Understanding key challenges in health and social care integration in Scotland: Principal Stakeholders' Perspectives

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Abstract

This study explores the challenges faced by Principal Stakeholders in achieving Scotland's strategic approach to health and social care integration. This is a developing area for academic literature, limited to, but not devoid of the experiences of integration of specific public sector areas and the experience of other countries that have implemented an integrated approach.

The research studies the views and opinions of 12 Chief Officers from three areas of public sector provision; the Scottish Government, Heath Boards and Local Authorities to elicit their initial fears and concerns, approaches and development. This qualitative research approach provided a richness and depth of data which is presented within the thesis. The evidence gathered informed the design of the influencing factors and a conceptual model for health and social care integration and importantly for future integration models which may be applied to future projects.

It is concluded from this study that health and social care integration while challenging, is achievable through a planned approach when considering the key influencing factors. The factors, are flexible depending on the stage of integration and the priorities of the Integration Board, and therefore should be used accordingly. The development of the factors would not have been achievable without the considerable input of the participants involved.

The key contributions of this research span across academic literature, research methodology and professional practice. The study contributes to the current research considerations by developing an approach based on the work undertaken by the professionals and learning from the unintended consequences of the experiences of such early intervention. Finally, the influencing factors and conceptual model are offered as evidence of the research undertaken as a contribution to practice. The value to academics, practitioners and the wider public service and agencies involved in integration lies in the frameworks contextual factors and ultimately the flexibility of application.

Acknowledgements

Many people have supported me in the production of this thesis and for that I am incredibly grateful. Unfortunately, I cannot include all the names however, many will recognise their contribution in the words which follow. For all your wise words, time and patience please be assured I was very humbled by your support and remain eternally thankful.

To my Supervisors, Dr Gerri Matthews Smith and Dr Janice McMillan, your ability to help steer me through a sometimes dark passage to achieve light at the end of the tunnel was incredible. Your enthusiasm for the topic, your clarity of support, professionalism and above all else your friendship remain trusted gifts which I will treasure.

On a personal note, I want to acknowledge the amazing help and support of my sister Carol. Without her unstinting support in so many ways, recognition of what I could achieve and the many hours of proof reading my life's ambition could never have been achieved.

To my wife Sepideh, I want you to know how much your love, support and sacrifices made during our first two years of marriage meant to me. Your encouragement from the first day was overwhelming and remains so. Perhaps now we can fulfil our hopes and dreams with our much loved son Sam.

Finally, this thesis is dedicated to my father, Robbie Stewart (1932 – 2012), whose inspiration always allowed me to dream big and to my mother Catherine Stewart whose pearls of wisdom throughout my life have been inspiring.

Declaration

I declare that this Doctorate of Business Administration thesis is my own work and that all critical and other sources (literary and electronic) have been properly acknowledged, as and when they occur in the body of the text.

Signed ……

Allan Stewart 29 March 2017

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1. Introduction

This chapter provides an introduction and overview to the study. This is achieved by firstly determining the aim of the research questions followed by clearly positioning the study within the parameters determined for the study, the background to the study, exploring why I undertook the doctoral research opportunity and examining why the research topic might be of interest to the community in which the study is set. Finally, a summary of the content of the chapters follows which provides an overview of the structure to help guide the reader.

1.1 Research Aim and Objectives of the DBA

The health and social care agenda is a topical subject for National, Scottish and Local Governments. The term integration is a broad and contested term and definitions vary according to the services being provided and by whom. Integration as defined in this thesis is the result of recent policies across the UK which have encouraged joined up working between health and social care providers. It is generally defined as care that is person-centred and co-ordinated across care settings. For care to be integrated, organisations and professionals bring together all of the different elements of care that a person needs. This can be within primary and secondary care settings. Organisations can have a different approach to integration, delivering a virtual model between organisations who share electronic patient data to a physical integration where health and social care professionals are physically integrated into a single location (Hobbs and Bermingham, 2016).

Working within such an arena it is difficult to escape the impact a significant change in policy direction should offer both the providers and the receivers of the service. Given the scale of the health and social care agenda, it is appropriate to narrow the focus of the research to ensure the significance of the research topic can be suitably addressed. Further determination of the topic is detailed in Chapter three however, to provide a stated aim for the thesis the overarching approach is:

To critically analyse principal stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration.

The research questions are:

- What are the experiential perspectives of key senior actors within the policy arena?
- What are the key challenges considered in the delivery of the legislative objectives?
- How do the actors understand the importance of other organisations' agendas?
- What key aspects of partnership working were employed in the implementation of health and social care?

1.2 Positioning the Research Study

Challenged with the implications of a health service which is reaching crisis point in consideration of funding, efficiency and the growing demands of service users, the Government has a challenge to implement a different approach. The National Health Service (NHS) which began in July 1948 and will soon reach a 70-year milestone, may only survive if the NHS can control and respond to the pressures it faces. The ability to continue funding at the unprecedented levels required for a service coping with service users living longer and with multi morbidity is clear to see and has been the subject of considerable press columns. However, in a period of global financial austerity, the risk of service standards reducing and financial budgets tightening will play a significant part in the viability of the service. Added to the issues of difficulties within the acute services of NHS are the much-maligned troubles of bed blocking, delayed discharges and not meeting performance targets aimed at the support of social care services and it is clear to see why difficulties exist (Gaughan *et al.,* 2015). Social Services however, face their own challenges and the ever-present spectre of financial viability, Local Government funding and supply continues to challenge the support offered for the patient's journey.

Against this economic background, the Government is challenging the NHS and Local Government to implement significant savings by reducing core, real time budgets and forcing the organisations to increase efficiencies – but at what cost. To support the challenges, the Government has suggested the approach used in other countries of combining health and social care into one locally managed service which will help to address the difficulties experienced. The Government's approach was summed up by the Scottish Government in 2011.

> *'Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission'.*

To achieve this, after the publishing of consultation papers, the Government passed legislation to introduce joined-up health and social care provision. The legislation was passed by the Scottish Parliament in February 2014 and came into force on 1st April 2016, bringing together NHS and local council care services under one partnership arrangement for each area. The Act; the Public Bodies (Joint Working) (Scotland) Act (2014) has created 31 Integrated Joint Boards across Scotland who each have the responsibility for the local health and care needs of patients. The Act is aimed at ensuring, that those who use services get the correct care and support whatever their needs and at any point in their care journey (the Scottish Government, 2014).

Given the extent of health and social care integration a number of key actors and stakeholders are involved in the delivery and receipt of services. These

include the various professional involved in the planning of the integration, professionals delivering the service and those receiving the service. The thesis examined health and social care integration from the perspective of the first group of stakeholders namely, the principal stakeholders involved in the planning of integration services. This group consists of the individuals who serve on the integrated joint boards and include Local Elected Members, Chief Executives of Local Authorities and Health Boards, Chief Officers from both organisations, (including primary and secondary health services), Financial, Human Resources and Legal representatives and Non-Executive representatives i.e. professionals who have no voting rights within the board and are therefore there to provide a professional perspective. This stakeholder group was selected as it was a group whose views, on examining the literature, had received little consideration. It was therefore considered that this gap in the literature offered a considerable opportunity for further examination. Considerable literature exists which examines the operational principles of implementing a solution for integration which, whilst valuable, misses the stage before this takes place. The thesis therefore examines the views of those individuals who have a principal role in the design stage. Setting out to understand why specific ideas were developed, decisions made and the challenges members of the board experienced in taking bold decisions to design the strategic approach to integration.

The research undertook to consider the implications of introducing the Act had for the role of Chief Officers in three key organisations; the Scottish Government, Health Boards and Local Authorities. All of whom were tasked with progressing the objectives of the Act.

1.3 Research Gap

Working together in a joined-up way has been a key component of Government agendas since 1997 (Balloch and Taylor, 2001; Kodner and Spreeuwenberg, 2002; Sullivan and Skelcher, 2003). Health and social care has been one area in which partnership working has been tried and tested and faced many challenges (Glendinning *et al.*, 2005) due to the divergence of services being provided by disparate organisations who see themselves as very different entities. A great deal of studies have focused on different elements of health and social care integration from the policy perspectives offered by Mazmanian and Sabatier (1989) to the difference in integration approaches of such academics as Lipsky (1980); Pettigrew *et al.* (1992) and Schofield (2004).

Many research papers extol the virtues of partnership working as a key component of integration (Waddock, 1988; Huxham, 1993; Dickinson and Glasby, 2010; Larkin *et al.*, 2011) but stop short of considering the views of Chief Officers, such as Chief Executives, Chief Health and Social Care Integration Officers and Heads of Services in relation to all the perceived challenges health and social care integration brings. This thesis undertook the challenge to elicit the views of Chief Officers and to understand their real lived experiences of health and social care integration. Ultimately the benefit to academic research is in the delivery of a fully considered thesis which uses experiences to interpret the different elements which have or continue to cause challenge in order to develop a set of influencing factors which should be considered for not only health and social care integration but arguably would be suited to integration policies associated with most organisational change programmes.

The thesis is focused on the early stage of health and social care integration – the development stage i.e. effectively the early stage of implementation, bringing together all parties to determine the strategic approach. This should not be confused with the full operational implementation stage where deployment of the solution takes place.

The thesis will also deliver a conceptual model which will shows the significance of each element and their specific role in delivering integration. The conceptual model guides the current thinking of the different stages of integration and their prioritised role in supporting the objectives of each of the Integrated Boards. The conceptual model has been developed to be flexible rather than the rigidity of other models identifying the key features of integration (Lyngso *et al.,* 2014; Packard *et al.,* 2013). Jackson *et al.* (2000) and define a model as an abstraction or simplification of reality used to explore systems and processes that cannot be directly manipulated.

1.4 Context and Initial Motivation for the DBA journey

The health and social care topic can be an emotive subject for many, and none more so than for me. The idea of considering the topic as a potential DBA study came from a number of life changing events; my experience of the health and social care support during my father's terminal health condition; reaching a crossroads in my career and determining a significant change in the future direction of my career and continuing my strive towards the fulfilment of my desire to continuously improve and be able to influence my knowledge and understanding of subjects which will have a direct impact on me and my family.

1.5 Researcher Profile

I have been involved in Local Government since leaving school in the early 1980s. My career has focused on many different elements of Local Government from initially being involved in service operational delivery to my current role as Business Improvement Manager, where I investigate the approaches taken to deliver customer services and implement new methods which are aimed at increasing efficiencies, while reducing financial cost. This can range from large scale technical projects through to working with external auditors to deliver best value.

I was initially slow to consider academic research, preferring to begin my work through an apprenticeship and it was only after transferring roles to work within the housing service that I considered a degree. This was the start of a long-term love of study culminating in this doctoral thesis.

1.6 Research Approach

To achieve the research aim and to meet the endeavour of contributing to research knowledge the greatest personal contribution this thesis provides is contained in the wise words of those participants who freely provided their time. The research attempted to explore the responses and understand the contributions of the Principal Stakeholders' experience through the use of interpretative phenomenology. This interpretivist approach provided the stakeholders with, in my view, a voice which had never been previously recognised. By making use of semi-structured interviews and setting them within the context of the themes derived from the literature review, the results offer an insight into the challenges being faced by Integrated Joint Boards. Many organisations are involved in health and social care integration, and while it is important that everyone has a role to play in delivering this approach it is also essential to ensure clarity is maintained through narrowing the research to three key stakeholders. For this purpose, the research focuses on the views and opinions of Chief Officers who are Scottish Government Chief Civil Servants together with Chief Officers from Health Boards and Chief Officers/Elected Members from Local Government, as shown at Figure one below. The latter two organisations are directly involved in the delivery of services through the board.

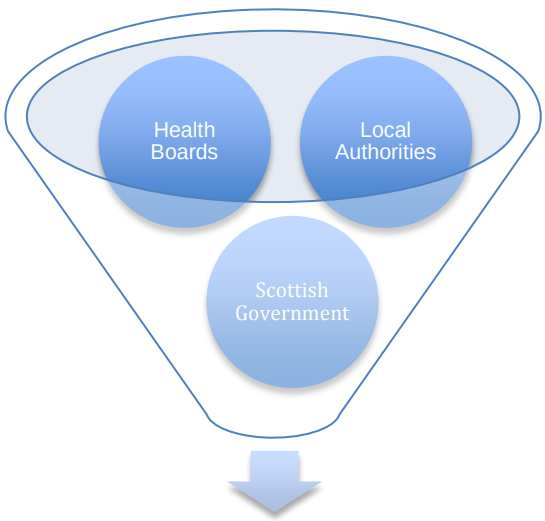


Figure 1: Principal Stakeholders

(Author)

The fieldwork was originally a challenge to arrange as the research was carried out within the timescale for the Integrated Joint Boards publishing their business plans and consequently the opportunity to interview the Chief Officers was limited by this dynamic. Nonetheless, 12 Officers did engage with and fully embrace the research being undertaken. The data analysis was undertaken manually which provided a greater opportunity to become closely involved in data at that level. This allowed for a greater management of the data and afforded the opportunity to hear and contextualise the data with greater clarity and to formulate the outcomes more effectively.

1.7 Implications of the Research

This research has a number of implications for both researchers and practitioners. In terms of contribution to research the benefits lie in the outcomes identifying considerations which should assist in the enablement of future successful integrations by avoiding some of the difficulties experienced by the current officers and their organisations. Each of the main characteristics of integration as shown in the outcomes offer considerable benefits. The second perspective offered by the study concerns the importance of developing a consistent collaboration between the stakeholders where trust is a vital component. Garratt (1996) and Abbot *et al*. (2008) established trust as key to the process.

A number of implications for practitioners have been developed which support the contribution to knowledge and accords with the majority of findings ascertained through the literature review. The outcomes identified five key areas for consideration when developing an integration solution. Each of the areas has a vital role to play and is flexible to the delivery i.e. the component will be considered to a greater or lesser degree depending on the stage of delivery and depending on the priorities considered by the integration board. By reflecting on the outcomes highlighted it provides practitioners with a working model at an early stage and identifies the key areas to focus resources towards. Each of the outcome areas are further broken down within the framework and throughout the thesis explaining some of the pitfalls which should be avoided but equally providing the

strategic level of understanding required. The thesis focuses heavily on particular areas such as governance, partnership working and trust as without these key elements any project may fail in its objectives.

1.8 How the Thesis is Organised

The thesis consists of six chapters together with several appendices provided as supporting material. This, the first chapter has the primary role of providing an overview of the research. Chapter two identifies the key areas of literature which are used to help shape the theoretical underpinning for the research through the determination of initial themes for consideration and to help provide an understanding of the valuable work which has previously been undertaken. Chapter three follows and introduces the methodology applied in the research. Methodology is a key chapter in this thesis, as it provides the researcher's philosophical stance which helps provide clarity to the views and opinions expressed within the remainder of the thesis. The chapter identifies with the interconnectivity of the approach to the building blocks of research as determined by Grix (2010), helping to clarify how the researcher's philosophical stance was determined. From the application of the researcher's phenomenological perspective the methods for gathering the rich tapestry of data, techniques for understanding the data and ultimately determining the findings are justified.

The thesis moves forward to Chapter four which presents not only the findings of the research but an analysis of the substantial volumes of data gathered during the research providing further context to support the objectives of the research. Chapter five provides the interpretation of the data, the synergy between the theoretical underpinning of the research, the considerations from the data and ultimately providing justification for the contribution to research determined by the researcher. Finally, Chapter six revisits the key contributions, and establishes whether the doctoral research questions have been addressed. The chapter also provides an insight into the limitations of the study and offers contributions to academic research and professional practice.

1.9 Summary

This chapter has explained the roots of the DBA study and the context in which it has been undertaken. The aim and objectives of the research has been justified and the underpinning consideration for the thesis shared with the reader. The chapter structure has been outlined and on this basis, the thesis will now proceed with a detailed exploration and examination of the underpinning literature.

2. Literature Review

This chapter has been written to provide consideration of the pertinent literature available within the research area. To focus the literature to the aim of the research which is, ***'to critically analyse Principal Stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration'*** it was necessary to establish which organisations the research refers to as principle stakeholders. There are a number of organisations involved with the implementation of integration, some of which have been providing health care services and social care services for many years in a quasi-collaborative approach. However, to ensure the research was narrowed accordingly the research focuses on three public sector organisations namely:

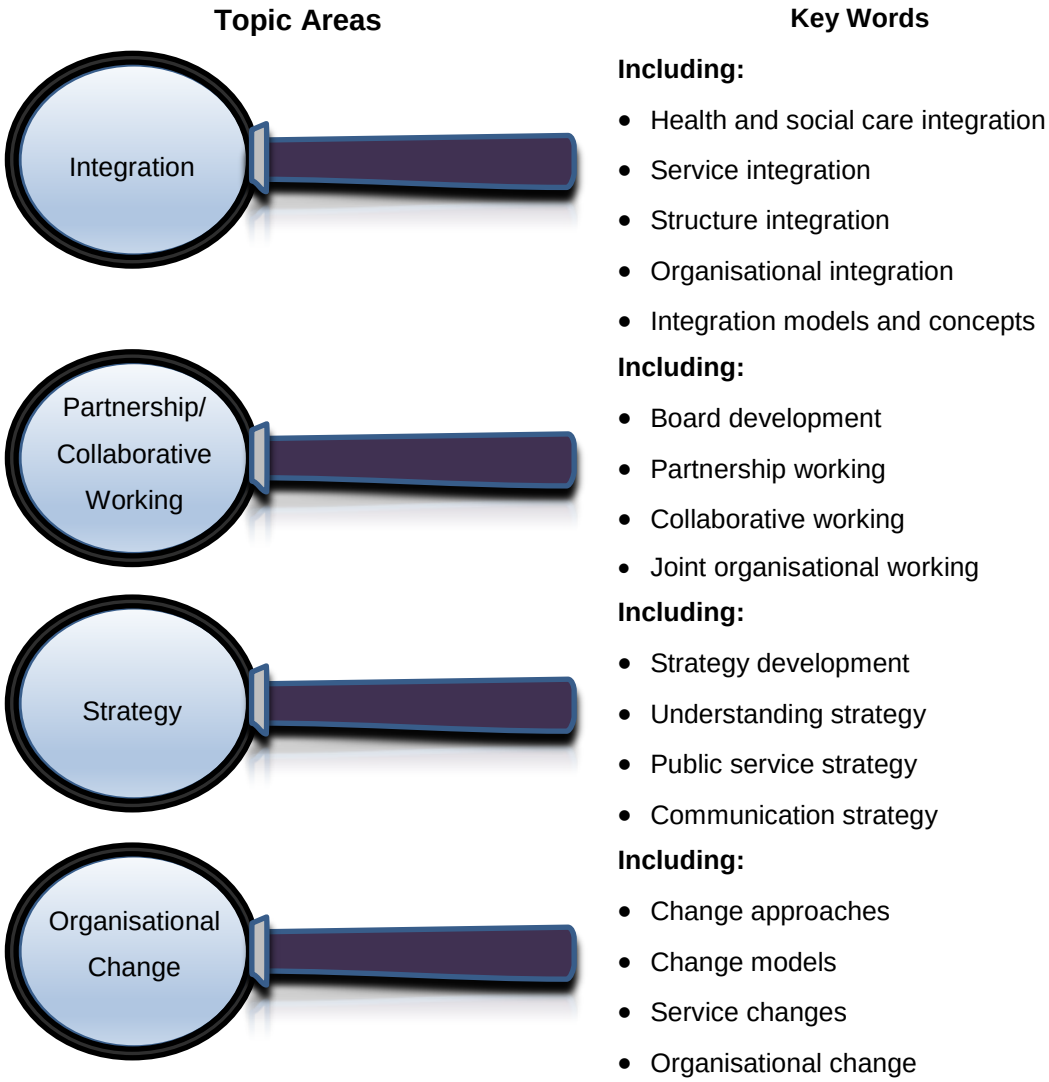
- The Scottish Government
- Local Authorities; and
- Local Health Boards.

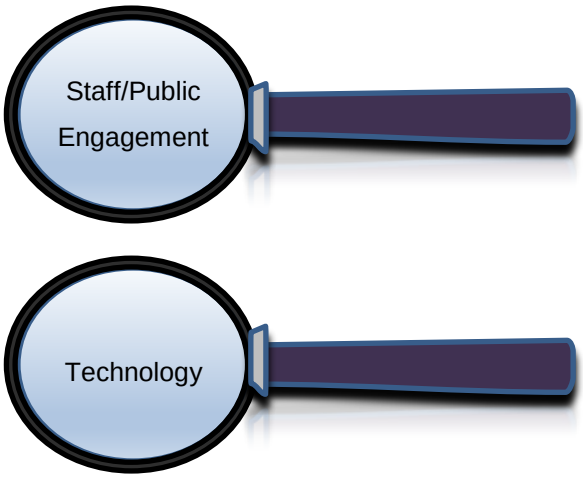
The three public bodies were selected as the main consideration for the research as the organisations which have a duty to ensure the success of integration. Private sector support is procured by these organisations and will alter as service requirements change, and while the public sector organisations may be restructured, the remit of delivering the services is likely to be retained. The chapter begins with an overview of the approach taken to identify the literature, together with the considerations of the researcher to focus the approach within themes which grounded the research further to the literature. The chapter considers the issues understood by many to be associated with health and social care integration. Further, it reviews the research undertaken and the models considered in the research. The chapter then takes us through the identification of discussion topics, grounded in the literature, which were used as the basis for the interviews with Chief Officers. The chapter therefore begins with a brief

description of the searches which were initially established, followed by a critical examination of the literature.

2.1 Approach

The review was undertaken by initially conducting a search of the literature based on a set of attributes considered which would require to be identified by any Joint Board undertaking an integrative process. An example of this would be, a Joint Board would need to set the agenda for delivering integration so may initially develop their partnership aims. These attributes were expanded as the research developed which will be discussed later in the chapter. The initial areas for consideration are detailed in the diagram below:





Including:

- Engagement models
- Workforce communication
- Public engagement
- Public service communications

Including:

- System integration
- Portal integration
- Health and social care systems

Figure 2: Literature Investigation Schema

(Source: Author)

Some of the initial literature was provided by 'grey' material such as legislative documentation, organisation publications and guidance documents. This was required to ensure my understanding of the rational for health and social care integration was clear to assist in drawing out some of the themes for consideration.

2.2 Literature Search Strategy

To ensure the literature review was conducted comprehensively from the considerable academic and organisation information which existed, the search was undertaken using the attributes detailed in Figure two above. To ensure the relevance of the literature to the current health and social care agenda, the search parameters were restrained to a 25-year historical search. This timescale ensured that significant literature relating to public service reform and earlier approaches to joined up health care provision and community health partnerships was considered without being significantly affected by historical literature dating back to community care initiatives. While it was important to understand the literature schema to be reviewed, noted at Figure two above, it was also important to ensure the research areas did not spread beyond the narrow scope of the thesis and to this end, literature relating to areas such as private sector provision was ruled out of the searches. By approaching the search in this way, the information could

be reviewed and channelled towards key themes which would help to identify a framework for the research questions. Considerable use was made of the library's electronic search engines with AB/Inform, ProQuest, EBSCO, Web of Science and Emerald publications providing the main constituents of the sources, supported by recommended materials from supervisors, fellow researchers, participants and colleagues. Information was guided through several filters to ensure it was: provided from credible and auditable sources ensuring, where possible, information was peer reviewed; from third party organisations, which were affiliated to appropriate research establishments and from approved public service reports. Information provided by the Scottish Government, Local Authorities and Health Boards also provided considerable early background reading. As the research was being undertaken during a period of concentrated effort from organisations to implement health and social care integration and a period of fervent authoring, it was necessary to continue to review the information being gathered to ensure new developments or findings were fully considered.

Having outlined the process adopted to initialise and maintain the literature research, the chapter moves forward to examine the content of the research identified beginning with placing integration within the public arena.

2.3 Public Service

Before the research considers the literature pertinent to integration it is helpful to consider the emergence of 'joining up services'. 'We are living in the age of the customer' (Clifford, 2012, p.553). A bold statement perhaps but one which is reflective of successive Governments' approach to giving consumers greater choice of service. Or is it? Reforming public services is not new; it predates the heralded reform agenda of the previous Labour Government (Newman, 2001). The focus, from the then bureaucratic, paternalistic, service provider (Osborne and Gaebler, 1992; Clarke and Newman, 2007) to a 'New Public Management' approach in which Hood talks about a 'public management for all seasons' (Hood, 1991), adopting a perceived greater cost-efficient, market oriented public sector model concentrating on the 'three Ms'; market, managers and measurement (Ferlie

et al., 1996). We will discuss the uncertainties political influence on public administration has later in the thesis and the effects of disaggregation and re-aggregation has on long-term service provisioning, financial management and ultimately collaborative working arrangements (both strategic and operational). Talbot and Johnson (2007, p.59) refer to the Labour Government's approach in the late 1990's and early 21st century, the phrase synonymous with 'joined-up Government' as an approach to creating more effective and efficient organisations by removing concerns about separate and fragmented parts of the public sector. Arguably, this time has also peaked (Dunleavy *et al.*, 2006) and we have moved beyond the new public management approach, superseded by a 'fluid setting in which there is no best way to do things' (Fenwick and McMillan, 2005, p.4). With this relative freedom, unchained by dogma, the opportunities exist to move towards a new way of working; one which can deliver a different model of health care. In 2011, Nicola Sturgeon MSP, then Cabinet Secretary for Health was quoted in the wellbeing and cities strategy proposal as saying, 'by 2020 everyone will be able to live longer, healthier lives at home, or in a homely setting'. One question remains though; are Governments particularly interested in providing choice or is it an approach which helps re-image service provision to suit the financial sustainability of service delivery?

The current economic climate and constraints on public spending is significant and comes at a time when the Government is demanding radical change within the health and social care sectors whilst constraining the ability to deliver the integration approach by considerably reducing funding to all parties, endangering its very viability. This may initially appear an incorrect statement with the Government's rhetoric about further funding for the health service however, the reality is that funding is still below inflation levels and any additional funding of the health service reduces funding to other public sector services. Storr (2004), suggests the transformational agenda is reliant on the trust and commitment of the relationship between the leader and the follower. Whilst these roles are open to interpretation, they are just as significant to the roles between Government and Public Services as manager to colleague. Maddock (2002) echoes this view, suggesting that

any new initiatives announced by the Government are doomed for failure unless policy makers provide appropriate means of support to the people delivering the policy change i.e. public sector staff and the service user. The theoretical notion of the Government is the expectation that services can be delivered more efficiently, with fewer resources when combined in a partnership with the key actors. The challenge for the Government is to break the mould of inefficient services and achieve efficiency while protecting standards and service delivery (Maddock, 2002). The challenge for public service organisations is to deliver the radical changes, with reducing resources and an increasing user base.

At this stage, it is perhaps important to place a definition around the term public sector. This may initially appear simpler than it is, as most of us have access to services provided by the public sector whether through Local Government, such as schools, library, refuse collection; or Police Service to the National Health Service (NHS), providing care services for all. In general, the public sector can be defined as providing services paid for through general taxation (therefore paid for by the public). Public Services are however less straightforward that they first appear (Flynn, 2012). As an example, health provision by the NHS may be free at point of provision however, the same service may be provided, using the same facilities but paid for privately through private health insurance. The service is provided by the private sector. To add further confusion, the service carried out privately but paid by the NHS becomes a fusion of suppliers working in a public/private partnership. We will look at this later in the literature review when we consider partnership working.

One of the difficulties with writing about the public sector is the potential changes on the horizon. The influences of the Brexit decision will be experienced as the Government moves forward with their decoupling plans over the next few years and the relevantly high standing of the leadership of the ruling party in Scotland will invariably lead to a review of the services being delivered. It is apparent from the rhetoric of the politicians that financial changes to budgets will continue to be experienced, reducing not

only the financial resources but reducing staffing resources by an unprecedented level. Additionally, politicians regularly suggest reviewing the structure of public services to maximise the potential for reform. As Massey and Pyper (2005, p.80) note, a view shared by Flynn (2012), 'politicians and bureaucrats have a penchant for moulding and re-moulding the shape and structures of the polities within which they function'. If designed to support the reform agenda there is arguably merit in adapting structures however, given the relatively short lived tenure of governing parties, whether Central or Local Government it is questionable the benefits that can be derived. The concept of adapting structures to suit political agendas is one which requires further exploration of this study will seek to answer this by posing this question to service deliverers.

In summary, political influences have a substantial role in the development and stability of health and social integration. It is not only a key and sizeable legislation change but also one that requires time afforded by successive Government to fully develop. There is a plethora of information relating to the political standpoint of health and social care integration but interestingly the information is more evident from grey literature such as Government and political papers and organisations with a vested interest in care such as the Kings Fund.

2.4 Integration

Since 1997 integrated working has been a key policy mechanism used by the UK Government in the delivery of public services (Balloch and Taylor 2001, Sullivan and Skelcher 2003). Kodner and Spreeuwenberg (2002) describe integration as 'a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors'. Integration is introduced for two key reasons 'efficacy', which Capitman (2003) identifies as providing 'functional status outcomes and delayed death' as opposed to the efficiency opportunities which Capitman (2003) suggests is aimed at a reduction in costs which can be

measured by a reduction in units of input or outputs within a certain time period.

Many considerations for integration exist from structural integration where collaboration is a broad concept encompassing the services (service integration) provided by organisations into a unique service delivery model where joint contracts, referrals between partners and the development of new programs and combined funding exists to achieve common goals (Sandfort, 1999; Borins, 1998; Sowa, 2008). Service integration is at a lower level, referring to a formal arrangement between service providers agreeing to service goals to ensure joint working between clients (Packard *et al.,* 2013). Systems integration exists at an Information Technology (IT) level, sharing information between organisations to provide a rich picture of clients (Fisher and Elnitsky, 2012). Packard *et al.* (2013) through their research identify four issues which remain unresolved and should therefore be addressed during the planning of integrated services. These include: widespread frustration with the inflexibility of financial resources from the different budgets which were a limiting factor in the development of true integrated programmes. Information exchanges through technical solutions, where the contractual, financial and fragility of early stage integration reduces the focus on how information will be shared within the new arrangements. The need to develop a sharing mechanism either through new systems or a shared solution such as a portal which all agencies can access is required to ensure success. Finally, Packard *et al.,* (2013) identified the association of information confidentiality between organisations was a key issue to resolve. Individual organisations are naturally protective of their client data and want to ensure the information is shared appropriately, as such the reluctance or unwillingness to share information is a frustration which ultimately has an impact on the client whose very existence is the ultimate reason for the integration.

Searches, using the strategy previously identified highlighted a number of different conceptual frameworks which recognised the main elements of integration identified by previous research. One article by Lyngso *et al.*

(2014) identified their recently published systematic review of the literature available through the main sources previously discussed, this was used as a key document in supporting the consideration of other articles. In their study of integrated measurement concepts, Lyngso *et al.* (2014) highlight eight common organisational elements which feature in building integrated care models. These include; IT/information transfer /communication and access to data; organisational culture and leadership; commitments and incentives to deliver integrated care; clinical care; education; financial incentives; quality improvement/performance measurement and patient focus. As identified by Lyngso *et al.* (2014), this is in keeping with Kodner and Spreeuwenberg (2002) consideration of integrated care. Considering these findings, the thesis evaluates the elements highlighted in the research using the headings which follow. These elements are also considered within the discussion topics developed for the interviews conducted with Chief Officers.

As stated previously in the introduction, integration considered in the thesis is from the perspective of early stage integration. While the thesis has considered public policy integration in the development of the research through influential work undertaken by Hood (1976) - a perfect implementation model which was reviewed and enhanced further by Gunn (1978); Hogwood (1987); Hogwood and Gunn (1984); Marsh and Rhodes (1992) and Sabatier (1986), the research refrains from driving forward with an examination of policy development. This decision was taken as it is not in keeping with the aim of the thesis in which the consideration of strategic development by Integrated Joint Boards was vital to its success. Equally, the research was not being undertaken to develop an operational model which if followed would result in a successful deployment. Sandwiched between the polar perspectives is the niche problem being considered by the research.

Hardy *et al.* (1992) suggest that a firm basis for collaboration does not necessarily imply its success as barriers still exist. This view is enhanced by Hudson (1987) who suggests the limitations of collaboration results in the inability of organisations to act independently which leads to work requiring to be undertaken by all parties to develop a relationship. This invests

unwarranted time and effort in developing those relationships when resources for the delivery of services is already limited. Arguably this view is ill conceived as the development of relationships lead to greater harmonious working between partners leading to a culture of connected working relationships. Carnochan and Austin (2002) consider this point suggesting the commitment of a focused leadership provides a central role in ensuring a clear and positive vision of the future for the new integrated organisation which focuses on outcomes rather than structural change as the achievement. This view is considered vital to partnership realisation as the importance of partnerships understanding the aims and objectives of the partnership is central to its success (Cameron and Lart, 2003). However, none of these studies explore how difficult the challenges of establishing a shared purpose can be (Drennan *et al.*, 2005). The ability to disseminate the message of what the partnership is trying to achieve is fundamental as there have been studies reporting the lack of a shared understanding of aims and objectives (Glasby *et al.*, 2008; Clarkson *et al.*, 2011) results in the failure of integration. These studies, while reporting the failure of integration, are limited in their analysis of the specific challenges of those failed examples. It is therefore understood that integration will only be successfully achieved if significant time and effort is input by the relevant organisations to build their relationship and the thesis will move forward to consider this approach.

2.5 Partnership/Collaborative Working

A variety of terminologies such as partnership working, collaborative working, integration and joint-working have been used to refer to this phenomenon, often interchangeably (Dickinson, 2006, p.376). Several definitions of partnership working exist including McGregor-Lowndes and Turner (2003, p.31) who record the legal definition of a partnership as 'the relation which subsists between persons carrying out a business in common with a view to profit'. However, this may be a reflection of the approach to partnership within the financially focused private sector rather than a direct reflection of public sector partnerships. Sullivan and Skelcher (2003), set out to comprehensively express partnership working in their longer definition as a 'negotiation between people from different agencies committed to working

together over more than the short term; with the aim to secure the delivery of benefits or added value which could not have been provided by any single agency acting alone or through the employment of others; and includes a formal articulation of a purpose and a plan to bind partners together'.

Considering the benefits which can be achieved from a united approach, Dickinson and Glasby (2010) argue that 'partnership working seems an intuitively helpful approach in some settings however, if the partnership does not set the desired outcomes then there is a major risk that the partnership becomes the main aim as oppose to achieving the outcomes. Powell and Dowling (2006, p.305) and Clarkson *et al.,* (2011) agree, suggesting some of the problems of partnership working are caused by a lack of clarity about the definition and expectations of the organisations. Both studies however fall short of considering how the failings may be changed to a positive outcome. McLaughlin (2004, p.103) contends the importance of partnerships has an 'inherently positive moral feel about it' and is akin to 'mother love and apple pie'. Dickson and Glasby (2010, p.820) perhaps using less embellished language appreciate McLaughlin's viewpoint arguing that by calling something a partnership we reduce the 'likelihood of resistance'.

Partnership working has become a core feature of public services (Dickinson and Glasby (2010). Larkin *et al.* (2011) argue that there are few politicians, professionals and academics who would argue against the principles of partnerships and collaboration in health and social care. This view is not shared by all. While there is an assumption that mutual benefits can be achieved through partnership working between public service organisations, the market and other social actors (Waddock, 1988), Glasby (2005, p.30) suggests that partners are attempting to move towards a filled circle when in reality there are many variations between the partners. The implications of which suggest that this is the ideal outcomes of partnership working rather than the actual outcomes. Cameron and Lart (2003) and Dowling *et al.* (2004) suggest partnerships have not always been met with support from organisations noting, the beneficial impact of partnerships have yet to be seen as the approach focuses on process rather than outcomes. Research

considers partnership working has as many failings as the approach tries to resolve. As Diamond (2006) notes, many issues are often ignored in partnership working such as the differences in size, remit and scale of the organisations, different professional interests, the voice of the public and differences in power and decision-making protocols. The opportunities that partnerships can produce are therefore obscured by the concerns of partnership working by the disengagement of the managers tasked with delivering it. This was not always down to the individual, as many managers were keen to develop the approach but were constrained often by the policies and perceived ties of the professional bodies of the organisation. Diamond (2006) further suggests the approach to partnership working has many weaknesses inherent in the model and as such, needs to move beyond the approach to examine the opportunities collaborative working brings.

Like partnership working, collaborative working within public sectors has been in place for many years (Metcalfe, 1993). Many Local Authorities have key strategic directives identified by their partnership working groups, often referred to at a strategic level as their Community Planning Partnerships. This form of partnership approach is often considered by organisations to help drive out efficiencies and create a seamless approach to services received by the citizen (Vangen and Huxham, 2003), delivering advantages for all parties involved in the relationship. A bold statement which lacks clarity of how the approach actually delivers the outcomes. Huxham (1993) identifies the advantages of collaborative working relates to developing a 'synergy' between the organisations involved. The advantage comes into play when something is achieved better together which could not have been achieved solely by one of the organisations involved. Huxham (1993, p.603) theorises the advantages further suggesting there are four benefits to collaborative advantage by avoiding; repetition, omission, divergence and counter production. Health and social care integration is a clear example of collaborative working, where organisations develop a relationship designed to work on areas of mutual interest (Everett and Jamal, 2004). This is a simplistic understanding of collaborative working suggesting, in direct

contrast to Powell and Dowling (2006, p.305) and Clarkson *et al.,* 2011 that relationships are easily formed.

The literature review previously touched on the inherent difficulties of working together, relating to the different culture, the uncertainty of the partnership relationship (Cramton, 2002), previous relationships (Jarillo, 1989) and management structures within different organisations. A key challenge of integration is developing a collective understanding for professionals with conflicting paradigms whose knowledge base and experience is very different (Williams, 2012). The reliance on developing the relationships without a strong degree of management learning between the organisations can lead to slow progress being achieved, identified as collaborative inertia by Huxham and Vangen (2004). Hibbert and Huxham (2005) suggest there are three approaches to developing managerial learning to support collaborative working. The first approach, and often one adopted by public sector organisations, although the report falls short of evidencing this conclusion, relates to learning which is supported by development through formal research methods, such as books, educational training and through learning from the managers' own experiences and the experiences of other colleagues. This approach is dependent on the ability of staff to learn in this manner and of course on the availability of resources as budgets to fund training of this nature is often the first area for 'low-hanging' budget cuts. Hibbert and Huxham (2005, p.60) refer to this methodology as 'transferable collaborative process learning'.

The second learning approach, which Hibbert and Huxham (2005, p.60) identify is 'knowledge transfer and knowledge creation'. The approach involves the 'passing or developing of substantive knowledge between partners' and the development of new knowledge between the partners as a result of working collaboratively together on a particular item. As Hibbert and Huxham (2005) suggest, this may not always be to the advantage of both parties as one may have gained more detailed knowledge, which the other parties may selfishly obtain through this method of knowledge gathering. Arguably though, a partnership is for mutual benefit and an equally balanced

contribution would be extremely difficult to achieve. The final approach, local collaborative process learning, suggested by Hibbert and Huxham (2005) relates to specific knowledge transfer, which is designed uniquely for the particular circumstances involved.

Similarly, Tsasis *et al.* (2013), argue that collective learning of institutionalised values, structures and social interactions is vital to integration. Tsasis *et al.* (2013, p.11) are proponents of Complex Adaptive Systems (CAS) theory which supports 'open systems with fuzzy boundaries'. The theory implies that the design, implementation and management of integrated care can be achieved by the actions of 'numerous, diverse and highly interactive agents, including individuals, groups and organisations'. This approach to organisational change enables relationships and the development of the integration to emerge based on the environment in which the actors' relationships develop. This approach cuts through the hieracrchical and process driven approach suggested by others and is more reflective of how sharing information naturally occurs in daily life. The change to a dynamic self-organising approach such as the CAS principles may be considered to lack even a minimal authoritarian approach to integration, often representative of existing structures.

Griffin *et al.* (1999) argue that the CAS approach, far from being less managed is adept at changing to deal with circumstances as they arise and is therefore more flexible in meeting the needs of an integrated system reliant upon different professions and experiences. Irrespective of the collaborative approach taken, it is clear the need to develop an integrated knowledge base not only specific to health and social care but to the wider dimension of the care agenda is vital to the success of the approach and to the viability of the consumer receiving a joined-up service. Financially, partnerships offer the opportunity to provide services through using a combination of skills however, if the financial savings is one of the main motives then the partnership may fall at the first hurdle, as honesty in addressing what the public anticipate from the service is vital in achieving success. This differs from Allen and Stevens (2007) who highlighted issues with finances,

indicating their research identified a shortage in ongoing financial support with infighting within the organisation as to where the financial resources would be best used. Gibb *et al.* (2002), acknowledges that different funding sources hinders opportunities to develop joint assessment mechanisms. The report limited financial consideration to specific approaches rather than the opportunity to prioritise funding within a large-scale budget.

Training was also perceived as an issue to ensure appropriate skills are maintained to deliver the services required. As one respondent to Allen and Stevens' (2007) research suggested, training is vital as 'when you catch a plane you don't expect a bus driver to be flying it'. Tsasis *et al.* (2013) consider integration should be reframed from a structural and operational perspective to an interactive learning process with those involved 'reconceptualised as learners operating with complex adaptive care systems'. The authors have developed a three stage 'learning to learn' model which provide an insight into the enablers and barriers to achieving integration success through learning. These consist of; the examination and understanding of how integration groups learn with, from and about each other; following CAS (complex adaptive systems) theory to highlight the dynamic complexity of care delivery and to introduce self-organisation as the mechanism for success and finally, the capacity to learn affects the outcome. Tsasis *et al*. (2013) suggests this can be achieved through two approaches; working with educational establishments to support directed early and continued training and by developing a learning environment which is designed to assist the service providers in developing an approach to abstract and problem seek to ensure delivery approaches are consistently designed for the purpose required rather than to address daily interactions. The approach to engaging in this mechanism is demonstrated in Figure three below. Brown *et al.* (2003) meanwhile contend that the provision of introductory and ongoing training leads to a shared understand of the aims and objectives of the partnership.

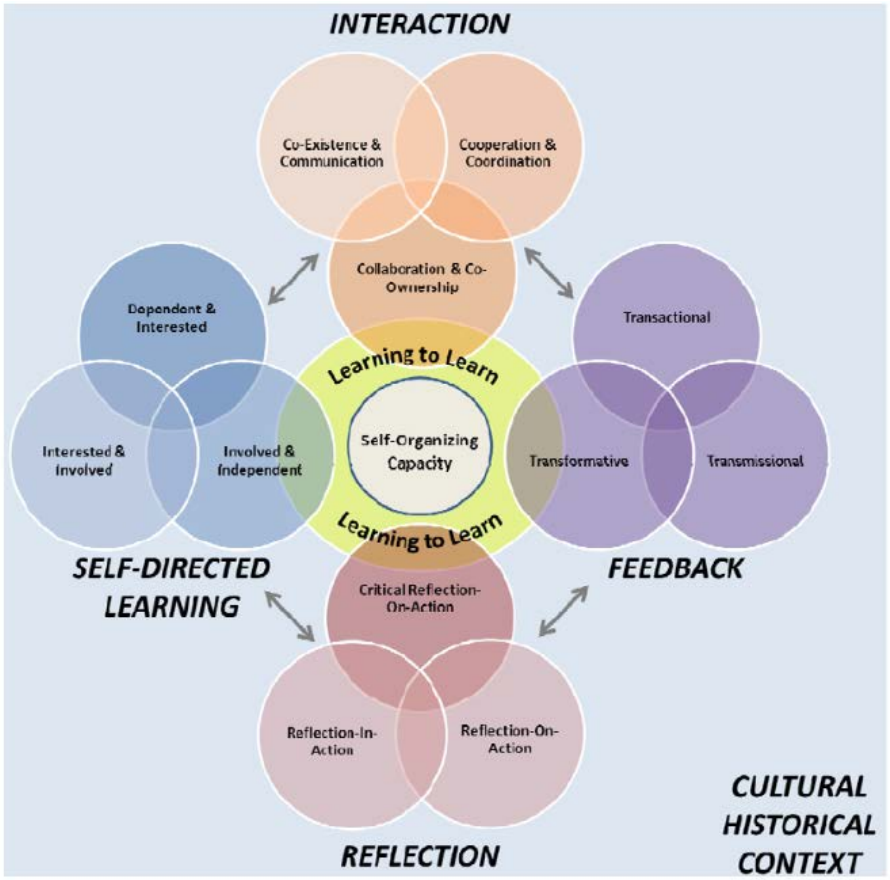


Figure 3: Learning to learn (L2L) model for care systems

(Sourced from Tsasis *et al.,* 2013)

By embracing this approach, the organisations develop a training led approach to achieve a fresh dynamic new consideration of how integration can be achieved. This approach also addresses the issue of communication within organisations as, the staff are learning together to define a collaborative approach where they understand the interdependencies the nature of integration brings. Combined training between inter-disciplinary groups, together with regular team meetings enforcing the aim and objectives of integration and providing a forum for understanding professional contribution, develops an understanding between colleagues of the roles and practices. This develops trust and builds rapport between the groups (Brown *et al.,* 2003). The development of knowledge sharing is a challenge to integration as Schein (2004) recognises knowledge is generally understood in two different ways, explicit knowledge which can be recorded and communicated easily as oppose to tacit knowledge which resides in the understanding of individuals and is difficult to capture. Child (2001) contests

Schein's view arguing that knowledge is only created by individuals and an organisation can only support creative individuals or provide suitable context for them to create knowledge. An important point, but one which loses the significance of recording knowledge rather than simply sharing it. Williams (2012) acknowledges the challenge of developing shared knowledge during integration and considers that the need to develop the knowledge base is dynamically required to deliver the substantive task of developing joint working approaches.

Researching the topic of partnership/collaborative working quickly identified the changing shift in understanding of the terminology and the perceptions of researchers in this field. Diamond (2006) provides a great deal of clarity on why the approach to partnership working has been overtaken by a more practical and synergised collaborative approach, arguing that realistically partnership working should now be ignored (Diamond, 2006). Hibbert and Huxham (2005) offer a three-stage model for developing learning principles for collaborative working. The approach finds favour within the academic fraternity as a sound approach with few writers arguing for only a few adaptations to the model. Complex Adaptive Systems is also a model identified by writers such as Griffin *et al.* (1999) and Tsasis *et al.* (2013). The model, although appearing to be unmanaged in its approach and chaotic in application, is identified as being adept at serving the purpose of collaborative working. More research is required in this area to further understand and critically review the CAS model, as initial understanding of the unsystematic approach fails to position the model to practical usability. This was a stimulating element of the research and arguably an area, which is the backbone to the thesis as all the information in each section, has pointed to the success and failure arising from collaboration. Other considerations have been developed such as Osborne (2006) who sees partnership working as a three-stage model of public administration and management moving from public administration through new public management to new public governance, an approach which Osborne (2006) determines is influenced by the emergence of networks where partnerships have become the new norm.

Epstein (2004) suggests that ‘a weak post-merger integration strategy can destroy a partnership’. It takes teamwork to build partnerships to ensure ongoing collaboration (Elson, 2002), adding further terminology to an area significantly challenged by the understanding of partnerships. Experience has shown that the integration of services works to improve quality of life where there is acceptable and equitable access to services. Elson (2002) further highlights seven outcomes from his research which are required to be fulfilled: teamwork is required to build and ensure ongoing partnerships; resources and skills should be invested in to support effective and timely progress; integration should be implemented as effectively as possible through skilled planning of the changes; clinicians, organisational and facilitation leadership is vital in the success and education should play a key part in ensuring successful planning and implementation. Allen and Stevens (2007) considered that leadership had to embrace all aspects of the integrated service. In their study, the lack of support for employees from management left employees feeling powerless, dissatisfied and alienated. The report further describes the leadership as a dictatorial process with staff being unable to provide the Board with the benefit of their experience as there was no course to the executive. Additionally, the feeling of no collaboration meant staff considered communication levels were low with staff only being made aware of issues on a need to know basis. Cooper, Robinson and Kippen (2013) suggest a new approach to participation should be considered, based on the experiences of other Governments. This approach encourages a ‘harnessing of the crowd’ approach to deliver innovative and cost effective social care.

2.6 Strategy

The strategic approach to delivering services is often called into question at times of difficulty or at times of success e.g. child-protection scandals or response to disasters (Walker *et al.,* 2006), but often strategy is formed from an idea, a conceptualisation of how things should be or from the successes and failure of similar approaches. Joyce (2000, p.75) in discussing strategic vision suggests, ‘a strategic vision is an articulation of what a public sector

organisation should be doing in the long term and what it is trying to achieve'. Organisations such as Local Authorities and the public sector, involved in a large change programme such as health and social care integration have key strategic areas that they will develop. These include areas such as; enabling and problem solving, responsive to needs, partnership working to deliver, transparency and access to information and organisational change (Joyce, 2000). We will look at these areas in greater detail as we progress with the literature review. In the case of health and social care integration, the strategic imperative of successive UK Governments is to deliver an integrated approach to health and social care, under a unified management structure (Robb and Gilbert, 2007). Many however, would argue that the reason for integration is heavily influenced by the Governments institutional pressure to reduce costs (Burns and Pauly, 2002; Fulop *et al.,* 2005,). Glasby and Peck (2004), identify that the success or failure of integration will be dependent on the integration boards' cognisance that they are attempting to integrate very different organisations. Different in organisational culture, leadership styles, concepts of citizenship and community accountability. Glasby and Peck's (2004) statement may not address the point. It is not the cognisance of the different organisations but the acceptance that they are different organisations and therefore develop an approach to embrace the differences and move forward. Successful achievement will require a significant behavioural change (Gilbert, 2005). Agreeing with the need for behavioural consideration, Robb and Gilbert (2007), taken from a dominant NHS lead, which appears to challenge the acceptance of partnerships, theorise that integration strategy requires a number of key steps to be taken:

- **Separatism,** creating a safe space for seconded and directly employed social care staff and reassuring them that their contribution is recognised and valued;
- **Consolidation**, consolidating the identity and value of social care staff and the promotion of social care services;
- **Integration**, demonstrating the integral value of social perspectives for all services.

Evans and Ross Baker (2012) highlight the differences in organisational structures between the key stakeholders tasked with delivering health and social care integration and the need to address the cultural differences. Walsh (1995) goes further, suggesting that the perceptions of the stakeholders involved are integral to the performance of the service as it provides the underlying logic for delivering the service. Without this cohesive approach, Evans and Ross Baker (2012, p.715) reflect that integration will be based on 'a different vision with interactions characterised by miscommunication and disorganisation'. Evans and Ross Baker (2012) suggests their research into effective integration is indicative of an 'acknowledgement of the importance of relationships; the levels of trust, buy-in, cooperation, and communication within and across health service providers which can either facilitate or hinder efforts to integrate care'. Allen and Stevens (2007) highlight the vital need for an explicit change management focus, where the cultural differences and financial challenges are addressed at an early stage by strong leaders who are willing to listen and learn from the staff they are training appropriately and empowering to deliver the integrated services.

There is of course another dimension, which requires consideration; strategic management of a public body requires a democratic influence from elected politicians and in the case of NHS Boards, Non-Executive Directors. The dynamic approach the politicians bring with a democratic perspective to the work of the organisation and the experience of private and public sector brought by Non-Executive Directors (acknowledging the roles can be the same) help to provide a balanced approach to setting the objectives of the organisation, the Board and the Chief Executive which will help to ensure the objectives are delivered. Many organisations, especially within the health service, publicly state their strategic objectives via a short sharp vision statement. Beckhard and Harris (1987, p.45) state 'more and more attention is being paid in both the planning process and determination of managerial strategies, to articulate the 'vision' or desired end state'. Beckhard and Harris (1987, p.45) however provide limited evidence of the impact of visioning on achieving outcomes. Unquestionably, the performance of a

public sector organisation and indeed the success or failure of localised integration will be significantly affected by the strategic direction of the senior management. Abbot *et al.* (2008) noted an apparent lack of a challenging style within the health sector but the support of non-executive directors helped address the scrutiny balance in strategic governance. Abbot *et al.* (2008) determined that the partnership effect of the board roles led to a method of working which embraced a climate of high trust and high challenge. Garratt (1996, pp 45-47) suggests a model of four main functions that an effective board should be concerned with to deliver an effective governance structure. The model is split into four sections and is represented at Table one. The model delivers a vital role in defining the role of the board and identifies an approach that should be consistently adopted across the culture of the national service. It is clear for successful integration that a key strategic requirement is the 'buy-in' of stakeholders, moving away from their internalised organisation perspective to a whole solution perspective.

There is a considerable weight of evidence applied to public sector strategy for separation and consolidation polices with authors such as Joyce (2000) articulating the need for longer term planning to achieve maximum strategic positioning. The research has focused attention on the role undertaken by the board delivering health and social care integration, key writers in this field (Garratt, 1996; Abbot *et al.,* 2008; Evans and Ross Baker, 2012), put forward conclusive arguments, underpinned by research outcomes which confirm the benefits of collaborative working between all members of the board and the need to drive progress through a detailed and communicated strategic approach.

	Short term focus on conformance		Long term focus on performance
External focus	**Accountability** • Ensuring external accountabilities are met, e.g. to stakeholders, funders, regulators • Meeting audit, inspection and reporting requirements		**Policy formulation** • Setting and safeguarding the organisation's mission and values • Deciding long-term goals • Ensuring appropriate policies and systems in place
Internal focus	**Supervision** • Appointing and rewarding senior management • Overseeing management performance • Monitoring key performance indicators • Monitoring key financial and budgetary controls • Managing risks		**Strategic thinking** • Agreeing strategic direction • Shaping and agreeing long-term plans • Reviewing and deciding major resource decisions and investments

Table 1: The main functions of boards

(Adapted from Garratt,1996)

At a strategic level, the vision of organisations competing to ensure their powerful participation in integration has the effect of undermining the approach as the disaggregation leads to an inability to develop agreed agendas (Regen *et al.,* 2008). The presence and evidence of a strong approach to leadership ensured the moral of the staff was high as confidence built (Gibb *et al.,* 2002). Drennan *et al.* (2005) point to the lack of effective management as a potential lack of experience in the management of partnerships. A lack of ownership and appreciation of responsibilities leads to a decline in the achievement of the fundamental drivers of integration and ultimately a decline in timeous treatments. (Glasby *et al.,* 2008; McCormack *et al.,* 2008). Gibb *et al.* (2002) noted the differences in the level of decision

making between staff groups with health workers being more empowered to make decisions than those of social care staff who sought the agreement of their decision makers.

Cultural differences are evidenced by professionals who, in some situations abhor the bringing together of different philosophies, experience, understanding and values to deliver an integrated service when, from their perspective, the role they play is the most important in delivering the better outcomes for the client and can therefore create barriers to effective joint working (Peck *et al.,* 2001). Scragg (2006), meanwhile perceives that health professionals have a lesser view of social care providers, resulting in a lack of appreciation of their contribution. Allen and Steven's (2007) research highlights the difference between acute and community health care, let alone social care. The research indicated a superiority within the different sectors with a lack of recognition of the work of community health care. This led to staffing issues with staff venting frustrations and feeling completely demoralised by the changes which were made. However, the 'Berlin Wall' consideration of health and social care, based on the view that sick people who require medical intervention are distinguishable from those who are merely frail or disabled and therefore have social care needs which are better served by the Local Authority (Dickinson and Glasby, 2010) requires to be revisualised. It is therefore important to establish a clear division of labour to ensure the skills of each partner can be fully utilised (Larkin *et al.*, 2011).

Summarising the research direction of the literature considered, short and long-term planning, the requirement of a strong and decisive strategic direction for integration at a national and local level. Garratt (1996) offers a model that determines the four key functions of a local board in achieving strategic progress. The strength of the model is in its adaptability i.e. the model sits equally well with Health Boards, Local and National Government and indeed private and voluntary sectors. The academic research in this area was unclear as to the rationale underpinning the approaches identified. This therefore poses several questions for further consideration; the effects of short and long-term planning, the opportunities to capture information

about lessons learned from local boards strategic direction and how those lessons are shared for good practice, the effects of Non-Executive and political membership of the board and how this influences decision making, and how strategy is communicated?

2.7 Organisational Change

Change is a continuous entity, it can be incremental or rapid, open ended, ongoing, adaptive and responding to changing circumstances with many different directions along the way (Kanter *et al.,* 1992) but it is always present. Embracing the challenges that change brings has been predominantly evolutionary within the public sector rather than revolutionary, as the key focus of the actors has been on delivering improved service quality, shifting the focus on how the services should be delivered to the greatest effect for multiple stakeholders (Kakabadse *et al.,* 2010). The nature of public service delivery, with the political agenda of successive Governments and local politics, means it has change running through its very core. One key difficulty of the change agenda is the maximisation of trust within the culture of the organisation as privatisation, downsizing, fundamental reorganisation and a 'more for less' culture has seriously damaged management and employee relationships (Kakabadse *et al.,* 2007). The report focuses on management and employee relations but it could be argued that the same principles are applied to customer relationships. Maddock and Morgan (1998), referencing the measurement and contracting culture of New Public Management, suggest the approach has stifled relationships and created a level of distrust amongst staff in the health service. The reluctance to fully engage in a change agenda is due to their suspicion of the Government and senior management, given their experiences of outsourcing and measurement protocols. Maddock and Morgan (1998) suggest assertion of the change agenda not only affects staff trust but also creates a deep psychological cultural barrier which fosters resistance to change. Yet arguably, two of the most important factors in organisational change relate to employees; recruiting or retaining and developing managers to implement change (Kanter, 1997 and Mullins, 2001). Burns (1978) further suggests the key role of leaders of any organisation is to

bring about change. Significantly the report details the need for change but fall short of identifying how change can be successfully implemented.

Many different models of organisational change exist and while it would be beneficial to consider a range of different models, the thesis is limited in its length. The literature review, will therefore reflect on two well-known models which have been adopted by the public sector, including the adoption of Total Quality Management (TQM), Business Process Re-engineering (BPR), and perhaps the most often used model in public sector, the Langley *et al.,* (1992); Plan, Do, Study, Act (PDSA) model. The model focuses on identifying:

- What are we trying to accomplish?
- How will we know that a change is an improvement? and
- What change can we make that will result in an improvement?

While the PDSA model may be more frequently used in the development of specific change agendas, the principles of the model are still appropriate for large-scale organisational change. The Scottish Government continues to adapt the PDSA model to initiate key policy directives. A recent example and a key policy directive, is the Early Years Collaborative approach being rolled-out by the Government to help deliver tangible improvement in the outcomes and reduce inequalities for Scotland's vulnerable children (Scottish Government, 2011). Another influential model for change, and arguably used more extensively across a myriad of organisations, is Kotter's eight stage process of creating major change. In his 1996 book, (although his model was first published in a 1995 article in the Harvard Business Review) entitled Leading Change, Kotter (1996) identifies eight stages:

- Establishing a sense of urgency;
- Creating the guiding coalition;
- Developing a vision and strategy;
- Communicating the change vision;
- Empowering broad-based action;

- Generating short-term wins;
- Consolidating gains and producing more change; and
- Anchoring new approaches in the culture

Kotter's model was developed from his own experiences and did not reference any external resources (Appelbaum *et al.,* 2012). Despite this unusual approach, Kotter's change management model remains a key reference today. Todnem (2005), suggests the continuing success of the model may be due to 'theories and approaches to change management currently available to academics and practitioners are often contradictory, mostly lacking empirical evidence (a conclusion which appears unsupported given that Kotter's change management model was derived from his experience) and supported by unchallenged hypotheses concerning the nature of contemporary organizational change management'. Despite this view, Kotter's approach is still widely in use today within the public sector. The danger however, is the approach to the stages. Kotter (1996) recommends each stage should be fully followed in sequence to ensure change is embraced within an organisation. As Kotter's model is based on experience rather than empirical evidence, there remains an uncertainty to the validity of this approach.

Arguably, the most understood and cited authors of organisational change theory are Kanter *et al.* (1992) Kotter (1996), Langley *et al.,* (1992) and latterly, Kakabadse *et al.* (2007, 2010). Research within the thesis suggests the most interesting element of the research on organisational change is provided by Kotter (1996). He presented a model which is very well known from a practical perspective but also with the academic field yet it is based on no empirical evidence, instead drawing its conceptual basis from the writer's own experience. Despite the well-known understanding of the models discussed, there remain doubts about the success of these and other organisational change models due to the limited empirical evidence measuring the success of direct application of the models. Having examined the literature relating to organisational change, there is evidence that the models have an influence in change but cannot be described as successful in a continuous approach to change management.

2.8 Staff/Public Engagement

There has been a notable drive by successive Governments to involve the public in having a greater input to service delivery. The ultimate aim of the involvement is aimed at improving service delivery, patient experiences and patient outcomes (Crawford *et al.,* 2002). A strong engagement agenda in health reforms addresses citizens' awareness of, and involvement in, service design and delivery (Attree *et al.,* 2010). Involving the public in decision-making was a keen policy objective of the last Labour Government. This was reflected in the Patient Focus and Public Involvement Policy Initiative in Scotland and is now a statutory duty for National Health Service Boards in Scotland (Anton *et al.,* 2007). The question which remains however is how much does the public actually wish to be involved in the decision making process and to what level? Public and patient preferences have been a talking point in recent years, resulting in a positive climate for discussion around the topic. The patient is the person most affected by decision made about their care, so who better to understand what level of decision making they would wish to be involved in, after all, the decisions made will affect the patient potentially for the rest of their lives (Mühlbacher and Juhnke, 2013). This was a significant report which examined evidence gathered from a questionnaire of over 600 patients. Patient oriented healthcare requires an understanding of patients' expectations and needs and providers can provide clearer choices and better inform the recipient if they understand the patient's thinking (Dolan *et al.,* 1996).

Providing the opportunity for shared decision making is not unique to the UK. Legare and Witteman (2013) identified similar initiatives were ongoing in 13 countries, designed to support patients to become heavily involved in the clinical decision making. The report focuses on patient involvement and choice of approaches but has limited acknowledgement that a possible outcome may be that the patient wants the decision to be made for them. Legare and Witteman (2013) note that patient involvement in their health treatment is most appropriately used where medical evidence supports different approaches to treatment. Further suggesting that three essential elements are required to ensure patient engagement is appropriately applied

including; an agreement between all parties that a decision is required; an understanding of the risks and benefits of all treatment plans and finally the guidance of the clinician and the patient's values and preferences. The approach builds on the work of Arnstein (1969) who developed a well-known and often quoted model for involvement of service users in decision-making, identifying involvement at three levels:

- Consultation – an approach, which enables the public to influence decision-making and be in effective control of the systems, they are seeking to influence.
- Collaboration - a joint decision-making approach with the clinician influencing the approach.
- Control - which allows merely for the public to be educated and influenced by those who are in power.

Both approaches have many benefits for the patient such as an understanding that they have the opportunity to make decisions that directly involve their health outcomes and a more detailed understanding of treatment plans. There are of course benefits for the organisations involved too including financial benefits. Tritter and McCallum (2006) have criticised Arnstein's (1969) theoretical model, suggesting that the three elements all relate to control, arguing that the model discounts patients own knowledge, experiences and expertise. They contend that Arnstein's (1969) model does not appreciate that some patient's see participation in the decision-making process as an achievement in itself. Sarrami-Foroushani *et al.* (2014), suggests that while many models have been published in relation to consumer and community engagement there remains a lack of consensus of definitions and terminologies for strategies and barriers in health care. Using their 'meta-review' method of analysing systematic reviews of the subject, Sarrami-Foroushani *et al.* (2014), developed an eight-stage model defining the key elements of consumer and community engagement (Figure four).

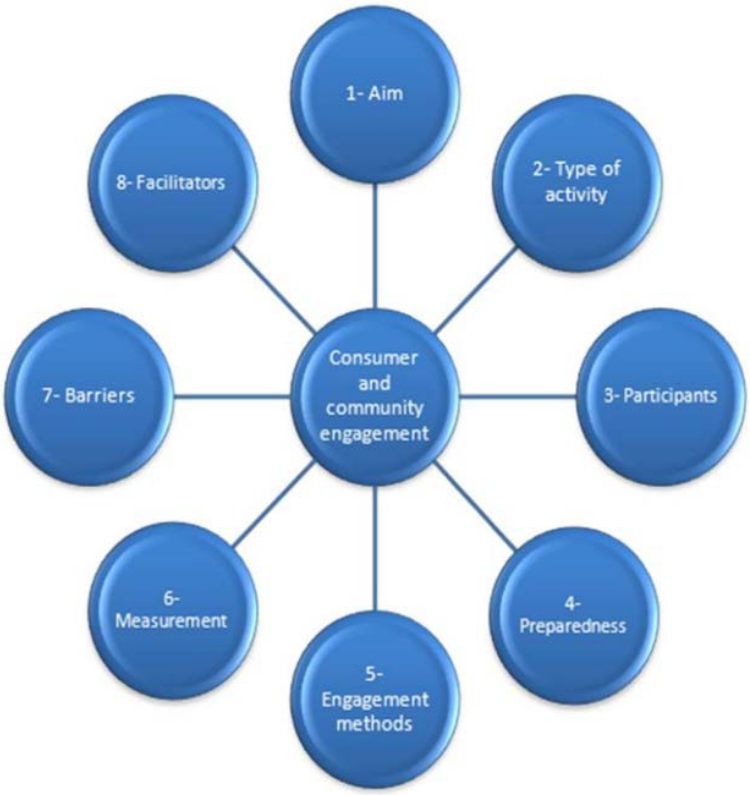


Figure 4: The eight-stage model for implementation of consumer and customer engagement

(Adapted from Sarrami-Foroushani *et al.,* 2014)

The eight key steps are:

- Aim – Identify the focus of the engagement.
- Type of engagement activity – Identification of engagement activities, which may include research, service planning, decision aids.
- Participants – Identification of relevant participants.
- Preparedness - Education and training in preparation for participation in CCE activities are crucial prerequisites for any CCE intervention.
- Engagement methods - Depending on the topic and the individuals involved, potential engagement methods can be developed and applied.
- Measurement – Evaluation and measurement, process and outcome evaluation.
- Barriers – identification of barriers e.g. cost, culture and population.
- Facilitators – Determining the potential enablers to implement and enhance the processes.

Foot, *et al.* (2014) suggest that today, comments relating to patients being in control and at the centre of decision making are commonplace by politicians and senior health providers. Berwick (1996) however, suggests that patients' views can only be achieved when they are present, powerful and involved at all levels. This approach focuses on the less vulnerable decision makers, as Wanless (2002) points out, this may be true for the more articulate patients in our society but not for everyone. O'Connor *et al.* (2009) have evidenced the benefits of involving patients in shared decision making about major interventions, showing that where patients share in decisions about invasive treatments, their wish to proceed with an intervention is often lower than comparable groups who have not shared the decision. While this evidence is specific to invasive intervention decision-making, it clearly evidences that decision making can have a key effect in health care packages. This perspective is shared by Wagner *et al.* (1996).

Public Engagement offered both gratifying and frustrating research opportunities. Undoubtedly there is valuable research undertaken within the field of consumer engagement however engagement specific to localised health and social care integration has been elusive. This perspective is reflected by Sarrami-Fouroushani *et al.* (2014), who used an analysis of substantial meta data to inform their eight-stage model for consumer and community engagement. The model expands on the influential work of Arnstein (1969) who developed a model for consultation which is limited to three main considerations relating to consultation, collaboration and control. While the model still has a valuable place in today's society, its limitations are evident. The difficulties in identifying clear models with which to conduct a critical evaluation suggests a lack of research in this area, or at the very least a lack of focus on the subject matter.

2.9 Technology

Access to information is vital for the delivery of a fully integrated health and social care service. The consequences of not sharing information has been clearly portrayed by the media over many years with high profile cases resulting in the public dismissal of Chief Officers involved in child protection.

The argument of data sharing, data protection and confidentiality rules are neither acceptable, nor defendable when a life is at stake. As a result, the Government has placed great emphasis on addressing information management irregularities and dealing with legislative misconceptions by service providers.

The successful implementation of information systems supporting the vast array of publicly delivered services has been persistently challenged by high failure rates (Kearney 1990, Clegg *et al.,* 1997). Much of the failure to achieve a workable solution has been as the result of the failure in delivering an information systems project which meets all the objectives required. Large scale project management has attracted a great deal of interest over the past thirty years with research produced ostensibly to examine the success factors critical to managing systems development projects (Coombs *et al.,* 2001) and identify best practice models. Clegg *et al.* (1997) accords with the development of best practice but suggests that, despite the existence of a considerable body of knowledge in theoretical models, failures continue. Clegg *et al.* (1997) further suggests that the continued failure of systems may relate to the ownership of the project, acknowledging that in many cases it is the developers rather than the users and user managers who own the system. Continuing the principle that information technology (IT) is seen as the solution, rather than a business solution being identified to resolve the challenge with IT only used as an enabler.

Integrating information technology between the stakeholders will be vital in the delivery of seamless services for the service user. A number of key concerns have been expressed in the ability to fully integrate the systems such as; different networks, security as Local Authorities are required to comply with Public Sector Networks (PSN) accreditation from the Cabinet Office but Health Boards are not. Consequently, the information cannot transcend the two networks without major security development. This has the potential for derailing integration, as a key objective for the Government is to provide services as digital by default. Does the implementation of health and social care require a fully integrated information system (IS) solution?

The main reason for integrating systems is the fulfilment of an enhanced, easily accessible and meaningful communication solution for service providers, service users and third-party suppliers of care. Operationally, an integrated solution provides an accomplished care pathway record for multi-disciplinary team work across the care spectrum (Work and Pawola, 1996; McNamara, 2000).

In the public sector, approaches to delivering IT based information systems solution projects are seen as an opportunity for reducing costs and ensuring there is a return on the investment for the system (Willcocks and Lester, 1999). While these are very valid reasons for providing this form of solution it does not take account of the socio-economic determinants of Government approaches to inclusiveness (Grimsley and Meehan, 2007), although arguably why should it, as the system relates to enabling delivery of a socio-economic approach rather than the approach itself. Moore (1995) conceptualised that the value of such a solution was, beneficial for the service users, based on the tangible strategic outcomes and their experience of the service. Kelly *et al.* (2002) further argue the value of the service must incorporate trust in the user society. The need to maintain data security as identified by Kelly *et al.* (2002) is fundamental to any system holding personal data however, the report misses an opportunity for consideration of joined-up service delivery. Brooks (2002); Christiansen and Roberts (2005); McCormack *et al.* (2008) all point to the inability to share information as a result of incompatible IT systems combined with the discouraging approaches of practitioners to share information contributes to sharing difficulties. Grimsley and Meehan (2007) consider the inherent organisational difficulties in delivering an information system, citing the bespoke requirement of a solution, which requires to consider the political and moral perspective of the stakeholders i.e. the relationship between the service user and the service provider will be determined by statute and professional and ethical codes. Walsham (1999, p.374) sums this up by identifying ‘the main elements in the design of an interpretative approach to information systems should consider’

- **Context** - arises from an analysis of stakeholder assessments, both current and historical.
- **Purpose -** is related to the stage of development of an information system (IS). At the early stage it supports feasibility assessment, during development it feeds back on design progress, and post-implementation it focuses on achievement of goals. For at all stages, purpose is concerned with achieving understanding (preferably shared).
- **Content** - relates to the system goals (functional, economic, human, organisational, social and political), acknowledging that stakeholders will have different perspectives and motives in relation to the project.
- **Facilitation -** requires the interpretive evaluator to assume a number of roles: facilitator of reflection, learner, teacher, reality shaper and change agent.

Avison and Young (2007), argue that the bespoke nature of an information system is in reality not warranted. The development of a system should be considered from the same enterprise perspective as an organisation would consider, when procuring a solution to support business infrastructure such as a payroll solution, the difference being that the solution is not based in one company premises but rather a networked UK wide. Additionally, Avison and Young (2007), suggest the difference between the normal deployment of an information systems solution for other businesses in comparison to the health service lies in the functionality of the information being managed. Generally, information systems support individual areas of work i.e. an individual hospital or clinic, as a UK networked solution the enterprise solution would support a conceptualised UK wide integrated care pathway, joining primary and secondary care to provide a full health and social care solution to information systems. The opportunity for delivering an information system framework based on a UK wide solution would address many of the issues discussed in the literature review and most importantly would provide the opportunity for a unified solution managed on a secure network which meets the needs of the service users and the key stakeholders alike.

There was little evidence of a stand-out key writer or specific debates in the information systems field. One research paper did however concur with the views of interviewees i.e. the need to develop a public sector solution, Avison and Young (2007), simply because the authors were proponents of a scaled UK wide system, which addresses the current convention of localised solutions. The research accords with the approach identified in the research paper, as it is the most effective and efficient approach, although appreciating, not the quickest approach. Other writers in the field of information systems Moore (1995); Walsham (1999); McNamara (2000); Kelly *et al.* (2002); Grimsley and Meehan (2007) offered research information related more to project management and how information should be managed within the context of that field.

2.10 Literature Review: Overview and Conclusions

The literature review initially identified the development of integration, examining the influences of 21st century Government policy making before focusing on considerations of integrated partnership frameworks. Ultimately seeking to identify the issues identified by previous research to develop a contextual background for the next stage of the thesis. It considered the terminology used by different writers and organisations while examining the validity of progressing a partnership approach against the confines of single organisation achievement. The review examined the impact of levels of integration by reviewing structural and systemic integration, raising concerns about concentrating attention towards structural redevelopment without engaging staff in achieving the aims and objectives of integration. Continuing with the development of partnership arrangements, the literature review assessed the different training models necessary to deploy a large scale integrative process, through understanding the needs and training of individuals and the collective.

The identification of topical areas continued with an examination of financial considerations derived from austere funding streams. The governance of integration was examined to identify the effects different leadership qualities and derivations had on the ability to form partnerships and ultimately deliver

the objectives of integration. Strategic influences and the defining of transparent partnerships was examined to understand the impact the different organisations and the key players had in developing a vision for the integration. This led the review to examine the cultural differences associated with the organisation and how the establishment of a board should be undertaken to achieve success by looking at short term and long term goal setting and delivery. A review of service delivery of this scale inevitably requires considerable change and the literature review examines different change models and the benefits and pitfalls of the models. The ability to define change models and use the approach the models offer is commensurate with effective change management. The opportunities associated with considering these models afforded support in the development of the discursive architecture for the interviews. Staff and public engagement is an umbrella consideration which can be associated with change and training, the thesis however considers this as a separate entity within the literature review, exploring and examining the appropriateness of engaging different groups to help them understand the aim and objectives of integration. The review considers the works of different research (Arnstein, 1969, Sarrami-Fouroushani *et al.,* 2014) in developing models again examining their benefits to ensure appropriate approach by the interviewees is considered. Finally, the research draws on the considerations of technology in achieving a successful integration, examining the negativities associated with limited information sharing protocols and systems.

Overall, the integration issues and frameworks identified by Packard *et al*. (2013) and Lyngso *et al*. (2014) established a significant foundation for current research into integration success. These common organisational elements which were identified formed the basis of question development for the discussion topics with the interviewees. In addition, change management was intrinsically linked to each of the elements identified and again helped to identify this as a separate topic worthy of exploration. In summary, the areas which were taken forward for further examination and consideration of the challenges the key actors in integration implementation to be explored during

the interviews included: understanding of integration; governance; collaboration/partnership development, performance, organisational differences, communication, training and extenuating factors.

3. Methodology

3.1 Introduction

This chapter outlines the theoretical underpinning for the research design and methods used during the preparation of the thesis. The aim of this chapter is to provide clarity of the research approach used, the reasoning for the methods applied and to provide justification for the approaches postulated. The chapter is presented in several sections. First the research aim and research questions are conveyed to set the foundation for the chapter. Following on from this, the chapter introduces research paradigms and the rationale for undertaking phenomenological qualitative research before discussing some of the designs that were considered but rejected. The chapter continues with a reflection of the ethical considerations of the data collection, the experiences of the pilot study, sampling methods, data analysis techniques and the approaches which have been followed before concluding the chapter with a realistic view of the quality and trustworthiness of the study.

3.2 Overall Aim

To critically analyse Principal Stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration.

3.2.1 Research Questions

1. What are the experiential perspectives of key senior actors within the policy arena?

2. What are the key challenges considered in the delivery of the legislative objectives?

3. How do the actors understand the importance of other organisations' agendas?

4. What key aspects of partnership working were employed in the implementation of health and social care?

3.2.2 Research Approach

The approach to providing an understanding of the research philosophy for the thesis is built on the considerations of Grix (2010) and Crotty (2012) which helps to clarify the key elements of the philosophical perspective.

Grix's (2010, p.59) proposition that 'ontology is the starting point of all research, after which one's epistemological and methodological positions logically follow''. Figure five sets the scene for the research approach. The initial concept of setting the framework for the thesis is a view substantially held by others. This is established by Crotty (2012) in his research, suggesting that research can follow a 'typical string', with the string dependent on the theoretical perspective considered, while Benton and Craib (2011), add further clarification with a definition, perhaps providing a simplified understanding of ontology, a question 'What kinds of things are there in the world? To set the initial layout for the methodology and to help the reader understand the researcher's standpoint the chapter will be considered in parallel to Grix's research building blocks.

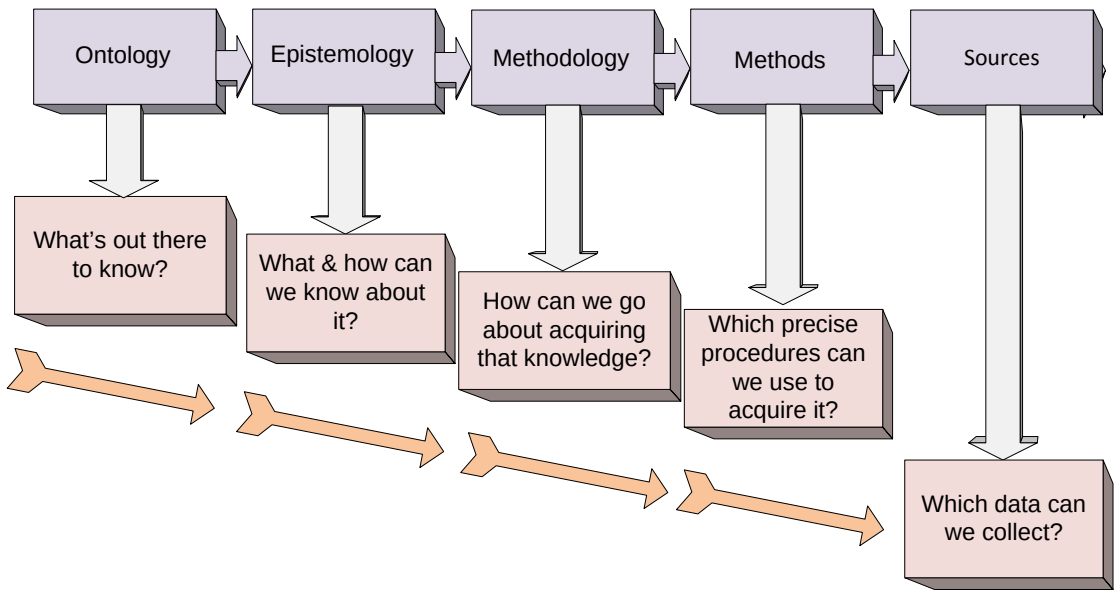


Figure 5: The interrelationship between the building blocks of research (Adapted from Grix, 2010)

3.2.3 Ontology

It is clear that ontology is not easily defined as one specific thing but instead has a meaning that covers a range of understanding. Hudson and Ozanne (1988) describe ontology as the nature of reality, how is reality defined? or as identified by Grix (2010), what is out there to know? Bryman and Bell (2011) suggest there are two questions to be considered when developing a philosophical perspective; should social entities be considered as an objective reality that exists without the external intervention of social actors or should the entity be defined from the subjective social perceptions and actions of social interactions. Their view is that there are two positions regularly referred to as Objectivism and Constructionism. Ritchie and Lewis (2003) offer a similar broad determination of key ontological positioning asking whether or not, social reality exists independently of human conceptions and interpretations; whether there is a common, shared, social reality or just multiple context specific realities.

While arguments will continue to take place regarding the different ontological positions, one clarity exists which is; to develop the research questions fully and to understand the philosophical considerations of the research, the researcher has to understand their own ontological perspective as this will affect the determination and phrasing of research questions, the methods used and interpretation of the data.

Developing an ontological perspective is a reflection of the senses and values that have been built up during one's development of understanding and perceptions. Grix (2010) rightly points out your ontological position is implicit in the way you interact with the world even if you know it or not. Bryman (2012) suggests that social phenomena and their meanings are represented by external facts which can be objectively studied to be understood. This is an objectivist view of external influencers which exist in their own right i.e. the consideration of a social existence devoid of external influence. Anderson (1990: p.268) argues a constructivist worldview is emerging from the objectivist view of an absolute and permanent rightness. Anderson suggests we should see all information and stories as human

creations that fit, more or less well with our experiences in a mysterious universe, regarding what we find from these experiences as our search for the truth and knowledge and values of the people of our time. Focusing clearly on the human experiences strategically links to the research undertaken. For the research a constructivist ontology has been taken which sits well within the aim of the thesis, which seeks to critically analyse the perceptions of Principal Stakeholders.

3.2.4 Epistemology and Axiology

Following on from Grix's (2010) assertion that everything logically flows from defining one's ontology, the next natural step is to look at the thesis' epistemological position. Benton and Craib (2010: p.233) describe epistemology as the philosophical enquiry into the nature and scope of human knowledge, concerned with distinguishing knowledge from belief. This is echoed by Bryman and Bell (2011) who posit an epistemological issue concerns the question of what is (or should be) regarded as acceptable knowledge in a discipline. This is simplified further by Grix (2010) who contextualises ontology and epistemology by recording; If ontology is what's out there to know then epistemology is what and how can we know about it.

Easterby-Smith *et al.* (2008: p62) consider that knowledge is based on facts and these can be considered in different ways; positivists assume that facts are concrete but cannot be accessed directly, while the subjectivist interprets facts as 'all human creations'. Of course, an epistemological stance is not purely defined by positivist or subjectivist considerations, there are a multiplicity of views which can be considered. One such contrasting epistemology is Interpretivism. Bryman and Bell (2011: p.17) identify that Interpretivism is predicated upon the view that a strategy is required that respects the differences between people and the objects of the natural sciences. Guyer (2010) identified with Kant's critique of pure reason (1998) when he proposed that perception of the world relates not only to the senses but to human interpretation of what our senses tell us. Throughout this thesis, the design used to understand the experiences of the interviewees is taken from an interpretivist stance. Specifically, the leadership

considerations of implementing health and social care are reflective of the views of Grint (2000) who determines that leadership is involved with shaping the way that organisational problems are defined and persuading others that the definition is correct. A view shared by Blaikie (2009: p. 93) who asserts that social reality is made up of shared interpretations that social actors produce and reproduce as they go about their everyday lives. Interpretivism is an ideal stance for the consideration of health and social care and the research undertaken to contribute to the thesis through peoples lived experiences.

Hartman *et al.* (2011, p.6) describes axiology as the value realm, through which the feeling for value becomes rationally structured, while Creswell (2007 p.17) suggests axiology is understood to ask, 'what is the role of values?'. It is clear that while axiology is aligned with understanding values, Becerra (2009, p. 85) considers the notion of value is hard to put into practice for empirical analysis as the concept of value measures is personal and specific to the context in which it is being considered. This may arguably be the case however; axiology still has a place in research as the values of the researcher still play a key role in the research being undertaken. The perspective of the value in the thesis is undertaken from an emancipatory perspective. Emancipatory, in the context that the researcher is identifying with the difficulties of implementing a legislative approach which conceivably will change the service of long established organisations. The researcher is therefore offering opportunities for the interviewees through the freedom to provide their experiences without boundaries.

3.3 Methodology

The design used for the thesis has been developed to provide a voice to the interviewees within a phenomenological design, which is concerned with the detailed examination of human lived experiences (Smith *et al.,* 2009, p.33). This approach will allow the thesis to provide an in-depth consideration of the experiences of the senior managers involved in delivering the objectives of health and social care integration. The research aim and objectives are delivered through the researcher's comparative understanding of the

meaning of each stage of the conversations derived from the lived experiences of the managers. The section which follows outlines the selected phenomenological approach which, to help the reader understand the development of phenomenology, includes background information of the considered academic work of proponents of phenomenology before moving forward with detailed consideration of the research approach appointed.

3.3.1 Phenomenology

Husserl (1982) is often credited as the founding father of the phenomenological movement (Dowling, 2007, Giorgi, 2004) and his considerations that we should venture to focus on each and every particular thing in its own right have encouraged much debate about the semantic and linguistic meanings that make social understanding possible (Van Manen, 1990). This provides the opportunity for the researcher to be more reflective of their perception of the phenomena being considered. Smith *et al.* (2009) aptly describe Husserl's approach to developing a state of mind which allows for the 'identification of the core structures and features of human experiences'. Husserl (1982) considered that in order to reach the deeper understanding of the phenomena, the researcher has to 'bracket' out the taken for granted considerations of our understanding of the everyday world. Bracketing in Husserl's (1982) view is affiliated to the approach taken by mathematicians when bracketing out, the 'taken for granted' elements of a formula. By achieving this, the researchers allow themselves the opportunity to consider their perceptions of the world using a more transcendental and philosophical approach to reduce their view of the data being considered to focus on the very essence of their experience of the phenomena considered. Ultimately, phenomenology is concerned with achieving the truthful essence of an issue, describing the phenomena as they appear to an individual's consciousness (Moran, 2000).

Heidegger (1962), a proponent of phenomenology and a student of Husserl (1982), offers a temperate approach to Husserl, believing that historical and cultural context must be considered in understanding the phenomena and appreciating the pre-knowledge and understanding of the researcher in

achieving the meaning associated with the phenomena (Romanyshyn, 1984). Heidegger's approach to phenomenology referenced the need for observational facts about people's existence or their mode of 'being in the world' [Dasein]. Heidegger's (1962) observations were hermeneutic in approach, characterised by a continuous movement encircling the data and the whole (Leonard, 1989).

Unlike Husserl's method of drawing on the researcher's imagination to vary their approach to visualising phenomena in a multi-dimensional way, Giorgi (1975) provides a four-stage model for considering phenomena rather than searching for the variations in the researcher's imagination. The model consists of developing an understanding of the whole data while 'bracketing' the researcher's beliefs from previous experiences to prevent pre-judging the data. Secondly, 'meaning units' are determined thus breaking the data down into considered areas for further interrogation during the third stage where final themes emerge from an ordered and systematic review of the data. The final stage is to develop the remaining themes further by describing them in relation to the specifics of the research subject. Of course phenomenology is not only principled by Huserl, Giorgi and Van Manen, a number of established academics have articulated a phenomenological approach including Ashworth (2003); Todres (2007); Dahlberg *et al.* (2008); Finlay (2008) and Halling (2008). While phenomenology offers an alternative to the absolute positivists it very much offers a philosophical understanding which is not an enigma to the majority of the population as Halling (2008, p.145) suggests 'In everyday life each of us is something of a phenomenologist insofar as we genuinely listen to the stories that people tell us and insofar as we pay attention to and reflect on our own perceptions'. With this approach in mind, phenomenology was ideal for the design for the research thesis. It allowed the researcher the opportunity to examine in greater depth the multifaceted elements of the expressive discussion flowing from the interviews. This allowed a deep understanding, with greater clarity of how they perceived, related to and achieved meaning from the perceptions of the managers in consideration of the challenges they faced in achieving integration.

It would be wrong to suggest that phenomenology was the only considered research design. Like many early career researcher's, the opportunity to consider various designs is significant as knowledge of the different designs is built. It would be impossible, given the scope of the research to detail each of the designs considered before favouring phenomenology however the reader may benefit from a brief acknowledgement to previous considerations. This reflection is advocated by Brewer (2007) who suggest the importance of conferring legitimacy of the knowledge developed and minimising challenge of the approach adopted.

3.3.2 Critical Realism

Critical realism was initially considered a favourable design for several months. The initial appeal of an approach which identifies with the subjective-objective dichotomy (Edwards *et al.,* 2014) of understanding knowledge was an orthodoxy too opportunistic to miss. The basic assumption of critical realism is the existence of a real world independent of our knowledge of it (Andrew and Collier, 1994). Many forms of realism exist, with their own individual philosophical standpoints however critical realism is specific. Bhaskar's (2008) view therefore considers that social influences do have a role to play in reality and we will only be able to understand the influence that role has if we understand the structure behind why these things happen. As a greater depth of understanding developed, the critical realist approach became less appealing. Discursive text relating to discourse analysis (Wetherell, 1998; Riley, 2002) became unconceivable and the nature of the analysis, with a greater focus on understanding the subject rather than understanding the opportunities for change which would be undertaken identified less with the aim and objectives of the research.

3.3.3 Grounded Theory

Grounded theory shares elements of the approaches used in phenomenology insofar as its approach to developing and identifying theory from collected data and understanding the phenomena are considered. Following emergence of the concept of grounded theory by Glaser and Strauss (1967), the approach, according to Bryman and Bell (2011) has become one of the most widely used frameworks. While the basic principles

of grounded theory were initially established by Glaser and Strauss, it is important to note that the theory has been subjected to different interpretations which have largely reviewed the positivistic and interpretivist allegiances of the theory. Contesting the original method of grounded theory and its leanings toward positivism, Charmaz (2006) contests that grounded theory is interpretive in its design as it emphasises 'the language, meaning and action and counters the mechanical application of the method' (Smith, 2015, p.56) As Bryman and Bell (2011) note the competing definitions of grounded theory, offer valuable insight into the differing views of the theory but make it less appealing as the presence of the competing accounts leaves it difficult to characterise the theory let alone apply the design in a definitive way. As such, whilst grounded theory may have offered a design at different stages of consideration of the thesis approach, it is difficult to justify the application of grounded theory when considering the exploratory examination of the experiences of key actors. For this reason, grounded theory was rejected.

3.3.4 Research Approach

Crotty (2012) similar to Grix, identifies the need to consider the methodologies and methods being employed in the research in order to justify the approach taken. Crotty's approach, please see Figure six below, begins with epistemology and follows through to the methods applied.

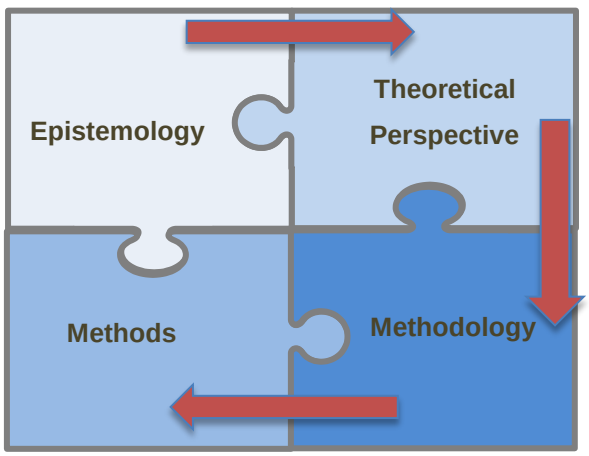


Figure 6: Four dependent elements of research

(Adapted from Crotty, 2012)

Whilst the thesis has previously discussed the epistemological and theoretical perspectives, together with the phenomenological design, it is important to further clarify the researcher's approach to defining the methodologies and methods used. The following discussion will help provide the reader with the understanding used in the thesis.

Continuing with Grix's five stage model and acknowledging the influences of Crotty's four elements approach, the thesis turns to consider the question of qualitative or quantitative approach. Bryman and Bell (2011) suggest the distinction between qualitative and quantitative is ambiguous because in doing so, it purports a fundamental contrasting position for some while other consider the difference as false. Bryman and Bell offer their identifiable differences between qualitative and quantitative research strategies below at Table two:

	Quantitative	**Qualitative**
Principle orientation to the role of theory in relation to research	Deductive, testing of theory	Inductive, generation of theory
Epistemological orientation	Natural science model in particular positivism	Interpretivism
Ontological orientation	Objectivism	Constructionism

Table 2 Fundamental Difference between quantitative and qualitative research strategies

(Adapted from Bryman and Bell, 2011)

Bryman and Bell's (2011) interpretation of the difference focuses on quantitative emphasis the quantification of the collection and analysis of data while, qualitative emphasises the wording of the collection and analysis of data. Silverman (2009) considers the specific understanding of how previous writers have conducted their research should be considered when the researcher is developing their own approach. By doing so, the researcher stands to gain a greater insight into how subject knowledge has been built, understood and how the research findings can be used to further develop knowledge. There is limited research of the subject within the context of the

Scottish approach however, academic offerings relating to the approach undertaken by English and foreign integration programmes favours qualitative research. Both qualitative and quantitive methods offer the opportunity for rich data however, as the researcher developed a greater understanding of Interpretivism and phenomenology, the consideration of a mixed methods approach became undesirable. Further, the desire of the researcher to undertake research which examines the experience of the key players in health and social care integration lends itself towards a qualitative approach. During the development of the approach, throughout the study years leading up to the research being undertaken, the researcher did consider the possibility of mixed methods, again though as understanding developed and further reading of previous approaches was undertaken the need to focus on a qualitative approach became clear.

Willig (2011, p.8) identify that 'qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry'. This view is considered from a perverse interpretation of what qualitative research is not by Strauss *et al.* (1998, p.11), according with Bryman and Bell (2011) who define qualitative research as 'any type of research that produces findings not arrived at by statistical procedures or other means of quantification'. While Ritchie and Lewis (2010, p.4) offer perhaps a more detailed simplified breakdown of qualitative research from a methodological stance perspective, as detailed at Table three below. Ritchie and Lewis (2010), drawing on the work of Immanuel Kant (1998) continues to greatly acknowledge the researcher's own abilities to interpret the phenomena being studied and to understand the social world surrounding them.

Perspective of the researcher and the researched
• Taking the 'emic' perspective i.e. the perspective of the people being studied by penetrating their frames of meaning • Viewing social life in terms of processes rather than in static terms • Providing a holistic perspective within explained contexts • Sustaining empathetic neutrality whereby the researcher uses personal insight while taking a non-judgemental stance
Nature of research design
• Adopting a flexible research strategy • Conducting naturalistic inquiry in real-world rather than experimental or manipulated settings (though methods varying the extent to which they capture naturally occurring or generated data)
Nature of data generation
• Main qualitative methods include: observation, in-depth individual interviews, focus groups, biographical methods such as life histories and narratives, and analysis of documents and texts
Nature of analysis/interpretation
• Based on methods of analysis and explanation building which reflects the complexity, detail and context of the data • Identifying emergent categories and theories from the data rather than imposing a priori categories and ideas • Respecting the uniqueness of each case as well as conducting cross-case analysis • Developing explanations at the level of meaning rather than cause
Nature of outputs
• Producing detailed descriptions and 'rounded understandings' which are based on, or offer an interpretation of, the perspectives of the participants in the social setting • Mapping meanings, processes and contexts • Answering 'what is', 'how' and 'why' questions • Consideration of the influences and the researcher's perspectives

Table 3 Methodological stances associated with qualitative research (Adapted from Ritchie and Lewis, 2010)

3.4 Ethical Considerations

Throughout the research, the principles contained within the university's research ethics and governance procedures have formed the approach undertaken by the researchers. In addition, the researcher has also applied the three basic principles of House (1990) when considering ethics:

- Mutual Respect – understanding others' aims and interests, not damaging self-esteem, not condescending.
- Noncoercion or nonmanipulation – not using force or threats or leading others to co-operate when it is against their interests.
- Support for democratic values and institutions – commitment to equality and liberty, working against oppression and subjugation.

These principles concur with the views expressed by Sieber (1992, p.18) who suggests her core principles when considering ethics should include:

- Beneficence – maximising good outcomes for science, humanity, and the individual research participants while avoiding or minimising unnecessary harm, risk or wrong.
- Respect – protecting the autonomy of (autonomous) persons, with courtesy and respect for individuals as persons. Including those who are not autonomous (e.g. infants, mentally ill, senile persons).
- Justice – ensuring reasonable, nonexploitative and carefully considered procedures and their fair administration; fair distribution of cost and benefits among persons and groups (those who bear the risk of research should be those who benefit from it).

In this study, the principles suggested by House and Sieber have been fundamental to the research interview approach. The research sample comprised senior managers of three distinct but related organisations which included three Local Authorities, two Health Boards and the Scottish Government. When considering the principles to be applied, as detailed above, the following approach was practiced.

3.4.1 Mutual Respect/Respect

Each of the interviewees was supplied with a copy of the University's research consent form (attached as Appendix one). The form clearly indicated the approach which was to be applied during the interviews and importantly how the data gathered would be used. Each participant was offered the opportunity, at the beginning of the recorded interviews to withdraw from the process at any stage if they considered the approach being taken compromised their values, professionalism, integrity or placed them in a position of concern in their current or future careers.

3.4.2 Noncoercion or Nonmanipulation/Justice

Each of the interviews were conducted in a relaxed atmosphere, generally within the participant's own office, with the exception of two interviews, where the participant arranged the meeting in a purposely prepared interview room. All interviews were held with only the interviewee and the interviewer present and the approach was relaxed without any stress or uncomfortable questioning of approach. The questions for the semi-structured interviews were provided several weeks in advance of the interviews and all participants were given the opportunity to withdraw any of the questions they did not consider to be appropriate or comfortable with. Assurances were provided to the participants that no right or wrong answer was being sought. The researcher was purely interested in their experiences of integration. No interviewee asked for any of the research questions to be withdrawn. A copy of the discussion topics can be found at Appendices two, three and four.

3.4.3 Support for Democratic Values and Institutions

The researcher has worked within public service organisations throughout his working life, as such the researcher is aware of the politics involved between the organisations involved. To ensure, the political differences of the participants did not heavily influence the interviewees, the questions were designed to minimise these concerns. Fisher (1993) considers the researcher should be aware of the responses provided by participants who have a desire to present themselves and their responses in a way which provides the best response rather than the appropriate response. It would

however, have been inappropriate for the researcher using phenomenology to try to manipulate the responses during the interview and the natural journey some of the questions took to ensure no organisational political bias was apparent. To this end, there was some responses which were distinctly critical of other parties. The findings and discussion chapters have been carefully analysed and written to ensure full consideration of this principle is applied.

3.4.4 Beneficence

Contributing to the academic knowledge of health and social care integration is a vital commodity of the research, not only for the researcher but for the interviewees who gave their time freely and supportively to ensure the research would fundamentally be well positioned to provide this outcome. The researcher therefore has a burden of debt to the interviews which will be repaid through the provision of a quality research study.

The preceding sections have provided the reader with details of the research philosophy being applied together with a detailed discussion of the methodology. The next section is aimed at providing an insight into the processes applied when conducting the study. This will help the reader to understand how data was collected, the sampling techniques applied and the analysis conducted. Additionally, the section will also consider the benefits of the pilot study and the lessons learned from the study which have helped to develop the approach applied

3.5 Process of Conducting the Study

This section is aimed at clarifying the data collection method ensuring the reasoning for selecting the methods used are clear and the rationale behind selection of the methods is understood. The section will begin with identifying the data collection method used, detailing the reasoning behind the selection of the method before progressing through the sampling approach determined and finalises the chapter with a discussion of the data analysis framework used.

3.6 Data Collection

3.6.1 Identified Method

When considering the data collection approach a number of practical considerations required to be understood. The key concern outweighed all other considerations, which was; health and social care in Scotland is relatively new and a narrow field and the initial concern was therefore was there the potential for the subject matter to provide enough data to validate the research. While this initially became a real focus many discussions both with the researcher and others, it was appreciated concerns were unfounded.

Mason (2002, p.53) considers the formative stage of evaluating and using data sources are ones which require practical consideration, namely:

- What am I interested in?
- Where is it located and therefore from which potential resources can I generate knowledge of it?
- What do I expect these sources to be able to tell me?
- How well does the use of these data sources match my philosophical stance?
- What are the practicalities of using these data sources?
- What are the ethics of suing these data sources?

It is with these considerations in mind the research approach was considered and addressed throughout this chapter. The research being undertaken is firmly rooted in health, and the opportunities of improving the way health and associated services are provided in an integrated way. When considering the subject, a key element was to identify an approach which would permit the examination of the experiences associated with integration. This being the case, the researcher was more interested in the ‘how’ questions rather than in the ‘how many’ questions. Holstein and Gubrium (1995) suggest, in order to encourage the participant to invest fully in the interview, it should be treated like a conversation where the interviewer should not be passive and distant. The opportunity to therefore gather rich data (Patton, 2005) from

senior managers who are able to express their perceptions and experience was vital to the research as the understanding of the information is made more valuable when the interviewee is observed during the process (Richards, 2009). When considering the topic, this view is shared by Baum (1995, p.463) who, in relation to health, considers the power behind such data allows for 'an understanding of the context issues that have become the concern of public health in recent years'. Additionally, as noted by Silverman (2009, p.13) if a type of research method is commonly used within your field, does it 'pay to swim against the tide'. Blaikie (2009) notes the involvement of an interviewer in qualitative research, identifying the requirement for an extended intensive period of involvement while the interviews are arranged and conducted. While Salkind (2011) raises concerns regarding the ancillary elements of semi-structured interviews, including time taken for transcription which may not only involve time but a substantial cost, coding and analytical understanding of the data, and for a researcher funding their own research, the potential cost involved in enabling the interviews to take place. Despite these concerns, the method which suited, not only the approach, but also one which the researcher considered offered the opportunity to become engaged with and part of the data collection was an interview. The continued approach was to focus on conducting the interviews in a semi-structured way, as this allowed for 'a certain degree of standardisation of interview questions and a certain degree of openness of response by the interviewer (Wengraf, 2001, p.62). The semi-structured interview provided a number of advantages and challenges From a positive perspective, these included as examples; the opportunity to explore responses in a more discursive way, challenging perspectives where they were contrary to common practice or views, ensuring clarity of the interviewees point was made and observing the interviewee as they discussed or emphasised their views. Conversely and in a negative way, the approach allowed for influences to be considered; for example, the temptation to lead a conversation based on existing knowledge or views required to be tempered or trying to make a connection with previous comments and leading the interview to confirm existing data required to be understood and managed. Specifically, elite interviews were

employed to ensure that the voice of the principal stakeholders of this change were clearly understood.

The opportunity to carry out elite interviews with the Chief Officers involved with this research also carried a number of advantages and challenges. From a positive perspective, the data collection process was benefitting from the views and comments of a group of individuals who were not only the principal stakeholders within their individual organisations but were highly regarded by the health and social care community. This was evidenced by one participant within the Scottish Government who highlighted key people to discuss the research topic with, within other organisations. Time and again, the names of the individuals previously selected for interview were identified. The Chief Officers, in addition to their knowledge of the subject had been vital players in shaping elements of the legislation, offering their views at Government led seminars and returning information to the Government through white paper recommendations. In the main, this was a group of dynamic individuals who between them had an average of over 30 years of experience in their particular field of knowledge. One of the main challenges with interviewing such an elite group was keeping the individuals on topic. As their knowledge was considerable, they would often stray from the point being questioned to discuss other, often unconnected elements of health and social care. The challenge was therefore to maintain the focus. Additionally, as this was a group of very senior staff, they are, in the main, used to dominating the conversation and direction. The officers did not take challenge easily when a point was raised that they had very strong views about. These challenging situations were also opportunities as it provided an opportunity to enhance research skills and practices for future interviews.

As eluded to previously, the semi-structured interview method is not without concern; the assurance that the participants are credible and can offer different reflections and even contending perspectives should be complicit to support the validity of the research (Rubin and Rubin, 2004). Relevance is also a considering factor in the research (Meara, *et al*. 1989) suggest the need to be observant of the interviewees desire to be informative and

relevant to the questions being considered. Norenzayan and Schwarz (1999) also suggest that the interviewees own philosophical stance may also have a significant bearing on how the participant responds, while Goldfried (1964) note the desire of participants to offer a favourable image of themselves which they may wish to be portrayed. To counteract some of these concerns, the participants were asked several questions in slightly different ways throughout the interviews to understand if the significance of their response changed and to ensure they fully understood the question. Additionally, the participants were offered the opportunity to review their transcribed interview to provide them with the chance to amend their responses – no participant accepted the offer.

3.6.2 Rejected Methods

The other main method which was rejected as inappropriate for the research being undertaken was focus groups. Focus groups were rejected for several reasons; the main reason was the researcher's desire to understand the individuals' experience of integration without hindrance. Health and social care integration is still at an early stage and consequently many Integrated Boards are still grappling with their approach. As such, it was considered by the researcher and arguably evidenced by the data provided through the interviews that the freedom to divulge their experiences in a private and sensitive setting, without consideration of commentary or potential reprisals was valued. Some of the participants offered very different views relating to the supportive nature of colleagues, as such a focus group may have stifled the conversation considerably. Additionally, and importantly, the senior managers involved in the process were extremely busy. The ability to timeously co-ordinate their diaries for a one to one interview was challenging. The opportunity to co-ordinate their diaries for a focus group interview would have been virtually impossible.

3.7 Sampling

Miles et al. (1994) suggest the approach which is usually accepted when undertaking qualitative research relies on a smaller sample of people to understand the context of the phenomena in more detail. They consider the natural approach for qualitative sampling tends to be purposive rather than

random as samples are selected to suit the requirements of the specific phenomena being considered. Silverman (2009, p.141) consider the purposive sampling choice is not an easy selection as it 'demands that we think critically about the parameters of the population we are studying and choose our sample case carefully on this basis'. Blaikie (2009, p.178) clarifies the selection process further by suggesting it is a 'matter of judgement' for the researcher to determine the sample from the most appropriate pool. Blaikie (2009) further suggests the opportunity to select based on contrasting outcomes e.g. successful and unsuccessful organisations. Qualitative research is dependent on the quality of the information derived from the survey participants, their subject knowledge and their ability to share information in an unfettered way. The initial determination of the subjects who will be part of the project is therefore vital to a successful outcome. This accords with the approach being undertaken as samples were chosen for their differing stages of development and the individuals' knowledge and understanding of the thesis subject i.e. their involvement in health and social care integration at a strategic level.

It is perhaps appropriate at this stage to note that the research is concerned with the experiences of the key actors in health and social care in Scotland. This focuses attention on a strategic layer of senior managers within the participating organisations who were able to offer narrative on the challenges associated with implementation. It is important for the reader to understand the pool of participants is narrow for this group as only 31 Integrated Joint Boards exist (Scottish Government), with eight of the boards working in multi-partnership arrangements with Local Authorities, narrowing the field of NHS Boards further to 14.

3.7.1 Sampling Process

At the time of the preparation for the research, background information showed that all joint boards had been established, although many were at different stages of development. In some cases, this may be attributed to the differing timeframes associated with the recruitment of Integration Chief Officers. It was apparent from pilot research gathering that selecting officers

from those involved with health and social care integration would not be an easy task. The desire to interview many officers was outweighed by the scope of the research, the time available and the funding available to travel to and from interviews if the participants were located in geographically restrictive locations. The need to funnel down the selection of officers was required and an approach which could be achieved within a timeframe which suited the main research had to be established. Searches of the web and contact with colleagues from different organisations helped to provide access to background information relating to key officers involved in each integration board. Access to joint board websites (where accessible) assisted with the provision of minutes of board minutes which further helped to understand the different stages of integration transition the boards were at. Discussions with a key officer within the Scottish Government also assisted in clarifying the detail behind perceived stages of development and information from the Government funded Data Sharing Board supported the information gathered. Using the information, the approach which was adopted was to initially filter the information based on two of the research questions which were:

1. What are the key challenges considered in the delivery of the legislative objectives?

2. What key aspects of partnership working were employed in the implementation of health and social care?

By considering these questions within the context of the information gathered, seven organisations emerged as potential participating organisations where contrasting views were evident and the different stages of development were clear. Of the seven organisations, two did not respond to any contact with the researcher, which meant that five organisations became the focus of the research. Particular joint boards (the research will not name the organisations to maintain anonymity of organisations which may be included in the research) which were perceived as successful early adopters of partnership working immediately attracted interest. The establishment of a partnership is arguably seen as an indication of the organisations' willingness to proceed with an integrated solution. The literature review provided a clear indication of areas for consideration with

Mason *et al.* (2004) advising of the need for successful partnership working to exist at a senior strategic level for organisational success. Hunter (1999) meanwhile, suggests that partnerships help to deliver greater financial management through devolution of budgets, decision making and the pooling of resources in a bid to make sure the service receiver achieves a service they need, not one which is foisted upon them by disjointed provision. While partnerships alone will simply not develop a successful allegiance Abbot *et al.* (2008) suggests the partnership effect of the board roles lead to a method of working which embraces a climate of high trust and high challenge.

Following on from the determination of the organisations, the next stage was to select the most appropriate participants. Information relating to the individuals who were members of the Integrated Joint Boards was readily available for the organisations and as the nature of the research was to focus on the strategic involvement of the partners, many of the partners would have been suitable. Some potential participants immediately declared themselves unavailable for interview again narrowing the potential number of participants. As previous experience was a considerable factor in determining the final choice, a selection of key actors were contacted to request participation. Twelve of the 13 participants contacted for interview responded positively and were gratefully accepted on to the research.

The next section provides information relating to the organisations and the Chief Officers that participated in the research. The organisations and participants are not named to maintain their anonymity. The information is therefore brief in detail.

3.8 Research Organisations

Five organisations participated in the research, with three of the organisations linked to the others either through partnership arrangements or through organisational support.

3.8.1 Organisation One - One Participant

Three senior individuals were contacted to participate from this organisation. One was available to support the research and was very supportive in the

giving of their time, energy and information. The Chief Officer had substantial experience in health and social care and had over 25 year's experience with the organisation and its predecessors at a senior level. The interview was conducted in the Chief Officer's own office in a very relaxed atmosphere. From the outset of the interview it was clear that the officer was very passionate about the work they were involved with and wanted to make a success of the integration agenda. The officer was very knowledgeable about many aspects of the research topic and provided clarity about the research the organisation had been involved with to progress their approach. The organisation is substantial, divided into many different divisions and has a workforce in excess of 30,000 to deliver the range of services it provides.

3.8.2 Organisation Two – Four Participants

Five senior individuals were contacted to participate from this National Health Service (NHS) organisation. Four were available to support the research which offered an array of knowledge and understanding of the subject. Each participant was a member of the Integrated Joint Board and was very aware of the challenges the board were facing in undertaking an integrated health and social care service. Two of the participants were based within the organisation's headquarters and had extensive careers within the NHS, mainly within their incumbent organisation, one was based within a separate administration building and the remaining officer was located in a community office. Again, both officers had been NHS staff throughout their working careers. Three of the meetings were conducted in the Officer's own offices with the remaining interview held in a purpose-built interview room. Similarly, to the situation described in the first organisation, all participants were very supportive of the research and were keen to express their views of the challenges that have been faced and will require to be overcome. The organisation is a substantial organisation with a workforce of around 8,000 staff across a range of divisions offering a variety of services to the public. The organisation has an annual budget in excess of £420 million. The organisation provides services to several geographically based joint boards.

3.8.3 Organisation Three – One Participant

Four Chief Officers were asked to participate in the process, two were on leave at the time of contacting and later responded to say they did not wish to participate, the remaining Chief Officer, an NHS member of the joint board, who did participate was very thorough in their approach and freely discussed the challenges which the organisation was encountering as they implemented an integrated programme. Correspondence with the officer to arrange the meeting was excellent and a very early date was provided which assisted with scheduling other interviews. The officer arranged the meeting in one of the organisation's meeting rooms at their headquarters. The organisation is a substantial organisation with a workforce of around 8,500 staff across a range of divisions offering a variety of services to the public. The organisation has an annual budget in excess of £700 million. The organisation provides services to several geographically based joint boards.

3.8.4 Organisation Four – One Participant

Two Chief Officers were initially asked to contribute to the research with only one responding. The Chief Officer had a great deal of experience in providing social work services and had worked for several Local Authorities in Scotland and England during their c. 30-year career. The officer was very clear in their account of the challenges however; they were hesitant to discuss some areas in detail. This was not expressly stated though the responses during the topical discussion were less detailed than those provided for other responses. The interview was arranged in a mutually convenient location to suit the researcher and the participant and the surroundings afforded a relaxed atmosphere through. The interviewee was keen to support the research and welcomed the opportunity to contribute to the development of research for future integration programmes. The participant is based in an organisation which has an annual budget in excess of £250 million and a workforce of c. 7,000 employees.

3.8.5 Organisation Five – Five Participants

All Chief Officers who were invited to contribute to the research accepted the offer and participated in one to one interviews. Experience of the officers

ranged considerable with two at a very senior level within the organisation and the remaining four at Senior/Chief Officer level. All staff were based within the organisation's administration and social work headquarters. One Chief Officer had multi-disciplinary public service experience having worked for both Local Authorities and the NHS. The remaining officers provided a wealth of social work knowledge. All officers were extremely candid throughout their interviews for which, the researcher is very grateful. All interviews were arranged in the participant's offices providing a comfortable relaxed atmosphere. One interview was reduced by 30 minutes as an unexpected situation arose during the interview. The offer of a further session was provided but was not required at that stage. The participants are based in a Local Authority organisation which has an annual budget in excess of £300 million and a workforce of c. 7,000 employees.

At the time the research was conducted, both Local Authorities and NHS boards had recently submitted their business plans for their joint boards and were actively participating in progressing the integration agenda.

3.9 Pilot Study

An initial pilot study, involving seven participants was undertaken during April/May 2015 using a semi-structured interview approach to test the questions developed from the literature review. Each of the seven participants were Chief Officers within two distinct organisations; one Health Board and one Local Authority. Both organisations had a historical partnership arrangement and were participating in the development of an interim joint integration board at the time the interviews were conducted. The Chief Officers therefore had experience within integration at an early stage of the health and social care integration agenda. The thesis at the time of the interviews had a focus on developing a technical solution for health and social care integration and therefore much of the discussion related specifically to technology, especially where the interviewees' disciplines were information technology focused. Consequently, some of the data collected during the initial pilot interviews did not transfer to the subsequent interviews and was therefore unable to be used. This explains why in the chapter to

follow, reference is made to 12 interviews but not all interviewees are quoted within the findings chapter.

The pilot study also provided the opportunity to test the method being used, to determine the benefits and negativity associated with a semi-structured interview approach and trial various questions, the order in which they were asked and the relevance to potential outcomes. One of the main benefits of the pilot study was to allow the relaxation into the role of the researcher, to become more familiar with the approach and to gain confidence in not only asking the questions but how to handle circumstances which may have arisen. Finally, the opportunity to conduct an analysis of data and consider connections to themes emerging from literature was significant.

3.10 Content of the Interviews

Following the interviews, the research questions were altered to suit the direction the researcher was keen to progress, focusing the research towards the operational challenges of health and social care integration away from information management and the technical challenges of sharing data between the organisations. This approach was agreed during several sessions with the researcher's supervisors. At this stage the aim and objectives of the research was adjusted accordingly and a refocus of the literature undertaken. The changes to the research represented a considerable undertaking for the researcher however the opportunities for developing the research to understand health and social care integration from a strategic perspective were significant and worthy of the decision. It is worthy of note that some of the areas for discussion during the pilot study were transitioned research interviews and provided a rich data set for analysis. To ensure the discussion topics supported the outcomes of the literature review and to correlate with the aim of the research, three sets of guiding questions were developed which related to the disciplines of the participants. A copy of the questions is available at Appendices 2, 3 and 4. The questions were divided into targeted subjects. These were:

- An understanding of the construct of health and social care within the organisation.
- The key characteristics of the organisations' roles and their partners' roles in implementation
- The development of the board and the support role of key players.
- The challenges associated with partnership/collaborative working.
- The approach to managing change within the organisation.
- The success and risk factors associated with integration.

The questions were developed as guidance for the interviewees in understanding what the subjects for discussion would be to allow the participants to prepare for the interview, additionally, as the researcher is not a career researcher, the comfort of having discussion topics for the interview was supportive. Questions were designed to open up discussion around the topics with the initial questions aimed at relaxing the participants in order to draw out greater detail as the interviews progressed.

The type of questions at the beginning of the interview helped position the participant in the research by providing answers to questions such as 'What is your role within the organisation?', What has been your involvement with health and social care integration? As the interviews developed, the questions were aimed at providing greater detail and focused clearly on challenges, approaches, outcomes and lessons learned e.g. 'What do you see as the role of the organisation(s)?', 'What have been the challenges of bringing the organisations together within a Board?', 'What cultural differences have existed?'. The semi-structured approach to the topics created an opportunity for the discussion to flow, which in many cases moved on towards the questions which had been prepared. Time management and maintaining focus on the discussion topics was an issue with some of the interviews and it was a challenge at times to refocus the discussion away from the interviewees' comfort zones without negatively affecting the interview. In essence though, this rarely occurred and where two interviews slightly overran the agreed one-hour slot, the researcher ensured the participants were comfortable with the additional time. The initial

interview was with a Chief Officer who the researcher had met several times at business meetings. It is wrong to say the researcher knew the interviewee in detail however, the initial acknowledgement of their previous meetings allowed the researcher to use to effect different interview techniques such as Rubin and Rubin's (2004) probing approach. One example of this was a participant switched from one subject to another during the interview and failed to return to the original discussion. The researcher continued to elicit the required data by saying 'Earlier we spoke about…., can you tell me more about the issues this caused for you?'' As the interviews drew to a close, the researcher reminded each participant of the aim of the research and asked if they considered any particular area had been excluded which they felt relevant. No participant suggested any further topics or questions to consider however one Chief Officer helpfully provided the names of several other potential participants who may prove helpful in providing their perspectives. Interestingly, after concluding the interview one individual Chief Officer opened a separate discussion to raise a critical observation of the integration process which they chose not to discuss during the interview. The participant later admitted that they felt more comfortable discussing their concern 'offline'. The researcher thanked the participant for their views and reminded them of the ethical code the research was conducted within.

3.11 Data Collection

Data for the research was facilitated using the following approach:

3.11.1 Stage One

An introductory email was sent to the desired participants which provided background information relating to the researcher, the aim and objectives of the research, the ethical approach to be adopted, the topical areas the researcher would like to discuss together with the anticipated timescale for the research. A copy of the email is included at Appendix five for reference. The email asked participants to contact the researcher to discuss the study in more detail and to arrange a suitable time and location for the meeting. Each of the Chief Officers who agreed to take part in the research were extremely courteous and supportive and contacted the researcher without further prompting. This limited the follow up process to seven selected officers who

did not respond to the email. A second email was delivered to the officers and despite, read receipts being received it was considered the officers were unwilling to participate and it would not be appropriate to request further support.

3.11.2 Stage Two

Confirmation telephone calls were made to the respondent's (in many cases this was the Chief Officers' secretary) and dates, times and locations confirmed by email. A further copy of the discussion topics was included with the email together with a copy of the university's research consent form. This provided the participant with the opportunity to consider any concerns they may have prior to the interview beginning.

3.11.3 Stage Three

An interview with each of the participants took place in a location suggested by the Chief Officer, which was in the main their own office or their organisation's interview/meeting room. Each officer was asked if they objected to the interview being digitally recorded and it was clarified that each recording would be coded prior to transcription to ensure the identity of the participant could not be identified. The researcher further clarified that the transcribed notes would only be available to them and the researcher's supervisors for support purposes only. During the interviews a pro-forma record of the interviews was initially prepared and used. The record initially seemed appropriate however, as the interviews progressed and the discussion flowed between topics it was clear that the written record was hindering the discussion. It was therefore decided to rely on the digital recording, after sound checks and test recordings had been completed, together with basic written notes.

3.11.4 Stage Four

Following each interview, the researcher sent an email to each participant thanking them for their contribution, time and candidness and asked each participant if they wished to review their transcribed discussion. While no one requested a copy of the transcription, two participants were interested in obtaining a copy of the final thesis.

3.11.5 Stage Five

The recorded data was reviewed and transcribed through a private arrangement with a transcription service. Prior to the recording being sent to the transcriber, all identifying information at the beginning of the interviews was erased and the file coded to anonymise the participant. The transcription process was time consuming, requiring a minimum of 3-5 days for each of the interviews. After the interviews were returned, additional work was undertaken to validate the quality of the transcription. Data were stored on a local Apple device at home. The device has Apple security password requirements involving alpha, numeric authentication. Data from interviews were recorded using a MacBook Air with the same level of password encryption. Data were unavailable to anyone within the researchers' home environment other than the researcher. No one had access to the data other than the transcription process described above and as information discussed with University Supervisors.

All participants' data were recorded using a coding process to ensure that data could not be linked to the participants, ensuring the data integrity was maintained at all times.

3.12 Data Analysis

Smith *et al.* (2009, p.79) suggest interpretative phenomenological analysis (IPA) can be 'characterised by a set of common processes and principles' e.g. moving from the particular, to the shared, and from the descriptive to the interpretative with a commitment to understand the participant's point of view. To achieve this approach, I considered the use of technology to identify the phenomena would be restrictive. After discussion with the supervisory team on the approach to be adopted, it was agreed the analysis would be conducted without technical intervention and by adopting the six-stage approach, illustrated at Figure seven, suggested by Smith *et al.* (2009):

Figure 7: Six stages of data analysis

(Adapted from Smith *et al.* 2009)

3.12.1 Step One - Reading and Re-reading

As described previously the data were collected using digital recording which was transcribed by an independent process. As such, it was vital to familiarise myself with the data in greater detail to ensure it could be digested and analysed appropriately. To ensure immersion in the data, the initial approach was to listen to each data set using headphones a minimum of six times to begin to understand the participant's approach to discussing the subject matter, to understand their language and get behind what they meant when they used specific phrases, to understand their views when they referred to similar elements but changed their phraseology slightly. This was an intensive period while listening to the recordings, engaging with the printed transcribed document and underlining, highlighting areas of potential interest.

3.12.2 Step Two - Initial Noting

This was a very interesting stage and arguably the most time consuming step. Listening to the recordings, co-ordinated with the transcripts was found to be an approach which continued to be useful. Continuing to get used to

the participants' voices, listening to the inflections, the honesty behind their every word it was easier to detail the researcher's views and thoughts about the participant's comment. The first element of this step was to start to pull together a list of words and terms which were commonly used during the interview including personally used terminology. To achieve this, I initially highlighted connected detail, using one colour. The understanding and depth of knowledge of the participants was very evident in the way they approached their response and the quality of the response. Evidence of active listening techniques were apparent which were often connected to the participant subtly veering from the questions asked to answer the questions they wanted to be asked. To enable me to manage the information a simple table document was produced which included the original transcribed response from the participants, set aside the thoughts and questions identified. An example of the table is included in Appendix six.

3.12.3 Step Three- Developing Emergent Themes

Continuing with Smith *et al.* (2009) approach, I started to break down the data of the individual participants further by placing the highlighted text into different table columns. This was useful but restrictive in being able to view the information appropriately so to continue to become immersed in the information I used large 'flip chart' paper to be able to visualise and compare and contrast the data (Strauss *et al.* 2008) on a larger scale rather than staring at a printed sheet or a computer screen. This approach worked well as the themes began to 'jump out' from the paper. I noted the themes on the sheets and transferred these to the columns in the prepared tables. Appendix seven provides an example of the document used to explore the emergent themes at step three.

3.12.4 Step Four - Searching for Connections Across Emergent Themes

This step was challenging for me as being relatively new to research, and wanting to be assured that the themes identified were appropriate and significant enough to provide a level of trustworthiness of the outcomes of the research undertaken. The process of identifying connections in reality had begun at step two of the process with initial word/phrase indicators being drawn together with the language used to express the participant's views.

Many of the themes which emerged became a synthesis of words and phrases. Smith *et al.* (2009) refer to this process as abstracting the data into patterns which can then be clustered (Miles and Huberman, 1994) and mapping words, phrases and notes into evident relationships, patterns of phrases and in some cases negative tones. A note of the number of times certain words or phrases were also recorded for information although it is acknowledged this does not increase the importance of those particular words.

3.12.5 Step Five - Moving to the Next Case

As the research involved evidence from more than one participant, analysis continued to progress, using the same approach identified at steps 1-4, and the analysis of the responses from the remaining participants. This was completed in isolation, as far as possible by ensuring the data analysis that had previously been undertaken was not considered during the next case analysis. This technique, known as 'bracketing' was initially introduced by Husserl (1982). As noted previously, bracketing in Husserl's view is affiliated to the approach taken by mathematicians when bracketing out, the 'taken for granted' elements of a formula. By achieving this, the researchers allow themselves the opportunity to consider their perceptions of the world using a more transcendental and philosophical approach to reduce their view of the data being considered to focus on the very essence of their experience of the phenomena considered. However, as I acknowledged the insider's perspective the need for bracketing was not felt to be strong. Ultimately, phenomenology is concerned with achieving the truthful essence of an issue, describing the phenomena as they appear to an individual's consciousness (Moran, 2000).

3.12.6 Step Six Looking for Patterns Across Cases

This stage progressed by laying out the data from stage 4 of each of the interviews. The themes were interpreted further, contextualising the information that had been gathered. Interestingly and somewhat anticipated as the process evolved, there was commonality not only between participants who were employed by the same organisation but with participants who were working in partnership with each other. Surprisingly,

two organisations who did work in a partnership together were very different in their views, tones and even the language used when discussing health and social care integration. At the end of this stage the statements, words and phrases which had emerged were developed into ten different themes.

3.13 Strengths and Limitations of the Research

The strength of the research was the opportunity to develop a deep understanding of the experiences of senior staff who offered a very candid and personal account of the challenges they are experiencing in implementing new legislation. Often, legislation is a by-product of progress and as individuals whose lives are affected by legislation it often goes unnoticed. By conducting the study using a qualitative approach of the key individuals who were purposely selected for the research allowed a level of understanding and knowledge which would not have been contributed to this field of knowledge.

There were a number of challenges associated with using the methods applied. The interview process was an experience, the uncertainty of ensuring the appropriate participants, the nature of the discussion topics, recording of data and transcription for an early career researcher all brought a level of anxiety. Much of the success of this stage was the result of the ease at which the participants became involved and reacted in a manner which made the interviews very flexible and relaxed. The design used specifically related to challenging personal understanding of phenomenology, defining and analysing the data and developing the themes. The framework used, defined by Smith *et al.* (2009), helped to maintain the approach and ensured I did not become embroiled in over analysing all of the data at too early a stage. These anxieties aside, the results of the research have been extremely satisfying. The research has not been without limitation. It is understood that qualitative research is usually conducted within a smaller sample size (Llamputtong and Ezzy, 2005) and the limitations of the research project created scale and time factors however, the opportunity to extend the research to other participants from Health Boards and Local Authorities each with potentially differing experiences would have been worthwhile. Finally, to

ensure accuracy of the data interpretation, the researcher's supervisors reviewed the information to audit the process, data and analysis.

3.14 Conclusion

In this chapter, the use of phenomenology as the research design was identified and supported by the methods described. Ethical considerations for the researcher were identified and discussed together with the sampling methods used, the selection process for the participants and background detail of the organisations involved. The chapter concluded by providing a review of the analysis method used to ensure the data was represented in a fair and consistent manner.

The findings chapter which follows provides a detailed description of the findings derived from the interviews with the participants. Direct quotes have been used extensively throughout the chapter to provide a rich understanding of the interviews, before moving on to the next chapter which discusses the findings in relation to the literature considered in order to develop a framework for future integrative projects.

4. Findings

4.1 Introduction

In this chapter, the findings will be presented in four sections. In section one the influence of health and social care legislation and the Government Section two considers the governance arrangements of the Integrated Joint Boards. This sets the scene for section three which follows on to discuss partnership working; considering the challenges of partnership working between the three organisations, the culture of the organisations and communication. Section four will follow on to consider resources, which will elucidate on the financial impact of conducting a major legislative change during the ongoing financial crisis. Additionally, the aspect of human resources and the impact of merging job roles and organisations together with ensuring appropriate training will be considered. The chapter has been divided into four sections to reflect four key stages of understanding from the data i.e. section one represents the developing views of what the legislation attempts to achieve. Section two moves the considerations forward to develop a clearer understanding of the strategic imperatives which require to be considered. Section three reflects on operation areas which will require further strategic consideration by the Board. Section four considers the financial impact of integration, organisational development requirements and technology.

It is worthy of note that there are inconsistencies in the number of quotes afforded to each participant. This is due to the level of understanding of each of the participants in relation to their particular discipline. Where a greater number of quotes have been attributed to Chief Officers One., Two, Three and Five it reflects the general knowledge each Officer has across the spectrum of health and social care integration. Officers with less quotes attributed to them, specifically Officers Eight, Ten, Eleven and Twelve have detailed knowledge of aspects of integration relating to legal, financial and technological. This lack of balance of opinion initially reduced the overall data however where the discussion focused on the discipline of the individual, the opportunities for ‘golden nuggets’ of information was achieved.

As noted previously in the thesis, the opportunity to conduct semi-structured interviews provided the ability to guide discussion to specific topics to ensure the views of the Chief Officers could be used to achieve data blended in opinion and practical experience.

It was clear from the initial pilot survey that technology discussion was practically considered by the officers. To clarify this point, when questioned about the challenges associated with integrating personal data across the different organisations, the participants were keen to discuss how a technical solution could be constructed using different databases. The strategic consideration of the challenges of technological integration appeared to be lacking despite encouragement to move towards that area of discussion. Practical problem solving was the outcome of the discussion. While the technology discussion was helpful in understanding some of the challenges, the determination of a required system could only emerge from a combination of the knowledge and experiences of the different disciplines within health and social care systems. These initial discussions during the pilot survey occurred at an early stage of the series of interviews to be conducted. After discussion with my Supervisors, the focus of the interviews changed from technology development to understanding the challenges of the principal stakeholders and indeed the focus of the research aim was modified.

4.2 Section One

4.2.1 Legislation

In 2011, the Scottish Government published its intent to achieve an integrated health and social care solution for Scotland by 2020. The document; the 2020 vision states the anticipated outcome of that vision.

The statement, highlighted in the introduction to the thesis (page three) was released to support the work required to tackle the significant impact of the challenges being experienced by public services. The challenges, when combined, have a significant impact on the Government's ability to maintain

and improve on the delivery of the National Health Service and associated services. The challenges, whilst not limited to, include financial viability, austerity measures, increasing population, reduced national insurance income and increased service demand stimulated by increasing multi morbidity and an aging population. To deliver a strategic response to these challenges, the Scottish Government published their vision that by 2020 everyone is 'able to live longer healthier lives at home, or in a homely setting'. To enable this to happen by 2020, the Scottish Government has set a clear set of objectives which will implement an integrated health and social care service with a focus on prevention, anticipation and supported self-management. The Government has also committed to day care treatment of the highest standard where the person is at the centre of all decisions. All of which is aimed at getting people back into their home or community environment as soon as appropriate, with minimal risk of re-admission'

The 2020 vision is not new. It is the latest culmination of many years of significant legislative changes inspired to deliver a fundamental change in the health of the nation and the collaborative delivery of services.

An interview with one Chief Officer made it abundantly clear the significance previous legislative changes has had on the impact to society in general, and importantly the localisation of significant impact within areas struggling to retreat from their industrial heritage.

> *'I suppose it is where legislation sits in relation to the cultural backdrop of each organisation. In contrast with other social policy and legislative solutions to other public health issues this [health and social care integration] is more complex. The cultural and locus of power/control is playing out more significantly'. As an example, 'look at the difference that legislative and social policy has made on improved outcomes in terms of coronary heart disease, cancer, strokes etc. In 1987, when it was conceived that Glasgow would become a smoke free city by 2000, it was covered globally because it was so*

outrageous that Glasgow could possibly achieve that and yet look at where we are now and the difference it has made'. (Chief Officer One)

In harmony with private business practices of restructuring, reducing and combining delivery methods, integration is seen as vital to the continued success of the health service. A health service greatly valued by receivers of its benefits since the NHS was first established. It is evident from many news bulletins, journals and political debates that current levels of funding are not sufficient to tackle existing or future needs if the anticipated growing trend towards longer life expectancy continues. Change is required to maintain services, with funding requiring to be used more efficiently towards the patients' health journey. One Chief Officer was specific in their opinion of the argument for change.

'Integration is a reflection of the way that society's needs have changed so we can look back and see that when the NHS was established in 1948 the experience of a lot of people was to get to retirement age in their 60's and then people tended to succumb quite rapidly to catastrophic illness and to die relatively young compared to today. When we look at the basis on which Social Work was established particularly under the 1968 Act, we can see that it's span was largely connected with the care of children living in chaotic circumstances again, entirely appropriate and a big priority for any Government. What we have seen throughout the developed world, particularly in the last 15-20 years is this rapid aging, people living longer and the important point – more and more people living with multi morbidities with multiple complex needs and what we were not aware of was that the systems of health and social work and social care more broadly, hadn't kept up with the speed of that change and society's needs. So, in order to care better for this cohort with multi morbidities who are living longer, we needed to be better at joining up how we worked.

We had to some extent seen in the same period, ever increasing specialisation in care and in the delivery of care. While in fact the greatest need was seen in the population who's suffering the greatest consumption in services, was seen in a population whose needs were multifarious and often not actually needing a very high-tech specialised response, what they needed was a co-ordinated response to help people look after themselves better'. (Chief Officer Five)

The motivation towards a combined health and social care solution may therefore be seen as the culmination of the continuous drive towards a holistic health and care solution. Studying the approach taken by other countries and the enactment of the legislation does not however ensure the success of the approach defined by Government but it does help to guide the approach further along the journey. It is clear from discussions with Chief Officers their commitment to integration with officers remarking:

'If we cannot do this in such a way that it makes life better for the people who are using the service and their families then there is no point in doing it in the first place'. (Chief Officer Five)

'This is a joint endeavour as the scale of it is very large and assuring public confidence needs a co-ordinated understanding of the objectives'. (Chief Officer Two)

'Let us get rid of the nonsense of double assessments, social work baths and health baths etc. My only concern is that while health and social care will inevitably grow stronger, we may miss the drive towards a more separate acute service and therefore end up with a greater division between them i.e. services which will require to be supporting each other'. (Chief Officer Three)

4.2.2 Government

Implementation of the legislation has produced very different perspectives of the role of the Scottish Government; the intention, funding, perception, knowledge and the support offered to take forward health and social care integration. It was clear from the interviews that everyone was familiar with their input and the support of others was seen differently by officers, organisations and officer groups. Consequently, comments during the interviews ranged from a negative perception of the support:

> *'The Government does not have a clue – it is all fairy'. (Chief Officer Five)*

> *'Stick a Civil Servant in my job for a year and let them see what it's like. Remember it's not just about service delivery but it is also about policy, strategy, local democracy, people' rights, human rights, managing the budget etc. The number of things you need to consider and encompass in the space of each week is inordinately complex'. (Chief Officer Two)*

through to the supportive and understanding

> *'Not sure why or how the scope crept from adult provision to what it is now, but it makes sense to have adult, older people, children and criminal justice in the group as otherwise you end up with more fragmentation'. (Chief Officer Three)*

Whilst infrequently stated, the perception from the interviews is that the underlying comments were based around change. Not perhaps fear of change, more concerns for the effectiveness of change in the current financial and political climate and the influence of the Government in driving forward their agenda. Participants made reference to the long-term plans of the Government and the democratic impact this will have on Council Services.

'Part of the Government's role must be to try and get the awareness and compromise between a locally defined democratic Local Authority and a centrally managed Health Boards. There is an immediate conflict there. (Chief Officer Three)

'If you have health and social care integration semi-detached and take out education, then what are Councils left doing? I think it is a worry for local democracy'. (Chief Officer Two)

'More interfering in local democracy versus the national picture, however in this regard they [the Government] may need to interfere more to achieve what is desired'. (Chief Officer One). Although the quote is referenced directly to Chief Officer one, this view was similarly shared by other Chief Officers, including Chief Officers six, eight and ten.

It is clear the levels of understanding of the legislation and support documentation differs between officers and organisations. This may be reflective of an inconsistency of the message being delivered which may ultimately result in an inconsistent delivery approach. The views of the initial and continuing support from Government were therefore conflicting, sometimes by the same participants during their interviews.

'Support was needed from the Government to start with but as you start talking about it and work out exactly what it is then it all makes sense. The strategic plan guidance was difficult to comprehend – so many questions. The guidance documents are still open to interpretation and have not been written in plain English. The budget element took a long time to understand and sort out – there just was not clear guidance on how it was going to work to start with'. (Chief Officer Three)

'The Government missed an opportunity to really learn from all streams of previous partnership working'. (Chief Officer One)

'The legislation that's there is enough for us to work through. Initially these things start off as a perception of Civil Servants then it has to be amended and worked on. I quite often think that there is a separation of people and the work that first comes out of these things doesn't bear a resemblance to the way you work locally. They have their job and we've got ours. My perception is that the Government are good at writing the legal stuff in that way. The worse thing would be for them to say here you are, now go and do it'. (Chief Officer Three)

The need for further support from the Government is also evident as some organisations raised concerns about the ability to manage the democratic process without further support from the Government, where Local Authorities and Health Boards share governance arrangements.

'It complicates the landscape to have another governance that we have to work through. Additional community planning partnerships, Local Authorities and the NHS Boards. The increased number of organisational groups means the difficulty we are facing is we now have more red tape to cut through which is making our lives busier'. (Chief Officer Three)

'The Government is in a difficult position as they have to recognize locally defined democracy which has got to be respected and at the same time the Health Boards is a centrally managed entity so you have an immediate conflict between the two. Part of the Scottish Government's role should be to try and get the awareness and understanding to get a compromise between the two'. (Chief Officer Two)

4.3 Section Two

4.3.1 Governance

Governance arrangements for a new Board which brings together different perspectives, ideals and existing protocols is a difficult prospect. Local Authorities have a committee structure, which is managed and attended by democratically elected Members, each with a politically motivated input into the running of the organisation and ultimately responsible to their electorate. By contrast, a Health Boards is run by Executive and Non-Executive Members interested in managing the operational and financial activities of the health service. The business of the Board is less politically motivated and more akin to the board room approach of a private enterprise where the Board is ultimately responsible to the Government.

Bringing together very different organisations into a single entity has been considered challenging by all groups. A view often reflected by the participants involved in the interviews.

> *'The Board's business is predicated on an expectation that leadership is joint and accountability and responsibility is shared. You need a statutory agreement between the statutory agencies in particular. If you rely entirely on good relationships when something happens, somebody moves or retires, it will fall apart. You need to have a written partnership agreement'. (Chief Officer Five)*

Power and authority is a clear factor in developing maturity of the Board. Some Chief Officers identified with a deterioration of their authority and raised concerns about their organisations flexibility as its power base decreased. While this view is understood it is also perhaps misjudged as the perception of power may belittle the willingness and desire to achieve service delivery excellence through a continued improvement plan being led by the Chief Officer. Others have seen it as an opportunity to consider a different approach which would bring benefits, often citing negative issues with the

continuing attendance of Chief Executives from all organisations at the Board.

> *'It is hard to work together differently and to delegate some of one's power and authority. Introducing the role of the Chief Officer and the Integrated Joint Board in commissioning services from the Health Boards and Local Authority has introduced a new dynamic which is challenging. It doesn't all have to be about protecting your budget and organisation and if anything that is a bigger step than was appreciated when we set out on this journey'. (Chief Officer Five)*

> *'It is difficult to be the head of a large organisation, working towards delivering excellent services only for a large section under your control to be removed and managed elsewhere. Especially when you had a vision which no longer accords with others'. (Chief Officer Eight)*

> *'There are power issues with Chief Executives attending the Board and briefing their Board Members before the meetings. We need to develop to a stage where they are not required to attend regularly'. (Chief Officer One)*

> *'All Chief Officers are bought into the health and social care vision, but there is still very much the protectionist view towards their own organisations and ultimately their individual powers'. (Chief Officer Seven)*

> *'It's a real challenge for Integrated Joint Boards to manage up as well as down'. (Chief Officer Two)*

> *'Still to resolve concerns regarding statutory bodies role'. (Chief Officer Three)*

The skills of the different members of the Board are often questioned. The concern held by some are that skill sets are not always commensurate with the role being undertaken which may impact on the quality of the discussion and decision making within the Board.

> *'Often very influential/powerful elected Members just seem to be completely overpowered and de-skilled when they are talking to a Head Teacher, or a Doctor, if it is an area they don't feel comfortable with or if they don't have a great education themselves, they don't operate in the same way. You can see that they are less comfortable [a lot of them] in an arena with Doctors etc'. (Chief Officer One)*

> *'We have a tendency to categorise people very strictly and some of this has been as much about learning that people don't all sit in neat pigeon holes. Those who are most challenging depends on individuals, party politics, lots of things which could come into play even the characters of the organisations' leader. Sometimes we have a leader who themselves has a very strong history in social care and sometimes their interest can lie elsewhere which can affect the good and the bad. If appropriate the legislation can show that people should work constructively together, but ultimately it's all about [developing appropriate working] relationships'. (Chief Officer Five)*

> *'You can listen to members of the board trying desperately hard to use us, meaning the board, but struggling to leave behind the 'you and them' mentality. There is a very different input from members of the board, some with a limited understanding of the legalities and board business'. (Chief Officer Seven)*

> *'It is very difficult to bring a board mentality together with a committee mentality'. (Chief Officer Nine)* [Gathered during the pilot interview but relevant to the second data interviews].

The governance of sharing data is a concern for the different individuals. All of the organisations place a very different value on data and the ability of others to understand and manage the data appropriately. Organisations have invested different levels of resources in ensuring their staff understand data management and this is reflected in the tiers of data accessibility, together. The perception of understanding of the resources, training and data skills and ultimately the trust level each group placed upon the other was palpable. Given the concerns of the individuals, it is difficult to comprehend how fundamental integration components can ever be successfully achieved in a harmonious environment. The need for this to be achieved was reflected by one Chief Officer below whilst others made their concerns clear.

> *'How do we make sure we have a consistent approach, safe means of transferring and holding information? Cramming two organisations with very different cultural backgrounds. Each at different stages of awareness of information security criteria. The danger may not lie in releasing the information but perhaps with the bigger danger of not releasing it'. (Chief Officer Ten)* [Pilot data]

> *'Shared information is the nirvana of integration and until such times as that happens it will be difficult to develop a singular view and therefore trust between teams of colleagues. The hierarchy around decision making is evident, the NHS places decision making responsibility at a lower level that Local Authorities who have pushed decision making upwards. Training has been complicit in this approach'. (Chief Officer Six)* [Pilot data]

> *'If you ask any clinician what they look at in patient's notes they will initially look at half a dozen pages. These are the vital notes to share and have as basic information. There will of*

course be a need for all information but as a basic shared approach then this information requires to be shared'. (Chief Officer Twelve) [Pilot data]

One thing which was clear from all interviews is the support for and clarity of the approach moving towards a locality based model for integration, although localities may not necessarily be geographically comparable.

4.4 Section Three

4.4.1 Partnership Working

Partnership working is a particular area where all interviewees had a clear view of the benefits and also the areas for concern, although all agreed that without a good quality and sustainable partnership the opportunities afforded by health and social care integration would be more difficult to achieve.

'Anybody can bring in legislation, change a structure, put somebody in charge and say you are now managing something. To work in partnership when you don't have those things is the hardest thing and if you don't put everything under one thing then you have to do some sort of partnership working'. (Chief Officer Three)

'The main thing about partnership working is to work together to better together'. (Chief Officer One)

It is clear from the interviews that the organisations have different views and understandings of partnership working. The challenge of partnership working is not therefore necessarily the development of joint approaches but is more focused on ensuring that all parties understand what partnership working is and how it is applied to the vison of the boards. What is less clear is whether this view is held only by the senior officers interviewed or also by the staff who will ultimately be working together to develop the partnerships.

'The key challenge is that people [need to]) work in partnership but how you actually get to that stage is difficult and the fact it can be blocked [by different organisations and Members] as well'. (Chief Officer Three)

'We are all here to help make sure that the business of the board goes smoothly and to make sure everyone has an equal say/place in the partnership [all the stakeholders]'. (Chief Officer Four)

Some boards have been in place for a longer period of time and as early adopters of health and social care integration have seen partnership working mature to a greater collaborative extent. Their focus has undoubtedly gone through many stages as the board's relationship has developed but now relates to achieving the ultimate objective of the legislation.

'I think there is a strong desire in the partnerships to achieve integrated services and I think the partnership is putting the person at the centre of that'. (Chief Officer Two)

During the interviews it was clear from all groups that there was concern that their role in the partnership would not be as fundamental as other groups which brought about some concerns that the organisation would lose some power. There were therefore a few comments which, on the surface endorsed equal partnerships however, the body language during the interviews when this was discussed offered a different opinion.

'Equal partners are vital'. (Chief Officer Three)

'I don't think Councils understand integration and therefore partnerships are in serious danger of becoming semi-detached'. (Chief Officer Two)

It is evident that the development of Boards and individuals has taken time. Some organisations have spent time on achieving a viable working board and this was clear in the discussion whilst other clearly see individuals struggling to come to terms with their role in the board.

> *'The biggest challenge is getting people out of their bunkers'. (Chief Officer Two)*

> *'People aren't always on the same page but as our journey has continued and developed there is a feeling that we are now using the same book when previously we weren't even in the same library'. (Chief Officer Seven)*

> *'You have to find ways to work together and manoeuvre through. Agreeing the vision you want to achieve can help you get around all the problems'. (Chief Officer Three)*

The interviews also identified views of partner organisations which may reflect deep routed historical relationship issues which, despite the opportunities for a fresh start afforded by the legislation, remain.

> *'Local Members are there as Board Members and not in their Council role'. (Chief Officer One)*

> *'Facilitated conversations are being undertaken and it can be patronising. These conversations should be pulled back to a sense of purpose'. (Chief Officer Seven)*

> *'There are issues around voting and non-voting members especially specific parties'. (Chief Officer Nine) [Pilot data]*

As the partnerships have become challenging, there is a temptation not to deal with the board issues but to focus on operational issues.

'When working on partnerships, ensure that the focus of the partnership is the relationship, don't get diverted by structural change'. (Chief Officer Three)

'Success has been clear in partnerships which exhibit really strong local leadership'. (Chief Officer Five)

Public Service organisations have a strong union influence who is heavily involved in most key changes occurring within organisations. Despite this, only one of the interviewees (Chief Officer Three) mentioned trade union support; 'we had partnerships with our Trade Unions so they were involved from the beginning which influenced the way we developed'.

4.4.2 Culture

The culture of the three interviewed organisations is very different. The differences are obvious in the responses to certain questions but also very clear in the thought process adopted by the individuals involved. Simple language is treated very differently with no clear consensus on a joint approach to what the person receiving the integrated service should be referred to. It is clear that health staff see the person as a patient, receiving medical support for their condition, whilst Local Authority staff have a multitude of names, again depending on the area of work being delivered. Some referred to the person as service user, client, recipient, customer or citizen. One interviewee (Chief Officer Eight) was very quick to point out that they were unhappy with the 'user' term, suggesting that a better term should be found for the 'beneficiaries' of the service which accords with all parties. This observation was identified during the pilot survey and led to the inclusion of further questions relating to cultural differences during the second data gathering interviews.

The interviewees understood the difference in language and were quick to identify with their own insecurities around the language they used. Some recognised that it was a territorial use of language which helped quickly

identify the background of colleagues they were working with. One officer was very honest in their observations, pointing out that the culture was based on perceptions of other organisations rather than factual information.

> *'Organisational behaviours are absolutely embedded and still tangible. People have moved on but legacy has been left behind'. (Chief Officer One)*

> *'The challenges remain in breaking down barriers and cultural differences. The Health Boards is going to really struggle with being open and transparent and having to justify what is done'. (Chief Officer Four)*

> *'Caution is there on both sides because of different cultures and perceptions. An acceptance has been reached that we do come from different views.' (Chief Officer Seven)*

Several officers were very pointed in their views. Their views are important within the context of the thesis, however to maintain their anonymity further I have referred to the officers as X and Y.

> *'Big differences in the way people treat and trust each other. The view is that Councils are more adversarial whilst there is none of that in the Health Boards. This may be due to the work undertaken in health to create a culture of respect and personal responsibility and a safety culture'. (Chief Officer X)*

> *'There's quite a lot of work around joint work and interactions as Members from both organisations come from different planets'. (Chief Officer Y)*

One officer was very clear in their assumption that cultural differences and the language that surrounds the culture is not the difficulty, pointing out that there is a great opportunity to move away from the ingrained approaches to a

new way of working. Chief Officer 1 noted 'the language may be very different but it's the behaviours that are much more telling'.

Clarity does exist in organisations where a unified approach has been taken.

> *'Single employer teams have seen a very positive difference'. (Chief Officer Five)*

> *'There isn't any good evidence that structural change gets the changes that you want therefore don't concentrate on it. It's a massive change programme when you also consider the number of senior officers involved from all groups, all focused on achieving the ultimate goal of integrated services'. (Chief Officer Three)*

Where some other boards were less mature in their development, the difference in language was apparent.

> *'The role of the Health Boards is just the same as it's always been and the Council is still delivering the same. I sometimes think it is just a waste of time as it's just another layer of decision making and management to go through'. (Chief Officer Four)*

> *'Difficult to envision the end result when even the culture and the language is so different'. (Chief Officer Seven)*

> *'Professions come from different places so it will initially be difficult to trust one another's skills and capacities'.* (Chief Officer Six) [Pilot data]

One suggestion which should be examined further in a future study related to the Government's approach to integration. Chief Officer One opined 'the Government has fundamentally missed an opportunity to set up a new body'

which would have addressed many of the issues being experienced. The officer suggested the new body would have greater strength to deal with staffing issues which have been heavily influenced by 'agenda for change'. While observing the benefits the 'agenda for change' approach has provided for the Health Boards the officer was also quick to note the effect it has had on pulling staff together into an integrated pool noting the change in colleagues' attitudes and the creation of a 'that's not my job' culture. The officer noted that a more co-ordinated approach which looked to future changes may not have resulted in the hierarchy issues being experienced. 'This just hasn't happened overnight; this has been years in the making'.

4.4.3 Communication

Good communication is always vital to the success of any new project. Communication between departments and individuals is difficult and with the added complication of communication between organisations who see their roles changing needs to be clear in order to achieve the outcomes required.

From the discussion during the interviews it is clear that communication between all parties has been variable.

> *'Everything is in boxes there isn't a lot of communication, even between departments never mind having open communication between two organisations. The barriers have been broken down but there is still a certain amount of distrust etc'. (Chief Officer Four)*

> *'In terms of the objective it is pretty clearly and consistently understood'. (Chief Officer Five)*

One officer questioned whether communication was the issue or whether individuals were internally politicking to suit their own needs, and not necessarily the needs of their organisation.

'Is it about the clarity of the communication or is it about the blockers in the system'. (Chief Officer One)

The initial understanding of what was to be achieved from health and social care integration met with several communication concerns and questioned the intent of the Government in changing the original remit from adult provision to a more general position.

'My main reflection is that where we ended up wasn't where they intended us to when we started out. I'm not saying it's a bad place I'm just saying it's not what they said at the beginning. The more you get into it, it becomes much bigger and more fundamental than I think was the original intention'. (Chief Officer Three)

Others, whilst noting a communication issue, were more resolute in their approach.

'Where it has been communicated well, I think people do get it but I wouldn't surmise from that that everybody has heard'. (Chief Officer Five)

There is a mixed understanding of the message being communicated by the Government led to concerns regarding the perception of health and social care by the public and the national press and how that would ultimately affect the success of integration.

'Although the Scottish Government is talking about this fairly radical strategy that came out last week, what is daily in the papers? Accident and Emergency waiting times, delayed discharge rates, etc. At the same time, the Ministers and the Cabinet Secretaries are driving a machine that is forcing resources, disproportionately to influence those figures so there is a mixed message coming out'. (Chief Officer One)

The emphasis that the Government is putting on the Health Boards is in relation to discharges, four hour wait times and that is entirely unhelpful. They are all targets which measure failure not success and the Government is obsessed by them. Why have nine health and well-being outcomes and pursue these ludicrous targets of four hour wait times, let's think about that in a different way. It's sending the wrong message'. (Chief Officer Two)

'The role of the media in influencing the public is interesting. There is no story in an old lady sitting in her own home receiving a joined-up service'. (Chief Officer Five)

Interviewees also expressed their views of communication across all Integrated Joint Boards to apply a consistent approach where practicable.

'We do need to achieve consistency and quality and I think that over time as annual performance reports come out, that will give us a good measure of consistency and appropriateness in terms of quality'. (Chief Officer Five)

The Government has produced the legislation, guidance practices and clarifications however, the application, understanding and assertions from the legislation and guidance is very different across the boards. While some organisations were concerned about the consistency across boards, others were more concerned with consistency across partnerships, especially where a member of the partnership was involved with numerous organisations.

'Communication will be shaped to some extent by the size of the Local Authority and how many Local Authorities relate to the Health Boards. Where you've got a coterminous Health Boards and Local Authority the relationship might be a bit different in terms of, it being easier to align Services. Where you have one Health Boards and several Local Authorities, it gets a bit more

difficult'. (Chief Officer Two)

Interestingly, the view of how well the objectives of integration has been communicated are contentious. There is a view from the Government that the message is clear which is reflected by two other Chief Officers.

'I think it is pretty clear about what the legislation is trying to achieve but I think delivering that is quite difficult, particularly at a time when resources are being cut'. (Chief Officer Two)

'The message is clear because what the Government is trying to do is so simply expressed and consistent in the way it is being expressed. The objective is therefore pretty clear and consistently understood'. (Chief Officer Five)

'I do think I understand the legislation. Coming from a point of understanding, it is difficult to see what other people's misunderstanding is. I think one of the keys to that is that there isn't actually a really quick and easy narrative around what it is that they are actually doing'. (Chief Officer One)

By comparison, this view is not held by all organisations.

'What came out at the end for the guidance was a bit vague, which I suppose is better than getting something that you don't want to see'. (Chief Officer Three)

'I think the objectives [of integration] are clear just now and how you are meant to do it. If Chief Executives and Chief Officers all have problems with it, how can you expect anyone else to understand it'? (Chief Officer Four)

'Anyone who says they understand health and social care integration is telling lies because the vast majority of officers at

a senior level that I have spoken to are unsure about it'. (Chief Officer Four)

4.5 Section Four

4.5.1 Financial Resources

Discussing finances was a very emotive section of the interviews. To put this in context, many of the interviews were undertaken within the month where the Government announced additional funding information. Additional, being a word which was disputed by many parties. The thesis is also being drafted at a time of unprecedented funding cuts in Local Authorities, staff reductions either through redundancy or voluntary severance and continuing demands of acute service delivery. One officer was keen to recognise the opportunities the new boards would have in delivering significant change despite the financial situation.

> *'I think that having delegated so much of their function and money to the IJB and introducing the role of the Chief Officer and the IJB in commissioning services from the Health Boards and Local Authority, they have introduced a new dynamic which is pretty challenging'. (Chief Officer Five)*

A further chief officer noted the current financial situation would be experienced no matter what the construct of the organisations were and perhaps afforded the opportunity for the transformation to help the financial situation.

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> *'The finance thing – is it feasible and possible to do what we need to do in a de-creasing financial envelope? But we would have separately been in a de-creasing financial envelope anyway so I suppose there is the potential that this does actually help and not make things worse'. (Chief Officer Three)*

Continuing with the positive view it was considered that

> *'Finance is the trickiest part of all. Directors of Finance have been engaged from the beginning and have developed good working relationship'. (Chief Officer Three)*

While there was obvious positivity supporting the financial position, it was clear that this view was not shared by all parties. The main message reflecting the concern held by the majority of those interviewed that the financial impact on Local Authorities and the Health Boards will be considerable.

> *'I think that makes life enormously difficult, you wouldn't go through a change process like this and at the same time, cut budgets. The focus becomes on saving money and not on integration. You are at risk of thinking integration is a way of saving money, when it is about delivering enhanced and improved services'. (Chief Officer Two)*

> *'I can understand why with the additional £10m that needs to be found and it is interesting as both the Health Service and the Local Authority and National Local Government say there has been that equivalent money taken out their budgets'. (Chief Officer One)*

> *'The financial challenge and especially the impact on Council budgets has led to people being very cautious.' (Chief Officer Seven)*

Concerns were also raised that financial austerity would become the focus of integration rather than service improvements.

> *'The delivery of Health and Social Care is massively complicated; it is not straight forward to deliver from a Local*

Authority or from the Health Service. If you then combine the two, the complications are magnified. If you then add in a budget cut where you spend a huge amount of your time trying to save money, I think it makes it even more difficult because you are diverted from trying to deliver high quality front line services in concern with performance management and you are diverted into financial management – that is a challenge'. (Chief Officer Two)

Officers expressed concern regarding their perception of the financial rhetoric promoted by the Government's financial announcement of increased funding for Integrated Joint Boards.

'Both organisations see it as their money being recycled and the truth is, it will be everyone's money recycled I would expect so both have got a sense of entitlement to get their hands on that money to help off-set the deficit which I understand. The IJB is in the middle of this and the Scottish Governments view is that the IJB's budget should be pinned to the outturn, not to the budget figure for the previous year but that's definitely not happening'. (Chief Officer One)

'The political thing - £250m. Our budgets were cut by £x m which is exactly the same £x m that went into the IJB and it is not new money it is old money which has just been moved and caused us to have more cuts within Social Work etc. The money in the IJB is paying for the living wage and the other half is paying for pressures and new initiatives that we are having to bring in to show that we are working to a locality model and delivering more community based care. We are working with a lot smaller budget but we are having to do an awful lot more'. (Chief Officer Four)

'The £250m – you've got every man and his granny telling folk it's for them and it can't possibly be, there is conflicting messages coming out from the Scottish Government so that isn't helping'. (Chief Officer One)

The impact of the overall public service budget position was not ignored by the interviewees with several discussing the impact of funding health and social care integration, with one officer referring to a 'rob Peter to pay Paul scenario'.

'The funding has been entirely complicated and unclear. The Government has created a narrative by cutting Council resources while the IJBs are protected. An unhelpful narrative whether it was intended or not'. (Chief Officer Two)

The timing of implementing health and social care may seem clear to the Government however this is not shared by other organisations.

'I cannot comprehend why they [the Government] would implement this legislation at this time. This is not the Scottish Government implementing previous legislation, this is their flagship policy so to implement it at this time is like a comedy of errors'. (Chief Officer One)

'Timing is difficult because quite clearly the health service has got problems in terms of meeting demand'. (Chief Officer Three)

Ultimately though the financial situation is long term and there is no prescription for settling the current climate. In the circumstances, to do nothing and continue with existing practices would be of no benefit to any organisation and importantly of no benefit to the recipient of the service. It will be a challenge as Chief Officer Five considered

'It is hard to work together differently and delegate some of one's power and authority and it is hard to get one's head round a new way of managing money'.

The reality is that integration will not make tangible financial savings in the short term but may help to drive out efficiencies which will lead to an improved structure of financing.

'It is understood from the raw figures that packages of care in the communities can cost significantly less for individuals than inappropriate institutionalisation. No one thinks the Government is actually going to make a saving through integration but what can be achieved is to use the money better. It's a double whammy – rubbish outcomes and the budget will be bust – those are the risks'. (Chief Officer Five)

The budget for providing care services is considerable with over £8 billion of spending within the integrated budgets which is more than one fifth of total public expenditure in Scotland. Proportionately the funding is huge but the overall figure is meaningless because it is only meaningful in relation to need.

Interviewees acknowledged the increase of £250m at the budget to support social care and while this is a welcome increase it is a small sum in relation to the scale of the task to be delivered. One officer noted their view of the resource discussion in a very pragmatic way

'I think discussions about the quantum of resource become a bit sterile if I'm honest it is all about how you use it, I guess'. (Chief Officer Five)

4.5.2 Human Resources

Health and social care integration is at a fairly early stage in its development. Consequently, many of the practical issues being experienced require to be

considered carefully. The management of operational resources is one such area. It is assumed that many of the roles will continue to be employed by the current employers as the Integrated Joint Board is not an employer however, to reflect the changes which are required to be implemented the development of a single employer with responsibility for staff related issues may be more desirable.

> *'I think they [the Government] missed a fundamental opportunity to set up a new body and really to say, this is a new body and we will TUPE (Transfer of Undertakings, Protection of Employment Regulations) people over into this new body but here are the terms and conditions and you will all be on the same Terms and Conditions'.* (Chief Officer One)

> *'I think whoever thought that you could actually form a completely successful body, really realising the intent of the legislation in this way is a fundamental flaw in my view'*. (Chief Officer One)

All interviewees were keen to discuss the impact salaries is having and will continue to have on integration. Many pointed out the implementation of agenda for change has had a considerable impact on the roles and responsibilities of health workers which ergo will influence the salary scales and expectations of Local Authority staff working alongside health staff. In a situation, reminiscent of the merging of regional and district Councils, staff some 20 years later still feel aggrieved about the different salary scales of staff employed to fulfil the same job. With agenda for change being introduced recently, the responsibilities and banding of health staff salaries is prominently placed in the discussions.

> *'There's a real alertness among health colleagues about what band they are. Bringing teams together where there's people further down the line, in particular home care staff and you've got a supervisor in one area that's had to double up their*

management because if they've got a rota which has got all Social Work home care staff on it and some of the health staff are in, and the Supervisor is getting paid less than some of the people that they are meant to be managing vice versa. They then need to put another Supervisor on to ensure there is management for both sets of staff. It's those sorts of things that can actually stop you being able to deliver if someone is needing to get discharged from hospital and you need to get a care package in quickly or you need to have a 24-hour care package – the practicalities of providing all of that have a knock-on effect'. (Chief Officer One)

These situations can very quickly become toxic for colleagues, leading to devalued staff and a break-down of the service which the Government are trying to improve. Two officers were vocal in their view that it is a situation which needs to be resolved through the legislation.

'If there was a will to take that on, it is much more difficult to do retrospectively and you would also then create an arena for paralysis in the system. We know from equal pay and agenda for change, you can lose two or three years momentum in an organisation while you are dealing with all of these things. There is also the national pay/grading in the NHS e.g. if I am bringing in two Management Teams to get rid of one Management Team for health and social care then the individual's conditions and pay are retained for one to two years. In the NHS they have lifetime conservation of their salary. Where is the efficiency in that, unless you are disproportionately eroding your Social Work Management?' (Chief Officer One)

Not everyone however has the same operational experiences as senior operational managers and offers a different perspective on the issue.

'The Health Boards remains the employer of staff and the holder of contracts and when we reflect on that business of a history of specialisation in the delivery of care vs generalization in a growing number of poor morbidities there is something very interesting there about helping to manage the staff delivering care in a way that lends itself to multi-disciplinary teams but better reflects the needs of people with multiple morbidities'. (Chief Officer Five)

4.5.3 Organisational Development

Development is a key element of all change projects. It is vital to understand what is required of each element of health and social care and arguably none more so than the work of the board. Successful training brings a combined understanding of the subject and allows the board to grow together toward a united approach. The earlier in the process training happens the sooner all parties are parties are in a position to begin their journey.

'We have been through three years of having development days and having discussions to get to know each other and all of those kinds of things. I think we have been lucky in having a group of people who have genuinely wanted to achieve the aim and I think the supporting structure has very much guided people in the direction of where we are going'. (Chief Officer Three)

Within such a complex arena, development requires to be multi-facetted to support the needs of health and social care given the complexity of the different services involved. To consider this approach many organisations have created a programme of training to ensure that all parties can work at the same level and to help address any of the rivalry and power concerns which may interrupt the boards objectives. The organisations which appear to be furthest advanced in the formation and normalisation of their board have been undertaking training for a considerable period of time and have woven the demands of the training into their regular meetings. It is

understood that many of the individuals who comprise the board will have limited experience in certain areas of board business. This has to be addressed to ensure a rounded and considered approach is capable of being achieved by all.

> *'I think one of the key things is that they need to be skilled in multi-agency service delivery. I think that is a real challenge because the range of services and the complexity of services that get delivered is really wide, particularly in relation to both partnerships that include children's services in them as well, that adds another huge dimension. I think there is going to be a challenge understanding that and the way we have dealt with that is before each IJB we have a one hour long workshop which is about trying to skill up the members of the IJB – prior to every IJB'.* (Chief Officer Two)

Specific boards were clear that the earlier development and normalisation of approach is considered the greater the effect it has on the outcomes for users of the service. To this end, many of the organisations had developed training plans for the different sectors who will deliver integration and had begun to roll these out.

> *'We've done a great deal of work with our staff to develop them and have them operational ready to take responsibility'.* (Chief Officer Six) [Pilot data]

> *'Requires work around collective vision, collective priorities, behaviours, ways of working, rules of engagement within the board'.* (Chief Officer Nine) [Pilot data]

External development support from the Government is valuable in ensuring consistency of the message and approach is delivered. The Government officer interviewed reflected this approach.

> *'Tied to that, we have put in place things like a leadership development programme for the Chief Officers. It has as much to do with the ethos as it does any tangibles we can put in place'.* (Chief Officer Nine) [Pilot data]

One Chief Officer recorded that development was not necessarily related purely to the seminar/classroom type approach.

> *'Development can also be about support, knowing people, being available and supporting when things get rough'. (Chief Officer Five)*

This is a very valid viewpoint as it was obvious from the interviews that different individuals were at different stages of their journey in developing their understanding, knowledge and experience of integration. This view was not reflective of others within the same joint board.

> *'The development days that the Government is running are a waste of time. I went to the first one I was really excited I thought I would be transformed – I wasn't and I was really disappointed. The second one I went to I was totally disillusioned so I don't know if I will bother going to the third one. The last one was IJB chairs that picked the topics but I didn't find it very helpful so maybe the third one will be better but I don't know if anybody has a clear understanding. People are just finding their feet'.* (Chief Officer Four)

Others were more philosophical about the level of training and the need to ensure that the training should be a long-term consideration.

> *'There is the recognition of a continuing development culture, which will grow and diminish as needs are identified and met'.* (Chief Officer Seven)

4.6 Information Technology

Information technology is a requirement of today's business environment and managing the technologies associated with all integration organisations are vital to the delivery of shared information as discussed previously. The complexity of managing different technology solutions is challenging, ensuring appropriate levels of access and ensuring information is available to the appropriate practitioners as and when required. Different approaches have been considered by Integrated Joint Boards across Scotland with the development of data sharing portals finding favour as the preferred solution. A great deal of this is due to the cost and development timescales of a replacement system which would meet the needs of all partners.

> *"We are struggling at this stage, as it's perhaps too early to determine the approach we need to take to technically share information. The more important considerations at this stage are to manage protocols for sharing information".* (Chief Officer Twelve) [Pilot data]

While Chief Officer ten did not directly advocate the need for focussing on sharing information as a priority status, he did nonetheless suggest that the road to sharing data was not as challenging as first appears.

> *"One of the great myths associated with data sharing is that you can never agree on how this can be achieved. In actuality, most organisation already have existing data sharing agreements which may require tweaked but can easily be achieved. Customers already expect that data is being shared and the majority of people, who are likeminded to my view, will be less concerned about risks and more interested in the benefits to be achieved". (Chief Officer Ten) [Pilot data]*

This view was contrary to that of Chief Officer Eleven, who was part of a working group exploring opportunities to consider collaborative technology solutions for all parties.

> *"We have to embrace the changes which are required to technology and cut across the boundaries of contract, financial impacts and develop or deliver a technology solution not simply used across one partnership but across Scotland as a whole. Only at that stage will we ever achieve a fully integrated service, accessible by all who require data access".* (Chief Officer Eleven) [Pilot data]

Ensuring consistency and parity of information is clearly determined there is a need to support early stage work to manage systems.

> *"We have completed some work which will help seed our approach to developing a shared technical solution by ensuring existing systems has been reviewed to have a matching data field for example the Community Health Index (CHI) number is now shared across all parties in a consistent way". "The CHI is only one matching number; other fields will be required to ensure we are considering the correct service user such as sex or date of birth. It really has to be a belt and braces approach".* (Chief Officer Twelve) [Pilot data]

4.7 Summary

In this chapter, the findings were presented in three sections. Section one connected the understanding of the legislation from the initial representation of the objectives for a more co-ordinated and joined-up service approach to health provision by the Government, through to how the civil servants tasked with energising the legislation approached the task. This focused on the Government's understanding of how that was being achieved through to the perception of the other parties. Section one ended with consideration of how the integrated service would be governed within the board tasked with its delivery. The outcomes from the interviews raised a number of issues beginning with the level of clarity of the message between all parties to the power struggles between organisations in developing the governance approach. Section two moved the understanding of the issues forward to

explicate the difficulties associated with the combining of the key organisational actors. Issues raised, which will be explored further include maturity levels of the organisations, the benefits of strong leadership, differences in cultural perspectives and the different levels of learning associated with broad members. The section also considered communication levels and how support can be achieved between organisations in ensuring the integration message is successfully targeted. Section three rounded the interviews to consider operational focused view. Consideration of the challenges of financial restrictions and understanding reflected the views of the organisations on service impact before determining how the management of staff and resourcing conditions created a delivery impact. Finally, to circle the discussion to the original objectives Section three translated the development needs of the organisations to ensure objectives could be delivered.

5. Discussion

5.1 Introduction

This chapter aims to develop the research findings and emergent themes and their components in order to explore the key issues associated with health and social care integration and the implications for practice. The chapter is presented in eight sections, firstly outlining the purpose of the research; secondly, moving forward to consider the findings of the study understood from the analysis of the interviews and supported by the detailed consideration of extant literature. The chapter progresses with an explanation of a conceptual model developed from the research findings. From this a set of key factors for the consideration of integration practice are presented. The chapter concludes with a summary before presenting the conclusions and recommendations in the next chapter.

5.2 Purpose of the Research

The research was undertaken during a period of considerable change in health and social care implementation. Where Integrated Joint Boards were at the genesis of their development and became responsible for the delivery of services and normalising partnership working arrangements. Within the same landscape, central Government introduced considerable austerity measures which presented 'real time' reductions in funding for Health Boards and Local Authorities. This reduced the available resources for integrated services development and implementation. With these major concerns subsuming the work to deliver integrated health and social care it was vital to understand the key challenges being experienced by those Chief Officers tasked with its very delivery. Recent literature around integration (Packard *et al.,* 2013 and Lyngso *et al., 2014*) established several key requirements to consider such as partnership working which was explored as part of this thesis and identified as an imperative to achieving integration. The research, through the adoption of interpretive phenomenological analysis aimed to explore and understand the experiences of those key actors involved in integration to inform current and future integration practice.

5.3 Governance

The first and obvious consideration of the research suggests that key policy actors from the three public sectors' organisations understand the fundamental need for change. All considered the approach to integration to be a joint endeavour in developing the legislation into a fully workable solution aimed at achieving a greater experience for consumers of the services they receive. While this was very clear from the discussion with Chief Officers, it was less so with the Elected Members of the organisations however, their political role may have influenced their views and thus struggled to understand the complexity of health and social care approach and the contribution integration may make to service provision. In such circumstances, the lack of clarity was considered to be attributable to a fundamental understanding of the policy directive. For many Elected Members this was the first time they were asked to contribute to an Integrated Board made up of representatives from the different organisations involved. This moved them from the more familiar setting of Local Government committee practices to a board approach. Indeed some Board Members had further limited experience and previous practice of community health partnerships which preceded health and social care integration. Respondents highlighted the need for a focused change in organisational approach and efficiency as echoed in preceding legislative changes aimed at a less bureaucratic and paternalistic provision thus allowing consumers to take ownership of their own service delivery (Hood, 1991; Osborne and Gaebler, 1992 and Clarke and Newman, 2007). Initially, the development of the legislation was heavily criticised by participants for the changing nature (scope creep) in which the key client groups identified with legislation being limited to adult provision.

As the understanding of the legislation developed and the opportunity to offer considered opinion on its implementation was provided, the focus of implementation extended to a much looser interpretation of the client group. While uncertainty of the Government intent may have been the perception of the organisational players, ultimately, they considered that there was 'no best

way' to do things. (Maddock, 2002; Storr, 2004 and Fenwick and McMillan, 2010).

The second issue to be addressed in moving forward with implementation is the differing understandings of purpose and details of the task of integration. In particular, practitioners perceived that there was a dichotomy of expectations of recognition of the resource implications of integration between the Scottish Government and Integrated Board Members. As confirmed by the Government's Chief Officer the legislation objectively focuses on improving the quality of joined up services for consumers through integrated service delivery. An intention echoed in the considerations of Balloch and Taylor (2001) and Sullivan and Skelcher (2003). From the perspective of the other respondents, a key impact of the legislation is around the cultural and structural changes required within a limited resource envelope and this is viewed as a key challenge in the implementation process. These changes, which not only focus on the development of an Integrated Joint Board, but also the logistical challenges of implementing processes and procedures are aimed at bringing together the different organisations into an integrated delivery entity as considered by Borins (1998); Sowa (2008); Packard *et al.* (2013).

The ability to see through the overwhelming minutia to focus on the key drivers for change thus sets the strategic setting for delivering a rich picture of service consumers' needs (Fisher and Elnitsky, 2012). The Health Boards and Local Authorities involved in the research did not explicitly state their consideration of academic literature when determining their approach. However, their considered key areas were implicitly linked to existing frameworks developed to achieve integration (Kodner and Spreeuwenberg, 2002 and Lyngso *et al.,* 2014). Despite the protestations by several interviewees surrounding how little the Government understands health and social care integration, the opportunity to obtain sustained support from the Government in setting up the integration journey was considered important. It was suggested that the Government's series of workshops and planned activities were considered helpful. This view was however not a view shared

by all as several interviewees vehemently discounted the need for support. Despite this, many of the organisations, including those who considered the Government's support to be unwelcome continued to attend the organised training and understanding sessions. This may appear contradictory however there was a need for them all to attend to help to clarify the objectives of the legislation to achieve consistency. Determining a constructive outcome from the data it was evident that the clarity which does exist between all parties is the need for further understanding of the legislation. Continued discussion is necessary to reach a critical tipping point where integration following a consistent approach becomes the new norm. However, a full understanding of the objectives of the legislation is still to be achieved across the policy arena.

The third issue which was raised concerns the integrity of the Government's objectives for health and social care integration. While the need for approaching health and social care as a joint endeavour was essential, there remained a reticence to wholeheartedly buy into the Government's vision. This appears to be for fear of a 'hidden agenda' influencing the remaining functions of the two key parties delivering integration. The concerns were founded on the pace of integrated change being delivered by the Government in relation to a Scotland wide agenda. This includes integrated fire service, police services, health as well as health and social care services. Along with this the Government's rhetoric around school education may be seen as the first steps towards the establishment of a Scotland wide children's services organisation. The research revealed this was a widespread concern which focused on the ability of the two organisations to pursue a truly locally defined democratic decision-making organisation. This concern was still articulated despite the interest in locality planning expressed by the Government.

The opportunities provided by additional support from the Government have not been ignored by the Health Boards and Local Authorities. The need for additional support is debated in different sections of this thesis however from a governance perspective, the need to harmonise procedural approaches

and joint working is arguably an opportunity missed. Vital considerations such as consistent contractual arrangements for staffing, technology contracts and indeed funding can and will only be achieved, especially across multi organisational joint boards, if Government support is provided to free existing agreements and reach a united approach. A simple, yet effective example of this is in the case of staffing arrangements. As both come together from the Health Board and Social Services there is a need for them to be managed and funded collectively as one team. This non joined-up approach has, over the years created disharmony among staff and the general public alike. As an example, even with the creation of unitary authorities in 1997 it took many years to harmonise the salary gradings of various staffing groups involved in this integration. While single status regrading approaches has all but resolved the grading issues, the disconnect created by the inability of the organisations to resolve the issues timeously created challenging relationship and team working issues which remain today. One particular participant raised serious concerns about the changes meeting the financial imperatives of health and social care integration simply through the extensive management arrangements that exist. One example which was quoted was the need for two managers to work within one field of work at all times simply because the staffing compliment was derived from two separate teams. When queried further with other officers it would appear that this was not a unique situation and indeed many examples of this type of duplication of effort were readily identified.

5.4 Partnership Working and Organisational Development

The perception of participants was that integration had been tried in various formats over the previous two decades, without real success. There was therefore a concern that the approach, unless fully understood by those tasked with its success would again fail to realise the benefits. That said however, it was understood that the time was right to develop integration especially given the increasing costs of individual care and the inability of individual organisations to continue to resource long term support. The variations were driven by demographic changes, as the population continues to live to a greater age resulting from the improvements in health and social

care interventions. The rising cost of care and an ever-decreasing source of revenue through, for example increased state pension costs, welfare costs and low inflation the need for changes in service delivery is self-evident (Allen and Stevens, 2007; Gibb *et al,* 2002). Of course, this continued growth in health care requirements is not static and resourcing to existing levels is not maintaining the service but merely reducing the speed at which the service fails.

One of the key attributes which the research identified was in ensuring all decision-making processes are fully recorded, audited and scrutinised. This is considered especially vital to ensuring good governance within a fledgling board and to ensure that early decisions have a clear logic attached to how they were derived. This initially appears to be a basic requirement of any organisation however; examples of poor practice were given including the derailment of the integration process within an organisation when relationships became disharmonious. When questioned about the trust and working relationship of Board Members, all interviewees stressed the need to achieve developed relationships built on trust, although many conceded the need for the relationships to mature further before they are confident that decisions are being reached appropriately. The trust of partners within an organisation was another attribute which was seen as delivering a successful board. Trust helps to ensure an atmosphere of achievability and greater understanding of the boards business, which Garratt (1996), Vince and Saleem (2004) and Abbot *et al.* (2008) establish as key to the process. In addition, despite the scale of support offered by the Government to facilitate health and social care integration, the level of understanding amongst practitioners, together with the level of trust of the Government's agenda remains low. The opportunity to build on those concerns for future project development and implementation is significant. Smith (2005) suggests a lack of trust of this level begins with the distrust of all parties; Government, managers and practitioners which marginalises the trust the public has in Government modernisation policies. Allied to the existence of trust is ensuring the practicalities of the governance of differing organisations was a potential issue for the establishment of the joint board. The recommendation

was for a separate entity devoid of the ties of Local Authority and Health Boards control being a preferred route.

Establishing a board which has responsibilities to both organisations is a soft option without the required strategic autonomy. Respondents considered a 'new body' would allow the development of delivery elements such as appropriate contract arrangements, staffing issues and team development which is lacking when organisations remain tied to their existing establishments and within the 'shadows of hierarchy' (Peters, 2011). The development of a unitary body with autonomous authority challenges the silo working of long established organisations which deliver services in a manner where processes and governance is often developed to suit 'bureau shaping' (Simon, 1976). Flynn (2012) and Rhodes (1992) identified with the complexity of organisational structures, suggesting the public sector is often more complex than it first appears. The multifarious development of organisations is often the result from additional services and legislative additions, often known as repetitive legislation Rhodes (1992). Massey and Pyper (2005) and Flynn (2012) suggested this is supplemented by the overwhelming desire of politicians to constantly restructure and change the service dynamics of organisations. The opportunity to create a new organisation untethered by such interference would be a positive step forward.

Displacement of power is an issue amongst practitioners. There is always a challenge when powerful organisations with Chief Officers with considerable influence and responsibility foresee a reduction in their control and budgets. Many organisations have not enjoyed a good relationship between officers at a managerial level as the boundaries have been blurred between service provision have reduced and financial impacts have been experienced. Relationships which have been challenging in the past have become intolerable in some circumstances and the requirement to work collaboratively has raised concerns over diminishing responsibilities. The research showed the concerns surrounding the financial impact of developing an Integrated Joint Board during a time of unprecedented

financial austerity in public services. The key issues here concerned the delegation of funding to the Integrated Joint Board while continuing to cut funding to the remaining services. Interviewees were apprehensive by the level of miscommunication around budgets, perhaps leading to a culture of resentment from other public service staff not involved with health and social care integration. One participant particularly referenced the re-distribution of funding being reported by Government as new money. Government rhetoric can substantially damage the objectives of change. It is of course, dependent on which side of the chain the issue is being taken from however, it is clear to all that funding is limited and services are greatly challenged to deliver existing services alongside this new initiative. Criticism can be levied at the Scottish Government for not proposing a clearer examination of funding streams prior to the integration initiative. This has led to uncertainty and complicated nature of resources.

It is arguably, the nature of all political parties to be limiting in their clarity around funding to project an image of greater financial accountability. Maddock (2002) and Storr (2004) are clear in their view of funding of any transformational project of this scale, and suggested that funding should be transparent, relevant and should help to build trust between all parties otherwise initiatives are doomed to failure. While innovation and challenge may help to drive forward change, reliance on an underfunded organisation to deliver a multi-faceted model may begin badly and suffer difficulties along the way. Data confirmed the level of apprehension amongst Chief Officers of their ability to successfully develop the Government's flagship health policy model during a prolonged period of austerity measures. Officers suggested the continuation of an approach where income is challenged by the restraint of Government to raise additional funds through increases in taxation. Set against a background of reduced disposable income of those being taxed is understandably challenging. The reality however is that we live in an era of demanding and competing services where we can either acknowledge the lack of funding or address it through appropriate and proportional increase or services may invariably be detrimentally affected.

Discussion around collaboration consistently led to the richness of data in the study. This is understandable given one of the key drivers of health and social care is to integrate services currently delivered by more than one source. The research identified several important elements to develop collaboration. The recognition from an early stage that collaboration is difficult involving the co-creation of a single entity (in this case) between partners from very different cultures, services, values, budgets, reporting and scrutiny arrangements, one democratically elected whilst the other is controlled by Government. While there are many proponents of partnership working extolling the virtues of these arrangements (Waddock, 1988; Huxham, 1993; Everett and Jamal, 2004; Dickinson and Glasby, 2010 and Larkin *et al.,* 2011), there are also considerable numbers of critics (Jarillo, 1989; Cramton, 2002; and Williams, 2012;).

It was evident that the recognition of a central, dynamic and transformational strong leader is an asset in developing partnerships as this role is key to negotiating and developing agreement and ultimately achieving the set objectives (Newman, 2005). Evidence of actual and perceived minimising of roles within some organisations were a destructive power in achieving partnership working as boards consisting of Chief Officers were reticent to give up their strong positions for fear of having a lesser role to play in the new board. Therefore, the need to ensure equality in the partnership was identified as a vital element. It was evident there was a strong desire from some parties to deliver on integrated services but their lack of understanding of the approach to achieving this was also evident. As the boards are comprised of different people from very different organisations, bringing different skills to offer and invariably different levels of understanding, the need to ensure everyone is at the same stage of development is a key element of achieving success. The difference between committee and board mentality was often discussed however the approaches to resolving the issue were less clear. The development of a substantial training programme was a solution which worked for two of the organisations. This ensured that members of the board were provided with the correct tools to achieve the desired outcomes.

5.5 Culture and Communication

The culture of the organisation should be aligned to the partnership working arrangements being developed by the board. However, it was evident that this was simply not the position. The organisations clearly had different cultures. The Scottish Government, continued to adhere to a clear command and control approach whilst the other principle actors were factual, clear and supportive but also clearly well managed, selective and politically driven. The Health Boards interviews retained a clarity of service delivery which was reflective of conventional wisdoms and the status quo. It was palpable from the interviews, the Health Boards staff considered their role within the partnership to be superior to the role of that of others as the well-being of the consumers was a role traditionally undertaken by their organisation. During the discussions, there was a clear understanding expressed that the role of medical practitioners was professional beyond the scope of others. This was a common theme that ran through the interviews with Health Boards staff and was not unique to any particular individual or locality. It is clear to observers that maintaining such a lofty opinion may have a negative impact on the behaviour and sustainability of integration boards.

In contrast, Local Authority staff had very different attitudes towards their approach to communication. Management staff understood the clear benefits integration had to offer but were very unsure how this could be achieved. The task appeared to be overwhelming and therefore to move forward staff need to deal with the developmental aspects of integration rather than some of the procedural, financial and peripheral issues. It would be inappropriate to suggest that this was the situation with all Chief Officers, as some were very driven to achieve the objectives of the legislation. Other Local Authority officers were clearly concerned with power within the board arrangements and uncertainty over their role. This may be understandable within organisations which have developed in a particular way, with a hierarchical structure which can no longer be supported. It was particularly clear from locally Elected Members who are being asked to think differently to the norm and perhaps differently to the role they conceived at the beginning of the Local Government involvement. Maddock (2002) identified

with the challenges of redesigning both Government structure to deliver greater efficiencies and roles within the organisation. Massey and Pyper (2005) and Flynn (2012) are clear in their views of challenging the structural approach of organisations to work better together to deliver improvements without slavishly conforming to a remould of public services at the behest of political objectives.

Consistency should be a key driver to change within the culture and communication of a new board. The language of the three Principal Stakeholders is very different which can lead to confusion for the end user. A clear example of this is when each interviewee was asked how did they refer to a consumer of the service. The answers ranged from Service user through Patient to Customer. This may appear to be straightforward but the significant differences in how the consumer is perceived in the mind-set of the organisations was vastly different.

Communication is of course a substantial element of any new project and ensuring appropriate communication with the different stakeholders was vital to the project. The success of communication was the recognition that different organisations were becoming one with a key goal of delivering health and social care integrated services Glasby and Peck (2004), Gilbert (2005), Robb and Gilbert (2007). There are many streams to communication; firstly, and most importantly the need for clear and strategic dialogue within the board, directing the objectives of the legislation and the localised requirements to achieve successful outcomes. As Evans and Ross Baker (2012) noted the success of effective communication between parties will facilitate trust, buy-in and cooperation between individuals. One of the key messages which was made clear during interviews and participant's reporting of discussion at professional workshops was the lack of successful cascading of relevant information to staff.

As 'organisations toil to transform from separate entities place to a unitary organisation business as usual' approaches are paramount. Focusing on the discussion, the research revealed that employees indicate a basic

understanding of the legislative objectives but a concerning lack of understanding of how their employing organisation will achieve them. This has led to a certain degree of frustration which if not appropriately managed will have a negative effect on the very objectives the Government wish the boards to deliver. A participant raised the issue that Chief Officers were so concerned with developing a formula that worked before communicating it would only lead to failure as employees had not been given the opportunities to develop the approach and therefore buy in to its success. Generally, a lack of communication has far reaching consequences which Walsh (1995), Allen and Stevens (2007) and Evans and Ross Baker (2012) suggested would lead to non-conformity, miscommunication and disorganisation, the very issues which successful communication strives to negate.

One concern of the research was the evident disconnect between organisations in relation to successful communication of integration and the role of joint boards to members of the public. Some organisations considered the consistent change message should be undertaken as an overarching role of the Government to make best use of the budgetary superiority of the Government in using the media whilst others were more hesitant in communicating any form of change to the public. The logic behind this school of thought was that the public consumer of the service should not be aware of the different groups involved but instead experience a joined-up approach through appropriately implemented processes. Larkin (2011) argues that clearly defined organisational roles and responsibilities will help to achieve a seamless provision of services for consumers.

5.6 Technology and Information Management

This section discusses the key findings that emerged from a specific discussion on information management and how technology may help enable the secure sharing of data. A strong emerging theme from the research related to the concern from all parties that sharing of personal data was difficult to achieve yet, organisations have long since established data sharing protocols which could be leveraged to share and manage data. The protocols exist to ensure the data is used within specific and agreed

principles however, integration requires that data becomes available for everyday use by the parties involved. Work and Pawola (1996) and McNamara (2000) established an early need for an accomplished care pathway record for multi-disciplinary teams as a key component of integrated health and social care. Many of the challenges associated with determining a consistent approach is the current array of data management systems which exist not only between partner organisations but across Scotland. Allied to the systems is the contractual arrangements which are in place and the multiplicity of integrations between other organisation systems. In one of the Integrated Joint Boards, three different social work information management systems existed, none of which connected or shared information with the Health Boards. Each of the Chief Officers interviewed raised data sharing as one of the key drivers to successful integration but considered themselves equally unable to deal with the problem.

Many Chief Officers suggested the need for consistency across information with a 'biting the bullet' approach to replacing existing systems with a Scotland wide information management system. The use of information has very different drivers for the various professionals who require it and raised concerns surrounding the professionals 'need to know' approach to information. Sharing of the information should only be available between the professionals providing the service. Sharing of information is not unknown in the public sector in Scotland and many organisations have started to engage with existing technology suppliers to provide a portal approach to sharing information. This will enable organisations to share data from different systems to allow it to be used and enhanced by others. The shared data is managed by accessibility protocols to ensure that appropriate access rights are in place before the professional can access the data. Trust, as Kelly et al (2002); Brooks (2002); Christiansen and Roberts (2005) and McCormack et al (2008) agree is a basic requirement of data sharing to ensure consumers are confident in the data management systems and in the use of their personal data.

Despite the different approaches to integrated data management being a stumbling block to achieving successful integration there is no solution being championed by the Government. The main finding from this research is that without a consistent and centrally led approach to this fundamental issue an opportunity to drive success is missing. If lessons are to be learned from previous pilot schemes relating to single shared assessment, joint health initiatives and trials of home health technologies it is that it needs to be led centrally. Only the Government can deliver umbrella legislation and resource to support the harmonising of data sharing protocols to enhance the use of personal data by the appropriate service provider involved.

Professional bodies also have a key role to play in harmonising professional practices and standards to eliminate professional biases to the access to data. Although not an unexpected finding the lack of clarity surrounding a single approach to shared assessment across all organisations was concerning. Hesitation in developing this process related to concerns about tailoring needs to each of the organisations requirements. There is significant evidence to promote the benefits of a single shared approach (Drisko and Grady, 2012) from the customer's perspective and of managing shared data for holistic consideration by the practitioners involved in the customer's care. It is understood that a centralised data management approach will not be without challenge contractually, competitively and financially however, there are many ways in which this can be collaboratively achieved.

5.7 Finance

This section discusses the main finding which emerged from the consideration of finance in health and social care integration. The finding, is built on the considerations of those interviewed together with the research undertaken into literature based on the financial impact of integration.

Only one, albeit multi-facetted finding emerged which related specifically to the current financial climate. The benefits of having a unified budget for integration were emphasised throughout the data however it was recognised

there was a difficulty given traditional organisational budget responsibilities. The introduction of a major legislative change within a decreasing financial envelope was identified as the biggest challenge faced by the Joint Boards.
All of the participants were concerned that the ability to undertake such a challenge would invariably lead to considerable degeneration of other services as budgets were streamlined within the Local Authority and the Health Boards to support integration. The insistence by the Scottish Government of the availability of new funding has been inaccurately portrayed, mainly by the Scottish Government as budget cuts are reflective of the scale of the increase being identified to support integration. If honesty and transparency in budget management is to be at the forefront of the legislation, then as Joyce (2000) notes this should be shared amongst all parties to become responsive to the needs of the customer.

The often publicly cited overrun of initial budgets against large scale Government projects for example the Scottish Government (Holyrood building) serves to remind us of the promise of new projects supporting reduced costs and improved approaches (Fulop *et al.,* 2005). Midwinter (2009), a prolific contributor to public finance research acknowledges the role of Local Government in managing the stress of short term fiscal policies on local services. Given the combined views of the academic arena and the implementers of policies perhaps now is the time to refocus the priorities of the Government and reshape fiscal policy to reflect long term strategic funding. This may enhance opportunities for health and social care integration away from funding of lesser important projects to develop an infrastructure which will meet the increasing demands.

The thesis has previously addressed communication and here it is considered necessary to provide further comment in relation to integration finance. It is understood that integration has an important role to play in the future abilities of the Government to deliver appropriate health care and is constantly the subject of debate between the Government, joint boards and challenge from the media. As noted above, budgets to deliver integration will constantly be the main focus of service delivery and the levels of funding will

invariably always be identified as the main consideration of many service failures. That said, it is inconceivable why, when a major piece of legislation is developed and introduced, all parties should not be sharing an agreed understanding of Government support budgets. Honesty and transparency in changing the communication approach to ensure consumers, deliverers and supporters are presented with facts which are not manipulated to any party's agenda must be achieved. Without this approach, the ability of implementers to buy in to making the legislation a success will falter.

5.8 Development of a Conceptual Model

A conceptual model relating to the understandings of the key players is shown at Figure eight below. This shows the flexibility of the different elements associated with the understandings. These are:

- Culture and communication
- Partnership working and organisational development
- Governance
- Technology and information management
- Finance

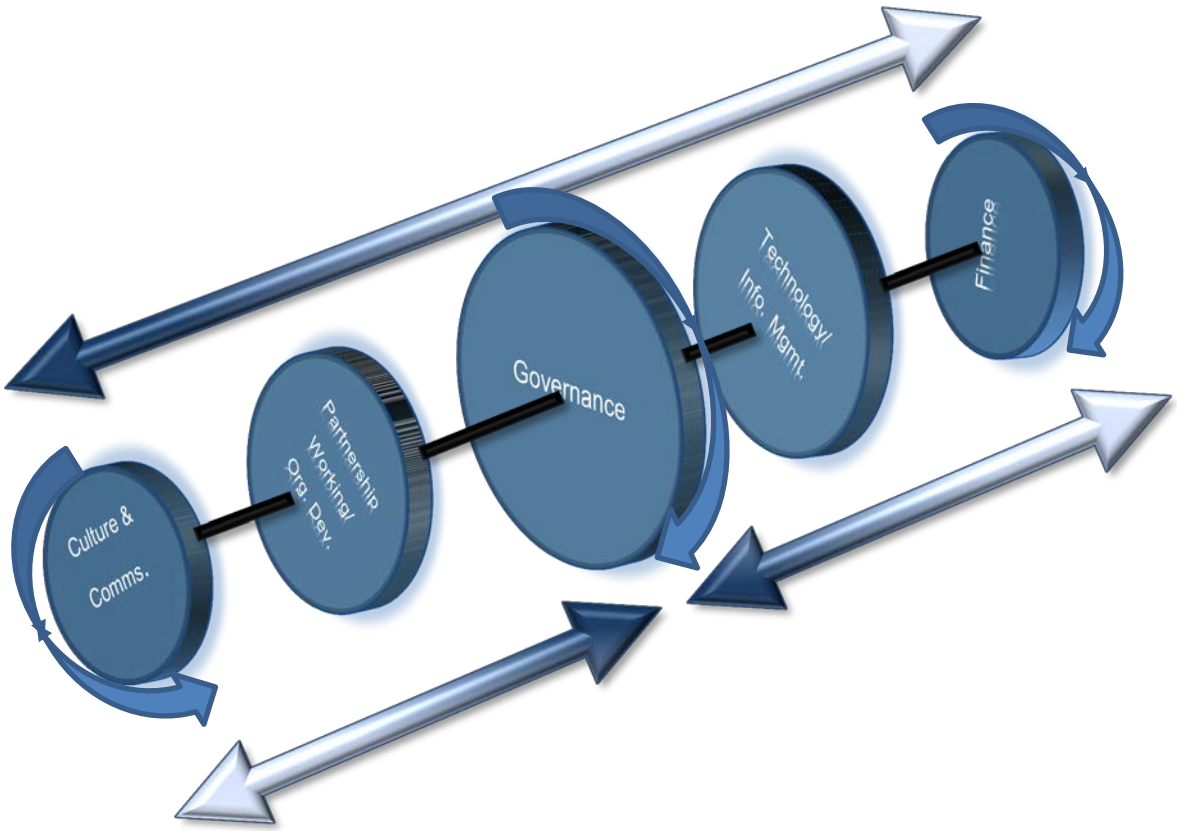

Figure 8: Conceptual model of factors influencing health and social care integration

(Source: Author)

It is suggested that each of these have a significant role to play in the successful outcome of health and social care integration. The model suggests the key role governance may play in integration, setting up the approach to integration and managing the delivery of the legislative approach. Ensuring that each of the other elements are co-ordinated in an appropriate manner and at the correct times to deliver integration. For this reason the circle has been placed at the centre of the model. The dynamic nature of the model demonstrates the evolution of health and social care integration along with the knowledge of the key players involved. The black rod demonstrates the interconnectivity between the five key elements of integration identified in the findings, linking each of the elements together and helping to drive the change throughout each element of the model. While governance is maintained as the central factor, the arrows at the outer

edges of the model depict the fluid nature of influence that the other factors may have at any given time on organisational integration. This allows the model to turn around to adopt the necessary approach required at any given time to ensure the balance of each element is maintained and applied as appropriate. While the indication arrows at the top and bottom of the model show that the fluid nature of the model allows each element to move forward and backwards from the Governance position to enable priority to be given to the particular function at any given time. The model highlights the dynamic nature of change and therefore differs from the rigidity of other models identifying the key features of integration which suggest direct causal linkages and direction of travel (Packard *et al,* 2013 and Lyngso *et al,* 2014;).

This is a model which has interoperability at its heart, allowing for the model to be deployed, in this instance for health and social care development, but equally for any form of integration dynamic. The model sets out the key elements associated with developing an integration framework, which are unlikely to significantly differ from subject to subject. As such, the model can be used in integration projects throughout the public sector and beyond. A key example of this, which is a topic being discussed at the moment, is the integration of schools to be managed by a central organisation, taking away ownership of education from individual local authorities. The principles associated with that integration model identify clearly with the development of a centralised health and social care approach and would therefore benefit consideration in contributing to practice. Equally, other topical subjects such as criminal justice social work integration with courts and prisons would find benefits from this model. The model has ostensibly been developed for public services however the functions discussed above can be practically applied to private sector integration such as the merger of two or more companies. As such the transferability of the model makes it significant.

Jackson *et al* (2000) define a model as an abstraction or simplification of reality used to explore systems and processes that cannot be directly manipulated. The model above suggests that this may not be the case as the concepts presented may be open to manipulation by individual actors

within specific contextual situations. Manipulation is the outcome of proactive and reactive choices made in seeking to make sense of and enhance control of the context.

The thesis earlier discussed policy development and whilst it was made clear that the focus remained at early stage integration modelling the conceptual model has a clear connection with policy design, focusing on key associations with the new management approach to governance and financial management. While it may not fully associate with Hood's (1976) vision of perfect implementation it is clear to see associated elements. Equally, the political context in play in today's society is represented through many of the elements including the approach to partnership and collaboration, using digital to maximise data management and accessibility to provide a greater patient journey.

5.9 Summary

This chapter has presented the culmination of the research undertaken for this DBA thesis and offers a conceptual model for consideration by Principal Stakeholders involved in future integration imperatives. The perspectives of the Principal Stakeholders' understanding of key changes in health and social care integration was the ultimate aim of the DBA research which was informed by the examination of associated literature and the development of research data from Principal Stakeholders leading on the implementation of the integration agenda. The concept model was derived from the outcomes identified through the research. The chapter concludes with descriptive outcomes of the key findings from the research and proposes these outcomes should be considered for future integration projects.

6. Conclusion and Recommendations

6.1 Introduction

The purpose of this chapter is to revisit the contributions to research the DBA thesis brings and to document the areas of research which would benefit from further consideration. The chapter is set out in five sections finishing with a consideration of the personal benefits the DBA has brought for the author.

6.2 Achievement of the Research Aim

The aim of the study was to critically analyse Principal Stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration. Additionally, the research aimed to develop a conceptual model which would help with the understanding of the outcomes and place the challenges at the centre of the research findings. It is considered the aim of the study has been achieved as a set of outcomes have been developed which are strategically developed for consideration at a board level but offer a significant degree of practicality which can be used to help guide operational considerations. This has been supplemented by the development of a visually constructed conceptual model which considers five key areas for successful.

Aided by the consideration of existing literature across which considered each element of integration determined in previous chapters, the thesis focused on the views and understandings of Chief Officers from Local Government, the Civil Service and Health Boards. These views were current and lived throughout the duration of the research. Views were also considered from Elected Members who held a senior role within the Integration Boards and who were able to bring significant knowledge of the subject matter and the workings of Local Government and health. The use of academic literature was invaluable in defining the initial themes which led to the subjects for discussion throughout the research. Subjects which ensured the discussion between senior officers and the researcher flowed without

significant clarification or consternation. The findings give rise to a number of implications for future research and practice which are discussed later.

6.3 Contribution to Knowledge

Central to this study is the determination of the areas considered for research based on the phenomenological analysis of key literature and research data. In the main, the findings of the thesis support many of the fundamental concepts of available literature. Where this thesis differs is in relation to the detailed understanding taken from the perspective of Chief Officers who are in the formative stages of health and social care integration. The addition of this new research, carried out during the establishment of Integrated Boards, their initial business cases and the evolvement towards operational models will help to establish a baseline for future research. Previous studies (Packard *et al,* 2013 and Lyngso *et al,* 2014) have focused on the instrument measures associated with integration with peripheral discussion from senior practitioners. While their approach is supportive for measurement of successes and challenges this thesis contributes further to practice, by developing a further insight to the challenges faced strategically and operationally by focusing on the views of Chief Officers who are engineering the implementation of integration and generating a proposed set of outcomes which, when considered during the planning stage may help to focus the approach.

In general, the benefits of the research lie in the outcomes identifying considerations which should assist in the enablement of future successful integrations by avoiding some of the pitfalls experienced by those officers and organisations. Each of the main characteristic of integration as shown in the outcomes offer considerable benefits. The importance of governance in the overall concept cannot be underestimated in achieving a strong foundation on which to build each of the components and enabling the development of customer centred solution as understood by Osborne and Gaebler (1992); Hood (1991); Clarke and Newman (2007) and Fisher and Elnitsky (2012).

The second perspective offered by the study concerns the importance of developing a consistent collaboration between the stakeholders where trust is a vital component. Garratt (1996) and Abbot *et al*. (2008) established trust as key to the process. This research has shown that it is possible to operate with a reduced degree of trust however where this is evident, the benefits to the progression of the objectives are considerable.

6.4 Contribution to Practice

The outcomes of the research provide a distinct perspective from Chief Officers of the challenges associated, in this case with health and social care integration but for use by any integration model. Offered to practitioners is the sound experiences from the evaluations of three different groups of Chief Officers; Civil Servants, Health Boards Officers and Local Government Officers. The latter can be further defined to include Elected Members. The thesis outlines how organisations have struggled with elements of integration and how learning can be applied across the sectors to support and indeed mentor each other.

A number of implications for practitioners have been developed which begin at the planning stage and progress through to the implementation and business as usual, embedded in practice stage. The thesis proposes that an early understanding of the objectives of the strategy, portrayed consistently to the different organisations through legislation is vital to the success and believability of the legislative goals. The health and care legislation, a model which has the capacity to drive change, confuses the target audience in the various iterations which were initially being developed. This led to, and in some cases, continues to contribute to confusion. It is therefore vital that in practice a sound and clear understanding of the objectives are determined. This is not of course unique to integration and while these should be applied to the beginning of any change project, they often remain unclear.

The second key contribution lies in the consistent understanding of all parties involved. Individually, each organisation unquestionably understands their role and therefore their contribution to achieving integration. The confusion

which arises, and must be avoided, relates to the cross understanding of each other's' roles and agendas. The thesis has throughout the document discussed trust and the potential impact of not developing trust. The determined situation is the issues with trust begin at a very early stage. Any change model will have a considerable impact on all parties and it is therefore vital to all that setting clarity at the beginning and enabling a clear understanding for others will contribute to a more informed discussion of what is trying to be achieved and will ultimately allow for greater agreement across all parties. It is appreciated that each organisation has their own influences to consider which may not be suited to all however a greater understanding of these will lead to the development of trust and consistency of approach. The outcomes of the thesis also focus on communication and the role of a dynamic leader. Throughout the data gathering sessions, many of the individuals interviewed played a vital role in the integration boards developed to achieve the change yet, their outlook offered a less than transformational approach (Newman, 2005). It was clear from the organisations who portrayed strong leadership throughout the interviews, projecting an image of confidence and a belief in their agreed approach were at an advanced stage of integration. Evidence suggest the ability to emerge as a transformative leader provides the confidence in others to support abilities.

6.5 Limitations of the Study

The aim of the study was to critically analyse Principal Stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration. To meet this aim, the study adopted an interpretivist phenomenological methodology to explore the views of the research literature and the data recovered from the interviews with the stakeholders. This approach was undertaken to expand the literature which is available on health and social care; literature which maintains a focus towards understanding the components of integration and the measurements of achievements rather than understanding the challenges. The research was not aimed at providing confirmation of the existing literature but merely

to offer a different view of integration using an interpretivist standpoint. This approach however offered a great deal of challenge in ensuring the views of those interviewed were appropriately challenged, given that it was their experiences but also appropriately represented without personal bias or misunderstanding. Smith and Osborne (2003) suggest this will be for others to determine.

The methodology, in the view of the researcher, was wholly suited to the sociological nature of the research being undertaken. The semi-structured interview method of data collection as such provides the opportunities for the interviewees to be relaxed and open to a more discursive approach. This, in some cases provided the 'nuggets' which helped to progress the research. That said however, it leaves the research open to criticism that the qualitative framework assumes a value free framework. The opposite however can be argued in defence of the research as the research methodology closely aligned to the framework defined by Grix (2010).

Turning to the practical perspectives of the research, the data was gathered from a sample of organisations and individuals involved in integration. The numbers involved may be considered as unrepresentative of the scale of the challenge and the number of organisations involved in integration throughout Scotland. Specifically, criticism may be aimed at the decision not to include the private sector within the scope of the study. The research was developed to understand the perspectives of Principal Stakeholders. The interpretation of Principal Stakeholders in this research is those having budgetary responsibility for implementation. As private support is procured directly by the Principal Stakeholders it was considered, the views of the private sector, whilst perfectly valid, would expand the research beyond the terms warranted by the scope.

Finally, the research was limited to Chief Officers and understandably due to the effects integration will have on consumers of the service there is arguably a concern that the views of the consumers should have been taken into account. As the research is based purely on the understanding of the

challenges the Principal Stakeholders have, the views of the consumers are of lesser importance within the research.

6.6 Future Research

A number of areas have emerged as potential opportunities which may warrant further research consideration. Uppermost in the considered areas is the longevity of the objectives of the research. The research was conducted at a time when business plans had been recently developed and submitted and approaches to integration were being formulated. The opportunity to return to the original organisations and indeed contributors within an agreed post implementation timescale to understand if their perspectives remained consistent with the findings of this research would be beneficial as it would assist in the determination of a long term set of principles which would form the foundation of integration implementation

The second area relates to the political dynamics of the integration agenda. As the political landscape of Local Government may arguably change more towards a single political governance structure, the impact of the change on funding, the dynamics within the leadership of the Integrated Boards and consumer expectations may provide a further insight into the political motivation of change programmes and how the effects impact directly on the existing undertakings. As previously stated, despite the scale of support offered by the Government to facilitate health and social care integration, the level of understanding amongst practitioners, together with the level of trust of the Government's agenda remains low. The opportunity to build on those concerns for future project development and implementation is significant. Smith (2005) suggests a lack of trust of this level begins with the distrust of all parties; Government, managers and practitioners which marginalises the trust the public has in understanding and supporting Government modernisation policies. The potential for changes in the political landscape may therefore warrant further understanding.

This research has been conducted ardently to consider the changes in health and social care. Integration is however an approach being fervently applied

to many public-sector approaches for example the development of unitary police and fire service services. The challenges of integration can be applied across the many sectors which will ultimately be affected by such change agendas. It is therefore offered that the findings from this research could be grouped with research conducted for other integration models to understand if there is scope for the development of a redrafted conceptual model which would support future projects. This is suggested based on the findings of experts with the field studied. Undoubtedly the breadth of knowledge which will be available from other studies may support further illustration of combined findings in order to provide a meaningful contribution to practitioners in similar yet different fields of practice.

Finally, it can be determined that there are two areas which may delay the importance of the integration agenda; namely technology and information management. The lack of clarity surrounding a single approach to shared assessment across all organisations is concerning. Hesitation in developing this process relates to concerns about tailoring needs to each of the organisation's requirements. There is significant evidence to promote the benefits of a single shared approach (Drisko and Grady, 2012) from the customer's perspective and of managing shared data for holistic consideration by the practitioners involved in the customer's care. The development of a suitable technology solution using an approach which suits all parties will be challenging but needs to be led by a Government directive in order to ensure a consistent view of citizen data and regulated access is available. Further research relating to the progress of a generalised subject of information management within this field would be valuable to the success of health and social care integration.

6.7 Recommendations

Within the previous sections a series of implications for practice has been identified as flowing from the study. Each of these have a considerable impact on the integration agenda moving forward and given that health and social care integration is on the cusp of considerable integration modelling

the following recommendations are made for consideration by Chief Officers and Practitioners alike.

6.7.1 Recommendation One: Build Upon Previous Experience to Legislate with Appropriate Power

Throughout the data collection process there was considerable criticism of the approaches taken by successive Governments to progress a form of governance capable of advancing a joined-up approach to health and social care for the consumer. Although participants could point to previous successes within their individual organisations these were minor. Difficulties arose from the differing contractual, financial and HR practices resulting in the 'bureau shaped' delivery models. To address these challenges and to reach harmonisation in procedures and approach going forward, it is recommended that the Government facilitates the development of a 'new body' with appropriate legislative power to cut across these issues to provide the body with the appropriate tools to deliver services which are fit for health and social care service delivery.

6.7.2 Recommendation Two: Ensure Delivery of Appropriate Approaches to Educational Development

A lack of understanding the legislation, from the Government's strategic imperative was evident from the data gathered through discussion. While continued collaboration within Integrated Boards is required to help understand the nature of local delivery it was clear that the required understanding of the concept and objectives of health and social care was lacking. It is therefore recommended that any future legislative directives which require substantial input from parties drawn from different backgrounds, professionalisms and experience are provided with consistent and in-depth knowledge building sessions, which identify with individual learning skills and starting knowledge. These centrally provided sessions should be accompanied by locally developed sessions, prior to each board meeting, which are tailored to suit the business agenda. This will help to ensure the foundations on which to build the required outcomes are present.

6.7.3 Recommendation Three: Set the Opportunities to Develop Trust and Challenge Power Management

It was observed that trust among partner organisations existed in many cases between individuals but less so at an organisational level. Data showed that distrust was determined from many elements including professionalism, power challenges, historical content and arguably the arrogance shown by some individuals. Additionally, trust issues were often derived from a misunderstanding of the outcomes and decisions derived from Board discussion due to inappropriate recording, auditing and management approaches. It was clear that where trust had been developed, these organisations had matured considerably in their ability to deliver change. The maturity of Boards was often accompanied by a central, dynamic and transformational strong leader. It is understood that the loss of power by individuals and indeed organisational power can be challenging however, without providing a context in which power can be redefined from individuals in a manner which helps develop trust the ability to work together is limited. It is therefore recommended that all issues of trust and power are discussed within the board in an open, and honest way, ensuring issues do not fester and derail the Board's objectives Only by doing this will it develop a maturity within the Board which to tackle the challenges of integration.

6.7.4 Recommendation Four: Define the Culture and Communication

The collection of data was often challenging due to the multiple ways in which language was used by the different parties to mean similar or the same thing. It was clear that little attempt had been made by any organisation to introduce a culture based on the new Board and were continuing to communicate in a way which caused confusion. It is therefore recommended that this is avoided by all parties and the development of a common culture and communication approach is developed and consistently used.

6.7.5 Recommendation Five: Implement Appropriate Information Management Protocols

A key challenge which every participant discussed related to information management. Information management was defined in two ways; the protocols used to collect consumers' data by all organisations and the lack of integrated technology to manage and share the collected information. In one of the Integrated Joint Boards, three different social work information management systems existed, none of which connected or shared information with the Health Boards. It is therefore recommended that defined and consistent protocols are developed nationally to avoid data' slipping' between different Boards and shared using a system which is fully integrated between all Principal Stakeholders. While this is a longer-term recommendation it is nonetheless a recommendation which will deliver a significant step change in the ability to truly deliver an integrated health and social care service.

6.8 Final Thoughts

It is now appropriate to return to the aim of this doctoral research, which was articulated at the outset of this study as:

To critically analyse Principal Stakeholders' perceptions of the challenges in the implementation of health and social care integration in Scotland in order to develop a set of influencing factors to enhance future integration.

It is proposed that by undertaking the DBA journey and contemplating each of the research questions set out in the thesis, the research aim has been fulfilled. Specifically, the aim has been accomplished through the examination of appropriate and supportive literature, the undertaking of the research semi-structured interviews using an interpretivist phenomenological methodology before presenting the outcomes of the research as a table of supportive considerations for the development of integration practices. To support this, a conceptual model was developed which helps the reader understand the outcomes from the research and demonstrates the flexibility required in achieving the goals set.

The thesis maintained focus throughout the research journey and the outcomes from the research presented add value to the academic body of knowledge and importantly to the researcher, to the practical application of future integration projects.

It is therefore appropriate to finish this thesis having suggested other areas for future research which may help to further the academic body of knowledge and to provide further clarity to the longer-term impact of integration models.

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Appendices

Appendix 1 - University Ethical Consent

Edinburgh Napier University Research Consent Form

Research Title: Understanding key challenges in health and social care integration in Scotland: Key stakeholders' perspectives.

Edinburgh Napier University requires that all persons who participate in research studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

1. I freely and voluntarily consent to be a participant in the research project on the topic of health and social care integration in Scotland to be conducted by Allan Stewart who is a postgraduate doctoral research student at Edinburgh Napier University.

2. The broad goal of this research study is to understand from key policy actors the challenges in the implementation of health and social care integration in Scotland. Specifically, I have been asked to participate in a semi-structured interview, answering questions in relation to my own organisation's approach and offering my personal opinion of the effects of health and social care integration in relation to the subject matter. This should take no longer than one hour to complete.

3. I have been told that my responses will be anonymised. My name will not be linked with the research materials, and I will not be identified or identifiable in any report subsequently produced by the researcher.

4. I also understand that if at any time during the interview I feel unable or unwilling to continue, I am free to leave. That is, my participation in this study is completely voluntary, and I may withdraw from it without negative consequences. However, after data has been anonymised or after publication of results it will not be possible for my data to be removed as it would be untraceable at this point.

5. In addition, should I not wish to answer any particular question or questions, I am free to decline.

6. I agree to my interview being digitally recorded and notes taken.
7. I have been given the opportunity to ask questions regarding the interview and my questions have been answered to my satisfaction.
8. I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

Participant's Signature Date

I have explained and defined in detail the research procedure in which the participant has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

Researcher's Signature Date

Appendix 2 - Semi-Structured Interview Questions Scottish Government

- What was the vision of the Government when developing the legislation?
- Why did you consider that integration was appropriate?
- What do you see it achieving?
- Why take this particular approach?
    - Why do you think this approach is the correct one?
    - What other approaches did you consider?
- Why do it at this time?
- Who does the Government consider are the key players?
- What do you see is the role of the Health Boards?
    - Is this the role of all Health Boards or are their different roles?
- What do you see is the role of the Local Authority?
    - Why do you say that?
    - Is this the role of all Health Boards or are their different roles?
- What outcomes do you expect the organisations to deliver?
- How will you know these are being achieved?
- What realistically is the timescale you anticipate integration will be achieved within?
- What do you anticipate are the barriers?
    - How can these barriers be overcome?
- How do you think resources will affect integration?
- Turning it on its head, what do consider are the risks of not integrating?
- What are your expectations of collaborative working to achieve integration?
    - What role should the public and private sectors play in this?
- How do you think consistency can be achieved?
- Have all the business plans been received?
    - Do you consider the organisations understand what you are trying to achieve?

    - Why do you think that?
- How will you measure success?
- What approach will be taken in the case of failure?
- How do you see good practice being shared?
- What support will the Government provide and at what stages?
- With current concerns around cyber terrorism, what is your view on sharing information between organisations?
- The aim of the thesis is to understand the key challenges in integration – is there anything missing for you as an organisation?
    - Is there anything you consider I haven't covered?

Appendix 3 - Semi-Structured Interview Questions – Health Boards

- What role do you think the health authority has in integration?
- What are the key challenges?
- What are your thoughts on timing of the integration agenda?
- Do you think integration is appropriate?
- How do you see integration being implemented?
- What do you think are the key drivers for health and social care integration agenda?
- What have been the key influences in developing your approach?
- How did you set about interpreting the legislation?
- Did you require clarification of the legislation?
    - Do you consider there are areas of the legislation which are unclear?
    - How did you go about understanding what was required in these areas?
- Who do you consider are the key players in implementing integration?
- What do you see is the role of the Government in this?
    - What do you consider are the expectations of the Scottish Government?
    - What do you consider are the outcomes expected by the Government?
    - How can you achieve these outcomes?
- What do you see is the role of the Local Authority in this?
    - What do you consider are the expectations of the Local Authority?
    - What part will you play in achieving those expectations?
- What support systems do you consider are in place to help with implementation?
    - Why do you think that?
    - Is support necessary?

- Do you think that each organisation is clear on what needs to be achieved?
    - Why do you think this is the case?
- What is the Boards understanding of collaborative or partnership working?
    - What approach has been taken to implement a partnership approach?
    - What have been the successes and difficulties in developing this approach?
    - Do you think the Government understands collaborative working to achieve integration?
        - Why do you say that?
    - Do you think the Local Authority understands collaborative working to achieve integration?
- What are your concerns/fears?
    - What approach do you think the Government will take if integration doesn't deliver?
- How far along the journey do you think you are?
- What do you consider you still have to do?
- The aim of the thesis is to understand the key challenges in integration – is there anything missing for you as an organisation?
    - Is there anything you consider I haven't covered?

Appendix 4 - Semi-Structured Interview Questions – Local Authority

- What role do you think the authority has in integration?
- What are the key challenges?
- What are your thoughts on timing of the integration agenda?
- Do you think integration is appropriate?
- How do you see integration being implemented?
- What do you think are the key drivers for health and social care integration agenda?
- What have been the key influences in developing your approach?
- How did you set about interpreting the legislation?
- Did you require clarification of the legislation?
    - Do you consider there are areas of the legislation which are unclear?
    - How did you go about understanding what was required in these areas?
- Who do you consider are the key players in implementing integration?
- What do you see is the role of the Government in this?
    - What do you consider are the expectations of the Scottish Government?
    - What do you consider are the outcomes expected by the Government?
    - How can you achieve these outcomes?
- What do you see is the role of the Health Authority in this?
    - What do you consider are the expectations of the Health Authority?
    - What part will you play in achieving those expectations?
- What support systems do you consider are in place to help with implementation?
    - Why do you think that?
    - Is support necessary?
- Do you think that each organisation is clear on what needs to be achieved?

    - Why do you think this is the case?
- What is the Authority's understanding of collaborative or partnership working?
    - What approach has been taken to implement a partnership approach?
    - What have been the successes and difficulties in developing this approach?
    - Do you think the Government understands collaborative working to achieve integration?
        - Why do you say that?
    - Do you think the Health Authority understands collaborative working to achieve integration?
- What are your concerns/fears?
    - What approach do you think the Government will take if integration doesn't deliver?
- How far along the journey do you think you are?
- What do you consider you still have to do?
- The aim of the thesis is to understand the key challenges in integration – is there anything missing for you as an organisation?
    - Is there anything you consider I haven't covered?

Appendix 5 - Introductory Letter

Dear

Health and Social Care Integration Research

I am a 3rd year (part-time) student at Edinburgh Napier University currently undertaking a research project for my postgraduate degree (Doctor of Business Administration) aimed at understanding the challenges in the implementation of health and social care integration in Scotland.

As health and social care integration is a relatively new legislation, and many organisations are still coming to terms with the prospect of achieving an integrated approach, it is an opportune time to consider the separate understanding of what the legislation hopes to achieve, with a view to developing a framework which can help to effect the change.

My interest in this field of research is based on both personal experience and the opportunity to implement legislative changes during my 30-year career in Local Government.

I am seeking permission to carry out research with members of your Joint Board to gather data for the research detailed above. This will involve a semi-structured interview with a very limited number of Board Members ideally, the Board Chairperson, the Chief Executive of each organisation and the Chief Health and Social Care Integration Officer. Where possible, I would also welcome the opportunity to interview a non-executive member of the board and a Local Member. It is anticipated the individual interviews would last no longer than one hour (per interview) in a location of your choosing, either within or near your workplace.

The interviews will be confidential and all data gathered will be anonymised before use in the thesis and any subsequent publications. I have enclosed a copy of the research consent form, which clearly sets out the conditions of

the interview. In addition, I can confirm that ethical approval has been sought from the University and approval granted. A copy of the approval is attached for your information.

After completing the research project, the findings will be published in my University thesis and data and research findings may subsequently be used to support publication of an academic paper.

My own Local Authority's Chief Executive is supportive of the work I am carrying out for my postgraduate degree and would be happy to confirm her support. Should you need to speak to my Chief Executive [redacted] for clarification on any matter, she can be contacted on Tel No: [redacted] or by e-mailing: [redacted]

The names and contact details of my supervisors at Edinburgh Napier University are as follows

Doctor Janice McMillan, Tel: 0131 455 [redacted],
E-mail: [redacted]@napier.ac.uk

Doctor Gerri Matthews-Smith, Tel: 0131 455 [redacted],
E-mail: [redacted]h@napier.ac.uk

If you are in a position to support this research and help me to achieve my post graduate degree I would be very grateful if you could reply to me by e-mail at [redacted]@live.napier.ac.uk or by telephone at [redacted].

My timescale for undertaking the research is the middle of February – May 2016.

I look forward to hearing from you.

Yours sincerely
Allan Stewart

Appendix 6 - Example of Data Analysis Step 2 Initial Noting

Name	Transcription	Exploratory Comments
Researcher	What role do you think that Local Authorities have in Integration and what do you see that role as being?	
CO X	I think Local Authorities are one of the two big players in terms of running and managing services alongside the NHS. The view of the Local Authority will be shaped to some extent by the size of the Local Authority and how many Local Authorities relate to the Health Boards. Where you've got a coterminous Health Boards and Local Authority the relationship might be a bit different in terms of, it being easier to align Services. Where you have one Health Boards and three Local Authorities, it gets a bit more difficult to get a partnership identity because there can be an emphasis on doing the same thing across the three partnerships rather than letting the partnerships develop their own identity.	• Interestingly the IJB is not referenced • Is there a concern regarding voice? • Does this imply favour towards one partner? • Importance of shared approach • Use of relationship rather than partnership • Raising concerns about the validity of partnerships? • Further reference to voice/identity? • Is this taken from an LA perspective?

Appendix 7 - Example of Data Analysis Step 3 Developing Emergent Themes

Emergent Themes	Name	Transcription	Exploratory Comments
	Researcher	What role do you think that Local Authorities have in Integration and what do you see that role as being?	
• Governance arrangements for integration • Collaboration to deliver service • Problematic relationships • Creating a new identity • Consistency of service • Over worrying the problem • Language of organisations	CO X	I think Local Authorities are one of the two big players in terms of running and managing services alongside the NHS. The view of the Local Authority will be shaped to some extent by the size of the Local Authority and how many Local Authorities relate to the Health Boards. Where you've got a coterminous Health Boards and Local Authority the relationship might be a bit different in terms of, it being easier to align Services. Where you have one Health Boards and three Local Authorities, it gets a bit more difficult to get a partnership identity because there can be an emphasis on doing the same thing across the three partnerships rather than letting the partnerships develop their own identity.	• Interestingly the IJB is not referenced • Is there a concern regarding voice? • Does this imply favour towards one partner? • Importance of shared approach • Use of relationship rather than partnership • Raising concerns about the validity of partnerships? • Further reference to voice/identity? • Is this taken from an LA perspective?