International Journal of Integrated Care – Vol. 9, 22 December 2009 – ISSN 1568-4156 – http://www.ijic.org/

Research and Theory

Faces of integration

***Paul Williams**, Dr., Reader in Public Management and Collaboration, Cardiff School of Management, University of Wales Institute, Colchester Avenue, Cardiff, CF23 9XR, UK*

***Helen Sullivan**, Prof., Chair of Government and Society, School of Government and Society, University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK*

Correspondence to: Dr. Paul Williams, Reader in Public Management and Collaboration, Cardiff School of Management, University of Wales Institute, Colchester Avenue, Cardiff, CF23 9XR, UK. Phone: +07732383527, E-mail: pmwilliams@uwic.ac.uk

Abstract

Theme: Two central themes permeate this paper—the interplay between structure and agency in integration processes and the extent to which this is mediated through sensemaking by individual actors.

Case study: The empirical base for the paper is provided by case study research from Wales which draws on examples of different types of integration in health and social care. The individual case studies highlight different interpretations of integration set against a background of the resources involved, processes employed and outcomes achieved.

Discussion: A wide ranging discussion exposes the complex interplay and dynamics between structural factors and the manner in which they enable or constrain integration, and individual actors realising their potential agency through leadership, professionalism and boundary spanning to influence outcomes.

The importance of structure and agency complementing each other to determine effective integration is emphasised, together with the scope that is available for interpretation and meaning by individual actors within the contested discourse of integration.

Keywords

structure/agency, sensemaking, Wales

Introduction

There is a long and chequered history of efforts to integrate health and social care in the UK [1–3]. Despite the apparent benefits to service users and providers of seamless services tailored to meet individual needs, a combination of professional, organisational, financial, statutory and other factors conspire against integration in many areas [4, 5]. Organizational fragmentation of health, social care and related services across the National Health Service, local government and other providers, and their respective differences in accountabilities, governance, culture and management are important obstacles. A variety of government interventions and reforms have sought to overcome these by encouraging a shared agenda, and devolution has allowed some divergence in approach between the countries of the UK. However, the integration challenge often remains acute despite repeated and well-intentioned efforts to achieve collaborative outcomes. The frustration with getting integration to work in practice has attracted the attention of researchers and policy makers, and there is a considerable body of literature that both offers theoretical insights into the complex issues involved [6–10], and practice guides to assist managers and practitioners in this field [11–13].

This paper examines integration through an exploration of the interplay between 'structure and agency' [14]—the role and manner in which structural factors either define or restrict the space for integrated action, and the contribution of individual agency in maximising or minimising the use of these opportunities to shape the outcomes of social action. In addition, a central theme of the paper is that this interplay is mediated through sensemaking processes [15] in which individual actors understand integration in different ways and

"seek to implement *their* understandings, to protect and promote their values and interests" [16, p. 124]. Here, outcomes can be seen as the result of multiple actors pursuing a plurality of interests rather than the enactment of normative understandings of integration underpinned by frameworks setting out the principles and architecture of an idealised integrated service or system [13, 17, 18].

The paper opens with a discussion of the role of structure and agency in integration, and the influence of ideas and sensemaking in shaping the course of individual action. It moves on to present the key findings from a recent research study of integration in health and social care in Wales [19] which is used to provide the empirical base for the paper. An outline of the policy context in Wales is provided together with the research methodology adopted, and then an exploration, through individual case studies, is undertaken of the different interpretations of integration highlighting the reasons for, and nature of integration, the resources involved, the processes used, and outcomes achieved. This is followed by a discussion of the dynamics of, and interplay between 'structure and agency' across all case studies with a focus on the ways in which structural factors enabled or inhibited integration, and conversely the manner in which individual actors used their 'agency' in the form of leadership, professionalism or boundary spanning, to influence the course of integration in practice.

Structure and agency in integration

The structure/agency debate is an enduring feature of the social sciences. It concerns those (structuralists) who believe that social, political and economic outcomes can be explained by 'structure' relating to form, function, context and setting, as opposed to those (behaviouralists) who argue that agency is the determining factor defined as the "ability or capacity of actors to act consciously … and to realise his/her intentions" [20, p. 94]. This debate is highly polarised and arguably falsely set up as 'oppositional'. Alternative approaches are posited by Giddens [21] who refers to a duality of structure, considering that the interplay between structure and agency is more dynamic and emphasizing the mutually important processes involved; and Jessop [22] who takes a strategic-relational approach avoiding the dualism of structure and agency and focusing on the interaction between strategic actors and the strategic context. The position we adopt in this paper is that: "actors make outcomes but the parameters of their capacity to act is ultimately set by the structured context in which they find themselves" [20, p. 254].

In relation to health and social care, the evidence base for explaining effective integration is complex, problematic and inconclusive prompting Kodner and Spreeuwenberg's [18] plea for an increased body of knowledge in this area. Studies of evidence-based practice reflect on what works [23], and on the drivers and barriers to effective joint working [4].

Figure 1 summarises the main structural and agential factors involved in integration identified by available evaluations, but the literature is less prescriptive in identifying the balance, strength, direction, sequencing and mixture of these factors. In the UK, successive government reforms and policy instruments have focused on structural parameters through the creation of new strategic and organizational vehicles, reconfigured joint services, and flexibilities to promote joint and lead commissioning and pooled budgets. Numerous recent examples of structural reconfiguration include, care trusts in England [24] and integrated health

Figure 1. Structural and agential factors in integration.

and social care trusts and boards in Northern Ireland [25]; financial and other flexibilities are made possible by the Health Act (1999); and, partnership working is encouraged through the establishment of community health partnerships in Scotland [26] and health, social care and well-being partnerships in Wales. These have been reinforced by legislation that places statutory duties on health and local government agencies 'to co-operate', and a powerful political rhetoric which champions the primacy of the citizen and service user in the design and delivery of public services. However, whilst structural reform is aimed at creating the 'space' for individual and organization action, the limited number of evaluation studies repeatedly point to unconvincing results caused by continued structural reform, and the practical difficulties associated with managing across different professional, organizational and cultural boundaries. Arguably, agency might not have attracted the same attention as structure, but there have been a number of interventions aimed at promoting inter-professional working [27] and integrated teams, and there is a growing realisation that actors in this field—leaders, managers and practitioners—need a distinct set of skills and capabilities to operate in this mode of governance.

The literature on collaboration between organizations and agents is bedevilled by problems of meaning and definition [10]. Different terms are used often interchangeably and there is no agreed definition [28–30] giving rise to confusion and misunderstanding. Integration is a widely used term in health and social care discourses, although again this is interpreted in different ways. Kodner and Spreeuwenberg [18] reflect a systems view referring to integration as the 'glue' that binds separate but interconnected components together; Leutz [31] refers to different levels of integration; integration is sometimes envisaged as a journey along a continuum [13] although the process along it is not inevitable and different positions may be fit for purpose for different circumstances and contexts, and finally, Glasby [32] considers that balancing depth and breadth of relationships between partners is fundamental to resolving the extent to which integration is pursued. Rosen and Ham conceive of integration in its complete form as "a single system of needs assessment, commissioning and/or service provision that aims to promote alignment and collaboration between cure and care sectors" [33, p. 2]. It can be vertical or horizontal; real, formalised or virtual; and can be manifested at micro, meso and macro levels. Characteristics of integrated organisations [13] include joint goals, shared or single management arrangements, joint commissioning, and joint arrangements for managing strategic and operational issues, and strategies for promoting integrated care [17] occur within five interlocking domains—funding, administrative, organisational, service delivery and clinical.

Conceptual ambiguity creates opportunities for agency, for actors to interpret and understand the nature and value of integration and to apply it in different contexts. Meanings are constructed in different ways [34] through individual framing—dynamic processes reflecting "disciplinary backgrounds, organizational roles, past histories, interests, and political/economic perspectives" [35, p. 4]. Critically, there is a close relationship between frames and interests, and they can be traced to sponsoring institutions and groups of actors [36]. Key actors sometimes referred to as 'boundary spanners' [37] operate as 'frame articulators' [38] helping to surface different meanings, and through effective inter-personal skills, networking, communication and negotiation, influence the course of integration design and implementation.

Research study: policy context and methodology

Although the legislative framework affecting Wales is broadly similar to the rest of the UK, policy divergence has been possible at both strategic and policy levels [39]. At a strategic level, Welsh Assembly Government developed a policy framework based on 'citizen-centred' and 'customer-focussed' services delivered in partnership across all sectors. An institutional structure was constructed with social care provided by 22 local authorities, and health care through 22 commissioning local health boards and 12 National Health Service Trusts delivering the services. At the time of the research, this arrangement was about to change with the abolition of the internal market and its replacement with seven local health boards discharging all health care functions [40]. The separation of health and social care between two sectors gave rise to complaints about lack of co-ordination, duplication, inefficient use of resources and insufficient focus on the service user stemming from differences in governance, accountability, culture and professionalism, exacerbated by incompatible performance management and budgetary frameworks [5]. In addition, inter-professional interests promoted integrated service models, and a national policy imperative aimed to re-balance healthcare from secondary to primary and community sectors. A number of structural features encouraged integration across health and social care boundaries including coterminosity of local government and local health board jurisdictions; financial flexibilities provided by the Health Act 1999 permitting joint commissioning and pooled budgets, and a supportive local partnership infrastructure underpinned

by statutory duties including health, social care and well-being partnerships, children and young people's partnerships and local service boards [41].

The research study was commissioned by the National Leadership and Innovation Agency for Healthcare in Wales (a capacity building organization) and designed to identify the key factors, influences and processes that determined effective integration. Particular attention was placed on understanding the balance and interplay between structural factors—whether they assisted or discouraged effective working between different agencies—and the role and influence of individual agency in leading and managing integration. A case study approach was adopted [42] with five cases selected to represent different approaches in different geographical parts of Wales. Each case study drew on an interrogation of relevant documentary evidence (reports and policy documents) coupled with a series of in-depth qualitative interviews with members of the local steering groups for each integration initiative. Between 12 and 15 interviews were completed for each case, typically lasting ~1 hour and based on a topic guide covering a range of themes including, contextual factors and drivers, role and purpose, governance arrangements, leadership and management, accountability, barriers, performance, resourcing and personal skills. The interviewees represented different organizations (local government, local health boards National Health Trusts, voluntary sector), different types of profession, included chief executives, heads of service, strategists and managers and practitioners responsible for policy implementation. The fieldwork for the study was undertaken between April and October 2008. All interviews were taped and analysed using comprehending, synthesising, theorising and recontextualising processes [43] to construct a thematic framework built from a scaffolding of categories, concepts and themes [44].

Integration in different contexts

The case studies provide examples of integration at different levels and in different contexts. The first type draws on the evidence of two cases—the provision of a specialised service for a vulnerable user group, and a UK-sponsored project designed to support people into secure employment; the second type involves two examples of integrating health and social care services within a defined local community area; and the final example relates to whole-system change and the redesign of health and social care services over a wide geographical area. Each case study briefly outlines the context and purpose of the initiative, the approach taken to integration, and the processes and resources mobilised to achieve their outcomes.

Service integration

This example was externally driven by a Social Services Inspectorate review of a local children's disability service that raised concerns about the fragmentation of resources; poor leadership; lack of clarity as to who did what; ineffective team structures and case load management; inadequate equipment and resources; problems with waiting lists; poor communication and information provision; inadequate consultation mechanisms with service users and a general lack of co-ordination between the individuals and agencies undertaking the service. The response to this catalogue of deficiencies was the establishment of a multi-agency project board, supported by a strategic manager funded with a time limited Joint Working Special Grant from Welsh Assembly Government, to design and deliver an integrated service.

The principles of an integration model were agreed [45] by the multi-agency board including, providing a single, simple route to access information, assessment, assistance and services; partnership working with an equal relationship with parent, child and professional; trans-disciplinary working with members of different agencies working jointly sharing aims, information, tasks and responsibilities; and a holistic approach to the needs of disabled children and their families. However, operationalising these and interpreting the nature, purpose and practice of integration proved to be highly problematical, not least because differing views among actors about what was possible or desirable. For instance, a local health board manager stated that: "I am not in favour of complete integration; I'm not convinced that it will deliver significantly more benefits for clients; it is too much hastle", and a medical consultant commented that: "If you have good co-ordination, a good atmosphere and culture and you respect one another, does full integration add anything else? It can be worse in terms of professional isolation, confused accountabilities and lack of support for on-going education and professional training". On the other hand, a health trust manager felt that full integration and pooled budgets were the only way forward, whilst a senior education manager favoured: "a half way house arrangement with staff co-located but retaining line management responsibility to their own agency and without the need to pool budgets". Service design and delivery were compromised by these different understandings, exposing the extent to which different professionals and organisations were prepared to negotiate power and authority.

In practice and without additional resources, an incremental approach was adopted with the co-location of some health and social care staff. This transition was not smooth and attempts to introduce a co-ordinated

management structure emphasised the difficulties and persistence required to rationalise and harmonise different bureaucratic, professional and administrative ways of working especially in relation to clinical and managerial accountability, unified systems and policies, and generic working. A local health board executive considered that problems of integration were hampered by the "professional elitism and anxiety of nurses" claiming that: "nurses have an intrinsic need to do things to people, whereas social workers are more empowering". Also, there was resistance from health workers at the prospect of being employed by a local authority, coupled with a fear of being managed by someone from a different profession. Although co-location, improved co-ordination and better management arrangements were considered a huge improvement on a previously fragmented service, some local stakeholders considered it insufficient: "people have moved—but I don't think that's enough—in reality there has not been much change" (service manager). Efforts to formalise the service with a legal agreement had so far failed, and there was a lack of consensus about its value. One view was that it was: "a lot of bureaucracy to achieve not a lot—incredibly complex, legalistic and bureaucratic" (local authority education manager). For others, the benefits of a legal agreement outweighed the difficulties of negotiating it as it provided security of funding from different partners and allowed the full potential of integration to be achieved. The importance of external funding for a project manager was considered to be vital, and in the opinion of a locality officer: "if the manager left, the whole thing would unravel and go backwards".

The second example was a project aiming to provide services for people with chronic health conditions to assist in their ability to seek and hold down jobs. This was part of a UK government welfare reform programme, it received guaranteed financial resources over three years, and was linked to a national network with whom experiences and best practice could be shared. It connected health interests with the Department of Work and Pensions through local jobcentre plus offices making clear links between health, well-being and work. The project devised a clear focus and purpose based on those people in receipt of incapacity benefit living in a particular geographical area, accessed through a single referral point and not duplicating existing services. Although the national programme promoted a particular model, there was some flexibility within its design and delivery to reflect local circumstances and needs. For example, one-to-one based courses were replaced by group based activities, and generic working was promoted within the delivery team. A small and tight steering committee with the 'right people at the right level' were responsible for the governance of the project: "it's a very effective and well functioning group; the people are supportive, fully engaged and see the benefits of the service; nobody seems to be professionally precious and everyone has something to contribute" (nurse director). There was evidence of effective and connected leadership, and the project was successful in being able to move rapidly from a design stage through to delivery on the ground. This involved a coherent and planned implementation structure, a clear understanding of who did what and when, and effective project management arrangements. In addition, the project had been able to demonstrate successful outcomes in terms of referral numbers and qualitative evaluation. The effect of this 'success' and 'the powerful boost of patient stories' (steering group chair) provided a great fillip to all those associated with the project and reinforced their commitment.

Locality or community-based integration

Two case studies demonstrated how integration was interpreted at a locality or community level, how different understandings influenced the way in which interventions were managed, and what outcomes were realised by these processes. The first involved delivering community health and social care services particularly for patients with chronic conditions. It was driven by a combination of local and national factors, both as a response to Welsh Assembly Government exhortations to work more collaboratively, and an outcome of local partnership working on integrated community health teams. Integration was approached through the application of a 'locality model', but this was understood differently by stakeholders on the partnership steering group. Different aspects of the model were emphasized: putting the needs of the service user at the centre of the design and delivery of services (chief executive of local health board); understanding local needs and linking to communities (clinical director); making the most cost-effective use of scarce resources (health service manager); keeping people out of hospital and developing primary and community services to support them (general practitioner); and, co-ordinating health and social care services at a local level (director of social services).

These interpretations came into conflict in discussions about the most appropriate size of population for the locality. The local trust adopted a cost-effective use of resources approach arguing that a larger size of population (c. 50,000) was more efficient particularly where specialist secondary care professionals were being used. Other interests favoured a lower number (c. 30,000) because a smaller population was neces-

sary to engage GP practices in organising and delivering their services across a wider area. The project was managed by two multi-agency forums—a development board and an implementation group—in a resource-neutral context with no dedicated resources to service or co-ordinate the structures or support professional development work. These tasks were undertaken from within existing agency portfolios, although a budget was set aside to fund clinical leadership and pump prime small projects.

The approach adopted by the project rejected a heavily prescribed top-down method in favour of one that aimed to engage practitioners in both the design and delivery of solutions, the intention being to minimise the problems of detachment that often occur between strategists and practitioners [46]. It was widely believed that the success of the locality model was dependent on the participation of general practitioners and other health and social care staff, so their participation in negotiating any change was critical in an environment seeped in professional sensitivities and territory. This approach was incremental and emergent [47, 48], where 'shapes formed in the mists' (medical director), and where the focus was on the identification, exploration and testing of various projects.

At the time of the research, the work had just moved to the implementation group and the operationalisation of an action plan based on workstreams covering different policy areas including multi-disciplinary teams, primary care mental health support services, and integrated community nursing teams. A number of the interventions included the re-packaging of existing initiatives to achieve 'quick-wins', and those that were new were the subject of ongoing scrutiny in terms of their relevance, practicability and adoptability. A matter of concern to some stakeholders was the insufficient attention being placed on evaluation and the extent to which either the individual actions were judged to be a success, or more profoundly, whether the locality model itself was a viable approach to integration.

A second case study concerned the evolution of a facility for a particular town which aimed: "to integrate primary, intermediate and community care, and nursing services to provide whole system health and social care". It was a multi-agency partnership project enabled through two significant 'structural' drivers—Public Finance Initiative funding to replace a local hospital, and Health Act (1999) flexibilities including pooled budgets to operationalise the integrated health and social care service. The development of the project spanned a number of years from a starting point of service fragmentation delivered from a range of locations where duplication and lack of co-ordination were manifest, to a current position of integrated management in a combined facility/service with 20 inpatient beds, 115 staff and a budget of c. £2m.

In this example, the prevailing view from respondents was that there was not a prescriptive model of integration being pursued; instead the outcomes were the result of a negotiated, emergent and pragmatic process between key stakeholders. So, whilst the new development was expressed as an integrated form, its early realisation was as a co-location of services with different agencies, although housed in the same building, continuing to undertake their individual roles and responsibilities separately as before. Some stakeholders argued that this physical proximity was a necessary precursor to health and social care staff getting used to working with each other; others however, took an opposing view arguing that the co-location stage should have been omitted and that full integration, especially integrated management, should have been tackled simultaneously. A 'half way house' was considered to be 'ducking' the pain of organisational change, wasting further time towards the achievement of full integration, and risking a belief by some interests that co-location was far enough along the integration continuum. Following the opening of the facility, a further two years elapsed before the necessary organisational and other arrangements were implemented for a more integrated service model.

The governance of the project was undertaken through a partnership board consisting of three main partners—-local authority, local health board and National Health Service Trust. Sustained leadership was identified as important in maintaining the initiative through complex and challenging negotiations, although the balance between strategic and operational matters had latterly become an issue. The progression from co-location to integration was facilitated by the appointment of an integrated services manager and the introduction of an integrated management structure to counter silo working, independent management of workloads, and duplication with service users experiencing multiple assessments leading to unwieldy, unsustainable and impractical referral pathways. Unsurprisingly, the process of managing change was problematic especially in the light of a commonly expressed view that it did not take much for the default position of organisational and professional self-interest to permeate a veneer of integration: "people naturally migrate to their own worlds" (nurse director). Staffing and professional issues were central to the integration process, revolving around tackling the clinical, professional and organisational barriers that obstructed the treatment of people in a holistic fashion, and dismantling the cultures and working practices rooted in administrative and professional convenience. A number of familiar difficulties were encountered in moving towards a more

integrated way of working, including the absence of unified terms and conditions of employment between health and social care staff; the problem of divided accountabilities—managerially to the integrated manager and professionally and clinically to the local authority or National Health Service Trust; the limitations of pooled budgets; and the problems of unifying and harmonising separate systems, policies and practices. For example, issues of clinical governance, risk management and patient confidentiality were interpreted differently by the respective health and social care communities. Integration in this example was far from the administration of a simple prescription, but the result of a convoluted and time-consuming process of constant negotiations between different interests with unpredictable outcomes.

Whole-system integration

A multi-agency initiative covering a large and disparate geographical area was the focus of the integration of health and social care services at a strategic level. The aim was to shift from secondary care to a primary and community-based model, and to focus on the elderly and people with long-term chronic conditions. The project assembled a large number of diverse individual and organizational stakeholders including three local health boards, three local authorities, a National Health Service Trust and a variety of voluntary organizations. These presented significant differences in relation to sector, culture, profession, experience, motivation, governance, accountability and expectation. This wide constituency of interests had the potential for creating added value within a congested policy area, but also the possibility of engendering tension, disagreement and conflict. The project co-ordinator reflected that: "the project means different things to different people at different times".

Integration was conceived through a negotiated common purpose and expressed in a vision and set of principles. The nature of the vision, rooted in making a difference to the lives of vulnerable people, was considered to be 'deserving' and 'socially just', and the power of its appeal resonated with the public service values of participating professionals and managers. It provided a justification and motivating force to guide them through the potentially lengthy and protracted process of collaborative working. The vision aimed to design and deliver solutions to enable more people to remain in their own homes, and to promote independent living and self-help. The construction, wording and crafting of the vision allowed different agencies to offer their commitment at a strategic level without too much conflict at the formative stage of the collaborative process. The advantage of such a vision was that it provided a degree of flexibility and interpretation, and could be operationalised in different ways. This allowed interventions and solutions to emerge in the context of changing political priorities, availability of resources and local circumstances, as long as they were consistent with the basic principles and values of the agreed model. The inherent problem of this approach was that whilst it promoted commitment and ownership at a high level of abstraction, different stakeholders had different views on how to achieve this and what, indeed, constituted 'delivery' and 'success'.

The project sought to build on an established culture of collaborative working in the area, and created machinery for governance which consisted of a high-level project board, a steering group and a number of workstream groups based around self-care promotion and prevention, developing community services and information technology. An existing National Health Service Trust director was appointed as programme manager, and a full-time project co-ordinator was also recruited from within existing resources to service and co-ordinate the project. In fact, the whole of the project was underpinned by the premise that any new solutions would be delivered from within existing resource envelopes—an assumption that was viewed by a number of stakeholders as unrealistic.

Operationalising whole-system change occurred through a range of heterogeneous working groups. These comprised key professionals in particular policy areas who undertook various mapping exercises of services and needs, identified and quantified problems and issues, examined best practice and developed models of delivery and care. Some of these were tested in practice using in particular, 'pilot' or demonstration projects to evidence the potential of new models of health and social care services e.g. locality model, intermediate care model, multidisciplinary community chronic condition management project, integrated IT systems. However, there was no planned approach to capturing and transferring the learning, partnering organizations were not receptive to the experience of, and evidence from 'pilots', and any learning was concentrated in a relatively small cadre of individual actors involved in the project. At the culmination of two years of work, a number of stakeholders claimed that the project had little to show for its efforts: "we have spent a great deal of time mapping out and exploring models rather than doing things" (senior local authority manager); "we have pilots all over the place and lots of scoping work, but no action because of the resource-neutral situation" (local health board director). This frustration reflected the complexities of collaboration involving large numbers of diverse interests, and the problems of converting policy intent into effective delivery on the ground. In addition, the incremental approach

to whole-system change inevitably meant that the benefits of collaborative working were not spread equally across all partners leading to some disengagement.

The dynamics of structure and agency

The case studies evidence a complex interplay between structural and agential factors, the main ones of which are highlighted in Figure 2. The overarching national policy context in Wales clearly was a key driver and enabler of, integration across all of the cases. The prevailing policy paradigm promoted the virtues of collaborative forms of working, and of designing and delivering services from the perspective of citizens and service users. User-focussed models dominated the discourse across all cases, with opportunities being provided for both users and their representatives to influence the integration process, for example as representatives on steering committees. In terms of policy priorities, a national focus on people with chronic conditions and a transition from secondary to primary care were critical stimulants in the case of the whole-system and locality cases. The flexibilities permitted by the Health Act were central to the form of integration developed in the community-based case study, although the bureaucratic and other difficulties involved in their use, and their perceived benefits did not meet with universal approval particularly in the children's disability service. The availability of funding from the Joint Working Special Grant was considered to be vital to the development of the children's disability service, although its time limited nature and prospect of termination was viewed with considerable concern.

Although coterminosity between health commissioning and local government boundaries were helpful, the commissioning/provider split between local health boards and National Health Service Trusts was a considerable source of tension particularly in view of the size and power of the latter. Across Wales, the absence of any integrated performance management frameworks between health and social care, and the perverse incentives of single accountability structures limited the promotion of integration. Similarly, national resource and planning frameworks did not provide underpinning for an integrated health and social care

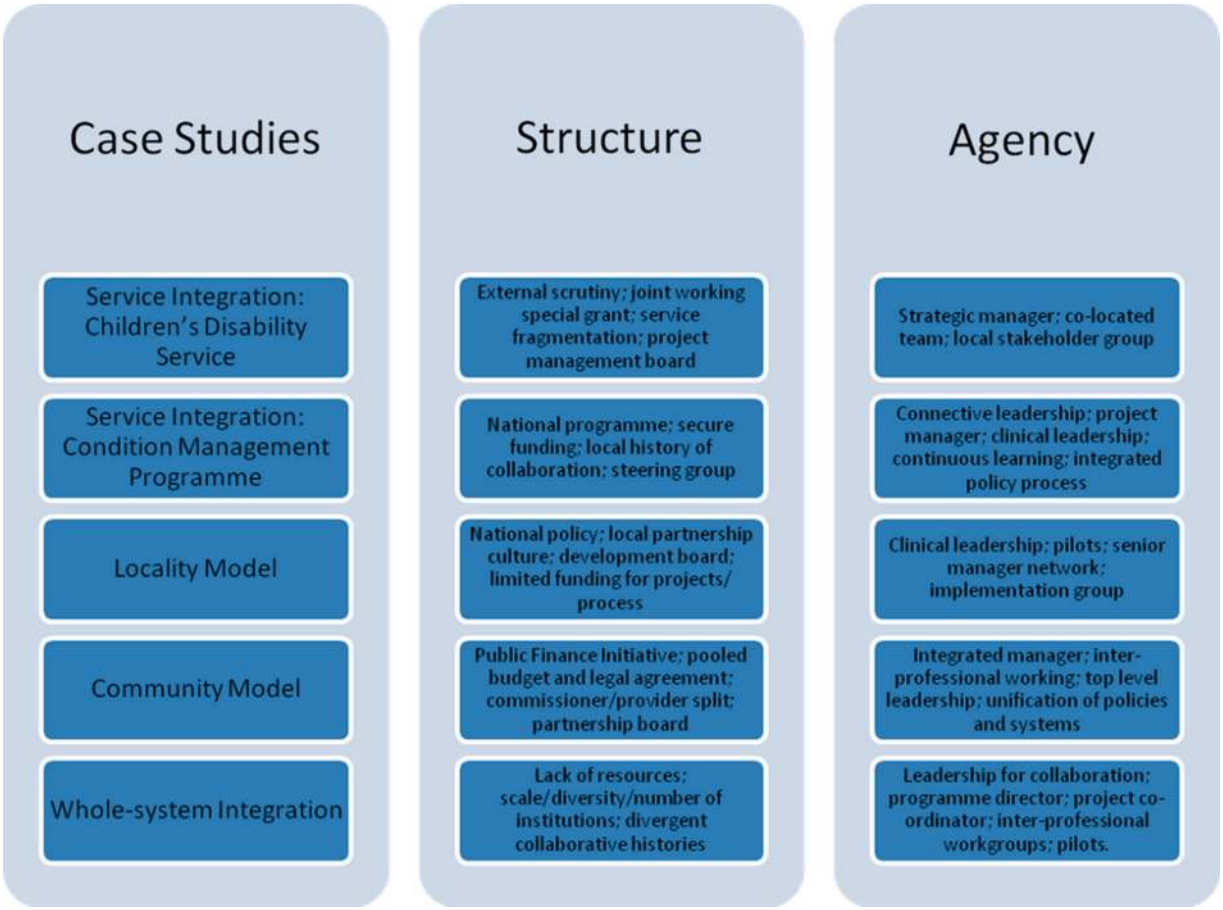

Figure 2. Structural and agential factors across the case studies.

system, and there were little or no extra financial resources to lubricate the process of, or support the design of new integrated forms of service delivery. A resource-neutral position was taken by cases, such as the whole-system example, and this placed significant limits on its potential development.

Governance structures took different forms in the case studies, highlighting a major tension between the need to create flexible, loose and networked arrangements to accommodate diversity and emergence, with the need to impose effective, inclusive, transparent and accountable decision-making frameworks to deliver change on the ground. This tension was observed in the dissonance between the partnership arrangements and those of the sponsoring agencies in a number of cases. Also serious was the potential 'gap' between strategists and practitioners, although this risk was recognised in some cases. As governance arrangements are dependent on effective agency—leadership, membership and management—partners might be expected to invest considerable effort in selecting, training and supporting key individuals in the partnership. However, the research evidence suggests the 'mix' of representatives and their ability to work together tends to be more a matter of luck than planning. At a local level, context played an important role in a number of cases. In the case of the whole-system example, the fact that there were a large number of diverse agencies involved across a wide geographical area conspired against a coherent approach and encouraged fragmented and unsustainable interventions. Conversely, in the condition management programme and the locality model, a previous history of effective collaborative working was considered to be a fertile antecedent to local integration—building on the social capital and personal networks developed over a period of time. Finally, the UK context was particularly instrumental in shaping the condition management programme because of its part in a national initiative, the availability of central funding, the links to other projects, and the focus on evaluation.

Structural factors provide the 'space' [49] for actors, both individual and collective, to act, and this 'space' is shaped or constrained in various ways. The extent to which actors were effective in using their capacity to act was demonstrated through leadership, interprofessional practice and integrated working, and boundary spanning behaviour. Leadership processes manifested themselves in many different ways in the case studies. In the community-based model for instance, a strong lead from key individuals at the top of the partner agencies over a sustained period of time was considered to be a vital ingredient in the realisation of the project. In the case of the condition management programme, leadership was described as being 'multi-level and connective' (local health board director) involving strategic leadership from a nurse director making links into mainstream programmes; leadership for governance from the chair of the steering committee; and leadership for day-to-day management from the project manager and clinical team lead. This was underpinned by close and trusting personal relationships based on common purpose directed towards resolving the problems of a vulnerable client group.

Leadership for collaboration was evident in the whole-system case reflecting the context of a diverse set of stakeholders and interests, dispersed and contested power relationships, and multiple motivations and objectives. A personal reflection of this approach was captured by one chief executive in the following manner: "I have to put time into it; to keep people herded together; I try to keep people focused and on-board; I focus on the vision which is around the citizen; I share views as well as chairing; I encourage others to participate and become involved; I value others; it's very much about visioning, being facilitative and involving others; and I work across interfaces". However, irrespective of the approach to leadership, it is undoubtedly made easier by the availability of resources. Part of the success of the condition management programme was the availability of new financial resources. This was not the case in the whole-system example, where change was predicated on resource-neutral strategies and little money was available to support the processes of integration. Leadership in this situation—however facilitative, empowering, inclusive and catalytic—could not compensate for this vacuum.

Central to the integration process is the impact it has on the many professional interests and practices involved, and the extent to which professional actors are prepared share power and work with others. The children's disability service was an example of where some professionals were prepared to be co-located physically under one roof in the expectation of benefiting from better co-ordination, but had less appetite to go further towards an integrated service because it threatened their professional role and status, particularly where there was a prospect of being managerially accountable to someone with a different professional background or organizational allegiance. In the community-based example, a number of critical structural factors had come together to provide the opportunity of an integrated service. However, the introduction of such a service was dependent upon the outcome of complex negotiations between deeply rooted professional interests and tackling the issues of harmonisation of staff terms and conditions; generic working; professional accountability; and the roles, responsibilities, cultures and working practices of different medical and social care professionals. Breaking down 'silo-thinking' was

difficult because organisational cultures and professional practices had been ingrained over many years, often premised on different world views, frames, perspectives and models [38]. For example, the collision between medical and social models of health generated tensions and frictions, as did the deliberations about boundaries and whether they should be sharpened or blurred. A consensus amongst interviewees suggested that professionals should not be asked to reject their underlying values and cultures but to work together to create a new form of working directed towards the ultimate goal of satisfying the needs of citizens and users. Important questions to resolve were how far integration was about improving the co-ordination of staff in the discharge of their respective, specialist roles and responsibilities, how far was it about encouraging forms of generic working, and could it be about both? Different views surfaced on these dilemmas in the community-based case study ranging from those supporting the status quo and the integrity and professionalism of individual specialists at all time, to those who accepted that, in certain professional areas (e.g. Occupational Therapists, Physiotherapists) respective roles were close, and some work might be undertaken interchangeably; and also that in assessment and monitoring or for support workers and administrative staff, generic working was appropriate because it reduced duplication and was more cost-effective.

Agency is perhaps best reflected in the particular skills and capabilities of key actors—the boundary spanners—who made an important contribution in the case studies in different ways. Dedicated actors—project manager, project co-ordinator, strategic manager, integrated manager—deployed a range of competencies necessary for integrated arenas. Competencies, such as an ability to develop and sustain inter-personal relationships based on trust, well developed communication skills, an ability to seek consensus and resolve conflict through negotiation and diplomacy, and an acute appreciation of the interdependencies between health and social care domains. The steering committees and integration processes required servicing and co-ordination. Key actors discharged these functions; they provided external visibility and contributed to their leadership. However, the resources to provide such capabilities were not evident. The few dedicated posts were reliant on externally funded time-limited schemes, there was still a strong presumption that collaborative working was an extra duty to be added to an already heavy workload, and training and development programmes in collaborative skills were rare.

Evidence of synergistic relationships between structural conditions and agential factors are very instructive for policy and practice. Certainly in the case of the condition management programme, a national programme providing substantial new resources over a significant timescale, a clear focus involving a defined client group, and a fertile local institutional context with a culture of collaboration, provided the backdrop for effective agential action through connected leadership, a dedicated project manager, an integrated policy process and a well functioning and inclusive steering group involving the right people at the right level. In addition, it was able to demonstrate 'success' through a variety of evaluation mechanisms. Conversely, the whole-system case study largely failed to add value because of the complexity inherent in working with a large number of diverse actors and institutions over a wide geographical area, the absence of any new resources, and the underlying tensions that existed between health and social care communities. The change model adopted to promote integration was based on the use of 'pilots' and demonstration projects but this proved to be flawed because of the problems of transferability, mainstreaming and knowledge transfer—the lack of receptivity of partner organizations in terms of time, resources and attitudes, their lack of competence, absorptive capacity and skills, and the difficulties of transferring particular types of knowledge particularly tacit forms that are generated within inter-professional and inter-agency settings [50]. Structure and culture have an important influence on learning and knowledge transfer [51] but in this example there was no coherent and planned strategy in place, merely a general expectation that it would happen spontaneously.

The implications of a lack of clarity about 'integration', and the scope that individual actors therefore have to pursue their own meanings and interpretations, and the effect this has on outcomes, is an important issue. There are normative models of what an integrated health and social care service ought to resemble [17, 18], but the components of these are capable of wide interpretation. The experience of the case studies is that the management of integration is more a process of deliberation and negotiation between local stakeholders than one of ideology and prescription. A broad consensus can often be reached over the aspirations for integration, such as providing efficient and effective use of resources or empowering service users and placing them at the centre of the design and delivery of services. But what these mean in terms of policy and practice, what emphasis should be given to them and how they can be achieved, differ between the many stakeholders involved in this policy sphere. There was apparent agreement on the principles of an integration model for the children's disability service, and the desirability of a locality model in another area, but these often masked contested interpretations. In addition, integration can be defined as much by a pro-

cess that is motivated by a need to move away from an existing unsatisfactory condition, as one that is driven by a desire to achieve an idealised state in the future.

If interpretation is important, the role of individual agency occupies centre stage and Hoskings and Morley's [16] depiction of an organizational process as the outcome of multiple actors pursuing a plurality of interests is helpful in this context. This is very much the case in this research particularly in relation to the respective professional interests in the health and social care communities. For instance, different actors were committed to different models of health (medical or social), and different actors positioned themselves at different points on the integration continuum [13]. The extent to which individual actors were successful in achieving their own interests and promoting their own valuations were partly determined by contextual factors, but were also heavily influenced by personal skills and behaviours.

The research identified a role for key actors in the integration process to both help shape and manage meanings, and to facilitate and co-ordinate the overall process. They acted as interpreters and communicators between different actors and organisations; they helped to articulate the frames of different actors and interpreted them in the context of collective action. However, in practice, they faced a common dilemma in situations where different understandings existed, namely, was it more beneficial to debate fully these differences at the start of the integration process, or was achieving sufficient consensus for moving forward a more pragmatic option? The first alternative risked paralysis and 'people walking away from the table' (social care manager) and 'the more clarification there is at the outset, the more potential there is for derailment' (health manager). Nocon [52] suggests that 'forms of ignorance' may be the better alternative because exposing differences to detailed scrutiny might just be too difficult to overcome. However, this strategy risks individual stakeholders claiming further down the line that particular approaches were not what they originally intended. Weick [15] refers to the key individual actors as managers of meaning and translators who help to bridge interests and professions, and Rieple et al. [53] perceive their value to reside in being able to understand the cultural and linguistic norms of various interests. Their value was underscored by a view expressed by a member of the steering group for the children's disability service: "if (*the name of the service manager*) left, the whole thing would go back tomorrow". A further complication in situations where understandings of integration vary, and where the process is emergent and negotiated, is determining how to gauge success or otherwise. It is difficult to agree predetermined measures of achievement where different understandings and interpretations co-exist, and multiple forms of evaluation based on different stakeholders need to be developed.

What is clear is that there is no right solution to the problems of integration, and local circumstances and actors shape 'the depth and breath' [32] of outcomes. In the case of the children's disability service, whilst problem definition was well accepted, the solution had proceeded little further than a co-location of services, primarily because of the intransigence of professional interests and their unwillingness to concede/share power. In the community-based integration of health and social care services, there had been a gradual, but time consuming progression along the integration continuum from fragmentation to an integrated management model, although the journey had not been prescribed nor the final destination reached. The 'locality' model referred to in another case study had been entirely socially constructed with different stakeholders expressing various interpretations of it, and the efforts to achieve integration through whole-system change using exemplars and pilots had floundered in the face of excessive complexity, the involvement of too many diverse actors and organizations over a large geographical area, and the absence of a strategy to capture and absorb any learning into the prevailing institutional framework. All the case studies faced a period of upheaval and uncertainty as a result of radical structural reform in the health service in Wales. Many existing partnerships, networks and relationships risked being destroyed or compromised.

Conclusion

Two comments from stakeholders involved in the whole-system case study reach the heart of the structure-agency debate: "the thing that makes it work in any type of structure is the commitment of the person—structures can be enabling or difficult" (voluntary sector representative) and "you can have the best, most effective and streamlined structures, but if people can't trust each other, any partnership will fail" (senior health manager). The message, as Hay [54] argues is that the central question is wrongly posed as oppositional and that there is a complicated interweaving and alchemy of structural and agential factors. This research underscores the dynamic nature of the process and the manner in which different factors constrain and enable action. In terms of policy and practice, change through structural reform alone is unlikely to deliver the aspirations of policy makers, and agential stimulants must be factored into the process [55]. More research is certainly needed to understand the interplay between the main factors in different integration contexts. Structural

change needs also to acknowledge the 'space' that is necessary to allow different interests to negotiate common purpose from positions of different meanings and purposes of integration.

In conclusion, whilst this paper might not discover the secret elixir of effective integration, it does juxtapose structural and agential factors in a manner that highlights their interdependence, and with a predisposition to agency-centred accounts especially in relation to sensemaking by individual actors in part to counter a structural bias in both the literature and by policy makers.

Reviewers

Ailsa Cameron, Senior Lecturer, School for Policy Studies, Bristol University, UK

Lars Edgren, Professor, Nordic School of Public Health, Göteborg, Sweden

Walter Leutz, Professor, Brandeis University Waltham, Massachusetts, USA/Heller School for Social Policy and Management and Schneider Institute for Health Policy, Brandeis University, USA

References

1. Challis L, Fuller S, Henwood M, Klein R, Plowden W, Webb A, Whittingham P, Wistow G. Joint approaches to social policy: rationality and practice. Cambridge: Cambridge University Press; 1988.
2. Clarke J, Glendinning C. Partnership and the remaking of welfare governance. In: Glendinning C, Powell M, Rummery K, editors. Partnerships, New Labour and the Governance of Welfare. Bristol: Policy Press; 2002. p. 33–50.
3. Snape S, Taylor P. Partnerships between health and local government. London: Frank Cass; 2004.
4. Cameron A, Lart R. Factors promoting and obstacles hindering joint working: a systematic review of the research evidence. Journal of Integrated Care 2003;11(2):9–17.
5. Snookes H, Peconi J, Porter A. An overview of the evidence concerning the effectiveness of services delivered jointly by health and social care providers and related workforce issues. Cardiff: WORD; 2006.
6. Loxley A. Collaboration in health and welfare: working with difference. London: Jessica Kingsley; 1997.
7. Ranade W, Hudson B. Conceptual issues in inter-agency collaboration. In: Snape S, Taylor P, editors. Partnerships between health and local government. London: Frank Cass; 2004. p. 32–50.
8. Mattessich PW, Monsey BR. Collaboration: what makes it work? St. Paul, Minnesota: Amherst H. Wilder Foundation; 1994.
9. Sullivan H, Skelcher C. Working across boundaries: collaboration in public services. Basingstoke: Palgrave; 2002.
10. Ling T. Unpacking partnership: the case of heath care. In: Clarke J, Gewirtz S, McLaughlin E, editors. New Managerialism, New Welfare? London: Sage; 2000. p. 82–101.
11. Hudson B, Hardy B. What is a 'successful' partnership and how can it be measured? In: Glendinning C, Powell M, Rummery K, editors. Partnerships, New Labour and the Governance of Welfare. Bristol: Policy Press; 2002. p. 51–65.
12. Glasby J, Dickinson H. Partnership working in health and social care. Bristol: Policy Press; 2008.
13. Integrated Care Network. A practical guide to integrated working. London: ICN; 2004.
14. Hay C. Structure and agency. In: Stoker G, Marsh D, editors. Theory and Methods in Political Science. London: Macmillan; 1995. p. 189–206.
15. Weick KE. Sensemaking in organizations. London: Sage; 1995.
16. Hosking D-M, Morley IE. A social psychology of organizing: people, processes and contexts. London: Harvester Wheatsheaf; 1991.
17. Glendinning C. Breaking down barriers: integrating health and social care services for older people in England. Health Policy 2002;65:139–51.
18. Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications—a discussion paper. International Journal of Integrated Care [serial online] 2002 Nov 14;2. Available from: http://www.ijic.org.
19. National Leadership and Innovation Agency for Healthcare. Getting collaboration to work in Wales: lessons from the NHS and partners. Cardiff: NLIAH; 2009.
20. Hay C. Political analysis: a critical introduction. Basingstoke: Palgrave; 2002.
21. Giddens A. The Constitution of Society. Cambridge: Polity Press; 1984.
22. Jessop B. Interpretive sociology and the dialectic of structure and agency. Theory, Culture and Society 1996;13(1):119–28.
23. Glendinning C, Dowling B, Powell M. Partnerships between health and social care under 'New Labour': smoke without fire? A review of policy and evidence. Policy and Politics 2005;1(3):365–81.
24. Ham C, Glasby J, Parker H, Smith J. Altogether now? Policy options for integrated care. Birmingham: University of Birmingham; 2009.
25. Heenan D, Birrell D. The integration of health and social care: the lessons from Northern Ireland. Social Policy and Administration 2006;40(1):47–66.
26. Forbes T, Scott N. Models of integrated community health partnerships. Stirling: University of Stirling; 2008.

27. Hudson B. Interprofessionality in health and social care: the Achilles heel of partnership? Journal of Interprofessional Care 2002;16(1):7–17.
28. Gray B. Collaborating. San Francisco: Jossey Bass; 1989.
29. Gajda R. Utilizing collaboration theory to evaluate strategic alliances. American Journal of Evaluation 2004;25(1):65–77.
30. Pratt J, Gordon P, Plampling D. Working whole systems. London: King's Fund; 1999.
31. Leutz W. Five laws for integrating medical and social services: lessons from the United States and United Kingdom. The Millbank Quarterly 1999;77(1):77–110.
32. Glasby J. The integration dilemma: how deep and how broad to go? Journal of Integrated Care 2005;13(5):27–30.
33. Rosen R, Ham C. Integrated care: lessons from evidence and experience. London: Nuffield Trust; 2008.
34. Lewicki RJ, Saunders DM, Minton JW. Negotiation. New York: McGraw Hill; 1999.
35. Schon DA. Educating the reflective practitioner. San Francisco: Jossey-Bass; 1987.
36. Schon DA, Rein M. Frame Reflection: toward the resolution of intractable policy controversies. New York: Basic Books; 1994.
37. Williams PM. The competent boundary spanner. Public Administration 2002;80(1):103–24.
38. Benford RD, Snow DA. Framing processes and social movements: an overview and assessment. Annual Review of Sociology 2000;26:611–39.
39. Welsh Assembly Government. One Wales: a progressive agenda for the government of Wales. Cardiff: WAG; 2007.
40. Welsh Assembly Government. Delivering the new NHS in Wales. Cardiff: WAG; 2008.
41. Welsh Assembly Government. Making the connections: delivering beyond boundaries. Cardiff: WAG; 2006.
42. Yin RK. Case study research: design and methods. London: Sage; 1994.
43. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess AG, editors. Analysing qualitative data. London: Routledge; 1994. p. 173–94.
44. Morse JM. Emerging from the data: the cognitive processes of analysis in qualitative enquiry. In: Morse JM, editor. Critical issues in qualitative research methods. London: Sage; 1994. p. 23–43.
45. Flintshire County Council Social Services Department. Integrating services for disabled children, young people and their families living in Flintshire: a strategy for change and improvement. Flint: Flintshire County Council; 2003.
46. Mintzberg H. The Rise and fall of strategic planning. London: Prentice Hall; 1994.
47. Carter C, Clegg SR, Kornberger M. A very short, fairly interesting and reasonably cheap book about studying strategy. London: Sage; 2008.
48. Mintzberg H, Waters J. Of strategies, deliberate and emergent. In: Segal-Horn S, editor. The strategy reader. Oxford: Blackwell; 1998. p. 20–34.
49. Martin GP, Currie G, Finn R. Leadership, service reform, and public-service networks: the case of cancer-genetics pilots in the English NHS. Journal of Public Administration, Research and Theory 2009;19(4):769–94.
50. Child J. Learning through strategic alliances. In: Dierkes M, Berthoin Antal A, Child J, Nonaka I, editors. Handbook of organizational learning and knowledge. Oxford: Oxford University Press; 2003. p. 657–80.
51. De Long DW, Fahey L. Diagnosing cultural barriers to knowledge management. Academy of Management Executive 2000;14(4):113–27.
52. Nocon A. Forms of ignorance and their role in the joint planning process. Social Policy and Administration 1989;23(1):31–47.
53. Rieple A, Gander J, Haberberg A. Factors contributing to the effectiveness of hybrid organizational forms: the case of new product development. Paper to the British Association of Management Conference. London: 2002.
54. Hay C. Structure and agency. In: Stoker G, Marsh D, editors. Theory and methods in political science. London: Macmillan; 1995. p. 189–206.
55. Hudson B, Henwood M. The NHS and social care: the final countdown? Policy and Politics 2002;30(2):153–66.