will be interpreted and disseminated collaboratively with stakeholders across WELC throughout the evaluation. The focus of dissemination is therefore local in the first instance, beginning with integrated care leads and programme managers. This will enable the application of evidence directly to the development and implementation of the programme, wherever possible and appropriate, in a timely manner, in order that it can influence and optimise the effective implementation of integrated care across WELC.

The methods of dissemination will be negotiated with stakeholders to ensure that evidence is disseminated in the most appropriate and useful way for any one particular organisation, network or individual. Methods are likely to include regular reports and presentations to appropriate forums within the WELC programme and at a local level; workshops to facilitate the assimilation of

knowledge into the development of the programme; and informal conversations with stakeholders. Developing collaborative understandings of findings will enable the uncovering of relational as well as structural barriers and facilitators to the realisation of the objectives of the programme. This learning will help stakeholders to understand these barriers and facilitators—why, how and in what situations they come about—and allow stakeholders, with support from the researcher in residence, to develop strategies to either replicate or eradicate them. In this way, the evaluation will work towards its objective of optimising the delivery of the WELC integrated care programme objectives.

The evaluation will also contribute to the wider body of literature in the field of integrated care at a national and international level through formal publications in academic journals, publications in professional journals, blogs and updates via social media, and presentations and workshops at conferences and events.

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