Integrated Care Policy Implementation in England:

A Case Study of a Community Based Integrated Care Service

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Abstract:

Discussion relating to the boundary between health and social care has existed since the inception of the NHS, with successive governments proclaiming the desire to ‘integrate’ care. This thesis draws on data collected from a case study community based integrated care service (CBIC), to explore the relationship between the macro level political environment governing health and social care integration in England, and the micro level managerial and organisational practice shaped and enacted within this context. Data collection took place between April 2017 and April 2019, using textual analysis, qualitative interviews and participant and non-participant observation. The methodological approach developed in this thesis integrates Fairclough’s Dialectical Relational Approach to Critical Discourse Analysis and Realist Evaluation, as a means to connect integrated care policy discourse with its enactment and operationalisation at the level of practice, within a critical realist ontological and epistemological position. Previous research has argued that integrated care policy works as a discourse to manage tensions between competing policy aims and to allow the continuation of austerity and fragmented health and social care services. Moving beyond its linguistic realisation within government policy texts, this thesis demonstrates how this discourse was put to work through implementation by actively shaping the materiality, managerial practices, and subjectivity of actors to mobilise neo-liberal economic austerity. Specifically, the resource pressure within the CBIC had a socially structuring effect on how the managerial, organisational, and technological resources sought to shape the subject positions of both health professionals and patients through the lens of *‘waste watching’*, when attempting to implement integrated care. This had a dislodging effect on concerns for improvements in patient experience and resulted in work intensification, stress, and lost application of skill for staff.

Keywords: integrated care policy discourse; health policy implementation; lean working; dialectical relational approach; neo-liberalism; austerity

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List of Abbreviations and Acronyms Used

BCF- Better Care Fund

CBIC- Community Based Integrated Care Service

CCG- Clinical Commissioning Group

CDA- Critical Discourse Analysis

CMO- Context-Mechanism-Outcome

CPE- Cultural Political Economy

CPT- Critical Programme Theory

CVS- Clearhedge Voluntary Support

DEA- Discourse Ethnographic Approach

DHA- Discourse Historical Approach

DRA- Dialectical Relational Approach

ECHC- Enhanced Care in Care Homes

FYFV- Five Year Forward View

HSCA 2012- Health and Social Care Act 2012

IC- Integrated Care

ICSs- Integrated Care Systems

LPI- Local Policy Implementers

MCP- Multi-Speciality Community Provider Model

OCC- Oaklea Community Care

PACs- Primary and Acute Care System

PCTs- Primary Care Trusts

RE- Realist Evaluation

STPs- Sustainability Transformation Partnerships

WPR- ‘What’s the problem represented to be’ approach

Chapter 1 - Introduction

1.1 Introduction

This thesis is about the relationship between the macro level political environment governing health and social care integration in England and the micro level managerial, organisational and workforce practices, which are shaped and enacted within this context. Data analysis is presented from a Community Based Integrated Care Service (CBIC) case study, delivering care largely in people's homes in a region in South-East England. I became involved with this project when I was awarded a PhD studentship to conduct an evaluation of the service change. As I preceded with the study, I became unable to detach the service evaluation I had been commissioned for from the political context in which it was operating, leading me to embark on a critical policy analysis of health and social care integration, using the CBIC as my case study.

Discussion relating to the boundary between health and social care has existed since the inception of the NHS, in which NHS services were made accountable to central government, are funded through general taxation and remain free at the point of use, whilst social care is the responsibility of local authorities and is funded through a mix of central and local taxation, as well as means tested co-payments (Glendinning and Means, 2004). It has been argued that from that point onward, increasing fragmentation and complexity in how services are commissioned, funded and provided, has led to a poor experience for patients receiving care from multiple services (Humphries, 2015). Between 1997 and 2010, the New Labour government tried to foster greater integration between health and social care through a variety of initiatives, including multidisciplinary teams, pooled budgets, and joint assessments and commissioning (Miller and Glasby, 2016; Carey, 2018). This study, however, centres on a CBIC case study that was developed and contracted between 2012-2016 within the context of government austerity and major legislative change through the Health and Social Care Act 2012 (HSCA 2012), which aimed at increasing competition (Player, 2013), whilst also placing a duty on government agencies to integrate care. In addition, the CBIC was also developed within the backdrop of policy strategy set out in the Five Year Forward View (FYFV) (NHS England, 2014) and the Better Care Fund (BCF) initiative, which claimed to move the direction of travel away from competition to enhanced collaboration.

This thesis takes a sociocultural approach to policy by viewing it as constituted within its political and social context and as engaged in and shaped by social actors (Bartlett and Vavrus, 2016). By integrating Fairclough’s (2002; 2005; 2008; 2013) Dialectical Relational Approach (DRA) to Critical Discourse Analysis (CDA) with Realist Evaluation (RE) (Pawson and Tilley, 1997; Pawson, 2006; Pawson, 2013), I developed the methodological tools to connect the integrated care (IC) policy discourse with its enactment and operationalisation at the level of practice and lived experience, within a critical realist ontological and epistemological position. Data collection, using ethnographic methods, took place between April 2017 and April 2019. It involved analysis of key organisational texts, semi-structured interviews with local policy implementers (LPIs) within the Clinical Commissioning Group (CCG), County Council and lead provider, middle managers, frontline staff, and patients, as well as observations within the integrated care office space, training sessions and meetings.

Previous research (Hughes, 2017) has argued that integrated care policy works as a discourse to smooth over any contradictions in the claim that integrated care can provide the solution to wide ranging and diverse issues within the health service, including poor public finances, high patient demand, fragmentation, and poor patient experience. In this sense, the discourse works to allow the continuation of austerity and fragmentation. However, moving beyond its linguistic realisation within texts produced by government and think tanks, I demonstrate how it is put to work through implementation by actively shaping the materiality, managerial practices, ways of (inter)acting, identities/subject positions of actors operating within the integrated care arena. It is argued within this thesis, using evidence from my case study, that the IC policy discourse worked ideologically to smooth over any inconsistencies and contractions with making funding reductions to the CBIC, whilst also claiming to improve patient care. This enabled economic austerity to be mobilised through implementation, where semiotic references were made to '*empowerment*' and '*integration*', whilst the material reality of resource pressure dislodged concern for improving patient care from actual practice.

1.2 Situating the CBIC within its policy context

In 2010, an 'age of austerity' began in the UK, with the Coalition government embarking on a strategy of severely curtailing public expenditure, aiming, it was claimed, to reduce the national deficit following the financial crash in 2008. As part of this strategy, the public sector had to reduce expenditure, and/or use existing resources more efficiently (Kerasidou, 2019). The NHS, whilst technically not receiving any direct funding cuts, received much lower-than-average funding increases, which were not in line with growing demand. The King’s Fund argued in 2017 that the ‘financial pressure on the NHS is severe and shows no signs of easing’, making the case that between 2010/11 and 2014/15 health spending increased on average 1.2%, compared to the historic annual growth rate of 3.7% (Robertson *et al.*, 2017, p. 13). Funding cuts to social care and mental health were more severe, with local authorities having to save 26% from their adult social care budgets between 2010 and 2014 (Miller and Glasby, 2016). These austerity policies in social care and mental health also had a direct effect on NHS pressures, as demand is increased when service users are then directed from these underfunded services onto NHS services (Kerasidou, 2019). Within the health and social care arena, the neo-liberal state, with its focus on reducing public expenditure (Navarro, 2020) was furthered by austerity measures that sought to increase the opportunities for the voluntary sector and for-profit providers, and to move the cost of health and social care into the unwaged realms of the home and community. This political and economic environment, in which health and social care came to be framed in terms of economic cost and benefit (Speed, 2016), provides the backdrop to the development and contracting of the CBIC case study.

Within this period of public sector retrenchment, the NHS underwent wholescale reorganisation under the HSCA 2012, which introduced greater competition into the health system. The Act abolished Primary Care Trusts (PCTs), which had previously held most responsibility for commissioning health care and replaced them with CCGs (membership organisations made up of GPs). Strategic Health Authorities, which had overseen PCTs and were accountable to the Department of Health (DH) were also abolished (Hammond *et al.*, 2019). NHS England was created with the intention of running the NHS, as opposed to the Secretary of State for Health (Humphries, 2015), splitting commissioning responsibilities with CCGs, local authorities, and Public Health England (Checkland *et al.*, 2018). Following controversy in the passage of the bill amid fears about creeping privatisation, the HSCA 2012 placed a 'duty to integrate' on NHS England, Monitor, CCGs, and Health and Wellbeing boards (Miller and Glasby, 2016). Within this context, the Clinical Commissioning Group (CCG) within my case study, began working with the County Council in 2012 on developing new ways of commissioning health and social care for the area through a process of competitive tendering.

Following the passage of the HSCA 2012, integration stook centre stage within national policy and was followed by raft of policy initiatives, including the BCF, Integrated Care Pioneers, and the Vanguards (see Appendix 1 for full description of these initiatives). Some have argued that the publication of the FYFV moved the agenda from competition to collaboration (Exworthy and Mannion, 2016; Hammond *et al.*, 2019), with others noting that despite rhetoric there were no actual legislative changes, with HSCA 2012 remaining the dominant framework (Allen *et al.*, 2017; Sanderson *et al.*, 2017). The FYFV set out the strategy for the NHS, centring on development of 6 New Models of Care, which aimed to integrate within and between health and social care (Miller and Glasby, 2016). 50 Vanguard sites were then chosen to test out and develop learning on these models of care (Morciano *et al.*, 2020). The CBIC Business Case was approved in November 2014 with the stated aim of providing assurance to the CCG Governing Body that the CBIC is aligned with the recent FYFV. This was particularly in relation to the focus on prevention, greater patient control, multidisciplinary community health teams, lead provider contracting model, new professional roles, and person-centred care. It was claimed explicitly that the CBIC was an example of the multi-speciality community provider model (MCP), which is detailed within the FYFV as one of the new models of care designed to drive through greater horizontal integration across primary care (GP practices), social services (social work and personal care provision), and community services (community & district nursing and therapy services). BCF money would then be used to help facilitate integration between social care and community services. By aligning the CBIC with the MCP model, the Business Case was not just claiming to be consistent with national policy, but implying it was a direct enactment of the FYFV. The CBIC contract was won by a social enterprise, Oaklea Community Care (OCC), and 'went live' in 2016 for service delivery.

The CBIC case study, therefore, provides an example of a service change that had the stated aim of integrating health and social care, using integrated teams, care co-ordination, person-centred goal setting and empowerment, within the English policy context of the FYFV, HSCA 2012, and austerity. Beyond this point, integrated care policy has maintained its dominance. Local organisations were asked in 2016 to come together to form Sustainability Transformation Partnerships (STPs) to further deliver the proposals set out in the FYFV by extending the new models of care, resulting in 44 STP footprints being defined across the country (Hammond *et al.*, 2017). The NHS Long Term Plan, published in January 2019, also announced a further commitment to spreading the new care models (Morciano *et al.*, 2020), when it argued that the NHS would move 'to create Integrated Care Systems everywhere by April 2021' (NHS England, 2019, p. 10). The Department of Health and Social Care (2021) more recently published the White Paper 'Integration and innovation:

working together to improve health and social care for all', setting out proposals to establish Integrated Care Systems (ICSs) as statutory bodies in all parts of England. The continued prominence of integrated health and social care policy means that findings from this thesis have ongoing relevance and implications for integrated care implementation going forward.

1.3 Aims of the thesis

The aim of the thesis was to investigate the way in which the IC policy discourse was operationalised through implementation within a CBIC case study. I therefore focussed my search on literature examining integrated care policy within the context in which my case study was developed and contracted. This literature fell into three categories, including those that 1) used policy implementation theory to argue for closer alignment of policy goals 2) evaluated government flagship integration policies against qualitative and quantitative outcome measures 3) drew on post-structuralist discourse theory to provide critique at the level of policy texts.

Studies within 1) and 2), expose the conflict and dilemma facing commissioners, providers, and frontline staff when trying to balance cost saving/service reduction aims with patient related concerns. However, lack the ability to develop a sustained critique of government policy and the underlying political factors driving this change. Whilst, viewing austerity as a relevant social/political context, they are not explicit enough in demonstrating how IC furthers these political aims. Studies within 3) provide the theoretical tools to apply a critical lens to integrated care policy in terms of the political work it performs at the discursive level. However, what is lacking is an examination of the way in which the IC policy discourse, as a facilitator of economic austerity, has been mobilised, enacted, reformulated, and resisted through the implementation of integrated care, and what the implications are for health professionals, and patients at the level of lived experience. This thesis aims to fill this gap.

1.4 Thesis contributions

This thesis was guided by the overarching research aim: To investigate how the IC policy discourse was operationalised and enacted through implementation within a community based integrated care case study at the level of commissioners, providers, frontline staff, and patients.

The research questions arising from this aim were as follows:

1. How have local policy implementers (CCG/lead provider/County council) constructed a community based integrated care service?

2. What are the potential implications for frontline staff and patients if this discursive work is operationalised into practice?’

3. How has the IC policy discourse and its constituent discourses been enacted and operationalised within a community based integrated care service?

4. What are the outcomes and implications for patient care and staff experience?

Empirically, this study offers a unique contribution to the integrated care policy literature by demonstrating how IC policy discourse worked ideologically to smooth over any inconsistencies and contractions with making funding reductions, whilst also claiming to improve patient care. This enabled economic austerity to be mobilised through implementation of the CBIC when semiotic references were made to *‘empowerment’* and *‘integration’*, whilst the material reality of resource pressure dislodged concern for improving patient care from actual practice. Firstly, I show how the IC policy discourse was drawn upon to legitimise the contracting out of community services with reduced funding. I then explain, using three empirical examples (generic working within integrated care teams, self-management, and auto-allocation scheduling), how the material reality of resource pressure in the CBIC had a socially structuring effect on the way in which managerial and organisational practices sought to shape the subject positions of both clinicians and patients in line with cost saving aims.

Specifically, I show how lean discourse was drawn upon to construe health professionals through the lens of *‘waste watching’*, which led to negative effects, such as work intensification, and reduced ability for clinicians to apply their professional skill, treat patients holistically, and case manage them across different services. These findings therefore contribute to the critical literature on lean working in healthcare by extending our knowledge of how the discourse of lean can be enacted within the realm of integrated care practices to create negative effects. By explicitly examining how lean discourse was operationalised through self-management, this thesis moves beyond current critical work, which centres its critique on the inherent neo-liberalism within the empowerment discourse. It is does this by showing how health professionals who seek to identify and eliminate *'wasted staff time and intellect'* through patient self-management can create disempowerment for staff and patients and conflictual interactions.

The methodological contribution made by integrating the DRA with RE provides the ontological tools and methodological resources to connect a sociocultural view of policy (as part of broader social structure) with its enactment within practice and effects at the level of lived experience. By drawing on RE's context-mechanism-outcome (CMO) heuristic, this methodological contribution, extends Fairclough's DRA by providing a systematic way for exploring the dialectical relationship between discourse realised linguistically through texts and non-discursive phenomena, going beyond simple advice given in Fairclough (2003) to combine CDA with ethnography. Furthermore, this methodology responds to those critical realist scholars (Porter, 2015a; Porter, 2015b; Alderson, 2021) who criticise the apolitical assumptions of realist evaluation.

From a theoretical perspective, governmentality studies provided me with the theoretical tools to connect neo-liberal governmental aims with the shaping of individual subjectivity, animated specifically through the lens of '*waste watching'*, as well as how these subject positions were drawn upon or resisted by actors on the ground. I argue that putting this theory to work through Fairclough's (2002; 2005; 2008; 2013) DRA contributes to governmentality studies, by providing a more nuanced analysis of the effects of neo-liberalism, by distinguishing between the linguistic realisation of discourse through texts and their variable internalisation into non-discursive practice. My analysis of context/response mechanism interactions also helped to show how pre-existing factors influenced the way in which clinicians more readily adopted managerially favourable subject positions.

1.5 Thesis structure

This thesis is made up of 8 chapters in addition to this introduction: a literature review, methodology, methods, four chapters of empirical findings, and a discussion and conclusions chapter.

Chapter 2 provides a review of integrated care policy literature, making the case for an empirical study that explores the way in which the IC policy discourse is operationalised and enacted through implementation at the level of the commissioners, providers, frontline staff, and patients. Chapter 3 demonstrates the way in which I integrated the DRA and RE to produce a methodological innovation that allowed me to meet this research aim. Chapter 4 details the specific data collection methods and analysis I used within my study to build my analysis, theory, and central argument.

Chapter 5 presents analysis from phase 1 data collection, in which LPI texts are positioned within discursive practice and used to develop critical programme theories (CPTs) that guided subsequent data collection. This chapter finds that *‘integration’* within the CBIC was redrawn to respond to continued structural fragmentation and resource pressures, with emphasis placed on shaping staff and patients into responsibilised subject positions.

Chapters 6 to 8 present the findings from phase 2 data collection. These chapters use three examples (generic working, self-management, and auto-allocation scheduling technology) to demonstrate how lean discourse was operationalised through integrated care practices, attempting to shape subject positions in line with *‘waste watching’* and dislodging concern for improvements in patient care.

Chapter 9 discusses these findings in relation to the research questions and academic literature. It sets out the main contributions, relevance of findings for ongoing policy and practice, organisational recommendations, and limitations of this thesis.

Chapter 2 - Integrated Care: Policy, Practice and Discourse

2.1 Introduction

This chapter will present an argument for examining integrated care policy implementation within a policy discourse framing. By taking this approach, this thesis will connect macro level policy/structure with micro level practices at the level of implementation. In what follows, I present a narrative review of integrated care policy literature, which fell into 3 main types. Research (both quantitative and qualitative) which sought to evaluate government flagship integrated care policies between 2012 and 2016 (BCF, Integrated Care Pioneers, Neighbourhood teams within Greater Manchester Devolution, Vanguards- detailed in *appendix 1*) (i.e. Morciano et al (2020)), policy review/position papers which discuss these integrated care policies in terms of effective implementation (i.e. Coleman et al (2020)), and studies that draw upon post-structuralist discourse theory to provide critical examination of the IC policy discourse, constituted within this period, at the level of policy texts (i.e. Hughes (2017)). Although my case study does not fall directly within these flagship policies, the CBIC was developed and contracted within this political context, as well as explicitly linked to the FYFV and new models of care by its commissioning body. This selection therefore allowed me to relate the political drivers and discourses operating through the studies reviewed here with the CBIC case study. It is not my intention to provide a comprehensive review of all recent integrated care studies. It is instead, to provide a critique of the dominant theoretical approaches to studying integrated care policy. I will argue that, although we can draw useful insights from these three bodies of literature, there is need for research that examines the way in which IC policy discourse mobilises its ideological work through implementation at the level of commissioners, providers, frontline staff, and patients using a critical realist approach to discourse analysis.

In section 2.2, I review quantitative and qualitative studies which evaluate flagship integration policies. I focus on those service changes that most reflect my case study in their attempts to integrate care horizontally. These studies are largely conducted within an evidence-based policy framing, where the intention is to provide information that is useful to policy makers going forward in the development of IC (Cairney, 2016). In section 2.3, I examine IC policy review/implementation articles, which also have the purpose of providing useful information to policy makers on how to improve IC policy implementation going forward. However, these studies engage more substantially in the politics of integrated care and draw heavily on implementation theory (i.e. Matland’s ambiguity/conflict model). Their arguments largely centre on increasing the clarity and coherence of IC policy aims between cost savings and patient care, whilst also remaining critical of rhetorical or disingenuous political posturing.

In section 2.4, I argue that despite consistently reporting that government onus on cost and service use reduction come to dominate at the level of integrated care implementation, both implementation and evaluation studies view austerity as a context to which IC, as an apolitical intervention, is introduced into. I argue, in favour of using a critical policy discourse approach, that the policy evaluation and implementation studies reviewed are limited in the following respects:

1) they lack the ability to develop a sustained critique of government policy and the underlying political factors driving change

2) policy implementation theories view policy discourse/rhetoric as separate to integrated care implementation, whereas policy discourse approaches explore the relationship between discourse and its internalisation into practice

3) although they view austerity as a relevant social/political/cultural context, they are not explicit enough in demonstrating how IC actually furthers these political aims.

In section 2.5, I argue that the advantages of critical approaches to IC policy that draw on post-structuralist discourse theory, is that they can explain how IC working as a policy discourse has been constituted within a neo-liberal austerity context. Moreover, this theoretical framing sees ICs construction as a solution to wide ranging aims across patient care, cost cutting and hospital admissions, as part of its political work. Ultimately, however, I argue the case for my study which moves beyond textual analysis to demonstrate how the ideological work of the IC discourse is operationalised through implementation. I also posit that using a critical realist approach to discourse theory is the best way of doing this.

2.2 Evaluation of flagship policy initiatives

In this section, I will discuss the evidence provided by existing evaluations of key policy initiatives that have attempted to integrate care horizontally within the 2012 to 2016 policy context. Selected studies include those that use quantitative methods (Erens *et al.*, 2019; Hinde *et al.*, 2019; Keeble *et al.*, 2019; McCarthy *et al.*, 2019;

Stokes *et al.*, 2019; Morciano *et al.*, 2020) and qualitative methods (Erens *et al.*, 2016; Eyre *et al.*, 2017; Round *et al.*, 2018; Starling, 2018; Stocker *et al.*, 2018; Islam *et al.*, 2019; Davis *et al.*, 2020; Maniatopoulos *et al.*, 2020; Mitchell *et al.*, 2020). Quantitative evaluations largely aimed to evaluate the services against cost saving and hospital activity outcome measures. Qualitative evaluations tended to evaluate implementation of the service and ways of working.

2.2.1 Quantitative studies evaluating impact on hospital activity and costs

Recent evaluations of central IC policy initiatives (integrated pioneers programme, better care fund, and vanguards) reflected the weak evidence base for IC achieving some if its main policy aims of reducing hospital admissions and costs. The selection of hospital activity and costs as outcome measures within the studies also reflected the dominance of these policy objectives. These studies, bar Stokes et al (2019) (funded by the European Union's Horizon 2020 research and innovation programme) were commissioned by the National Institute for Health Research (NIHR) Policy Research Programme (funded by the Department of Health and Social Care), either as part of the new models of care Vanguard programme in England evaluation (Morciano *et al.*, 2020), or evaluation of the Integrated care and support pioneers programme (Keeble *et al.*, 2019). Other studies were commissioned and funded by NHS England via the specific Vanguard site (Hinde *et al.*, 2019; McCarthy *et al.*, 2019; Davis *et al.*, 2020; Kasteridis *et al.*, 2020), as part of the local vanguard evaluation requirements, in line with NHS England guidance. These studies, therefore, fit within an evidence-based policy framing, in which focus is given to whether policy is meeting its objectives, in terms of 'what works'. The hope is also that learning about policy design and implementation will be fed back to policy makers, in order for policy to be improved (Sanderson, 2003). These studies do issue several criticisms, including difficulties in judging success of these impact measures too soon, and inability to capture patient outcome/experience data alongside hospital activity and costs. However, it is argued here that the evidence-based policy framing of these studies means they perpetuate dominant political interests and are unable to develop a sustained critique of the focus on hospital activity/costs at the expense of patient related concerns.

a) Weak evidence base

Some studies found no impact on reducing hospital activity at all. Stokes et al (2019) found no effects of pooling budgets through the BCF on hospital use and costs, whilst Hinde et al (2019) found no statistically significant effects of the Harrogate Vanguard pilot (aimed to integrate mental health, social care, primary care, and community health services in a single team) on secondary healthcare activity. They also concluded that there was a lack of support for the hypothesis that the vanguard would result in cost effectiveness, given the £500,000 cost of funding the service.

Other studies identified some modest impacts. A Department of Health commissioned evaluation of the integrated pioneers programme found that the increase in the pioneer emergency admission rate was smaller and significantly different from the non-pioneer comparison for the first year (2014/15), but the effect was not statistically significant in 2015/16, suggesting some marginal but not concrete evidence of effect (Keeble *et al.*, 2019). Morciano et al (2020) conducted the first independent national evaluation of the impact of three of the major Vanguard care models (Multispeciality Community Provider (MCP), Primary and Acute care system (PACs) and Enhanced Health in Care Homes (EHCH) on the official policy objectives of reducing emergency admissions and total bed days in hospital finding only modest reduction in emergency admissions. Again more modest impacts were identified by Kasteridis et al (2020) who evaluated the impact of two integrated care PACs models (Complex Care Team and Enhanced Primary Care) which were introduced in South Somerset for people with complex care needs. Service utilisation was not significantly reduced, but death rate was significantly lower for those in the first Enhanced Primary Care cohort. Two studies, Morciano et al (2020) and Hinde et al (2019), make preliminary suggestions that these IC initiatives are unlikely to achieve their cost saving aims, whilst McCarthy et al (2019) explicitly analysed the cost impact, alongside secondary care use of a EHCH vanguard in Gateshead, with cost reduction only showing in the long term.

b) Criticism of judging success in the short term

Many of these studies were critical on the basis that short term evaluations were unlikely to be able to demonstrate benefits (Keeble *et al.*, 2019; McCarthy *et al.*, 2019; Kasteridis *et al.*, 2020; Morciano *et al.*, 2020). For Kasteridis et al (2020) and McCarthy et al (2019) these criticisms were methodological and not attributable to unreasonable governmental expectations. For McCarthy et al (2019) they argue that statistical techniques, such as interrupted time series analysis and difference in differences are inappropriate for short term evaluations because there are too few data points post intervention to determine impact. They argue that given their analysis showed no impact in the short term, but moderate impact in the long term, it is unlikely that the service would have been scaled up and rolled out. This argument frames their research firmly within an evidence-based policy perspective in which they view research evidence as having a linear relationship with policy decisions. Criticism is therefore warranted on the basis of difficulty in obtaining the correct information for policy makers to base their decision on.

Keeble et al (2019) and Morciano et al (2020) also listed methodological issues, such as not enough time for changes to emerge in the data, confounding events influencing the control group, and bias in the data. However, they are also slightly more explicit in their criticism of governmental expectations. Keeble et al (2019, p. 7) argue directly that ‘it is ambitious to expect unequivocal changes in a single high level and indirect indicator of health and care integration, such as hospital admissions to arise as a result of changes in local health and care provision across organisations brought about by the pioneers in their early years’. This criticism moves beyond research methodology and actually seeks to break the link between integrated care and impacts on hospital admissions, describing it as an ‘indirect indicator’. This suggests the causal connection between the two is not directly related, regardless of what research methodologies are adopted. Morciano et al (2020) also provide some criticism of governmental expectation that the new models of care will achieve short term success, and are particularly critical of plans to roll out the new models of care in the NHS Long Term Plan when effects are unlikely to be detectable in the short term.

That being said, Keeble et al’s (2019) caveat ‘in their early years’ suggests that there are still potential long-term benefits. They also make the additional point that there would be benefit from measuring impact beyond 2 years. Despite noting in the article that despite the amount of policy interest, there are few, if any, studies able to demonstrate a link between the two. It is therefore curious why they assume that there is potential for sustained impact, or why they fail to question what motivates this policy interest in reducing hospital admissions, despite this consistent lack of evidence and their own weak findings. Similarly, Morciano et al's (2020, p. 832) criticisms mainly relates to the difficulty of detecting changes in the short term and so suggests that policy makers should 'refrain from judging policy success too soon'. These quantitative studies, within an evidence-based policy framing, are not able to challenge the focus on hospital activity and costs in any sustained way, nor can they challenge the underlying political drivers behind the service change.

c) Inability to capture patient outcome data

That being said, whilst not objecting to the actual principle of evaluating hospital activity and costs, Morciano et al (2020) and Davis et al (2020) (Davis et al (2020) article written by same research team as Hinde et al (2019)) were both critical of their inability to capture broader outcome measures relating to patient centred data or locally defined measures of success. Both studies highlight that this focus was a result of priority given within NHS England monitoring. For Morciano et al (2020) this influenced the selection of the outcome measures chosen within the research. By contrast, Davis et al (2020) collected qualitative data, which aimed to capture the experiences and values of those involved in delivering the integrated community service. However, there were substantial difficulties in accessing staff and patients and limited ability to incorporate the findings into the ongoing work of the vanguard. The quantitative analysis which failed to demonstrate a reduction in hospital activity or a reduction in costs was the only element of the research that was used to make commissioning decisions, leading to the discontinuation of the service. Because the vanguard was working to provide the required monitoring and evaluation data on emergency department attendance for NHS England, other potential benefits were not captured. The authors offered criticism on the basis that ‘population health outcomes showing impact on patients, staff and wider population remain elusive’ (p. 3). Lack of data captured by the vanguards relating to local objectives or patients was also commented on by Morciano et al (2020).

The studies discussed above direct a level of criticism at both short-term evaluations of hospital activity and costs, as well as the difficulty in obtaining patient outcome data due to NHS monitoring priorities. Ultimately, however, whilst able to develop critique on the basis outlined above, the research, largely commissioned and funded by government, is inevitably conducted within the frame of evaluating stated governmental objectives. The starkest illustration of this is the almost unanimous conclusion that any changes in hospital activity/costs would not be detectable in the short term, begging the question whether the research team could have come to this conclusion without actually conducting the analysis. This point is reflected in Glasby and Miller’s (2020, p. 46) concern that despite numerous high quality research evaluations being conducted into integrated care service change, ‘we could probably guess what the next national evaluation of integrated care initiatives is likely to say before it is commissioned’. Sanderson (2003) has also questioned the validity of using public money to fund such evaluations, which ultimately add little new knowledge. Given their findings of negligible impact, these studies are also limited in their inability to engage in the fairness of difficult, if not unachievable, expectations placed on health providers, especially when they face being decommissioned (i.e.

Davis et al (2020)). Nor do their calls for patient outcome data engage in the political conflict or antagonisms present between these aims and reducing cost/service utilisation.

I would argue that the articles reviewed highlight that neo-liberal aims of reducing public expenditure on health care are being perpetuated through IC implementation, at the expense of patient related and locally developed concerns. Furthermore, provider behaviour was being shaped in response to NHS England monitoring, suggesting that within organisational practice, cost cutting aims are coming to dominate. However, we are lacking thorough understanding how organisational healthcare practices are being shaped by these pressures and what the impact is on patient care. If providers focus their efforts on collecting hospital admission and financial data, at the expense of patient outcomes, then these priorities may come to dominate many areas of practice. It is important to note that the Vanguard sites had access to a £200 million transformation fund (Miller and Glasby, 2016) and still struggled to meet these aims, with one service decommissioned on this basis (Hinde *et al.*, 2019; Davis *et al.*, 2020). This begs the question of how those tasked with implementing integrated care service changes will fare under an austerity context, beyond the pilot programmes.

2.2.2 Qualitative studies highlighting conflict between policy objectives

Four qualitative evaluations, Stocker et al (2018), Mitchell at al (2020), Eyre et al (2017), and Maniatopolous et al (2020) all conduct qualitative evaluations of integrated care services (vanguards/neighbourhood teams in DevoManc/Integrated

Pioneers) and contain findings that expose some of the conflict and contradiction between a focus on reducing hospital activity and costs on one hand, and patient centred outcomes on the other. These conflicts operated between those at the macro level (NHS England) and meso level (commissioners, local authority, provider), i.e. Maniatopolous et al (2020), and between this meso level and the micro level (frontline staff), i.e. Eyre et al (2017). These qualitative studies, similarly, to the quantitative studies, are all funded by government sources as part of policy evaluation. However, their qualitative methods allow for greater exploration of the experiences of those operating at the meso and micro-level of IC implementation and the difficulties they are having in negotiating these competing aims.

Stocker et al (2018) explored stakeholder’s views of an EHCH vanguard prior to implementation. Interviewees included those from the local authority, CCG, NHS England, care home managers, senior nurses, GPs, and representatives from the third sector. Interviewees were found to make attempts to negotiate potentially conflicting aims by balancing the quantitative measures focussed on admissions with complimentary qualitative person-centred measures that were concerned with the ‘older population living happier and healthier lives’ (p. 5). Although the authors argue that this approach aligned with NHS England’s approach, which sought to combine a range of metrics, this was not reflected in Maniatopoulos et al’s (2020) findings on the implementation of the new care models programme across 5 sites in North East of England. Their interviews with 66 key informants (clinicians, chief executives, commissioner managers, project managers) involved with implementation revealed antagonism between the experiences of these implementers and the changes and expectations imposed centrally by NHS England. They found that those on the ground, particularly CCG senior managers, struggled with the pressure placed on them to achieve efficiency savings and to achieve performance outcomes relating to hospital admissions, with this severely hindering progress. The result was that these targets dominated local initiatives and damaged opportunities for shared learning.

In addition to a conflict of interests between the meso level (providers, commissioners, etc,) and the macro level (government, NHS England), Eyre et al (2017), in their evaluation of the Waltham Forest and East London integrated care pioneer programme, identified conflict between senior leaders and managers who were concerned with reducing hospital admissions and making financial savings, and frontline staff at the micro level, who were more focussed on improving patient experience and interprofessional working. This led the authors to argue that the programme did ‘not focus enough on the people at the heart of the integration processes’ (p. 11). Nevertheless, there was also evidence from these studies that despite these conflicts, allegiance to the overall integrated care narrative was maintained when meso level actors viewed integrated care as a ‘moral imperative’ (Stocker *et al.*, 2018, p. 3)/the ‘right thing to do’ (Eyre *et al.*, 2017, p. 9) or they viewed maintaining the status quo as untenable (Maniatopoulos *et al.*, 2020).

Mitchell et al (2020) sought to investigate ways of working within co-located community health and social care neighbourhood teams, as part of health and social care devolution in Greater Manchester, by interviewing a mix of operational (community health or social care) and strategic level staff (NHS or local authority). They found three main factors which may affect the success of the teams: 1) the vision and leadership of integration, 2) organisational level integration and 3) professional workforce integration. Interviewees reported that the co-location allowed them to gain greater knowledge about other professional’s roles, that communication and discussion about patient care was much easier, and they could more easily give information to patients about other services. The study, therefore, identifies benefits arising from integrated care teams relating to professional working and patient care. The authors point out that benefits identified, however, will not necessarily reduce costs or achieve efficiency savings in any substantial way. This led the authors to be critical of the way in which the vision of integration shared by health professionals in relation to improving their ways of working and patient care, are not effectively evaluated by measures of success relating to hospital activity (hospital admissions & length of stay) and costs.

The strength of these qualitative evaluations is that they begin to expose in greater detail how conflictual integrated care aims and differing priorities between actors and agencies within the health and social care arena come to surface within implementation. They also begin to make a normative argument, which privileges the experiences and viewpoints of those on the receiving end (frontline staff and patients) over policy makers. Maniatopoulos et al (2020) and Eyre et al (2017) highlight the negative consequences when financial savings and hospital admissions come to dominate in service implementation, whilst Mitchell et al (2020) show the potential benefit when the concerns of frontline staff and patients are prioritised. However, what we do not have is a systematic study of how cost saving and service use reduction aims, and concerns about poor fragmented health and social care that the types of integration practices, described in Mitchell et al (2020), are designed combat, play out through the implementation chain.

2.3 Policy implementation literature

The policy implementation/review papers that I discuss below put forward the limitations of having wide ranging and sometimes conflicting policy objectives within IC policy. This criticism is largely considered, however, from the perspective of improving implementation through greater clarity and alignment of objectives. Policy review papers (Humphries, 2015; Goddard and Mason, 2017; Harvey *et al.*, 2018; Raus *et al.*, 2020) begin to highlight the potential difficulty of achieving the wide-ranging aims of IC at the level of implementation. Goddard and Mason (2017) emphasise that the ‘elastic concept’ of integrated care is often unclear, ensuring the need for ‘clarity about the precise nature of how integrated care is operationalised and implemented’ (p. 2). Both Harvey et al (2018) and Raus et al (2020) argue that a political balance needs to be struck between competing policy aims of improving user experience and independence on the one hand and reducing hospital admissions and costs on the other. Questions are also raised about the chances of substantial success within a context of structural fragmentation between health and social care and inadequate funding (Humphries, 2015). However, why these competing policy aims have occurred, what this political balance might be, or detail as to the consequences of this conflict, are not alluded to.

Two studies (Miller and Glasby, 2016; Coleman *et al.*, 2020) draw on policy implementation theory (Exworthy and Powell’s (2004) ‘big and little window’ policy stream model and Matland’s (1995) ambiguity-conflict model respectively), whilst Exworthy et al (2017) use the TAPIC (transparency, accountability, participation, integrity, and capability) model of desirable governance attributes, in order to provide theoretically informed explanations as to why the lack of clarity, ambiguity, or conflict inherent within these policy initiatives leads to ineffective implementation. Collectively, these studies and the theoretical positions that they draw upon, provide an argument for greater clarity in policy making and implementation and greater alignment of objectives. This implies that if only policy makers could be clearer and more consistent in their objectives relating to integrated care, the more successful implementation will be.

Exworthy et al (2017) argue that IC implementation in England since 2010, fell short of the transparency criteria with the TAPIC model, due to the number of initiatives and pilots, such as the Better Care Fund, Vanguards and Sustainability Transformation Partnerships, which obscure policy decisions by creating ‘complexity and organisational chaos’ (p. 1127). For example, initial implementation of pilots were closely followed by subsequent announcements for new initiatives, with the Pioneers programme being left feeling under-supported after the announcement of the Vanguard pilot and their £200 million Transformation Fund (Miller and Glasby, 2016). Similarly, in the last year of the vanguards, focus was beginning to move onto the development of Sustainability Transformation Partnerships (STPs) and Integrated Care Systems (ICS) (Coleman *et al.*, 2020). This suggests that policy initiatives would benefit from clear, focussed, and dedicated government support.

In addition to viewing mixed messaging and conflict between policy initiatives as a reason for failure, the policy implementation literature also directs critique towards contradictory goals. Miller and Glasby (2016) use the ‘big and little window’ policy stream model developed by Exworthy and Powell (2004) which draws on Kingdon’s

(1995) policy stream model to critique the Coalition government’s approach to IC implementation. Following Kingdon (1995), the three streams to be considered are: policy (goals & objectives), process (causal, technical, and political feasibility), and resources (financial and human). They add to these, three dimensions: vertical (the link between central government and local agencies), central-horizontal (links within and between central government departments and national bodies), and peripheral-horizontal (links within and between local implementation agencies). Successful implementation is more likely to occur when there is alignment between the streams within the three dimensions. Within the vertical dimension, the authors highlight the mixed messaging between on the one hand, the government’s objective for better outcomes for individuals through the adoption of the narrative for person-centred integrated care and claims to allow bottom-up flexibility to develop local priorities, and on the other hand, top-down central control through the implementation of the Better Care Fund, which focusses on reducing hospital admissions and length of stay to achieve cost savings. Ultimately, they are critical of this top down approach, in favour of local discretion which will both allow for more effective implementation of integrated care, as well as a greater focus on patient related and locally developed objectives (Glasby and Miller, 2020).

Making a similar argument, but drawing on Matland’s (1995) ambiguity-conflict model, Coleman et al (2020), also highlight the conflict between top down implementation approaches to integrated care concerned with hospital activity and bottom up approaches which focus on locally developed outcome measures. Matland’s model classifies policies along conflict and ambiguity axes, with conflict occuring between goals and how they are met. Coleman et al (2020) provide two key examples. 1. During the early stages of implementation, the Vanguards were encouraged to develop locally developed approaches and outcomes. However, once into the second year of the pilot, NHS England began to subject them to greater monitoring of system activity, such as emergency admissions, emergency department waiting times and hospital bed days. Vanguards needed to demonstrate improvements in this area to secure funding for the third year of the pilot, despite this not being specified at the outset. Coleman et al (2020) highlight how this contradiction can potentially manifest itself as a detriment to improvements in patient care, with vanguards being discouraged from pursuing initiatives that take time to implement, such as prevention, or other service improvements that were not captured by the hospital activity metrics. 2. NHS England expressed desire to roll out the New Care Models across the country in through Sustainability Transformation Partnerships in 2016, which conflicted with using bottom-up implementation to capture and incorporate relevant learning. Rolling out the care models also presupposed benefit, which undermined the commissioning of evaluation studies to determine whether the vanguards had achieved their aims. Coleman et al (2020) are therefore critical of IC policy implementation on two fronts. The top-down approach to implementation can act as a detriment to locally developed patient related outcomes, and the level of conflict between policy goals damages opportunities for successful implementation.

In addition to their implementation focussed critique, both Miller and Glasby (2016) and Exworthy et al (2017) do make implicit normative arguments for the value of integrated care implementation and critique is levelled at the government when, as the authors argue, they make disingenuous or opportunistic claims to integrate care.

Exworthy et al (2017) noted that a discourse of integrated care had achieved particular resonance in the UK House of Commons, with Miller and Glasby (2016, pp. 174-176) commenting that the importance of integrated care was ‘widely recognised and endlessly discussed, both in national policy and local practices’ by 2015, and in fact took ‘centre stage within coalition health and social care policy (at least rhetorically)’ through the passing of the health and social care bill. Exworthy et al (2017) directed criticism of the coalition government for falling short of the integrity criteria within the TAPIC governance, due its ‘sudden conversion to the notion of IC’ which could be described as ‘an opportunistic attempt to save the bill rather than a genuine attempt to integrate care’ (p. 1128). Miller and Glasby (2016) are also critical of the government’s rhetorical commitment to integrated care, which they contrast with genuine attempts to integrate. In their article reflecting on a one-day workshop held with IC researchers and policy makers, they question whether it is ‘a buzzword which means all things to all people?’, reflecting the empty appeal that integrated care has (Glasby and Miller, 2020, p. 43). In his other IC policy commentary papers, Glasby (2016; Glasby, 2017) sets out a more overt position on the detriment to patients if care is not integrated, as well as a claiming that if the IC agenda has lost its focus on achieving ‘better services and better outcomes for people’s lives’ then it has become ‘part of the problem rather than part of the solution’ (p. 2). Within Coleman et al (2020), there is also implicit normativity in favour of a concern for patient welfare and not simply implementation effectiveness. An example of this is their critique that ‘accounts that emphasised long term meaningful sustainable ‘bottom-up’ change could therefore be in direct conflict to those which required the demonstration of quick results to satisfy the political needs of the programme’ (p. 13). Present in all three studies, therefore, is critique of government policy when it is felt that their attempts to integrate are actually playing into wider political aims, or simply represent 'rhetoric'. There is also an implicit and sometimes more explicit normative critique developed when this works to the detriment of improvements in actual service delivery for patients.

There seems, however, to be a separation between what is considered political work (demanding quick results to justify political decisions (Coleman *et al.*, 2020), or making claims to IC just to pass controversial legislation without any real intent (Miller and Glasby, 2016; Exworthy *et al.*, 2017)) and what Exworthy et al (2017, p. 1128) describe as a 'genuine attempt to integrate care'. In the case of Coleman et al (2020) and Miller and Glasby (2016) their suggestions for improved implementation are based on setting clearer, realistic and compatible goals, and the allowance of bottom up and locally based development. I would argue that these suggestions, deny the presence of the political arguments that they have also made within their work. In this sense, why would policy makers take heed of these suggestions when they do not actually further the political work, i.e., passing pro-competitive bills or meeting policy objectives around reduced hospital activity that has already been identified. More, therefore, needs to be said about the political factors that are driving the use of conflicting objectives and mixed messaging and how this then relates to the critique developed.

Miller and Glasby (2016) and Exworthy (2017) discussion of IC rhetoric and its use in passing through the HSCA 2012 bill can give the impression that IC rhetoric represents empty words. Whilst, although useful in governing the system of meaning in allowing controversial bills/policy to pass through, this discourse remains unconnected to IC implementation. In the view of Miller and Glasby (2016) and Exworthy (2017), when we come to study implementation, we are better to draw on theoretical frameworks, such as big and little policy windows and the TAPIC model of effective governance, rendering the connection between policy discourse and implementation lost. However, I would argue that we can begin to use evidence from these implementation studies, and some of the evaluations discussed earlier, to begin to connect these two levels. This can be identified in Coleman et al's (2020) findings that vanguards were discouraged from pursuing initiatives that take time to implement, such as prevention, or other service improvements. And Davis et al's (2020) finding that vanguards focussed on measuring and reporting hospital activity, in line with NHS England's requirements. Here, IC policy discourse, is not simply working as a rhetorical device to allow the passage of austerity/privatisation but is being operationalised in implementation through vanguards having to demonstrate quick benefits in terms of hospital admissions, leading to direct implications for ways of working and patient care. Warning of negative implications for patients, comes from Glasby's worry that if IC has moved away from concerns about improving people's lives then it has become part of the problem (Glasby, 2016). We, therefore, see in these articles the beginning of links between policy discourse and its implementation effects, and a normative critique developed on this basis. However, I would argue that the theoretical perspectives drawn on in these studies do not provide them with the tools to make overt normative arguments in favour of policy focussed on patient care and/or locally developed outcome measures. Nor do they allow them to fully conceptualise the political work that is taking place through the integrated care discourse, the wider political narratives that IC is situated on, and the link between this and implementation at the level of practice.

2.4 Austerity context

Across a range of evaluative and policy implementation/review studies, (Erens *et al.*, 2016; Exworthy *et al.*, 2017; Goddard and Mason, 2017; Round *et al.*, 2018; Starling, 2018; Erens *et al.*, 2019; Maniatopoulos *et al.*, 2020) there is explicit reference to the austerity context in which IC is operating in. However, this is presented as a political contextual factor that IC, as an apolitical intervention, is being introduced into. For example, Starling (2018, p. 53) who developed a framework of 10 lessons for health and care integration based on interviews with Vanguard Leaders, argued that further extension of IC care models will be ‘challenging in what is an increasingly financially squeezed health and social care context’, whilst within Round et al’s (2018) evaluation of an integrated care service in South London, advice is given to ‘take into account the macro environment and policy context’ when developing future integrated care models (p. 301). Erens et al (2016; 2019) in their national evaluation of the integrated pioneers programme trace the change in focus from the person-centred vision originally advanced by the pioneers to a focus on organisational fragmentation and financially driven goals linked to hospital utilisation. They argue specifically that the change in direction is consistent with national policy orientation towards limiting demand and pressure on the acute sector. However, they stop short of explicitly arguing that IC is used to further these political aims by placing IC within what they have termed the ‘integration paradox’. This means that ‘as the need for effective integration intensifies to improve outcomes and save costs within an increasingly adverse financial setting, so it becomes more difficult to secure change due to the same pressures of increased demand and fewer resources, which often result in a retreat into more “siloed” ways of working’ (Erens *et al.*, 2016, p. 121). The ‘adverse financial setting’ is in this case still a contextual factor, which makes it ‘more difficult to secure change’. This is despite consistent findings, discussed in section 2.2 and 2.3, that concerns around reducing costs and service utilisation come to dominate, *as a result* of NHS England monitoring.

This assumption remains within much of the literature. Erens et al (2016; 2019) still imply that IC is the victim to a wider cost cutting policy agenda that has diverted its aims towards organisationally and financially driven goals. Instead, of seeing it as inherently underpinned by the same political ideology. Maniatopoulos et al (2020) drawing upon Pettigrew et al’s ‘receptive contexts of change’ framework is the only non-discursive study to locate IC implementation fully in its neo-liberal ideological context. The ‘receptive contexts of change’ framework seeks to recognise the influence of contextual factors at the macro, meso, and micro levels. They claim that this theoretical framework allows them to locate IC policy in its political and ideological contexts and at the micro level of practice. This has the advantage of locating the antagonism occurring at the level of practice within a neo-liberal ideological context, emphasising efficiencies, measuring performance, and containing public spending. The limitations of using the ‘receptive contexts of change’ framework, however, are that the article is unable to launch a developed critique of this political context and unable to develop a normative argument as to why we should favour local initiatives over centrally driven objectives, arising from the neo-liberal context.

So far, this chapter has made the case that data from recent IC evaluations and policy implementation studies provide provisional evidence that concerns about restricted resources and hospital admissions come to dominate within IC implementation, creating conflict and antagonism with attempts to prioritise locally driven and patient related objectives. These antagonisms operate between the micro level (frontline staff/patients) meso level (Commissioners/local authority/provider) and macro level (Government/NHS England). However, I have also argued that the theoretical perspectives used in the studies reviewed so far are limited in the following respects:

1) they lack the ability to develop a sustained critique of government policy and the underlying political factors driving change
2) policy implementation theories view policy discourse/rhetoric as separate to integrated care implementation
3) although some studies view austerity as a relevant social/political/cultural context, they are not explicit enough in demonstrating how IC actually furthers these political aims.

I will now go on to review studies that take an explicit critical policy discourse theoretical approach to studying integrated care. This theoretical position sees IC as constituted within a certain political context, as constructed through problematisations, and as acting as a conduit for constituent discourses through its broad appeal. It also sees IC itself as performing political work to further ideological aims. However, ultimately these critically orientated studies (i.e. Hughes (2017) limit their analysis to the level of texts produced by government and think tanks. It is that this stage that I will make the case for my study, which seeks to investigate how IC policy discourse can be put to work at the level of implementation to reproduce its ideological work.

2.5 Critical policy discourse studies

As discussed in section 2.3, policy implementation studies Exworthy et al (2017) and Miller and Glasby (2016) emphasised the discursive and rhetorical dominance achieved by integrated care at the governmental level and its key role in ensuring the smooth passage of the Health and Social Care Bill. Critical policy discourse studies have also made the case for the dominance of the IC policy discourse. Glynos et al (2015), who draw on the logics approach to critical policy analysis, in their analysis of documents produced by the King's Fund, Nuffield Foundation, Future Forum, and the government, also argue for the importance of the passing of the health and social care bill, in which through a series of rhetorical moves 'integration elevated to the status of overriding objective of the NHS and competition essential to its realisation' (p. 59). From this point forward integrated care can be characterised as a 'master political logic' which marginalised other visions of health and social care (p. 2), with a 'duty to integrate' placed on NHS England, Monitor, CCGs, and Health and Wellbeing Boards in the HSCA 2012 (Miller and Glasby, 2016).

Hughes' (2017), moving beyond the passage of HSCA 2012, conducted an analysis of 56 policy, legislative, debate, and grey literature documents (published mainly between 2011-2016 to reflect a more recent iteration of IC policy, and in particular the publication of the Five Year Forward View (FYFV) and new models of care). She found that a dominant discourse of IC is repeatedly and consistently framed within these documents as a solution to a range of problems, such as, demands placed on the system through an increasing ageing population, poor care through fragmentation of services, restricted resources, and high numbers of hospital admissions. Although there are no studies tracing the discourse of IC post this period, as described in section 1.2, the development of STPs and ICSs onward from 2016 to the present period, suggests that IC is still the dominant organising narrative in the health service.

By taking a discursive view of IC policy, these studies are taking a sociocultural view of policy that sees IC discourse as framing the delivery of desirable health and social care in a particular way, so as to limit other ways of thinking, writing and speaking about it (Bacchi, 2009). They are also interested in the way in which broader policy is shaped and enacted by social actors at different levels within practice (Bartlett and Vavrus, 2016). Practice being the routine and habitual ways that actors come together and engage in social life within a particular domain (Chouliaraki and Fairclough, 1999). Several articles have noted that the dominance of the IC discourse within policy and practice is not reflected in the weak empirical evidence for meeting its aims of reducing hospital admissions and improving patient care (Eyre *et al.*, 2015; Hughes, 2017; Carey, 2018). This may partly explain why successive policy initiatives, such as STPs and ICSs, have been built on advancing the new models of care, despite the weak empirical evidence for their success, as discussed in section 2.2. This means that integrated care, working as a system of meaning, is able to garner support and allegiance for this particular framing of desirable health and social care, despite not actually working to achieve the aims articulated within the policy discourse. This has led Hughes to argue that IC is not an intervention which provides a ‘rational solution to a technical problem’ (Hughes, 2017, p. 74), but is instead, a discourse that performs certain political work. The notion of IC as not reflecting a rational solution to an objective problem chimes with Jones’ (2018a) experiences when evaluating the integrated care pioneer programme. Her ‘impression from fieldwork was that the policy does not actually exist’ (p. 263), leading her to call for a sociocultural approach to studying IC policy implementation attuned to the workings of power and different interpretations of what the policy meant between different actors. This may suggest that part of ICs appeal and ability to garner support is its broad reaching and flexible nature. Also suggesting that calls from policy implementation theorists (i.e. Coleman et al (2020)) for greater clarity and consistency of goals are unlikely to be heard.

It has been argued that part of this broad appeal may arise from the ability of the IC discourse to construct integrated care as a single solution to a wide range of problems within the health service (Eyre *et al.*, 2015; Hughes, 2017). Hughes’ study, which draws on Bacchi’s (2009), ‘what’s the problem represented to be’ approach (WPR), looks at the way problematisations inherent within the policy imply certain assumptions and values, generating certain solutions and mitigating others. Analysing policy problematisations means that whilst accepting there are issues within social life that are troubling, problem representations in public policy are not fixed, and may be constructed within certain contexts and reflecting certain political assumptions. When we examine policy through problematisations we start to examine the way in which governments play an active role in the construction of ‘problems’ (Bacchi, 2009). Problematisation of fragmentation (Glynos *et al.*, 2015; Hughes, 2017), an ageing population (Hughes, 2017; Carey, 2018), poor public finances and high numbers of hospital admissions (Hughes, 2017) are inherent within the IC discourse and work to render integration as an effective solution. IC discourse, therefore, plays an active role in constructing meaning in the health and social care arena.

Discursive approaches to policy analysis see policy, and their inherent problematisations, as constituted in its political context with certain policy gaining dominance through a process of negotiation and struggle between competing discourses (Fischer, 2003; Howarth, 2010). Hughes (2017) argues that the political context in which IC has been constituted is one in which there are long term concerns about the ageing population, hospital admissions, and how to manage the NHS within the context of growing demand and costs. This is particularly realised within the current austerity context, in which neo-liberalism, focussing on seeking efficiencies, value for money, cost containment and return on investment, is hegemonic (Hughes, 2017; Maniatopoulos *et al.*, 2020). Glynos et al (2015) also discuss the emergence of the dominant IC discourse in relation to the passing of the Health and Social Care Bill 2011, which it has been argued was ideologically motivated legislation designed to further neo-liberal aims of increasing privatisation and furthering distrust of professions, in favour of patient centred care (Speed and Gabe, 2013; Speed and Gabe, 2020). Critical policy discourse theory, therefore, provides us with the conceptual tools to view IC as being constituted within the neo-liberal political context of the UK government’s austerity agenda post 2008, and not as a separate apolitical intervention introduced into this context.

For Glynos et al (2015) the problematisation of fragmentation emerged through the passing of the pro-competition Health and Social Care Bill, with worries emerging about how fragmentation would arise from providers competing against each other for the most financially worthwhile services, whilst abandoning those that have lower perceived return on investment. Integrated care was then able to present an attractive vision on the basis of its ‘‘empty’ oppositional status’, (i.e., being against fragmentation, but less clear on what it actually stands for) (p. 56). Within a neo-liberal context, the claim that IC provides a solution to the problematisations of hospital admissions and poor public finances is particularly appealing and reinforcing of this dominant economic narrative. The ageing population (with a recognition that members of this population are likely to be living with multiple morbidities) are constructed as the main drain on financial resources through their inappropriate use of service, including hospital admissions, and the central burden that need to be responded to if health services are to remain sustainable within this context (Hughes, 2017; Carey, 2018). IC claims to provide joined up care for the elderly population as the main recipients of health and social care, so that they are treated mainly in a community or home setting, reducing their use of secondary care services, (Maruthappu *et al.*, 2014; Shortell *et al.*, 2015). IC is therefore actively constructed as the solution to the problematic ageing population.

Examining the way in which the post 2008 austerity context and the hegemonic neo-liberal economic order has influenced both the construction of these problems and integrated care as the solution, is useful in appreciating the political and discursive nature of IC policy. The theoretical concept of fantasmatic logics (Glynos and Howarth, 2007; Howarth, 2010), however, helps explain why certain problematisations and solutions take hold in the way that they do. Glynos et al (2015) draw on the logics approach to critical policy analysis, employing the concepts of social, political, and fantasmatic logics to analyse what they see as the hegemonic struggle over UK health care provision. Social logics refer to the dominant norms of a practice, political logics are the ways in which these norms are contested, defended or transformed, and fantasmatic logics aim to capture the energy that allows social norms to retain their grip, and political logics to be ‘energised by fantasies’ (p. 20). The logic of fantasy offers a narrative in which an obstacle is successfully overcome, but a horrifying disaster awaits if the obstacle remains (Glynos and Howarth, 2007; Howarth, 2010). The fantasmatic appeal of IC is based on pitting it against the horrifying scenario of fragmentation, which links to anxieties about ‘lack of co-ordination’, ‘wasteful duplication’ and patients falling through the cracks of services (Glynos *et al.*, 2015; Hughes, 2017, p. 81). Standing in opposition to fragmentation also has common-sense appeal, with arguments for greater fragmentation of health services almost impossible to make (Stokes *et al.*, 2019; Glasby and Miller, 2020). Furthermore, ICs appeal, can also be linked to a ‘fantasy of demography’ which positions the ageing population as a major threat to the welfare system, providing impetus and a sense of urgency for reform to the health service through integrated care (Lindberg and Lundgren, 2019, p. 6).

2.5.1 What political work does the IC policy discourse perform?

So far, I have argued that integrated care policy can be seen as a dominant discourse that has established itself within policy and practice, as the solution to wide-ranging problems within the health service. The problematisations implicit within the 2012-2016 iteration of IC was made possible by the austerity context and fears relating to greater competition in the passing of the health and social care bill. However, discourse does not just have a representational function. Power operates through discourse and power dynamics are reproduced through the enactment of discourse (Eyre *et al.*, 2015; Jones, 2018a). Policy discourse can therefore be seen as performing certain 'work' to further dominant interests or reproduce power dynamics, and not just reflective of the political context (Fischer, 2003).

Integrated care has been discussed in terms of the work it performed to ward off criticism of the pro-competitive reforms within the passage of the Health and Social Care bill. It has been argued that IC was used to mitigate concerns and controversy relating to enhanced competition and was in some sense opportunistic, rather than reflecting genuine attempts to improve the co-ordination of services (Glynos *et al.*, 2015; Miller and Glasby, 2016; Exworthy *et al.*, 2017). Glynos et al (2015) have argued that the compatibilising rhetoric of choice drawn upon in the passage of the HSCA bill, not only renders integration and competition compatible, but enables competition to actually serve integration. IC therefore worked as a political logic to marginalise concerns relating to fragmentation arising from the pro-competitive reforms and provider blind provision (the decision for service delivery is based on capacity to deliver a good service, not the type of organisation), allowing the passage of the bill and the introduction of greater competitive forces within the health service. In this sense, IC is working as a rhetorical device to further the political aims of introducing greater competition in the health service. The IC discourse, therefore, does not just frame and construct knowledge in relation to health and social care in a certain way, but actively works to reproduce dominant neo-liberal power structures through its effects.

Moving beyond the passage of the HSCA bill, integrated care is also seen in terms of the work it performed to further the government's cost cutting and austerity agenda. Through its promise of reducing costs through integrating these services, and framing the benefits of greater integration in terms of improvements through patient centred care, the IC discourse is able 'to manage tensions between the desire to restrict growth in public expenditure whilst maintaining the popular NHS, and to manage tensions between the different funding regimes of health and social care' (Hughes, 2017, p. 83). By managing these tensions, IC in this way allows the continuation of a divided health care system and austerity (Hughes, 2017). As well as helping us to explain why certain problems and solutions retain their grip, fantasy helps to explain why potentially contradictory elements, such as maintaining good care within the NHS, whilst restricting resources are rendered compatible. It is actually a central feature of 'fantasmatically structured enjoyment' for discourses to possess contradictory features and for them to be managed in this way (Glynos and Howarth, 2007, p. 147). In this sense the IC discourse is providing, in effect, discursive cover for the continuation of austerity through its ability to smooth over some potentially contradictory features.

By viewing IC policy as constituted within the austerity context and not as an intervention introduced into this context, we can begin to explain more fully why, within practice, concern with reducing hospital admissions and costs at level of research, NHS England monitoring and provider behaviour, have come to dominate at expense of efforts to improve patient care. However, due to Glynos et al’s (2015) and Hughes’ (2017) analysis of policy/legislative/grey literature texts, their arguments relate mainly to the way in which discourse is operating at the macro governmental level and not how it translates into everyday practice within the health and social arena. However, using the evidence discussed in sections 2.2 to 2.4, we can begin to link Hughes’ (2017) argument for the IC discourse’s ability to manage these tensions, with the way in which austerity is mobilised at the level of IC practice. As it stands, however, we are lacking a systematic research study that employs a critical policy discourse approach to trace the IC discourse through its enactment, reformulation, or contestation at the level of practice and what the potential effects are for commissioners, health providers, frontline staff, and patients.

In fairness, Glynos et al (2015), in full exposition of their argument, posit that to fully understand the political dimension of the IC discourse, it must be considered in relation to the way in which it naturalises and marginalises critique of the social logic (dominant norms of a practice) of provider blind provision. Implications of this at the level of practice are discussed in terms of the justice of organisations providing care, the extent to which staff can inform decisions, working conditions, and the delivery of good health and social care. Hughes’ (2017) study, although only beginning to touch on implications for practice, also comments that further austerity can impact negatively on population health.

There are, however, some limitations with these approaches. Glynos et al (2015) show concern for implications at the level of practice when the IC discourse performs work in marginalising contestation of provider blind provision, in terms of the organisational types that may be legitimised in the contracting process. Similarly, Hughes' (2017) comments about the potential harmful implications of austerity is useful in beginning to connect the IC discourse with effects at the level of lived experience. However, there is a danger here that these criticisms could slip into the same limitations inherent within Miller and Glasby (2016) and Exworthy et al (2017) in which IC discourse is purely a rhetorical device to further alternative aims. What my analysis of evaluative and implementation literature showed was that at the level of practice, providers were left dealing with the contradictions and inconsistencies inherent with the discourse when trying to implement integrated care. Above, it is suggested that the IC discourse works to render incompatible elements compatible. However, what are the implications when these potential incompatibilities manifest themselves through organisational and managerial practice within the provider and for patients?

Full demonstration of Bacchi's (2009) WPR approach, drawn upon in Hughes (2017), involves analysing the way in which certain problem representations (problematisations) may lead to effects, such as attributing blame and responsibility to certain groups, or having impacts on lived experience, opening up the potential for analysis of the effects of the IC discourse at the level of practice, using this approach. Viewing IC policy through its problematisations has been useful so far in understanding how it has garnered such a high level of appeal, how it frames acceptable ways of thinking about health and social care, and the political context in which it has been constituted. The ability to begin connecting these problematisations with effects at the level of lived experience is a strength of

Bacchi's approach, which she acknowledges is often lacking in Foucauldian post-structuralist approaches to policy analysis.

However, there are reasons, I argue, for not viewing integrated care policy, *solely,* in terms of the effects leading from certain problem-solution pairings. Firstly, this approach is not able to capture the ideological dimension of the IC discourse, in the sense of explaining why some problematisations within the discourse take precedence over others at the level of practice. By contrast, Chouliaraki and Fairclough (1999, p. 26), in their critical realist conception of discourse, describe its ideological work as 'constructions of practices from particular perspectives which iron out the contradictions, dilemmas, and antagonisms of practices in ways which accord with interests and projects of domination'. This allows us to think through the ideological work performed by the IC discourse in actively obfuscating its neo-liberal aims, whilst playing lip service to concerns about improving patient care. The onus is also placed on judging the ideological nature of discourse through its generative power to create effects at the level of practice when working dialectically with more enduring structures and material reality. This means discourse can be considered as 'empty words', when discourse is not internalised into non-discursive practice (Chouliaraki and Fairclough, 1999, p. 29).

This approach to Critical Discourse Analysis (CDA) was developed within Fairclough's (1989; 1992) early work and extended further through explicit framing within critical realism through the Dialectical Relational Approach (DRA) to CDA, in Chouliaraki and Fairclough (1999) and Fairclough (2002; 2005; 2008; 2013). Discourse within this approach is more limited than that used by many discourse theorists (Fairclough, 1992), and is different from the post-structuralist approach to discourse drawn upon by Hughes (2017) and Glynos et al (2015) discussed in this chapter. As a method of analysis, CDA focusses on studying semiosis, which is the meaning making created through texts (any instance of language use, visual images, sounds) and the way that meaning making relates to other non-discursive mechanisms within social practice. As an element of social action, semiosis works in three ways. 1) to construe social practice through different discourses (ways of representing/systems of meaning), i.e. neo-liberal discourse 2) as a facet of action through interaction and 3) in the constitution of identities (Fairclough, 2013). This contrasts with post-structuralist discourse theory that sees social practice as constituted within discourse.

Chouliaraki and Fairlough's (1999) distinction between 'empty words' and discourse internalised into practice, also allows us to conceptualise the distinction between discourse that has rhetorical value, in for example, allowing the smooth passage of controversial bills, and discourse that is operationalised into practice when commissioners, health providers, managers and clinicians are asked to implement integrated care. This theoretical perspective can therefore most usefully link the discursive work identified by Glynos et al (2015) and Hughes (2017) at the policy level and generative power of discourse to create change when internalised into practice through NHS monitoring and provider behaviour in attempting to meet cost saving aims, whilst being tasked with implementing integrated care change (Eyre *et al.*, 2015; Erens *et al.*, 2016; Stocker *et al.*, 2018; Coleman *et al.*, 2020; Davis *et al.*, 2020; Maniatopoulos *et al.*, 2020; Mitchell *et al.*, 2020; Morciano *et al.*, 2020). These studies reveal a level of antagonism and conflict between NHS England and providers, as well as a level of conflict between the priorities of senior management, frontline staff, and patients, suggesting that actors may differ in the extent to which they accept or resist dominant policy narratives, as well as in the way they experience the effects of integrated care implementation.

The second issue with a sole focus on problematisations, such as in Hughes (2017), is that it does not appreciate the power of the IC discourse to act as what Glynos et al (2015, p. 60) see as ‘a master political logic or conduit through which a set of wider discourses and fantasies can play themselves out’, which may in themselves perpetuate neo-liberal political aims. For example, Jones (2018a) argues that based on her experiences as a researcher on the national evaluation of the integrated pioneers programme, policies are often symbolic and oversold, with policy makers more likely concerned with reducing hospital admissions and saving costs than with achieving ‘person-centred co-ordinated care’. Carey (2018) in his critical analysis of integrated health and social care policy also argues that these policy changes relate to cutting costs and reducing support for patients, extending privatisation, and diverting attention away from structural issues within health and social care, such as poverty and inequality. However, he also positions integration policy within a focus on individual choice and autonomy. Discourses of ‘patient-centredness’ have themselves been linked with political agendas around increasing choice, competition and cost-cutting (Speed and Gabe, 2020). Jones’ (2018a) argument treats the discourse of IC as merely having rhetorical value, whilst viewing ‘person centred co-ordinated’ care as something separate that policy makers are simply not concerned with. However, discourses of person-centred care can also be seen as actively working through integrated care to further the same political aim. Following on from the argument made above, we must also look to determine the way in which ICs constituent discourses play into the contradictions, dilemmas, antagonisms, and problematisations operating at the level of practice, in order to determine their ideological effects.

Integrated care has therefore been seen as conduit for discourses relating to ‘greater choice’ ‘autonomy’ and ‘personalisation’ (Glynos *et al.*, 2015, p. 65). Integration in particular articulates a preference for patient choice through the patient choosing the best integrated care package or by constructing a personalised package of care (Glynos *et al.*, 2015). Some have argued that the publication of the FYFV, however, moved the agenda from competition to collaboration, with no mention of competition at all within the document (Exworthy and Mannion, 2016; Hammond *et al.*, 2017; Hammond *et al.*, 2019). However, despite the lack of mention of competition, the publication of the FYFV and its further policy iterations into STPs/ICS, used integrated care as conduit for further discourses that can also be argued further the aims of the neo-liberal state, especially in relation to pushing the cost of health and social care into ‘the unwaged realms of the home and community’ (Speed, 2016, p. 2). Firstly, in addition to the call to action in 2013 to meet the £30bn funding gap, the FYFV called for efficiency savings of £22bn to be made by 2020 (Kerasidou, 2019). Key to achieving these efficiency savings were the development of new models of care (Hammond *et al.*, 2019). This helps to explain why the focus on cost cutting and reducing hospital admissions came to dominate in the studies discussed in sections 2.2 to 2.4. However, achieving a reduction in hospital activity and achieving efficiencies was also linked with a greater focus on community care, prevention, patient empowerment and self-care (NIHR CLAHRC Greater Manchester, 2019;

Coleman *et al.*, 2020), with self-care being central to NHS strategy set out in the FYFV (Jones, 2018b). Patient empowerment and self-care have also been linked with neo-liberal aims of removing responsibility for health from the state onto the individual (Salmon and Hall, 2003; Ellis *et al.*, 2017). Integrated care, as the conduit for variety of minor discourse, therefore, warrants further attention, given its ability to potentially obfuscate the political work operating through these minor discourses.

Earlier I highlighted that some of the policy evaluations (Eyre *et al.*, 2017; Maniatopoulos *et al.*, 2020; Mitchell *et al.*, 2020) and policy implementation studies (Miller and Glasby, 2016; Exworthy *et al.*, 2017; Coleman *et al.*, 2020) began to make preliminary normative arguments in favour of privileging the concerns of patients over the cost saving aims of policy makers. However, I also argued that the theoretical perspectives drawn upon in these studies do not provide the tools for explaining why some objectives should be privileged over others. Similarly, I would argue, the relativism implicit within the post-structuralist approaches to integrated care policy also limit the ability to make clear normative arguments in favour of certain kinds of health and social care practice. If problematisations, within Hughes (2017), are all equally constructed then what argument do we have for privileging certain problematisations over others. If it is the case that certain problematisations may lead to negative effects for patients and health professionals, then why privilege their interests over elites who may benefit from the neo-liberal system. Similarly, it is unclear on what basis Glynos et al (2015) can argue for why alternative social logics, such as *provider pluralism* as opposed to *provider blind provision*, should take precedence.

By drawing on Fairclough’s (2002; 2013) critical realist approach to discourse I can avoid this relativism by adopting a moderate constructionism. This approach adopts an explicit normative agenda that seeks to determine and expose the often opaque ways in which unequal power relations between social groups are produced and reproduced by discourse. This means that some problematisations capture difficulties within social reality better than others with some problematisations working explicitly to further the aims of dominant groups at the expense of those with less power. Fairclough’s approach to discourse analysis, therefore, enables explicit normative critique (evaluates realities based on to what extent they match values for a just society) and explanatory critique (by showing these realities to be a result of structures and mechanisms) to be developed through research findings, and so providing the theoretical tools for me to assess integrated care implementation from the perspective of patients, compared to the cost saving aims of policy makers.

2.6 Relationship of literature review to research questions

In this chapter, I have made the case for studying integrated care policy through a policy discourse theoretical framing that sees integrated care as the dominant narrative framing health and social care, as positioned as a solution to a wide range of problematisations, and as reflecting a neo-liberal economic logic. I have drawn upon and taken inspiration from studies that view integrated care through post-structuralist discourse theory (Glynos *et al.*, 2015; Hughes, 2017), especially in relation to ICs problematisations, the role of fantasy in energising it as a political logic, and its ability to act as a conduit for minor discourses. I have also shown using evidence from evaluation and implementation studies of government flagship integration policies between 2012-2016 that NHS England monitoring, CCG, and provider behaviour was dominated by cost saving and service use reduction aims at the expense of locally defined priorities and improvements in patient care. This suggests that lying beneath the surface of the IC policy discourse are problematic implementation practices due to the lack of attention paid to patients.

This chapter has argued that what is lacking is a systematic examination of the way in which the IC policy discourse has been mobilised, enacted, reformulated, and resisted through the implementation of integrated care, and what the implications are for health professionals and patients at the level of lived experience. We, therefore, do not know what the potential negative effects are when the IC discourse, which has been constituted within a neo-liberal austerity context, is operationalised into practice. Finally, I have made the case for studying integrated care policy through a critical realist approach to discourse outlined by Chouliaraki and Fairclough (1999) and extended by Fairclough (2002; 2005; 2008; 2013) through his Dialectical Relational Approach. This approach has the benefit of being able to theorise the ideological nature of IC discourse in which it actively obfuscates its neo-liberal aims. Its distinction between discourse realised semiotically and the internalisation of discourse into non-discursive practice centres analysis on the generative power of discourse to create change within IC implementation, and it provides the tools for making an explicit normative argument in favour of the concerns of patient care and frontline staff.

The aim of this study is therefore to investigate how the IC policy discourse is operationalised and enacted through implementation at the level of commissioners, providers, frontline staff, and patients within my case study CBIC. The four research questions that come out of this aim are as follows:

1. How have local policy implementers (CCG/lead provider/County council) constructed a community based integrated care service (CBIC)?

2. What are the potential implications for frontline staff and patients if this discursive work is operationalised into practice?

3. How has the IC policy discourse and its constituent discourses been enacted and operationalised within a community based integrated care service?

4. What are the outcomes and implications for patient care and staff experience?

2.7 Conclusion

In conclusion, I have reviewed existing integrated care policy evaluation and implementation literature and have demonstrated that at the level of implementation there is substantial conflict between its cost saving and patient related aims. I have proposed studying integrated care policy through a critical policy discourse theoretical framing to explain how IC policy is both constituted within a neo-liberal austerity context and performs work to further this political objective. I have made the case for my study which will seek to explain how the ideological work of the IC discourse is operationalised through practice at the level of commissioners, providers, frontline staff, and patients within a critical realist study.

Chapter 3 - Methodology: Integrating the Dialectical Relational Approach to Critical Discourse Analysis and Realist Evaluation

3.1 Introduction

As outlined in the literature review chapter, the aim of this study is to investigate how the IC policy discourse is operationalised through implementation within a CBIC case study, at the level of commissioners, providers, frontline staff, and patients. The four research questions that came out of this aim are as follows:

1. How have local policy implementers (CCG/lead provider/County council) constructed a community based integrated care service (CBIC)?
2. What are the potential implications for frontline staff and patients if this discursive work is operationalised into practice?
3. How has the IC policy discourse and its constituent discourses been enacted and operationalised within a community based integrated care service?
4. What are the outcomes and implications for patient care and staff experience?

I made the argument within the literature review for meeting this research aim using the Dialectical Relational Approach (DRA) to Critical Discourse Analysis (CDA), developed by Chouliaraki and Fairlough (1999) and Fairclough (2002; 2005; 2008; 2013) on the following basis:

1. Appreciating the ideological capacity of discourse to smooth over contradictions and antagonisms within practice to accord with dominant interests allows me to view IC policy discourse through its potential to actively obfuscate its neo-liberal aims

2. By viewing discourse in its semiotic form as ontologically distinct, yet dialectically related to other non-discursive mechanisms, DRA allows me to assess its ideological effects through its internalisation (or not) into practice. This places a research focus on the potential generative power of discourse to create change through implementation of health and social care integration at the level of commissioners, providers, frontline staff, and patients

3. The critical realist theoretical underpinning provides the tools to make an explicit normative and explanatory critique when evaluating the potentially negative effects of integrated care implementation for patients and frontline staff.

In this chapter, I make the case for a methodological innovation that combines DRA and realist evaluation (RE). I posit that this provides the ontological tools and methodological resources to connect a sociocultural view of integrated care policy (as part of broader social structure) with its enactment at level of practice through empirical research. In this way, I develop clear methodological guidance for exploring the dialectical relationship between policy discourse and micro-level organisational processes and effects at the level of experience, which therefore enabled me to answer my research questions. I also argue that there are currently no other methodological approaches for systematically examining the dialectical relationship between discourse realised semiotically and non-discursive mechanisms within policy evaluation. My approach therefore represents a novel development that contributes to the methodological literature and can be applied in other research studies.

In section 3.2, I detail the ontological and methodological assumptions within the DRA. In section 3.3, I explain how the approach allows me to position my CBIC case study within health and social care practice and wider policy discourse and structure. In section 3.4, I also make the case that there is insufficient methodological guidance on how to explore the relationship between semiosis and the other elements of social practice. I argue that by integrating the DRA with the initial programme theory concept and the context-mechanism-outcome heuristic from realist evaluation, I was able to develop a methodology that allowed me to answer my research questions. In section 3.5, I will set out the basic tenets of realist evaluation and how it draws on critical realist principles to provide useful insights into the evaluation of micro level processes within the CBIC. Ultimately, however the methodology is limited through its attachment to scientific realism.

In section 3.6 I will begin setting out the methodological process that I took when conducting my study and the way in which I integrated RE with DRA. The methodology is divided into two phases, with phase 1 focussed on answering research questions 1) and 2) by developing Critical Programme Theories (CPTs). CPTs are theoretical propositions of what might happen when discourse drawn upon linguistically by local policy implementers when describing the CBIC is enacted and operationalised at the level of implementation. These CPTs then provided a broad framing for the main data collection period in phase 2. In section 3.7, I will set out the analytical process for developing more comprehensive context-mechanism-outcome (CMO) theories during the main empirical work in phase 2, which allowed me to answer research questions 3) and 4). These CMOs seek to explain the way health professionals are influenced by contextual factors when responding to resource mechanisms to produce outcomes. However, by pushing the CMO heuristic through the dialectical-relational approach, as opposed to scientific realism, I was able to explore the relationship between semiosis and materiality, managerial practices, technology, social interaction, identity, and values and beliefs, whilst also explaining the dialectical relationship between the CMO and the interdiscursive and structural levels.

In section 3.8, I discuss my use of normative and explanatory critique. In section 3.9, I provide a summary of the chapter’s central argument. This chapter therefore provides the blueprint for my novel integration of DRA and RE, as well as the ontological, epistemological, and axiological assumptions underpinning the approach. This blueprint sets the basis for the way in which I collected and analysed my data (chapter 4), and my exposition of the research findings, data analysis and theory building presented in this thesis (chapters 5-8).

3.2 The Dialectical Relational Approach

The DRA is a theory of, and a methodology for, analysing discourse that is underpinned by a critical realist philosophy of science (Fairclough, 2003; Fairclough, 2013). The theory of discourse sees macro level social structure, social practice, and micro level events in dialectical relationship with one another. Within critical realism, social structure refers to relatively enduring structures, which act as the background to social interaction, and have a constraining or enabling effect on people's lives (Archer, 1995; Fairclough, 2013). This may include class, inequality, race, gender, generation, power, policies (Alderson, 2015). The relationship between social structure and what happens in events is not straightforward and is mediated by social practice. Social practice, such as the social practice of classroom teaching within the UK education system, including its semiotic dimension, discursive practice, are the relatively stabilised ways that social life is accomplished in particular domains. Orders of discourse control linguistic variation within social practice by deeming what can and cannot be said (Fairclough, 2003). Fairclough draws on Gramsci's concept of hegemony to show how orders of discourse become hegemonic when they win the consent of the majority (Fairclough, 1992).

Within social practice itself, the different moments (discourse realised semiotically, power, social relations, material practices, institutions/rituals, and beliefs/values/desires) work in dialectical relationship (Chouliaraki and Fairclough, 1999; Fairclough, 2008). This theory follows the critical realist assumption that each of the elements of social practice contributes its own distinctive generative powers to the production of social life. Each moment 'internalises' the others without being reducible to any of them. Discourse is therefore a way of social relating, a material practice, a mode of forming beliefs/values/desires, an institution, and a form of power. Social practice always has a reflexive/positioned nature to it (Chouliaraki and Fairclough, 1999). Social reality is therefore mediated through discourse, whilst other elements remain causally efficacious (Zotzmann and O'Regan, 2016).

Within analysis, Fairclough advocates analysing the way semiosis construes social practices through different discourses, i.e. neo-liberal discourse, its roles in social interaction and in the constitution of identities (Fairclough, 2008; Fairclough, 2013). The study of semiosis should not be conducted in isolation, however, as CDA is ultimately interested in the 'emergence, reproduction, and transformation of social structures' and the contribution of semiosis is in this process (Fairclough *et al.*, 2002, p. 5). Fairclough et al (2002) also makes explicit calls for critical realism to take a greater account of semiosis in the process of social structuration. The DRA is placed firmly within the tradition of critical social science through an explicit aim to identify the role the semiosis plays in the reproduction of unequal power relations, ideological processes and human wellbeing through its dialectical relationship with the other moments of social practice (Fairclough, 2008).

In order to study the role of semiosis within this broader social process, Fairclough (2013) advises oscillating between a focus on specific events (the semiotic aspect of an event being described a text), social practice (the semiotic aspect being described as discursive practice) and more abstract social structures. His basic analytical approach is to analyse the specific semiotic features of a text (interviews, transcripts, tv programmes, visual images, and sound effects), how they relate to discursive practice (the production, consumption, and interpretation of texts) and wider social practice and structures. At the level of discursive practice, Fairclough is interested in how texts draw on a mix of discourses (ways of representing), genres (semiotic aspects of ways of (inter)acting), and styles (semiotic aspects of identity and ways of being), as part of the constitution of social life (Fairclough, 1992; Fairclough, 2003). Texts are both simultaneously socially structured and part of reproduction or transformation of those structures (Chouliaraki and Fairclough, 1999; Jørgensen and Phillips, 2002; Henderson, 2005). By drawing on certain discourses and occupying certain subject positions, actors actively reproduce the structure that ultimately has a constraining and enabling effect on them (Fairclough, 2001b). Power, therefore, works through discourse to perpetuate dominance of some groups over others, as well as being a productive force in helping to create subjects that ultimately reproduce those power structures (Jørgensen and Phillips, 2002).

Within the DRA, and most importantly for this study, discourses (ways of representing, i.e. neo-liberal discourse) can also be operationalised through being dialectically objectified as materiality, technology, or organisational practices, enacted as new ways of (inter)acting, and inculcated as new ways of being/identities (Fairclough *et al.*, 2002). Following a critical realist ontology, theses discourse may remain unactualized within the ontological level of the real, with their actualisation and transformation being dependent on interaction with contextual factors and the agency of actors (Zotzmann and O'Regan, 2016). Fairclough et al (2002, p. 9) stress that in contrast to post-structuralism, it is important to ‘explore the various extra-semiotic mechanisms that contribute to the variation, selection, and retention of semiosis’ into practice.

3.3 Application of Dialectical Relational Approach within thesis

Building on the arguments made in chapter 2, I argue that the focus of the DRA on 1) the dialectical relationship between structure (including macro-level policy) and events, and 2) the dialectical relationship between the moments within social practice provided me with the tools to meet my research aim and answer my research questions. Firstly, the DRA provided me with a theory that positioned the events and social action taking place in my CBIC case study within health and social care practice and in relation to broader social structure, including neo-liberal austerity, and the macro level policy environment between 2012 and 2016 set out in the introduction and literature review. This approach allowed me to explore how broader political mechanisms operated through my case study, as well as working to reproduce or transform structure (Archer, 1995). This enabled me to go some way in meeting the aim of this study to investigate how the IC policy discourse was operationalised through implementation at the level of commissioners, providers, frontline staff, and patients.

For Fairclough (1992), the order of discourse is the semiotic structuring element of social practice, guiding what can and cannot be said. As argued in the literature review, the dominant narrative governing the health and social care arena is the IC policy discourse and its constituent discourses. This meant I assumed that this discourse had an influence on linguistic variation within the CBIC. However, within a dialectical-relational approach to critical discourse analysis, discourse is not only realised semiotically but is also differentially internalised through the other elements of social practice. The second dialectical focus of the DRA, therefore, provided me with the ontological tools to connect the IC policy discourse with its operationalisation and enactment into specific practice, such as power, social relations, material practices, institutions/rituals, and beliefs/values/desires within my case study. This therefore allowed me to answer my research questions, which focus on IC policy discourse and practice at the level of commissioners, providers, frontline staff, and patients. This had the advantage that I was able to determine the differential retention, resistance, and contestation of discourse into practice, whilst judging the ideological effects without presuming a linear connection between structure and events.

3.4 Methodological limitations

The DRA's methodology is a variation of Bhaskar's explanatory critique and is based on four stages. The first stage is to focus on a social wrong in its semiotic aspects. The second is to identify obstacles to addressing the social wrong. This stage involves exploring the dialectical relations between semiosis and other elements of practice, as well as conducting interdiscursive analysis which links textual analysis, social practice, and social structure. Stage 3 involves considering whether the social order needs this social wrong, which means determining the ideological nature of discourse. Stage 4 is concerned with identifying possible ways past the social wrong by examining how it is contested resisted and challenged (Fairclough, 2008).

Throughout his work, Fairclough provides detailed advice on analysing how the linguistic structure of specific texts relates to discursive practice (Fairclough, 1992; Fairclough, 2001b; Fairclough, 2003). In terms of understanding the broader relationship between social action (including texts), social practice and structures, he advocates using DRA within transdisciplinary research projects that draw on a range of social theories (Fairclough, 2008) . He also claims that linguistic analysis of texts can be combined with ethnography, given that the researcher is situated within the field of enquiry and is able to collect data on the different moments of practice, such as materiality, social relations, processes, and the beliefs, values and desires of participants (Chouliaraki and Fairclough, 1999; Fairclough, 2003). My plan was to use ethnographic methods within my study to explore how the IC policy discourse related to these aspects of practice within the CBIC. However, there was no specific guidance on best practice for conducting the ethnographic research in relation to the semiotic analysis (Belfrage and Hauf, 2017). Nor did simply combining ethnographic methods with CDA provide a way of differentiating the differential power held by commissioners and senior managers within the provider over frontline staff and patients who were largely on the receiving end of CBIC service change. Furthermore, given the commissioned nature of study (detailed in the introduction), I also needed a way of clearly conceptualising what specific aspects of the CBIC were being introduced to frontline staff as part of the service change and how they were responding.

I have developed a methodology within the thesis that allowed me to put the DRA to work through a critical evaluation of IC policy discourse by providing a systematic approach for exploring 1) the dialectical relationship between macro-level politics/structure and social action/events 2) the dialectical relationship between moments within social practice and 3) how 1) & 2) apply specifically within the CBIC service change with an impact on frontline staff and patients. This approach involved combining linguistic analysis of texts and discursive practice with the initial programme theory concept and context-mechanism-outcome heuristic from realist evaluation. The initial programme theory concept was revised into critical programme theories, which are theoretical propositions of what might happen if discourse drawn upon in the construction of the CBIC by LPIs, is operationalised at the level of implementation through a range of discursive and non-discursive mechanisms. These critical programme theories are then explored within the main empirical section of the project with the aim of developing more comprehensive context-mechanism-outcome theories, which analyse the way mechanisms interact with pre-existing contextual factors to produce outcomes. The mechanism concept is used to explore the dialectical relationship between discourse realised linguistically through organisational texts and other causally efficacious elements of social practice.

In section 3.2 below, I explain the basic tenets of realist evaluation, its links to critical realism, and how as methodological approach, it provided a broad framework for structuring the data analysis when evaluating social practice within my case study and the specific introduction of the CBIC service change.

3.5 Realist Evaluation - basic tenets and links to Critical Realism

I demonstrate in this section how realist evaluation provided the theoretical and methodological tools to enable to me to structure my analysis and theory building in relation to some of the non-discursive phenomena of social practice when collecting ethnographic data within my case study. Realist evaluation is a theory-based approach to the evaluation of complex interventions/policies, or service change, developed originally by Pawson and Tilly (1997) and in later work by Pawson (2006; 2013). Realist evaluation draws on the stratified ontology of critical realism (Bhaskar, 2013), which allowed me to focus on the underlying causal mechanisms that led to change, within a complex notion of causality that accounts for varying contexts (Westhorp, 2018). This stratified ontology, posits that there is a world in existence, which is partly beyond the perceptions of the researcher. Reality, however, is stratified into three domains: the real, the actual and the empirical. The real is beyond the perceptions of humans and contains the generative mechanism and structures that generate all phenomena. The actual contains all of the phenomena in existence, whether they have been perceived by actors or not, and the empirical contains all those phenomena which are actually perceived by humans (Bhaskar, 1979; Bhaskar, 2013). The generative mechanisms, although hidden, are real in the sense their effects can be partially experienced or observed (Walsh and Evans, 2014). A stratified ontology means that social structures operate at many different levels and so their effects can be a result of many different interweaving complex interactions. This leads to a complex notion of causality in which generative mechanisms can cause a variety of different effects at different times and places. Critical realists, therefore, talk of demi-regularities, as opposed to strict regularities described in positivist work (Angus and Clark, 2012). Pawson and Tilley (1997) draw heavily on this stratified ontology within their evaluative approach to show how it is only by going beneath the inner workings of a social intervention and exploring the impact of contextual factors that we will determine how change is created. This ontological position allowed me to think through what mechanisms were creating change beneath the surface of empirical observation within the CBIC and the impact of individual, professional, organisational, and political contexts that the CBIC was being implemented into.

A further benefit of critical realism's stratified ontology for the evaluation of the CBIC is the ability to theorise the connection between the underlying causal mechanisms creating change and impacts at the level of lived experience for frontline health staff and patients. The process of unearthing causal explanations in critical realism (Bhaskar, 1979) and realist evaluation (Pawson and Tilley, 1997; Pawson, 2006; Pawson, 2013) is called retroduction. Using Bhaskar's (1979) stratified ontology means looking at what is going on in the observable level of the empirical and asking what must be possible within the social world in order for us to be able to observe these events. In realist evaluation, retroduction is described as using 'both inductive and deductive logic' to think 'through what causal powers might be at work in producing observed patterns or changes in patterns' (Greenhalgh *et al.*, 2017, p. 1). These effects at the level of the empirical are considered to be ontologically real and caused by the identified causal mechanisms. The benefit of this for my study was the ability to evaluate the impact the service change had on the lived experience of my participants.

Secondly, realist evaluation's focus on continual theory generation draws on critical realism's epistemological position (what constitutes valid knowledge). The constructivist epistemology of critical realism, posits that what we are able to perceive in the empirical domain is also influenced by human interpretation (Bhaskar, 1979; Bhaskar, 2013). The role of research, within critical realism, is therefore to build theories about the generative mechanisms and structures within the real domain. But, these theories are open to being challenged and revised at a later date, due to the limited and fallible nature of human interpretation in the empirical (Schiller, 2016). The role of generating theory in this way is also central to realist evaluation. Initial programme theories are developed and continually refined throughout the empirical phase of the research, as new evidence becomes known, which either strengthens or discredits the existing theory (Pawson and Tilley, 1997; Pawson, 2006). This idea that further research serves to expand on what is known about a social intervention is therefore embedded within critical realist assumptions about how we generate new knowledge, and the continual refinement of that knowledge. The framing of my project using an initial theory which guided the further empirical phase, enabled a clear and focussed data collection and research design for the study.

The main empirical phase is centred on the development and refinement of context-mechanism-outcome (CMO) theories, which aim to provide this explanatory theory. The CMO is described as a heuristic device used for framing research data in ways that account for the mechanisms (resources introduced by the service change + reasoning and responses of actors) in operation, the pre-existing contextual factors which inhibit or enable those mechanisms to fire, and the resulting outcomes (Pawson and Tilley, 1997; Pawson, 2006). Dalkin et al (2015) usefully build upon the heuristic by disaggregating the mechanism concept into separate resource mechanisms and response/reasoning mechanisms, which they argue helps to distinguish between contexts and mechanisms. I was then able to map the DRA's non-discursive moments of social practice onto the CMO heuristic. I did this by examining knowledge I had gained through ethnographic data collection of the social relations, materiality, organisational/institutional factors, and mental phenomena operating within the CBIC onto the context, resource mechanism/response mechanism, and outcome concepts. The CMO was therefore a useful heuristic in exploring causative change within the micro-level implementation of the CBIC.

Despite drawing on elements of critical realist philosophy, the architects of realist evaluation, Pawson and Tilley (1997) and Pawson (2006; 2013) and those researchers prominent within the RE community, such as Dalkin et al (2015) and Jagosh (2020), place themselves within the paradigm of scientific realism, rejecting some of the central tenets of critical realism. They deny its normative and emancipatory objectives, instead attempting an objective and value neutral approach to empirical enquiry (Pawson, 2016), that gives less focus to structural forces in favour of testing narrow hypotheses designed to test specific causal pathways (Pawson and Manzano-Santaella, 2012; Dalkin *et al.*, 2015; Pawson, 2016). Their preference for scientific realism is derived from their research aim of establishing 'effective and ineffective implementation' (Pawson and Manzano-Santaella, 2012, p. 177) and providing useful insights to policy makers and professionals on 'what works, how, in which conditions, and for whom' (De Weger *et al.*, 2020, p. 7), as opposed to seeking to critique power structures. It is for these reasons that realist evaluation has received some criticism from critical realists who argue that RE inadequately engages with power asymmetries between stakeholders engaged in the service/intervention/policy under question, and that it fails to analyse deeper, partially hidden structures at the level of the real which account for the political factors driving change (Alderson, 2021). Finally, its axiological assumptions (role of values) have been criticised for maintaining the fact/value distinction and rejecting the emancipatory elements of critical realism, leaving realist evaluators with the task of instrumentally explaining the objectives of policy makers, and not evaluating for whom the results are desirable and undesirable (Porter, 2015a).

Realist evaluation, underpinned by scientific realism, was not quipped, therefore, to enable me to meet my research aim to investigate how the IC policy discourse was operationalised and enacted through implementation within a CBIC case study at the level of commissioners, providers, frontline staff, and patients. This is because its failure to engage with structural mechanisms did not provide the tools to explore the relationship between micro level implementation and the macro level political environment governing health and social care integration. Furthermore, I still did not have a way of examining the dialectical relationship between discourse and the non-discursive moments of social practice, or the way in which power was operating through my case study. Below, I detail the way in which I combined realist evaluation and the DRA within the two phases of my research to enable me to answer my research questions and meet some of the methodological limitations within both approaches.

3.6 Phase 1- Developing Critical Programme Theories

The first stage in my methodological revision was to develop what I have called *Critical Programme Theories* (CPTs). CPTs combine the initial programme theory concept from RE (Pawson and Tilley, 1997; Pawson, 2006; Pawson, 2013), with the DRA (Chouliaraki and Fairclough, 1999; Fairclough, 2008). CPTs seek to draw on the advantages of framing an evaluation using RE’s initial programme theory, whilst accounting for some of the ontological and axiological limitations associated with their scientific realist assumptions and the benefits of DRA. They also enabled me to meet my research aim of exploring the relationship between the IC policy discourse, as constituted within a neo-liberal austerity context, and the meso and micro level implementation of integrated care. Critical programme theories are theoretical propositions of what might happen if discourse drawn upon in the construction of the CBIC by local policy implementers, is operationalised at the level of implementation through a range of discursive and non-discursive mechanisms. These critical programme theories are then explored within the main empirical section of the project with the aim of developing more comprehensive context-mechanism-outcome theories, which analyse the full range of mechanisms and how they interact with contextual factors.

3.6.1 Initial programme theory development in Realist Evaluation

The development of initial programme theories is a useful methodological tool because it focuses the research process on developing explanatory theory of how the introduction of a specific service is creating change, whilst also providing direction for the forthcoming data collection. However, the development of programme theories suffers from some limitations, linked to RE’s scientific realist principles. Firstly, it is suggested that initial programme theories should be developed using organisational documents, policy documents, and interviews with policy makers and intervention designers, as these sources of data will provide knowledge about the design of the intervention, the resources that have been introduced, the ideas and practices that staff will need to accept and the desired outcomes (Pawson and Tilley, 1997). This selection, however, is based on gaining epistemic access to knowledge about the service change due to either the unique position held by these actors, or the relevance of the documents to the service change. The analysis of these data sources does not account for the differing positions of power and competing interests that may exist between these interviews and recipients of programme resources (Alderson, 2021). Nor, would it reflect that policy and organisational documents are also produced within these relations of power, as well as constituted within a political and structural context (Fairclough, 2001b). Following RE’s attempts to conduct value neutral and objective analysis, data from these interviews and documents would therefore be examined uncritically for the power dynamics, interests, and structural contexts in which they have been constituted. As such, the initial programme theories developed from this analysis, would be presented as value neutral and objective, when in fact they would represent particular interests and power dynamics operating within the service change and context.

3.6.2 Analysis of texts to develop Critical Programme Theories

To combat these limitations and enable me to meet my research aim, CPTs were developed using similar sources of data to RE’s programme theories. However, the ontological position of the DRA assumes that these texts, as part of social action, are dialectically related to social structure, as well as the other moments of social practice (power, institutions, social relations, mental phenomena) (Chouliaraki and Fairclough, 1999). This meant that the language used to describe the CBIC by policy makers/intervention designers had the potential to contribute towards meaning making, which could be operationalised through mechanisms within social practice, as well as play a role in the reproduction or transformation of social structure (Fairclough, 2008). Realist programme theories would have been interested in theorising how mechanisms at the level of the organisation, social relations, and mental phenomena were operating. However, they would not have examined the operation of power or discourse. Drawing on the DRA meant that I analysed texts discursively to determine the way in which they actively constructed and contributed towards change within the CBIC, as texts (Fairclough, 2003). CPTs therefore allowed me to think through how the discourse articulated through these texts may be operationalised dialectically as materiality, new ways of (inter)acting, or ways of being (identities) (Fairclough *et al.*, 2002; Fairclough, 2005; Fairclough, 2008; Fairclough, 2013).

The selection of relevant texts came from two main sources. The first were those existing documents produced by organisations in positions of power over the discursive framing and non-discursive implementation strategy of the CBIC. The second were interview transcripts generated from interviews conducted by me with senior managers within these organisations. These organisations were operating at the meso level of interest within this study and included the lead provider (who had won the contract to deliver the CBIC), Clinical Commissioning Group (responsible for commissioning the CBIC), and County Council (responsible for social care). Within this study, I have termed these meso level organisations ‘local policy implementers’ (LPIs). This was to emphasise the mediating role they were playing between broader politics and structure relating to health and social care integration and micro level implementation within a specific locality. They were also organisations/actors who had greater power over discursive and non-discursive resources, with potentially differing interests and values to the recipients of managerially directed resources, such as frontline staff and patients (Van Dijk, 1993). From this point on, I will refer to these sources collectively as LPI texts.

Analysis of these sources drew on stage 1 in Fairclough’s (2001a; 2008) methodological approach to focus on a social wrong in its semiotic aspect. This involved treating those texts as a ‘semiotic ‘point of entry’’ (Fairclough, 2008, p. 169) into investigating the way in which the IC policy discourse was operationalised through implementation within the CBIC. The way in which these organisations described the aims, strategy, and problems to be overcome linguistically, constituted what Fairclough (2008, p. 176) describes as ‘imaginaries’. These were projections of the way practices and interrelationships would work within the CBIC. These texts, therefore, represented an entry point into thinking about the discourse underpinning the change and its potential dialectical transformation within implementation.

The LPI texts not only had a constituting function but were also conditioned and shaped within particular a structural and social context. At the level of discursive practice, texts are produced, distributed, and consumed within a particular social context, and so the meaning making realised linguistically both simultaneously draws upon and contributes to existing systems of meaning and discourse (Fairclough, 1992; Fairclough, 2001b; Fairclough, 2003). Although Fairclough is interested in how texts draw on a mix of discourses (ways of representing), genres (semiotic aspects of ways of (inter)acting) and styles (semiotic aspects of identity and ways of being), my analysis was less focussed on the specific genre and style of the text, and more concerned with how the ways of representing (discourses) might be dialectically operationalised within implementation. These discourses and potential enactments were then seen in terms of how they were situated within and contributed towards wider social and structural change.

The benefit of developing critical programme theories, which linked wider policy discourse and structures to potential enactments at the level of practice within the CBIC, was that it began the theoretical process of exploring 1) the dialectical relationship between macro-level integrated care policy and social action/events 2) the dialectical relationship between moments within social practice and 3) how 1) & 2) applied specifically within the CBIC service change with an impact on frontline staff and patients. In this sense, wider structures, such as the prevailing neo-liberal economic system provided the limits of possibility (Fairclough, 2003) in terms of what policy discourse was operating at the governmental level, and then again by those at the level of LPIs. As such, this methodology was able to link what was going on at the wider structural and political level, and its relationship to the micro level processes going on within CBIC implementation. However, I did not take a deterministic view of discourse, which is why CPTs were developed as theoretical propositions which needed to be explored within the main empirical phase. Following a critical realist ontology, this discourse may remain unactualized within the ontological level of the real, with their actualisation being dependent on interaction with contextual factors and the agency of actors (Zotzmann and O'Regan, 2016).

3.6.3 Normativity and value-based analysis

Within the literature review chapter, I challenged policy evaluation and implementation studies for lacking the theoretical grounding to develop both a normative critique of findings and a preference for a particular vision of health and social care. As such, I incorporated critical realism's emancipatory and critical orientation into the development of CPTs. In this way, CPTs took the imaginaries constructed by LPIs and enabled me to think through the potential 'social wrongs' created if they were to be operationalised and enacted at the level of implementation. By focussing on social wrongs, critical programme theories provided a way of framing the CBIC evaluation within a critical approach to social science research and ensured that any negative effects arising from the CBIC are evaluated through a normative lens.

Critical social research implies that you are both searching for causes that are hidden and therefore ideological and illuminating how this ideological work may lead to disadvantage for some (Fairclough, 1992). As discussed in the literature review, ideology within CDA is seen as 'constructions of practices from particular perspectives which 'iron out' the contradictions, dilemmas and antagonisms of practices in ways which accord with dominant interests' (Chouliaraki and Fairclough, 1999, p. 26). By interrogating the assumptions and discourse drawn upon by LPIs and situating this discursive work within wider power structures, the research had the critical intent of trying to expose false claims and critique problematic social practices. Problematic social practices could relate to either a needs-based or representational based problem. A needs-based problem might occur where discursive representations of benefit claimants mean that they struggle to survive on minimal welfare support once this is enacted through policy. A representational based problem may be where certain sections of society are represented in an unfavourable or disadvantageous way, such as unfavourable representations of immigrants to the UK (Fairclough, 2001a).

Within the context of developing CPTs, I looked to theorise what needs based problems might happen if the contradictions, dilemmas, and antagonisms which have been smoothed over at the discursive level, came to play out once enacted as ways of (inter)acting, ways of being and as materiality, in ways which were disadvantageous to frontline staff and patients. In respect to representational issues, I examined who and what were problematised within the discussion of the CBIC? Were some problematisations silenced and others made more prominent? Were some actors more blameworthy than others? Mulderrig (2017b) applies Lawrence's (2004) work on policy framing to her Critical Discourse Analysis of a UK government's obesity campaign. Here, she shows how 'individualising' frames which problematise individuals, allow government to limit their involvement, and 'systemic' frames which problematise broader governmental and structural factors invite government intervention (Lawrence, 2004; Mulderrig, 2017b). Critical programme theories, therefore, sought to theorise what might happen if these problematisations were enacted and operationalised within the implementation of the CBIC, in relation to frontline staff and patients and what might be the negative consequences of this. These theories were set out as 'if/then' statements. This is on the basis that initial programme theories are more limited and less explanatory than the full context-mechanisms-outcome theories developed through the final stages of the research (Jagosh, 2018; Jagosh, 2019).

What, therefore, do CPTs tell us? CPTs aimed to present initial theoretical propositions of what might happen if the discourses within LPI texts were dialectically operationalised as discursive and non-discursive mechanisms, leading to certain effects at the level of patient and staff experience. It was the not intention to provide full exploration of the contexts, resource mechanism + response mechanisms and resulting outcomes, as CPTs were intended to provide initial guidance for phase 2 data collection. Following the DRA, the mechanisms provisionally explored within CPTs were material enactments that may have been introduced to staff, including new technology, physical space, managerial procedures. CPTs also focussed on the way health professionals may respond in terms of their professional identity and interactions with other staff and patients. Whilst the resulting outcomes were at the level of experience, i.e. job satisfaction, stress levels, the extent to which patients are happy with the care they have received.

3.7 Phase 2 - Development of Context-Mechanism-Outcome theories

Once developed, CPTs were used as an initial guide to explore some of the potential problematic implementation effects that may have arisen once the discourse realised linguistically by LPIs was operationalised and enacted within implementation. The findings of which enabled me to answer research questions 3) and 4). However, it is important to stress that the approach of this thesis is not hypothetico-deductive, and data collection proceeded in a much more exploratory and inductive way than is usually found in realist evaluation. Within realist evaluation, initial programme theories are described as hypotheses to be tested, with these hypotheses presented to interviewees for them to confirm or refute in the process of theory building (Pawson and Tilley, 1997). In this study, CPTs are theoretical propositions which guided the areas of inquiry. It was presumed likely that those discourses drawn upon by LPIs, given their power of discursive and non-discursive implementation, were likely to be operationalised lower down the implementation chain, which is one of the justifications for using that data source to develop CPTs in the first place. However, it is also assumed that discourse, and the operationalisation of discourse, is complex, ever shifting, and contested when interacting with pre-existing contextual factors and the agency of actors (Fairclough, 2001b). Therefore, the enactments at the level of implementation may deviate from what was proposed in phase 1 and data collection needed to be flexible enough to capture this change. It was, however, also considered of analytical interest to see how the discursive assumptions articulated by LPIs, and their links to wider policy and structure, were drawn upon, reformulated, or resisted through the implementation chain.

As mentioned in section 3.6.3, CPTs are presented as ‘if/then’ statements to highlight their exploratory nature and to provide an initial guide for further data collection. The aim of the main data collection period in phase 2 was to answer research questions 3) and 4) by developing theory on how the IC policy discourse and its constituent discourses had been enacted and operationalised at the level of implementation within the CBIC and what the implications were for patients and frontline staff. For this part of the theoretical development, I drew on the CMO heuristic from Realist Evaluation. Below, I will describe the approach to analysis taken for each of the constituent parts of the CMO and how connections were made between these parts to form the theories. As with the discussion of CPTs, I will explain the integration of RE and DRA as I go through the section.

3.7.1 Resource mechanisms

I conceptualised resource mechanisms as textual (organisational newsletters, websites, posters, or communicative events, such as staff meetings), which I analysed as semiosis that contributed to meaning making within the CBIC. Those elements of social practice that Fairclough et al (2002) theorised as the objectification of discourse (material, technological, organisational, or managerial procedures) that are in dialectical relationship with semiosis and have the aim of influencing health professionals to behave, interact, or act upon their identities in a way aligned with the aims of the CBIC were also conceptualised in this way.

a) Textual resources

Textual resources were analysed as the second ‘semiotic ‘point of entry’’ (Fairclough, 2008, p. 169) into the research field and to explore the theoretical propositions developed through CPTs. The data analysed under the textual resources banner, included written or verbal communications relating to areas of interest identified within the analysis of LPI texts and discussed within the CPTs. These texts were either existing pieces of secondary data, such as newsletters or website text, or from verbal interactions observed by me whilst conducting observations. The purpose of analysing these texts was to identify the way which the discourses (ways of representing) identified in LPI texts had been deployed, reformulated, or resisted semiotically within implementation. Or the way in which new discourses had been drawn upon when interacting with particular contexts at the level of implementation. This enabled me to build on the initial theories developed within the first phase of the research, as well as to explore the dialectical relationship between discourse, realised semiotically through organisational texts, and their non-discursive enactments down the implementation chain. It was presumed, following Fairclough (2003), that communication through texts within an organisation is a central part of social practice and contributes towards meaning making within the organisation, whether this is through direct consumption by actors, or dialectical transformation into other practices.

Following a critical realist ontology, the level of the real consists of materiality, structures, human agents, or partly enduring discourses that have causal powers. However, the stratified ontology means that discourses may remain latent until being actualised through interaction with contextual factors and the agency of actors (Zotzmann and O'Regan, 2016). Therefore, the dialectical transformation of discourse realised linguistically through textual resources into non-discursive mechanism was not a given and needed to be established through analysis. The textual resources are therefore seen as a fundamental part of social practice within the CBIC, as well as representing discourses that may or may not have been dialectically transformed into other forms of practice. This was important for my study because it allowed me to trace the way in which the political and ideological work of the IC discourse was mobilised in practice, without presuming a linear relationship between discourse and its effects.

b) Dialectical transformation of discourse into managerial, organisational, technological, and material resources

It is important to note that the objectification of discourse with the aim of influencing health professionals to behave, interact, or act upon their identities normally contained a substantial semiotic dimension. For example, managerial resource mechanisms often involved linguistic communication. However, these aspects of communication were often described to me second hand within interviews and were closely intwined with the managerial procedure. I therefore felt it was more useful in aiding causal explanation within the CMO theory to group these semiotic and non-semiotic elements together under one mechanism. The label attached to the mechanisms aimed to provide a conceptual indication of the process operating beneath the surface of empirical observation, sometimes encompassing both semiotic and non-semiotic processes. In the analysis chapters 5-8, I discuss these resources in terms of their dialectical relationship with discourse realised linguistically through organisational texts. The resource mechanisms below would also be discussed within RE. However, the purpose of discussing their dialectical relationship with discourse highlights that social practice always has a reflexive and positioned nature to it, and that their introduction can work to achieve wider political aims.

Managerial resources are conceptualised as the objectification of discourse in the form of managerial/organisational procedures, processes, managerial decisions, or attempts by management to guide and persuade staff. I have also included phenomena within this that is partly textual, such as semiotic communication within the office that I did not witness first-hand but was described to me by interviewees as exerting a level of influence on them. Organisational resources are similar but also include efforts by non-managerial staff to influence other staff in line with dominant discourse. Technological resources are conceptualised as the operationalisation of discourse in the form of technology that was introduced to frontline staff and had a constraining or enabling influence on their working lives. Material resources are conceptualised as the operationalisation of discourse in the form of materiality, such as the physical layout of the room.

3.7.2 Contexts

The resource mechanisms introduced as part of the CBIC, are introduced into pre-existing contexts, which will influence the way in which actors reason and respond to the resource mechanisms. The aim of the thesis is to evaluate the changes brought about specifically by the resource mechanisms introduced as part of the service change and their dialectical relationship with IC policy discourse and neo-liberal structure. It therefore sees contextual factors as an analytically separate reality that resource mechanisms are entered in to (Pawson and Tilley, 1997; Pawson, 2006). Realist evaluation sees actors within the service change as either rejecting or accepting the resources according to contextual factors at the individual, interpersonal, institutional, or infra-structural system. These contextual factors will either make it conducive for actors to accept the premise of the change and alter their thought processes and behaviour accordingly, or they will act as inhibitors (Pawson, 2006). When providing examples of contextual factors operating at the infra-structural system level, Pawson (2006) discusses political backing for the intervention and governmental resources. The issue here is that this wider governmental influence is treated simply as an inhibiting contextual factor and removes the political nature of the resources that are being introduced in themselves. This was a criticism I directed at studies in section 2.4, i.e. Erens et al (2016). As such, only theorising the infra-structural system level, within the realm of pre-existing contexts, prevents analysis of the ideological forces which work to smooth over the ‘contradictions, dilemmas and antagonisms’ (Chouliaraki and Fairclough, 1999, p. 26) within resource mechanisms and response mechanisms. I, therefore, conceptualised contextual factors within my CMOs as largely arising from individual, interpersonal, and institutional factors, such as age of patients, health conditions, and professional identity. These contextual factors influenced the extent to which health professionals were likely to accept or reject the resources introduced to them. However, I saw political and structural factors as working dialectically through a process of emergence to govern the resource mechanisms and the responses they are trying to generate from frontline staff.

Within the development of critical programme theories, I treated LPI’s discussion of problem contexts as to some degree constructed and these problematisations as capable of performing political work in themselves. The treatment of context within the analysis of phase 2 data, involved assigning them a different ontological status than the contexts discussed within LPI texts. Within this phase, I presumed that I was not dealing within imaginaries and projections put forward by LPIs. But was instead analysing data which was illustrative of the phenomena under investigation. These contexts were considered to be reflective of the pre-existing contexts in which resource mechanisms were introduced and response mechanisms triggered.

3.7.3 Response mechanisms

Response mechanisms within this thesis aim to capture frontline health staff's responses to the enactments of discourse introduced to them in their working lives, as part of the CBIC. In conceptualising these response mechanisms, I drew on both RE and the DRA. As mentioned above, RE sees actors within the service change as either rejecting or accepting the resources, influenced by contextual factors (Pawson, 2006). Central to RE is whether actors are induced by the resources on offer to change their reasoning (a psychological mechanism) and then consequently change their behaviour (a behavioural or interactional mechanism) to meet the intervention's aims (Dalkin *et al.*, 2015). The psychological, behavioural, and interactional response mechanisms can correspond to the ways of (inter)acting and ways of being (identities) set out by Fairclough (2005; 2008; 2013) in the DRA. If actors accept the resources on offer then we might say that they accept them into their ways of being and internalise them within their identity by adopting certain subject positions. Occupying a subject position/identity means seeing, representing and acting upon yourself in ways in line with what is required and not required within a particular discourse type (Fairclough, 2001b). If actors change their behaviour because of this then we might say that they have changed their ways of (inter)acting. Fairclough (2005, p. 931) also sees the implementation of a successful strategy in policy/organisational terms, as the 'operationalization of new representations and imaginaries (new discourses and narratives) in new ways of acting and being and new material arrangements'. The benefit of thinking about psychological, behavioural, and interactional response mechanisms in this way is that it emphasises how policy makers/organisations are seeking to influence ways of (inter)acting and identities in a way that is inherently political and normatively based, as well as highlighting the power dynamics in operation between actors who are interacting. Within different discourse types subject positions are set up between actors (Fairclough, 2001b). For example, Fairclough (2005; 2008) cites the example of the discourse of new public management enacting the identities of public service managers, with the consequent interactions between management and workers being changed. Fairclough's conceptualisation is therefore useful in theorising the dialectical relationship between the response mechanisms normally discussed within realist evaluation and discourse (ways of representing).

Fairclough takes up Foucault's position by placing the effects of discursive practice upon social identity and social interaction centre stage within his textually orientated approach (Fairclough, 1992). This also reflects CDA's conception of power as also productive in helping to create subjects, as well dominating (Jørgensen and Phillips, 2002). Within Fairclough's method of textual analysis, these identities and interactions are realised semiotically through the language that is drawn upon within social practice. I, instead, captured identity and ways of (inter)acting through RE's mechanism concept. Identity and ways of (inter)acting, within the DRA, are to a great extent a discursive phenomenon as they are constructed linguistically. However, they are also dependent on the embodied self, agency, and material reality which has an enabling and constraining impact. They are therefore both a discursive and a material phenomenon enacted in real life settings with causal powers (Zotzmann and O'Regan, 2016). I therefore used interviewee responses from health professionals, in terms of their reflections, opinions and descriptions of how they viewed themselves in their role and interactions with patients, and my observation data, to develop the response mechanism aspect of the theory. This mechanism was then illustrative of an embodied subjectivity, which aimed to encapsulate both semiotic and physical/material aspects of identity and interaction that were causally efficacious, within the CMO.

3.7.4 Context/response mechanism interactions

I viewed the discursive and non-discursive resources that were introduced to actors, as doing so within a pre-constituted reality. This pre-constituted reality includes the agentic properties of individuals, as well as contextual factors at the individual, professional, interpersonal, and organisational level, which influence their agentic responses to the resources being introduced to them. These contextual factors are also a product of their own dialectic between discursive and non-discursive elements of practice. However, I was interested in evaluating the very specific resources that were being introduced as part of the service change, and so analytically, separated off this pre-existing context. This may therefore impose an artificial level of inertia on these pre-existing contexts. However, given that the focus of the study is on the change created by programme resources, this provided an analytical frame for understanding this process.

This thesis draws on a realist social constructionist view of the subject (Fairclough, 1992; Elder-Vass, 2012), which means ‘while our capacity to be agentic subjects exists independently of any particular social influences, the kind of subject or agent that we will become is the outcome of our social interactions’ (Elder-Vass, 2012, p. 202). In this sense, our subjectivity is partly socially constructed. However, we are also agentic, biological and material beings that are pre-constituted prior to discourse, capable of reflecting on our actions and making decisions (Fairclough, 1992; Elder-Vass, 2012). This means I viewed actors as capable of resisting and reformulating the ways of (inter)acting and identities encouraged within organisational discourse. For Foucault, subjectivity is something that is brought into being through relational activity and is unknowable outside of discursive practice (McGushin, 2014). As pointed out by Elder-Vass (2012), however, the capacity for resistance within Foucault's thought points to similar agentic beings as described by him within his realist social constructionist view of the subject. The difference for the purpose of my analysis is that Fairclough (2002; 2005; 2008) maintains separation between the identities/subject positions people take up and ways of interacting. By contrast, Foucault (1982, p. 27) refers to the 'mode of subjection' in which subjects both recognise themselves in line with ethical conduct and then act upon this ethical self in their behaviour and relations with themselves and others. I found Fairclough's conceptualisation useful because sometimes health professionals strongly resisted viewing themselves through the identity delineated in organisational discourse. But, however, were left due to both disciplining and subjecting forms of power enacting this discourse through their behaviour and interactions with patients.

3.7.5 Outcomes

The outcomes within the CMO are the result of resource mechanism/context/response mechanism interactions. Fairclough's (2002; 2005; 2008) focus on the operationalisation of discourse into materiality, new ways of (inter)acting and ways of being provided a useful way of reconceptualising RE's resource mechanisms and response mechanisms, so that they are discussed in relation to their dialectical relationship with discourse. Using the outcome element of the CMO provided a way of connecting social mechanisms with their impact on the lived experience of staff and patients within the CBIC. Outcomes reflected the beliefs, values and desires elements of social practice (Chouliaraki and Fairclough, 1999), including patient's experience and preference for certain types of care, and staff's satisfaction with their professional role and workforce practices.

This has benefit over approaches to post-structuralist policy analysis, such as Bacchi (2009) WPR approach, discussed earlier in chapter 2, which has the strength of focussing on the assumptions and presuppositions underpinning policy and how these problematisations in themselves can lead to problematic effects. However, the relativism of the poststructuralist approach underpinning WPR prevents it from engaging with the real effects of these problematisations, with Bacchi (2009) asserting that the effects discussed are much more subtle and rely for their understanding on theoretical perspectives, such as, poststructuralist discourse psychology and feminist body theory. Critical realism's stratified ontology prevents this kind of theoretical bind, which precludes providing links between politics, micro level practice, and the impact on patient and staff experience. Following Sayer (2011), concepts, such as discourse and discipline, are useful tools in social science explanation, but mean we can miss a person's evaluations of the world in terms of what is meaningful and impactful to them. When this is disregarded, 'it can produce an alienated and alienating view of social life' (p. 2). This thesis takes the perspective that the operationalisation of the IC policy discourse had an impact on people's lived experience, and this was at least partially captured through theory building. From an epistemological perspective, the theory developed within this thesis linking contexts, mechanisms and the consequent outcomes will always be only partial and constantly open to revision.

3.8 Normative and explanatory critique

As discussed in section 3.6.3, CPTs were developed on the basis of potential needs based or representational problems that may have occurred when discourse was operationalised through the implementation of the CBIC. Critical social science involves developing both a normative critique (evaluates reality to the extent they match up to values of a just society) and an explanatory critique (explains existing realities to be the effects of structures or mechanisms) (Fairclough, 2013). Whilst acknowledging that we only have partial access to reality through the development of CMO theory, I evaluated these theories based on both forms of critique.

Examination of the outcomes within the CMO configuration was used to assess the normative implications of the discursive and non-discursive enactments of the IC policy discourse within the CBIC. As part of this evaluation, I adopted CDA’s normative agenda that seeks to determine the way in which unequal power relations between social groups are produced and reproduced by discourse. This involves overtly taking the side of the oppressed and has the emancipatory agenda of readdressing power imbalances (Jørgensen and Phillips, 2002). Within this study, although not considered oppressed, I developed my normative critique based on the interests of patients and frontline staff, who I considered to have least power, compared to management, policy makers and wider elites. A critique was then developed when I judged through my findings that a needs-based or representational issue had arisen from the CBIC.

The social practice illustrated through the CMO heuristic works in dialectical relationship with wider structure. It is both shaped by it, but also works to reproduce or change it (Bhaskar, 1979; Fairclough, 1992). Drawing on Bhaskar's (1979) explanatory critique, the DRA argues that if the structures and mechanisms identified perpetuate false beliefs by presenting reality in a superficial or misleading way then this opens up the possibility of critique. These structures and mechanisms are ideological if they work in opaque ways that benefit dominant groups over others (Fairclough, 2001b). Therefore, I developed an explanatory critique by examining the CMO theory for evidence that exposed the false beliefs perpetuated by the integrated care discourse that work to benefit dominant groups, as well as providing evidence of the way in which this ideological work was reproduced through social practice.

3.9 Conclusion

This chapter has set out the methodological approach that I developed and applied within this thesis, which involved a novel integration of elements of RE and the DRA. The central argument is that this integration provided the methodological tools for exploring the dialectical relationship between the IC policy discourse, constituted within a neo-liberal structural context, and micro-level organisational processes and effects at the level of experience within the CBIC case study. I began in 3.2 by setting out some of the key tenets of the DRA, before showing how this theory of discourse helped me to meet my research aim and answer my research questions in 3.3. In 3.4, I set out the ways in which the DRA approach was limited by lack of guidance on how to analyse semiosis in relation to the other elements of social practice, before introducing by integration of DRA and RE. In 3.5, I demonstrated the ways in which realist evaluation assisted me with exploring social practice within the CBIC. In 3.6, I explained the first phase of my methodological development, which involved the development of CPTs, which present theoretical propositions of what might happen when discourse drawn upon by LPIs was operationalised at the level of implementation. In 3.7, I set out the way in which I combined elements of both RE and DRA to develop more comprehensive CMOs, which explored the dialectical relationship between discursive and non-discursive phenomena to create impacts on lived experience for both frontline staff and patients.

Chapter 4 - Methods

4.1 Introduction

In the literature review chapter (2), I proposed that research is needed that investigates the political and ideological work mobilised by the integrated care policy discourse at the level of practice, particularly at the meso (CCG, local authority, lead provider) and micro level (organisational/managerial practices, frontline staff, and patients). In the methodology chapter (3), I presented a methodological innovation that sought to combine Fairclough's DRA with elements of RE. I argue that this innovation provided the methodological tools to connect integrated care policy discourse with its enactment and operationalisation at the level of practice, within a critical realist ontological and epistemological position, in a way not currently present within the methodological literature. The DRA sees 1) macro level social structure (including macro politics and policy), social practice, and micro level social action in dialectical relationship with one another, and 2) within social practice itself, the different moments (discourse, power, social relations, material practices, institutions/rituals, and beliefs/values/desires) in dialectical relationship. Integrating the DRA with RE provided the ontological tools and methodological resources to connect a sociocultural view of policy (as part of broader social structure) with its enactment at level of practice. In this chapter, I will set out the way in which I went about collecting and analysing data to produce the central theoretical findings and argument within the thesis.

Firstly, in sections 4.2 - 4.4, I discuss the CBIC as the case study for addressing the research questions. In section 4.5, I discuss issues relating to accessing the research site and how data collection was influenced by gatekeepers within the research. In section 4.6, I discuss how my own personal values influenced the development of the project and the methodological approach taken. I also consider the political and normative agenda of CDA, which is integral to the study. Sections 4.7-4.10 focus on the conduct of phase 1 research. I set out the sampling, data collection, analysis, and theory building approach that I took to analyse LPI texts and to develop CPTs. In sections 4.11-4.14, I detail the sampling, data collection, analysis, and theory building approach I took to developing context-mechanism-outcome theories that explore the dialectical relationship between the moments of practice with the CBIC case study (phase 2). I then explain how I explored the dialectical relationship between what was happening at the level of practice within the case study to broader social practice and structure. In section 4.15, I discuss the ethical approval process, the main ethical issues within the study and how these were handled and mitigated throughout the project.

4.2 Case study research

I chose to use a case study research design because it provided a good way of exploring a sociocultural approach to policy implementation, which was interested in the way in which broader policy is shaped and enacted by social actors at different levels (Bartlett and Vavrus, 2016). Case study research was also well suited to studying integrated care policy through a critical realist lens because it provided a unit of analysis in which to develop explanations of broader social mechanisms that operated through the case. The CMO theory developed from my case study research is therefore aimed at developing theoretical generalisations to health and social integration practice more widely. Within critical realism it is presumed that these broader social mechanisms may be operating beneath the surface and must be explained theoretically through combining empirical research and theory. Within a critical realist ontological position, my case study organisation is considered an entity formed of a set of parts, with parts interacting to create real causative change (Vincent and Wapshott, 2014). Critical realism's constructivist epistemological position means that the theory generated through combining data collection and theory only ever represents a socially mediated and interpreted insight to this causative change within the case (O'Mahoney and Vincent, 2014).

4.3 Why is the CBIC a good case study of English integrated care policy?

The CBIC case study provided an example of an attempt to integrate health and social care, using integrated teams, care co-ordination, person-centred goal setting and empowerment, and reflected the English integrated care policy context between 2012 and 2016. As set out in section 1.2, the CBIC was put out to competitive tender following both the duty to integrate placed on public health bodies and the onus put on increased competition within the HSCA 2012. Just prior to contracting, the publication of the FYFV (NHS England, 2014) shifted policy discourse from competition to collaboration, with the CBIC Business Case explicitly positioning the service change as delivering both the new models of care and the Better Care Fund. The CBIC is therefore an appropriate case study to explore the enactment of integrated care policy discourse articulated through the HSCA 2012 and the FYFV (NHS England, 2014). This is not an evaluation of one specific policy, but an exploration of the way a broad integrated care policy discourse (& constituent discourses), containing certain assumptions and problematisations were drawn upon, negotiated and recontextualised, in dialectical relationship with non-discursive moments, through a series of practices at the level of implementation.

4.4 CBIC description

The CBIC was delivered through a lead provider contracting model by OCC and was originally split into 4 localities (East Hallstone, West Hallstone, East Greenfay, West Greenfay). Each locality was made up of what was termed integrated care teams, which included community nursing and community rehabilitation staff who visit patients in their home for those particular geographic areas. Please see Appendix 2 for full description of the integrated care teams and the types of patients they provide care to. Initial attempts to 'integrate' hosted services (i.e. speech and language therapy, stroke early assisted discharge), with the community rehab and nursing teams were reversed early on the CBIC's history and prior to data collection. Demographic information for Hallstone and Greenfay contained in Appendix 3.

4.5 Accessing the research site

Given the commissioned nature of the study, I already had permission from senior management to access the organisation and conduct data collection. In the early stages of the project, the Director who had been involved with my recruitment acted as the main 'gatekeeper' as she had ultimate power to grant and deny permission for me to access certain data (Hammersley, 2006). The role of the Director was particularly important in gaining access to external interviewees as part of phase 1 data collection. Here, she facilitated access by virtually introducing me to key actors within the CCG and county council. Once I had begun my main round of fieldwork as part of phase 2 data collection, two middle managers within both the Hallstone and Greenfay localities acted as my main gatekeepers in terms of facilitating access to the office space, meetings, and frontline staff. These middle managers had responded to my email request and were enthusiastic and helpful in facilitating my research. However, facilitation from my gatekeepers could have precluded certain areas of data collection or access to interviewees. As argued by Hammersely (2006, p. 54), ‘even the most friendly and cooperative of gatekeepers will shape the conduct and development of the research’. That being said, the Director’s reasoning for her interviewee selection fitted with my criteria, and none of my requests for access were turned down and interview invites were forwarded on to frontline staff by these middle managers at my request.

4.6 Reflexivity

This section will demonstrate how I employed reflexivity to acknowledge the way in which my own values and academic background influenced the research and analysis and how I accounted for this in my thesis (Mauthner and Doucet, 2003).

4.6.1 Personal reflections on development of methodological approach

Given the commissioned nature of the project, I initially planned to use Pawson and Tilley’s (1997) RE to guide the data collection and analysis, as this was described in the literature as an approach to evaluating complex interventions that would generate useful knowledge for policy makers and practitioners (De Weger *et al.*, 2020). It was at the initial programme theory development stage that I began to have some concerns about the approach. Following the guidance given in RE (Pawson and Tilley, 1997) for developing initial programme theories, formulated as if/then statements, I began this process by interviewing 5 LPIs, from within the lead provider. When analysing this interview data, I noticed that what was being articulated were normative assumptions about patient responsibility and the reduction of service use, without much reference to austerity and the political factors influencing this drive. LPIs also constructed certain groups as problem contexts, i.e., resistant patients who were too dependent on services, resistant staff to moving to generic working, and nurses who were not very ‘good’ at case management and self-management. The problem contexts that LPIs chose to focus upon were mainly directed at the individual level, whilst ignoring wider structural and systemic issues. I became interested in what work was being performed when problems are individualised in this way, and what the impact was for those actors who were constructed as part of the problem.

Whilst still favouring critical realism as a philosophical paradigm, I began to explore Fairclough’s (1992; 2001b) CDA as a way of understanding the role of ideation, discourse and language within the service change, whilst still accounting for the real changes and effects that were occurring. These observations and reflections led me to work on developing the methodological approach described in chapter 3, which seeks to integrate RE with the DRA to CDA. What began as an evaluation that aimed to evaluate the official objectives of the service change, in line with providing information and knowledge to the lead provider, within an evidence-based policy framing, turned into a project situated within a critical approach to social science that viewed the CBIC case study as an enactment of wider policy discourses. This development was partly a consequence of my own political standpoint, in the sense that I am anti-austerity and a supporter of left-wing politics. This meant that I found it difficult to approach the project from a scientific realist position that would seek to deny the political and normative assumptions evident in the data. My academic background in political science and public policy, also meant that my personal interests and training led me to be interested in the workings of power within the study and the potential impacts on social justice that may result.

4.6.2 Acknowledging values within the research project

Drawing mainly on the critical realist epistemology and ontology set out by Chouliaraki and Fairlough (1999) means that I adopt an overtly political standpoint within the data analysis and argument developed. CDA does not attempt to be value neutral and objective in its approach to research and the analysis of data, with Fairclough (2001b) acknowledging that he writes from a socialist perspective. As discussed in section 3.8, I overtly take the side of those with the least power and have the emancipatory agenda of exposing and readdressing power imbalances through my research (Jørgensen and Phillips, 2002). On this basis, I developed my normative and explanatory critique from the perspective of needs based and representational problems for frontline staff and patients. I then expose and critique dominant power structures on this basis.

I have attempted to be as reflexive as possible by attempting to recognize the way in which my own values and perceptions may have influenced the way I have conducted the research. I am also making clear that the intention of the study is not to attempt to produce an objective analysis by acknowledging its political intent. The choice of texts, interviewees and observation data in my study was selective and the analysis will have been invariably influenced by my own perspectives and values. All research, however, involves the imposition of the researcher's values onto the data and so this is not unique to critical textual approaches (Phillipov, 2013). Furthermore, a critical realist constructivist position holds that we can only ever gain a partial view of reality (O'Mahoney and Vincent, 2014). The data I chose to analyse, therefore, was led in part by my motivation to conduct critically orientated research that exposes the unequal and oppressive elements of that reality (Fairclough, 2003). That being said, my arguments about the ideological nature of discourse and its effects were developed through close empirical inquiry, which analysed texts on equal footing with interview and observations data to explore the dialectical relationship between the moments of social practice and their effects.

4.7 Phase 1- analysis of local policy implementer texts and development of Critical Programme Theories

As outlined in chapter 3, CPTs are theoretical propositions of what might happen if discursive assumptions drawn upon in the construction of the CBIC by LPIs is enacted and operationalised within implementation and practice, which enabled me to answer research question 1) and 2). Below, I will detail the data collection methods, sampling, and data analysis techniques I used to analyse the texts discursively. I will then explain how I moved from this textual analysis to develop the CPTs. Following Fairclough (1992; 2001b; 2003), who treats a range of semiotic material, such as conversations, interviews, written documents, television programmes, as texts. I analysed both official documents produced by LPI organisations and interview transcripts with senior figures within these organisations, using critical discourse methods (list of texts in Appendix 4).

4.8 Data collection & sampling

4.8.1 Selection of key documents for analysis

As part of phase 1, I selected key documents for analysis, which had been produced by LPI organisations. These included the CCG's CBIC Business Case, and OCC's tender response and CBIC awareness video developed for organisational staff. These documents were selected on the basis that they provided sources of evidence of the way in which the CBIC had been communicated linguistically at the early stages of development and contracting. The documents, however, were produced for different reasons and audiences, and at different times. For example, the Business Case was developed in 2014 to provide an updated specification of the CBIC to persuade the CCG's governing board to approve the service change. Whereas the CBIC tender response was written in 2015 by the lead provider with the intention of setting out how their specification would meet the CCGs requirements, in terms of integration and service design.

Analysing documents produced by both the CCG and the lead provider had the following advantages. Firstly, the CCG's Business Case was more strategically focussed and aimed to demonstrate how the CBIC aligned with national policy. This text therefore provided a semiotic 'point of entry' (Fairclough, 2008, p. 169) into the dialectical relationship between practice within the CBIC and wider policy discourse and structure. Whereas those produced by the lead provider focussed more on the granular detail of how the service change would be delivered, constituting ‘imaginaries’ (Fairclough, 2008, p. 176) of the potential dialectical relationship between the moments of practice within health and social care integration. Secondly, analysing this range of documents allowed me to trace the evolving way in which the CBIC was being constructed through the early stages of its development and how this related to the dominant integrated care narrative.

4.8.2 Semi-structured interviews

I conducted semi-structured interviews, between April 2017 and April 2018, with 5 members of senior management (CEO & 4 senior managers) within the lead provider, 3 interviews with senior managers within the CCG (previous CEO, & 2 senior managers), and 1 senior managers within the county council). All interviews were conducted in a quiet meeting room at the interviewees’ place of work. They lasted between 60-90 minutes, were recorded on Dictaphone and transcribed verbatim by me. The sample was purposive (Bryman, 2015) in the sense that all interviewees were selected on the basis that they had been involved in the original scoping or development of the CBIC, the bid writing or contracting process, management of the CBIC, or were from an organisation working with the lead provider on some aspect of integration, and so assisted me with answering research questions 1) and 2).

The interview schedule (Appendix 5) was designed to find out how these actors described the early stages of CBIC development, the main influential factors in the policy context, the problem/solution pairings it is constructed through, what resources were being introduced to health professionals and patients and what the desired outcomes were. For example, I asked interviewees what the driving forces were behind the development of the CBIC to try gain a sense of the central problematisations it was claimed to be responding to. The reason for conducting semi-structured interviews with these actors was that it enabled me to structure the discussion, as well as providing the flexibility for me to explore avenues that were raised by interviewees in greater depth by asking prompting and probing questions. It also meant I was able to go off script if interviewees raised issues that I had not yet considered (Bryman, 2015).

These interviews reflected the ‘theory gleaning’ exploratory interviews, advocated in RE, which seek to determine how the programme will work, for whom, and in what circumstances (Manzano, 2016, p. 353). However, given the dialectical-relational theory underpinning my approach, the interviews were aimed at ‘gleaning theory’ in relation to the two types of dialectical interaction to be explored in the study. That being said, semi-structured interviews were particularly useful in drawing out the ‘imaginaries’ (Fairclough, 2008, p. 176) put forward by LPIs that could then be theorised in terms of their potential dialectical transformation within implementation. Temporally, these interviews were conducted after the publication of the official documents analysed and so provided further evidence of evolving nature of CBIC’s discursive development.

4.8.3 Treatment of both interviews and organisational documents as texts

I treated both the interview data and organisational documents as texts. However, the interview data was co-constructed between myself and the interviewees through the reciprocal dialogue of me asking the questions and them responding, with the explicit purpose of enabling me to analyse this data discursively. I therefore played an active role in the construction of this data (Nikander, 2012). The organisational texts, instead, represent pre-existing secondary data sources that were in part designed to be persuasive and consumed by an external audience (Fairclough, 2003). My ability to direct questions at LPIs through interview questions assisted me with answering research questions 1) and 2) because I was able to capture a level of granular detail about the CBIC in a way not possible through official documents. This assisted greatly with theorising the potential dialectical transformation of discourse into materiality and social relations.

4.9 Data analysis

The ‘order of discourse’, set out in chapter 2, describes the semiotic resources available within the health and social care arena, whilst my analysis of LPI texts showed how these resources were drawn upon during specific interactions (Fairclough, 2001a). Discourse within these specific interactions is flexible and contextually mediated in ways that can potentially lead to social change. Discursive practice is therefore not purely a top-down process, and people resist, recontextualise and appropriate dominant discourse, as well as accepting and internalising them (Fairclough, 1992). This meant that my analysis of LPI texts centred on the way in which they drew on the dominant narratives outlined within the literature review, as well as the novel and contextually specific ways of discussing the service change, which also at times drew on a variety of minor discourses that had not previously been discussed in detail.

I used academic literature to help me name discourse types, indicating that these representations are shared by groups of people and have a degree of consistency. This helped me to highlight that discourses operate at a higher degree of abstraction and so can generate multiple specific representations that come within that discourse (Fairclough, 2003).

Below I set out the questions I used to analyse the texts. However, some questions were more relevant to some texts than others, depending on whether the text provided evidence of dialectical relationship 1) or dialectical relationship 2) (as per definition set out in section 3.3).

1) What is the purpose of, and the context behind, this text?

As discussed above, the texts that I chose to analyse were produced by different agencies and had different purposes. They also differed as to whether the data was co-constructed through primary data collection or represents pre-existing secondary data. I therefore made on notes against this question so that I could incorporate this context into the analysis.

2) What is going on specifically within the text, and how do these linguistic features within the texts draw on discourses (ways of representing) at the level of discursive practice?

To aid with my analysis, I used the main questions (attached in Appendix 6) set out by Fairclough in Language and Power (2001b), as I found this the clearest and easiest to operationalise within linguistic and interdiscursive analysis.

3) What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

4) What were the main imaginaries put forward for how the CBIC will provide the solution to these problematisations? i.e. material enactments, processes, etc.

5) What ways of (inter)acting is this discourse trying to enact between patients and clinicians?

6) What identities/subject positions is this discourses trying to enact for patients and clinicians?

Questions 3-6 fed directly into thinking through possible theoretical propositions of how the discourse realised linguistically within texts may be operationalised and enacted within implementation.

4.10 Developing Critical Programme Theories

Following the textual and interdiscursive analysis, I then conducted inferential work to move to theoretical propositions in the form of CPTs. As discussed in the methodology chapter, given the critical focus of this study, CPTs are if/then statements of the way in which the operationalisation of discourse may lead to needs based or representational problems. To move from linguistic/interdiscursive analysis to the development of CPTs, I drew on the critical realist processes of abduction and retroduction. Critical realism differs from empiricist methods in the sense that theoretical explanations are generated through combining theory and empirical data. Critical realism therefore seeks to explain what is going on at the ontological level of the real to explain the empirical observations found within the research data (O'Mahoney and Vincent, 2014). CPTs offered initial propositions of these theoretical explanations that were developed through the main body of data collection and analysis. They also provided a guide on what future data collection needed to take place.

Abduction is the central method of inquiry when developing CPTs because 'it provides the starting point for retroductive inferences' (Ritz, 2020, p. 462). For Jagosh (2020, p. 122), abduction is the 'gut feeling, hunch or informed imagination that leads to new ideas for generating theories and testing possible mechanisms'. The creative element to abduction was particularly pertinent in the development of CPTs, in which I thought creatively about potential ways in which the discursive work realised within the texts may be enacted and operationalised into practice. I then drew on the closely related process of retroduction, which involved using existing research findings and theory to help produce potential explanations of how these mechanisms might work. Retroduction asks what must underlying causal mechanisms within reality be like to explain such manifest empirical phenomena (O'Mahoney and Vincent, 2014; Jagosh, 2020; Ritz, 2020). This was an iterative process in the sense that the creative thinking helped prompt literature searches, and findings from the literature helped prompt further creative thinking that helped fill in the gaps of the if/then statements.

This process of abduction and retroduction within phase 1 was used to explore the two dialectical relationships of interest, 1) the dialectical relationship between structure and events mediated by social practice, and 2) the dialectical relationship between the moments within social practice. To develop theory on these two dialectical relationships, I followed Fairclough's (2008) advice to draw on social theory in combination with the DRA. Firstly, I drew on Glynos and Howarth's (2007) concept of fantasy to help explain the way in which the CBIC Business Case worked to reproduce the integrated care discourse as hegemonic. This concept forms part of a broader poststructuralist discourse theory that Fairclough (2013) has cited as having some compatibility with CDA. Fairclough (1992; 2003) also advocates combining his approach to textual analysis explicitly with Foucault, as Fairclough's three functions of texts (representation, action, identification) link with Foucauldian concepts of knowledge over things, relations with others, and relation with oneself, ethics and the moral subject respectively. I also drew inspiration from Mulderrig (2017a), in her work analysing an obesity campaign in the UK, which brought together the text analytical methods of CDA with a Foucauldian analytics of power, in order to link micro level realisation of discourse with macro level political theories. As part of my theoretical development, governmentality studies (Foucault, 1991b; Du Gay, 1996; Miller and Rose, 2008) helped me to explain the connection between neo-liberal structure and the shaping of subject positions/identity within the CPTs. Although Fairclough (2001b) works as ontological ‘under-labourer’ (Bhaskar, 2014) for connecting the occupation of subject positions with the reproduction or transformation of structure, it is studies of neo-liberal governmentality that provided theoretical assistance with connecting wider neo-liberal political projects with shaping of individual subjects as ‘responsibilised’ ‘enterprising’ and ‘empowered’. However, as discussed in section 3.2, this thesis employs an overall theory of power that sees it working both ideologically through discourse to actively benefit dominant groups, as well as in the production and occupation of subject positions in line with this ideological work. The approach to theory building is displayed in figure 1 below. I provide an example of this process in Appendix 7.

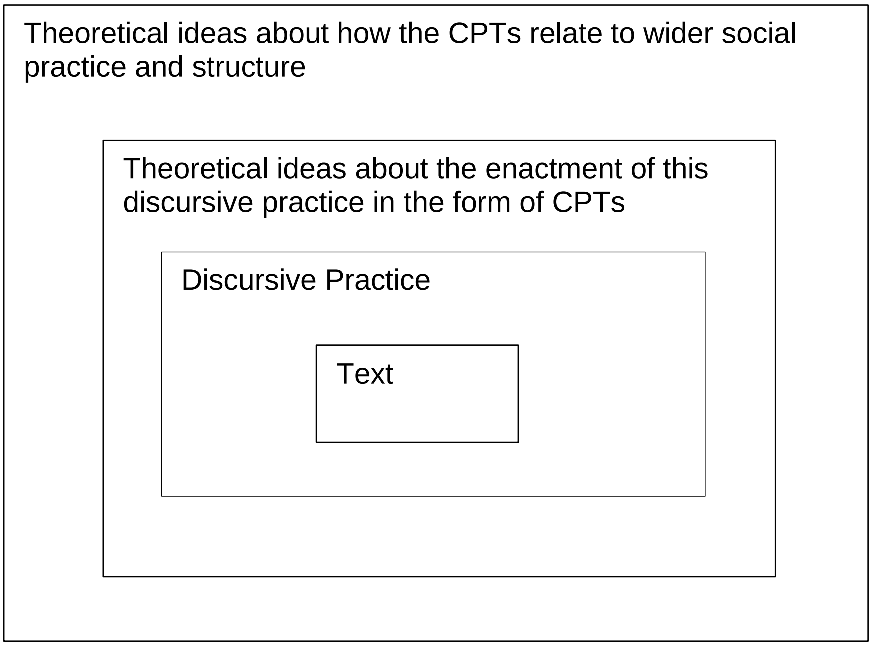

Figure 1- theory generation process within phase 1

4.11 Phase 2 - main empirical section using ethnographic qualitative methods

In section 3.5 of the methodology chapter, I described the purpose of developing CMO theories. In this section I explain how the I collected and analysed the data used to construct these CMOs. The CPTs signposted prospective samples of health professionals and patients for interview and sites of observation. Data collection proceeded on a theoretically informed basis, exploring further sources of data as they became apparent during the fieldwork process. I kept the fieldwork in phase 2 open enough to be able to capture what mechanisms were in operation during actual implementation and did not attempt to simply test or refute the theoretical propositions developed in phase 1. Within a critical realist approach, theories are expected to be fallible and mechanisms may not be actualised, meaning that data collection proceeds in an open and inclusive way (O'Mahoney and Vincent, 2014). To aid with this process, I kept an 'intellectual diary' in addition to my fieldnotes (O'Reilly, 2012, p. 104). This provided space to reflect on the ongoing themes and findings emerging from the data as I went along. These emerging analytical ideas then steered me to what data I would like to access next, as part of theoretical development.

The CPTs that I developed were grouped under two main themes 1) *generic working within integrated care teams* 2) *patient self-management*. Theme 3) *auto-allocation scheduling* emerged through data collection in phase 2. Theme 3 emerged following one of the early interviews with a middle manager in phase 2 data collection. Although the idea of introducing systems and processes to change the way visits were scheduled had been raised by LPIs, the auto-allocation scheduling system

(Cbernet) had not yet been introduced. Based on the some of the assumptions articulated by the middle manager, I began to theorise that auto-allocation was a further enactment of the problematisation of staff decision making identified within phase 1 and an extension of the systems and processes that had been discussed. From this point forward, I began asking staff about the auto-allocation system in my interviews, making observations relating to this technology during fieldwork, and collecting texts related to auto-allocation. In this instance, findings emerging from phase 2 data collection became a central analytical theme within the study and guided future data collection and analysis.

4.12 Data collection & sampling

4.12.1 Texts

Before entering the field, I was not aware of which organisational texts would be most relevant, so I mainly identified these whilst conducting my observations and interviews. The texts were analysed against the three central themes in the study. For self-management these included material from health coaching training, a staff newsletter, and communication during an office stand-up meeting. For generic working, these included a staff newsletter and communication during a staff *'integration meeting'*. For auto-allocation, this included a company website, poster, and promotional video. Reasons for selection are included in Appendix 8. I also drew on some supplementary texts, such as an OCC staff consultation document and the strategic needs assessments published by the local authority for Greenfay and Halstone. These provided supplementary and contextual information but were not subject to Critical Discourse Analysis. The texts selected for analysis (both written and verbal communications) were treated as communicative events (instances of language use) (Fairclough, 2003) which were being introduced into the organisation, as part of the service change being investigated within the study. This way of selecting relevant organisational texts could be challenged on the grounds of being arbitrarily selected (Sriwimon and Zilli, 2017). Firstly, I sometimes came across these texts by chance, and at times only deemed them to be relevant to particular theories once I had attended the meeting. Relevant texts may therefore have been missed or ignored that could have led to alternative interpretations. However, identifying texts whilst I was in the field ensured that those selected featured as events within the social practice under investigation, with the potential to illuminate understanding of the problematic aspects of this practice (Leitch and Palmer, 2010). Furthermore, it is also the case that data selection offers just a sample of potential data sources (Bauer and Aarts, 2000).

Secondly, my decision to treat verbal communications during meetings as texts, whilst treating verbal communications heard during my day-to-day observations and interview data as illustrative of mechanisms that have non-discursive elements could be considered arbitrary. This difficulty reflects the consequences for empirical research of holding a theoretical distinction between the discursive and non-discursive, leading Jorgensen and Phillips (2002) to question whether it is possible to demarcate the line empirically between these moments in dialectical interplay. The constructivist epistemological position of critical realism holds that the theories we build about the world are only ever partial and fallible interpretations of partially hidden mechanisms. This means that I could only ever gain access to knowledge about non-discursive mechanisms through listening to the interpretations of my interviewees or through interpretating their behaviour and discussions myself. Exploring the dialectical relationship between discursive and non-discursive mechanisms therefore meant at times selecting which data I considered to be a text and which I considered to be illustrative of a non-discursive moment for the purpose of theory building. This to some extent has imposed an artificial dividing line between my sources of data. However, I treated communications delivered in meetings or training as texts, given that they were more akin to formal organisational communications in the same way as newsletters or website text. This is compared to interview responses which were less pre-scripted and provided insights to events, processes, and experiences whilst staff carried out their working lives.

4.12.2 Semi-structured interviews with staff

I conducted semi-structured interviews with middle managers and frontline staff to collect data, which would help build context-mechanism-outcome theories. The aim was therefore to collect data on the resources being introduced to frontline staff (managerial, technological, material), how their responses (ways of being and ways of (inter)acting) are influenced by pre-existing contextual factors (individual, interpersonal and institutional) to lead to outcomes for staff and patient experience and welfare. Unlike the interviews conducted with LPIs, interviews with frontline staff did not have the intention of eliciting imaginaries as to how they proposed the CBIC would work. Instead, and following a critical realist ontological position, the intention was to gather data which provided a conceptually mediated insight into real processes that are taking place within the practice of the case study (Manzano, 2016). By adopting a critical realist orientation, I viewed the interview process as co-constructing meaning through the interactions between myself and interviewee. I also took the insights and experiences of interview participants as important data when constructing social explanations, whilst also appreciating that interviewees are located in wider social relations and structures which have a constraining and enabling effect on them (Smith and Elger, 2014).

4.12.2.1 Sampling

The selection of interviewees within my study was done on the basis that the data from these participants could assist with the development of all or part of the context-mechanism-outcome theories. This means that the type of sampling I used was purposive or theoretical because interview participants were selected directly on the basis that they could contribute to both answering my research questions and building theory and explanation within the study (Mason, 2018).

a) Middle managers

I sought to speak to middle managers within both the Hallstone and Greenfay localities as they were able to provide good sources of data on the resources being introduced into staff. Given the small number of middle managers and their central role in engaging with and managing frontline staff, I sought to interview the full sample within this grouping. I therefore interviewed 3 middle managers who had responsibility for oversight of the whole locality (either Hallstone or Greenfay), and 6 middle managers who either had responsibility for overseeing the therapy or nursing services for either Hallstone (2) and Greenfay (4). I interviewed middle managers in

June/July 2018 ahead of interviewing frontline staff. This enabled me to revise my interview schedule with community nurses and therapists on the basis of any new insights.

Following the interviews with middle management, data collection proceeded in four stages. I interviewed a total of 27 frontline staff during these rounds. The full sampling breakdown is contained in Appendix 9.

b) First round of interviews

For the first round of interviews with frontline Hallstone staff (taking place in August 2018), I sampled a range of professional bandings within both community nursing and community rehabilitation. This ensured that I had sampled throughout the team and could begin initial analysis, enabling me to think through what further data I needed to collect. Sampling a range of staff from different professional bands was important as professional role/identity was deemed a relevant contextual factor within theory building. It was also the case that staff's relationship to resources differed depending on their role, i.e., the introduction of generic roles only applied to those at band 3 and the self-management drive was more explicitly directed at bands 4 and above in both rehab and nursing. It also meant that when I began my observations, I had some insight into the workings of the teams and their professional roles. I interviewed one of the voluntary sector workers, Josie, during this round of interviews, following a suggestion from the 'gatekeeper' director discussed earlier.

c) Second round of semi-structured interviews conducted during Hallstone office observations

During my time conducting observations, as well as making fieldnotes on what I was seeing, hearing, and feeling, I also took the opportunity to identify further interviewees. During my observations, I became aware of the central role that the senior community nurses play in the office, and their unique role spanning both managerial and clinical duties. The time they spend performing triage means they are frequently in the office, engaging with junior members of staff and providing them with advice and guidance on their day-to-day role. I built up rapport with one senior nurse (Lucy) who seemed particularly influential in the team. Building up rapport through this informal conversation enabled me to arrange a formal research interview with her. This also had a snowballing effect (Bryman, 2015) when she facilitated an interview with one of the nursing assistants within her team. On several other occasions, senior clinical staff facilitated access to band 3 staff who I had found harder to reach.

As detailed above, during my second round of sampling I relied on key informants and snowball sampling associated with ethnographic research to gain access to research interviewees (O'Reilly, 2012). Through meeting and building up rapport with more senior key informants, this generated trust from their band 3 colleagues and enabled them to feel more comfortable in taking part in the research. The danger of using this kind of sampling technique is that it can skew the research data in favour of particular kinds of individuals (Hammersley, 2006). Nevertheless, these key informants only facilitated access to the types of professionals that I had previously identified as theoretically important. However, it was the case that through snowballing I spoke to more health professionals working in East Hallstone than other localities. This was a particularly close-knit team who tended to support each other's viewpoints and so the theories I developed may be skewed in favour of the perspectives from this team. However, I also sampled interviewees from the two other localities to provide a counterbalance, and to an extent, the data I analysed was always guided by whether interviewees consented to participate or not. During this round of interviews, I also interviewed Lottie, the second voluntary sector worker, who told me that she also hot desked in the Greenfay office and attended the leg club (open clinic for patients with leg ulcers/wounds). I invited her to take part in a research interview on the basis she would be able to provide different insights to Josie.

d) Third round of interviews- purposive sampling from West Greenfay

After completing my main body of fieldwork in Hallstone, I moved on to begin recruiting interviewees within the Greenfay locality. My initial analysis had led me to conclude that there were not any major significant differences between the West and East Hallstone localities in terms of the theories I was building. My interviews with middle management in Greenfay, however, highlighted some novel aspects to the West Greenfay locality that distinguished it from both Hallstone and East Greenfay. Firstly, I was told that because of the geographical area that the patient population of East Greenfay inhabited, these staff rarely came into the shared office. It was reported that the staff in West Greenfay by contrast were frequently in the office and had experienced some initial but significant interprofessional barriers and resentment between the nurses and rehab staff. Generic working within West Greenfay also appeared to be more advanced than in any other of the localities across Hallstone and Greenfay, and a turbulent implementation period had been described by middle managers. Given constraints of time, I therefore decided to exclude East Greenfay from my interview sampling and focus on West Greenfay, which appeared to present a theoretically interesting and novel data sample.

In sampling interviewees from West Greenfay, I particularly directed by search towards generically trained assistant practitioners on either the community nursing or rehab team and band 5 lead nurses. 1 of 4 contacted on the community rehab team accepted and 3 of 3 contacted on the community nursing team accepted. My focus on the implementation of generic roles for assistant practitioners arose from the original CPTs, but then was guided further through data collected in Hallstone and from Greenfay middle managers. Band 5 lead nurses were of particular interest because it was reported to me by senior band 6 nurses that lead nurses perceived the Cbernet system as taking away their ability to review patients on their case list and by default their care coordination role. This professional group were hard to reach due to resource pressures and workload issues, but I gained consent from one band 5 lead nurse within this locality. In addition to these interviews, I also spoke to a band 6 senior nurse, 1 matron, 1 physio and 1 associate practitioner within West Greenfay.

e) Final round of interviews

Given my difficulty in recruiting lead nurses in Greenfay, I returned to the Hallstone sample. I was informed by a middle manager that the two previous lead nurses had resigned so she forwarded on my recruitment email to two further band 5 nurses who she described as now occupying the lead nurse role (Penny and Raquel).

4.12.2.2 Conducting the interviews

Similarly, to Pawson and Tilley's (1997) approach, I developed my early interview schedules using my analysis of LPI texts and CPTs, to go beyond the initial 'theory gleaning interviews', discussed in section 4.8.1, with the hope of developing more fully fledged and detailed context-mechanism-outcome theories. I would therefore describe my interviews with health professionals as theory based. However, my style of interviewing and schedule was much more open and flexible than that described in RE. Pawson and Tilley's (Pawson and Tilley, 1997) approach overstates the clarity of the programme theories used to inform their interviews. They also advocate a very overt approach to confirming, falsifying and refining the theory, which can bias responses and preclude the exploration of new theoretical insights and themes (Smith and Elger, 2014). Furthermore, I considered the interview responses illustrative of non-discursive moments which were working in dialectical relationship with discourse. I therefore view both discourse and its enactments as flexible and contextually mediated (Fairclough, 1992), which meant I wanted to keep my interviews open enough to capture the evolving way in which integrated care was being implemented. The interview schedule evolved throughout the course of the interviews as I began narrowing down the focus of theories that were emerging and I revised the interview schedules slightly after each round of interviews (interview schedules attached as Appendix 10).

4.12.3 Semi-structured interviews with patients

I conducted 6 semi-structured interviews with patients and 3 of their partners/friends to collect data on patient experience outcomes and contextual factors. The main body of data collection focusses on the resources introduced to staff and their responses, which was captured through my interviews and observations in the organisational setting. Patients have little awareness of changes in organisational process, but they are aware and have opinions on their engagements and experiences with frontline staff (Manzano, 2016). I gained insight into the effects of the context-mechanism interactions on patient care through my interviews with staff. However, this was also supplemented with a small number of patient interviews. It was important to gain this perspective from patients, as their opinions, concerns, and perceptions may differ from health professionals (Griffiths, 2009). Patients are considered as having unique insight into their own lives and experiences, and these insights should be used to informed service delivery and design (Brookes and Baker, 2017; Flott *et al.*, 2017).

4.12.3.1 Patient sampling and recruitment

The inclusion criteria that was applied for patient involvement in the study was that they 1) had the cognitive and hearing capacity to be interviewed 2) they had a proficient level of spoken and written English to take part in the study, or there is a health professional available that is able to act as a translator, without any additional financial cost to the study 3) they had had recent contact with the community nurse 0-3 months 4) they had been seen by at least one other member of staff on the community rehab team. Consent to contact was obtained from 12 patients within the Hallstone locality and 3 patients within the Greenfay locality, with 6 (5 Hallstone and 1 Greenfay) patients agreeing to be interviewed (informed consent process described in full in section 4.15.2 C below).

These patient interviewees provided a useful source of data because they had received care from across the co-located nursing and rehabilitation teams. This gave me the opportunity to ask them about their experiences of receiving care from ‘integrated’ services and the potential of having both nursing and rehabilitation tasks conducted within one visit (interview schedule attached as Appendix 11). However, a limitation of my sample was that I struggled to gain access to patients who were housebound and receiving daily insulin administration from the nursing team. This meant I lacked data from long term users of the service who were largely the target of the managerial self-management drive.

My sample of interviewees may have been skewed because less vulnerable patients were more likely to consent, which is why I had trouble accessing housebound patients receiving long term care from the nursing service. Concern has been expressed in the literature about how patient participants tend to be ‘the posh articulate’ and the importance of ensuring access to a range of patients with different experiences (Haywood *et al.*, 2015, p. 1075). By excluding those patients who did not have the cognitive and hearing capacity to be interviewed and did not have a proficient level of spoken and written English to take part in the study without an interpreter, I was already potentially excluding some of the most vulnerable patients. My inability to gain access to the longer term and vulnerable patients meant that their perspective may be lacking in any changes to the service that might be brought about by the research (O’Halloran *et al.*, 2019). Time and resource held by both myself and the frontline staff who were assisting me with recruiting patient interviewees created limitations.

4.12.3.2 Conducting the interviews

Interviews were conducted in participants' home and were audio-recorded and transcribed verbatim. My approach to interviewing patients, although still semi-structured, was more open than my interviews with frontline staff. This was for several reasons. Firstly, the topic of the interview was sensitive as it involved asking patients about their personal healthcare. This means that questions may evoke 'powerful emotional responses such as anger, sadness, embarrassment, fear and anxiety' (Elmir *et al.*, 2011, p. 11). Asking questions in an open way ensured I gave the patients the opportunity to lead into discussion topics that they were comfortable with. Secondly, I was unsure of how much knowledge patients had of the service change, so I tried to be open particularly at the beginning of the interview to gauge their knowledge and understanding of the CBIC, in terms of how I proceeded.

4.12.4 Participant and non-participant observation

I conducted observations of staff in the Hallstone office between 24th September and 5th October 2018. The observations within West Greenfay took place between 3rd December and 7th December 2018. My participant and non-participant observations contributed towards theory building in several ways. Firstly, I treated my observations of meetings and training sessions as communicative events to be analysed discursively as textual resources (semiotic dimension of social practice). Secondly, I treated data generated from observations of day-to-day interactions in the office as contributing towards theory on the other moments of practice (i.e. materiality, social relations).

a) Observation of communicative events

During these meetings I acted as a non-participant observer where I made notes on my laptop on what was being said, interactional dynamics between participants, and the atmosphere. These notes were typed up in full each evening. During these observations I did not actively contribute or participate. It may, however, have been the case that my presence influenced the behaviour of participants through the Hawthorne effect (when behaviour is modified through awareness of being studied) (Wickström and Bendix, 2000). This may have had more of an impact during meetings such as the *'integration meeting'* which had fewer participants and my presence was more obvious.

b) Observations of day-to-day interactions in the office space

During these observations I considered myself to be much more of a participant observer, as I was hotdesking in the office similarly to frontline staff. My intention was to try to experience the office as those who normally work there, which is a key part of ethnographic data collection (O'Reilly, 2012). Guided loosely by phase 1 analysis in what I looked out for and recorded as fieldnotes, I also attempted to be open to recording observations that seemed like they could potentially lead to new theoretical insights. I made notes on the atmosphere, physical layout of the room and the location of the different members of staff, interesting conversations that I heard, who was speaking to whom and what about. I also struck up informal conversations with staff whilst sitting at my desk or in the kitchen and I made notes on these interactions, with some of them leading to more formal interviews. These notes were recorded in note form into my laptop whilst in the office and then I typed them up in full each evening.

I had originally expected to make most of my observations on the way in which the community nursing and community rehabilitation teams interacted with one another. However, I soon realised that the interaction between the teams was extremely limited within all localities. Some of my own experiences and confusion when trying to figure out who was who in the office, due to the lack of differentiation of uniform and lack of explicit signs indicating which team sat where, reflected some of the responses given by interviewees. This was particularly the case in the big open Hallstone office which housed East, West, and hosted teams, where staff would often report that they did not recognise clinicians beyond their own team. Unexpectedly, I found that some of the most useful data captured during my observations of day to day working in the office were notes made on discussions held by the nursing team relating to the housebound criteria. These observations were then able to inform some of the questions I later asked in interviews, reflecting the theoretically informed way that I proceeded through data collection.

4.13 Data analysis

4.13.1 Texts

The aim when analysing the textual resources was to explore the dialectical relationship between semiosis being introduced into the organisation as part of the CBIC service change and non-discursive mechanisms taking place within practice (data collected through interviews and observation of day to day working). Moreover, it was to situate this semiosis in dialectical relationship with the wider political context through analysis at both the interdiscursive and structural level. Analysis of texts was not conducted on the basis that they would necessarily be directly read and consumed by frontline staff. Fairclough (2003) has claimed that supplementing CDA textual analysis with research into consumer responses is beneficial. However, an observation from fieldwork was that many staff very rarely read their emails or formal communications from the organisation. Many also seemed to be suffering with IT issues which meant it was difficult to access their email even if they wanted to. I treated textual resources, instead, as sources of data which reflected meaning making being introduced into the organisation whether this was directly consumed or dialectically transformed into non-discursive resources. The textual analysis tools and questions asked of the data were the same as that detailed in section 4.9 of this chapter.

4.13.2 Staff interviews and observation data coding

I analysed the semi-structured interviews with staff and patients and the observation data of day to day working in the office differently to the way in which I analysed the textual resources. This was because I was attempting to capture a range of ontological phenomena and how they related to one another within CBIC practice. Manzano (2016) has argued that within interpretivist interviews the aim is to elicit narratives, whereas in realist research interview data is considered to be evidence of real phenomena and processes. Given the dialectical relational theory underpinning my approach, I attempted to analyse the interview and observation data in a way that captures the real phenomena and processes I was gaining partial access to, as well as the discourses that these processes are in dialectical relationship with. This is on the basis that my ontological position sees all elements of social practice as having a reflexive and positioned nature to it (Chouliaraki and Fairclough, 1999). By analysing non-discursive mechanisms as discursive enactments, I was also attempting to relate the mechanisms operating at the level of practice with wider political and structural mechanisms.

As described above, I began analysing my data as I went along during the fieldwork process. This ensured that I proceeded with further fieldwork on a theoretically informed basis. I coded the first and second round of interview data and the Hallstone observation notes using the same coding approach. Although not developing grounded theory, I was influenced in part by some of the techniques to coding of qualitative data. During these stages, I coded segments of data with a code name that represented either a context, resource, response, or outcome and put them under my three central themes. The code name attempted to provide a conceptual label that explained what was being represented in the data at a higher degree of abstraction (Charmaz, 2014). These concepts were categorised within the following sub-levels: contextual factors (individual, interpersonal, institutional), resources (managerial, technological, material), responses (ways of (inter)acting and ways of being/identity/subject positions adopted), outcomes (in terms of either patient or staff experience). I then wrote a memo exploring the concept further and initial ideas on how it may relate to other contexts, resources, responses, and outcomes. This ensured that the segments of data I was analysing were always viewed in relation to theories I was looking to develop (Pawson and Manzano-Santaella, 2012; Punton *et al.*, 2016).

The explanations given by participants are analysed in relation to social constraints and enablers, including wider discourse and structure (Smith and Elger, 2014). In the memo, I therefore made analytical notes about the way in which the resources and responses related to discourse identified through analysis of the textual resources, within phase 2, the texts in phase 1, and the literature review, which is part of the work of viewing interviewees explanations in relation to the wider context. By attempting to demonstrate the link between the responses (illustrative of mechanisms) described by participants themselves and their relationship to discourse and structure, this follows an approach to analysis that participants themselves may not agree with (O'Reilly, 2012). Periodically, I would make notes in my intellectual diary as to how the emerging findings were relating back to the CPTs developed within phase 1 and what future data collection needed to take place to explore the current theory further.

By round 3 and 4, I moved onto more focussed coding, which involves proceeding with codes that are most significant in terms of the theories I was developing. These codes were also more conceptual than some of the initial codes to ensure greater ontological depth. When analysing round 3 and 4 data, I looked for data in relation to these codes, which sped up the analysis process. At the same time I compared data from each round under these codes to ensure consistency (Charmaz, 2014). By round 4, I perceived that I had gathered enough data to produce convincing explanations.

4.14 Context-mechanism-outcome theories and relationship to wider theory

As mentioned in chapter 3, to move from the empirical data to theories that attempt to explain change at the level of practice, as well as the dialectical relationship between this practice (represented through the CMO) and structure, I used the critical realist processes of retroduction and abduction. The process of redescribing the mechanisms within the CMO begins with the coding of research data. This coding process uses the creative element of abduction to attempt to go beneath the surface of the empirical data to produce explanations with ontological depth at the level of the real (Jagosh, 2020). By linking these resource and response codes with discourse, I was retroductively seeking to explain the deeper causal mechanisms at play, by asking what must the social world be like to explain the mechanisms that I was observing. In this sense, what are the discourses and systems of meaning operating within the social world that are working dialectically with these mechanisms. Following a critical realist ontology, the movement of discourse from the level of the real to the actual is dependent on interaction with contextual factors and the agency of actors (Zotzmann and O'Regan, 2016). Therefore, in the development of my CMO theory, I explored what contextual factors were present which resulted in the differential retention and inclusion of discourse into both the resource mechanisms and response mechanisms.

As discussed in section 4.10, I again drew on neo-liberal governmentality (Foucault, 1991b; Miller and Rose, 2008) to help explain the types of responsibilised and enterprising (Du Gay, 1996; Miller and Rose, 2008) subject positions that resources were attempting to shape within the CBIC, as well as their link with reproducing the neo-liberal state. However, within phase 2 data analysis, I found that resource mechanisms were working in different ways in their attempts to influence staff. I therefore needed theoretical assistance to retroductively explain the operation of power through these mechanisms. Within chapters 6 and 7, I drew on work by Waring and Martin (2016), Martin and Waring (2018) who have sought to expand the study of neo-liberal governmentality by drawing on Foucault's pastoral power. I applied their theory to show how middle managers, acting as pastoral intermediaries, employed both disciplining and subjectifying forms of power when translating governmental discourse to shape the subjectivity of frontline staff. However, I drew more exclusively on Foucault's (1991a) disciplinary power in chapter 8 to explain how power was working through the technological resource mechanism. I then followed the process outlined in section 3.8 to develop a normative and explanatory critique based on my theories.

My approach to theory building is expressed in figure 2. CMO theory developed from my case study was considered to provide theoretical generalisations about health and social care practice more broadly and how this was working in dialectical relationship with structure.

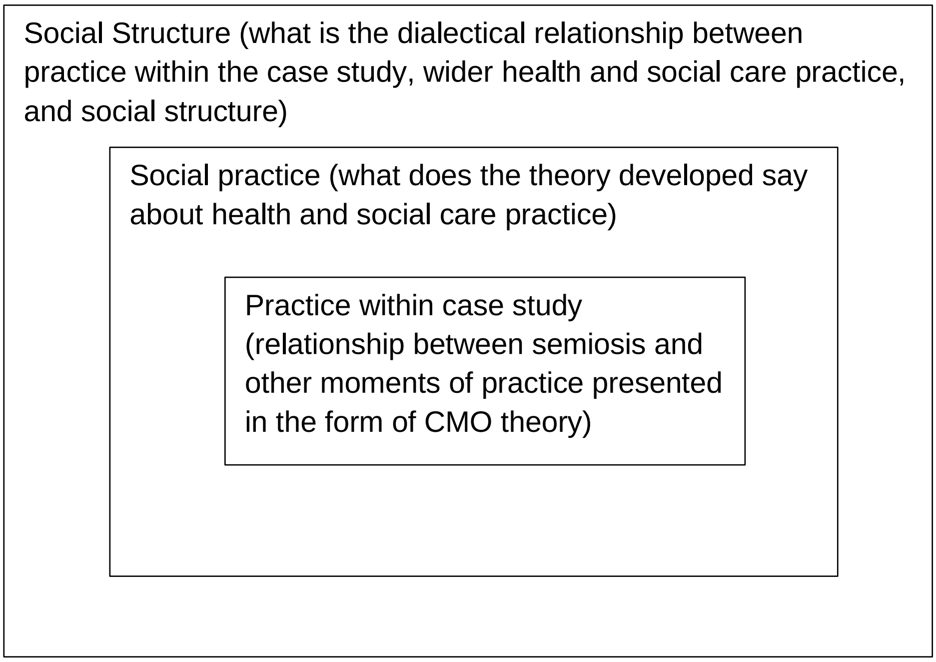

Figure 2- theory generation process in phase 2

4.15 Ethical considerations

This study posed several ethical issues that I had to consider during the planning and conducting of the research, as well as the storage and analysis of data. All research involving people must consider the ethics of the research. However, research taking place in a healthcare setting, involving health professionals and patients, presented particular ethical considerations that required additional caution (Griffiths, 2009). Below, I detail both the ethical approval process and the ethical issues I considered within my project.

4.15.1 Approvals process

I ensured that I carefully followed and adhered to the regulations and guidance stipulated by the NHS Health Research Authority (HRA) and gained all the necessary approvals before beginning my research project. For phase 1 data collection, I received ethical approval from the University of Essex Ethics Committee, given this aspect of data collection did not involve frontline health professionals or patients. Phase 2 data collection involved frontline staff and NHS patients so required approval from the HRA. As part of this process, the Research Ethics Committee (REC) reviewed the study and deemed the study to be ethical, whilst the HRA judged the project to be satisfactory in terms of governance and legal compliance.

4.15.2 Main ethical issues

a) Involvement of patients and the public

An ethical issue arising from the development of the study was that patients and public were not substantially involved in the design, nor were they involved in collecting any data or conducting analysis. The benefits of patient involvement being that it ensures the focus of the research takes into account their perspectives and priorities, encourages more practical research design, and leads to greater critical analysis of research findings (Griffiths, 2009). The reason for not including input from patients and the public was inadequate time and financial resource within the project, being completed by a sole researcher. However, I did consult the Service User Reference Group for the University of Essex on the acceptability and appropriateness of my plans for conducting observations within the open plan office space and team meetings where I would potentially hear identifiable patient information without gaining the consent of those patients. The group did not suggest any major revisions to my planned data collection and reported they were willing to accept the very small risk associated with this approach.

b) Confidentiality

The recruitment of both patient (interviews) and health professional (interviews and observations) participants into the study required that I take into consideration maintaining confidentiality of their contact details. Ensuring confidentiality means that identifiable information is not disclosed without permission during the research process (Wiles *et al.*, 2008). In order, to ensure confidentiality to patients and to make sure I complied with the General Data Protection Regulation (GDPR), I was not able to view personal patient information ahead of gaining informed consent (Grady *et al.*, 2019). As such, a member of staff obtained consent to contact from patients so that I could then contact potential participants by telephone to discuss the study further with them. For staff, consent to contact was not deemed necessary, given that acquiring their contact details was less ethically sensitive. An email from their manager providing them with an opt-out was deemed sufficient.

Within the analysis of data and PhD writeup, I used pseudonyms for all participants to ensure anonymity and as a way of maintaining confidentiality. I also gave all the organisations and texts featured in the research pseudonyms to protect the integrity of the organisation itself and the people that work within those organisations. Research participants were advised within the consent process that all efforts would be made to ensure anonymity, but if direct quotes are used it cannot always be assured that they will not be recognised in the research. It is also the case that given the contextual information provided about the lead provider that someone familiar with the area and service would be able to identify the organisation in the research.

c) Gaining informed consent (interviews and observations)

For those patients who had given consent to contact, I telephoned them to discuss the study and to ask if they were happy to arrange a date/time/location for me to visit them either at their home, a local GP clinic, or health clinic, depending on what was most convenient to the participant. It was important that I tried to minimise the inconvenience of taking part in the study to avoid harm to patients (Griffiths, 2009). All participants requested that I visit them in their home as this was most convenient. During the initial stage of the visit, I took participants through the information sheet and study consent form, reiterating their right to withdraw from the study and providing the opportunity for them to ask any questions before proceeding. Following this, participants completed and signed the consent form to provide full informed consent.

For staff (frontline and management), I also ensured that they provided full informed consent. All patient and staff information sheets detailed the aims and objectives of the research, why they were being asked to participate, what was being asked of them, and how their data would be handled and analysed. I also provided opportunities for all potential interviewees to have any questions answered and reminded them of their right to withdraw. It was also be reiterated to interviewees that if I became concerned for patient or staff safety, I would have a duty to act on these concerns and confidentiality cannot be upheld. It was important that I ensured that all interviewees gave full informed consent so that they are fully aware of the potential risks of taking part and that they agreed to take part being aware of those risks (Seidman, 2019).

In advance of conducting the observations in the integrated care offices, I supplied all staff with an information sheet and consent form by email, and they were given the chance to opt out, as opposed to requesting they signed an individual consent form. As mitigation, staff were still supplied with the same level of research information within the consent form and information sheet. They were also supplied with my contact details and advised that I would be sitting in the office with a poster above my desk with my name, role, and photograph, if they wished to discuss the research and to opt out of data collection. I also placed several posters around the office, indicating my presence in the office. The limited number of participants in meetings and training facilitated the ease of supplying all attendees with the information sheet and consent form ahead of the session and providing the opportunity to have questions asked.

All information sheets (both staff and patients) and consent forms are attached in appendix 12 and 13.

d) Harm to participants

Potential sources of harm to participants taking part in research could include physical harm, psychological harm, such as loss of self-esteem, embarrassment, and material harm, such as loss of time and resources (Bryman, 2015). There were no major risks of harm for participants taking part in the research. However, interview questions relating to healthcare is considered a sensitive topic (Elmir *et al.*, 2011) and so poses minor risks to patient participants through distress caused by discussing issues relating to their care and their condition. However, none of the questions related to personal issues that were likely to cause embarrassment and none of my patient participants appeared distressed or uncomfortable when discussing their care with me. To minimise harm, patients gave full informed consent before taking part in the research and they were advised they could decline answering any questions they wished. If patient participants had become distressed during the interview, or they had indicated a health issue that needed attention then I would have signposted their care coordinator as the appropriate person to contact.

Interviews with health professionals did not pose any major risks of harm. All questions related to them in a professional capacity and were unlikely to cause any distress. Interviews did involve taking up a small amount of time, but the length of the interview was altered flexibly depending on participant's other commitments and the date was arranged at the convenience of participants. The issue of time appeared to be more substantial for frontline staff as opposed to patients, with some patients keen to speak to at length both during and after the interview. Two interviewees who lived on their own and saw family only occasionally, seemed especially keen to chat to me beyond the interview, offering me tea and biscuits and asking me about myself. I made sure that I gave these interviewees my time and attention to avoid a ‘smash and grab’ approach to data collection, which can make participants feel used (Brewer, 2000, p. 61).

The observations that took place within the integrated care offices of day-to-day interactions and of the training/meetings did not pose any major risks to participants. Some participants may, however, have felt self-conscious if they had known they were being observed. Time is needed to for those you are observing to get used to you so as not to affect their behaviour (O'Reilly, 2012). One member of staff in Hallstone did approach me and say ‘Oh, you’re the one that is here to spy on us’. This was said in jest. However, I cannot be certain that some members of staff did not view my role in the office as one of a managerial spy. My attendance at the health coaching training lasted for a full day and I sensed that participants quickly got used to my presence and I chatted to many of the attendees informally. My attendance within the integration and the rehabilitation team meeting involved a higher chance of making attendees uncomfortable with my presence, given the smaller number of attendees and the duration of the meetings only being an hour. To try to mitigate this, I provided a verbal introduction to myself and the research, which hopefully worked to put the attendees at ease.

The potential harm to patients from the observations was that they would be identifiable to me without gaining their consent, which could result in embarrassment, stress, and anger if I were to hear details of personal health conditions. It became apparent during the observations that given the familiarity with each other’s patients, health professionals tended to refer to them in shorthand, rendering patients unidentifiable. However, at times I did overhear detailed and specific information about health conditions affecting patients. No information that could potentially render patients identifiable was recorded by me and only anonymised field notes were made. It would have been impracticable for me to gain patient consent, as it could not be known which patients would be discussed during the day-to-day observations or meetings. It would have also impeded staff’s ability to carry out their role as a health professional if they were preventing from potentially mentioning patient identifiable information, which could have created more harm to patients than me overhearing these discussions.

e) Power dynamics between researcher and participants

I was attuned to the differing power dynamics operating between myself and my participants. Patients are often considered to be in a relatively powerless position where they may be feel nervous to say what they think (Griffiths, 2009). I attempted to build up rapport with my interviewees to ensure they felt as relaxed as possible. This is considered essential to trying to readdress the power imbalance between the researcher who can be perceived as an expert (Sivell *et al.*, 2019). Despite being in a stranger’s homes at no point did I feel uncomfortable, although it must be acknowledged that I was potentially vulnerable as a lone researcher.

During interviews, some frontline staff either appeared or expressed nervousness to me about providing responses critical of management. In these instances, I would verbally reassure interviewees of confidentiality and of the independence of the research. I also worked hard to use my body language and tone of voice to make interviewees feel comfortable. My interviews with LPIs can by contrast be considered ‘elite interviews’ (Harvey, 2010, p. 195). The power dynamic differed here in the sense that although I had control over the interview agenda, these interviewees were used to exerting control over others through their managerial position and so were more likely to challenge the questions I asked. This happened on two occasions, once with the ex-CEO and once with a senior manager in the CCG, where they objected either to the wording or the framing of the question. Ultimately, however, my control over the data analysis and write-up affords me with a power over research participants as my interpretations of the data and the argument I develop is within my remit.

f) Data management

All interviews were audio recorded and transcribed by myself. Any information relating to the name and address of participants was removed so that they could not be recognised and replaced with a researcher code. A master list identifying participants to the research codes data and electronic data was held on a password protected computer, and hard paper/taped data was stored in a locked cabinet, accessed only by myself, within a locked office.

Identifiable research data will be saved for the duration of the research project (4-5 years). After the project has been completed any identifiable data (i.e. sound files, identifying codes) will be destroyed securely. Anonymised transcripts, anonymised field notes will be stored post-project within an encrypted folder on my own personal laptop. This data will be kept for a maximum of 10 years. I will be the only person to have access to this data, but it may be shared with other academics for the purpose of publications. Some open access journals require that anonymised data is stored in their repository to ensure transparency in research and so anonymised qualitative data may be stored in this way for a maximum of 10 years.

4.16 Conclusion

In conclusion, this chapter has detailed the sampling, data collection, analysis, and theory building approach taken within this study. The methodological development put forward in chapter 3, details how integrating the dialectical-relational approach to CDA with elements of RE provided the theoretical and methodological tools to connect a sociocultural view of policy (as part of broader social structure) with its enactment at level of practice, within a critical realist ontology and epistemology. This chapter sets out how I went about collecting data from LPIs (documents and interviews) which were analysed discursively to develop CPTs. These CPTs provided theoretical propositions of what might happen if the integrated care discourse and its constituent discourses were enacted and operationalised within implementation. I used these CPTs to guide further fieldwork within the main empirical phase. This chapter then set out how I used semi-structured interviews with middle managers, frontline staff, and patients, participant and non-participant observation of the day-to-day office working, team meetings and training sessions to collect data on the non-discursive moments of social practice. I explained how I analysed organisational texts as the semiotic dimension of this practice and how I related the discourses realised through these texts dialectically to the other moments of practice. I then showed how I expressed this analysis through the context-mechanism-outcome heuristic to help show the causal processes at play within the service change, including how contextual factors influenced responses to the operationalisation of discourse. The final stage of theory building involved drawing on wider social and political theory to retroductively explain the relationship between wider structure and the practice within the case study.

Chapter 5 - Local Policy Implementers and the Construction of a Community Based Integrated Care Service

5.1 Introduction

The analysis presented in this chapter aims to answer research questions 1) and 2). It does this by firstly showing how the CBIC is constructed discursively through LPI texts, and secondly by theorising what might happen when this discourse is operationalised and enacted into practice. In line with the DRA, I discuss the dialectical relationship between the LPI texts, social practice, and structure. LPI texts, as social events, form part of the social practice of health and social care and are constrained, enabled, and interpreted through the semiotic dimension of this social practice, the order of discourse. These texts are therefore both simultaneously socially structured and part of reproduction or transformation of those structures (Chouliaraki and Fairclough, 1999; Jørgensen and Phillips, 2002; Henderson, 2005). Secondly, I discuss the potential ways in which the discourse (systems of meaning and ways of representing) realised linguistically through the texts may be dialectically transformed at the level of implementation into material, technological, or managerial resources, responses in the form of identities/subject positions adopted, ways of (inter)acting, and effects for staff and patient experience. This dialectical relationship between discourse and the other moments of social practice is also considered in terms of their upward relationship to structure (Chouliaraki and Fairclough, 1999; Henderson, 2005). Ultimately, I argue that the discursive practice within the LPI texts may work to reproduce the ideological work of the IC policy discourse in perpetuating economic austerity.

In section 5.2, I begin the work of answering my first research question, ‘How have local policy implementers (CCG/lead provider/County Council) constructed a community based integrated care service (CBIC)?’. I situate the early construction of the CBIC within the IC policy discourse by showing how the CCG’s Business Case constructed the service change, prior to contracting, through the same solution-problem pairings within the wider discourse discussed in the literature review, and by drawing intertextual links to national policy. I draw on the concept of fantasy (Glynos and Howarth, 2007; Howarth, 2010) to help explain how these solution-problem pairings are energised, particularly by appealing to integrated care’s ‘beatific dimension’ in providing the solution to the ‘horrifying scenario’ of maintaining the status quo. Borrowing from Glynos and Howarth (2007), fantasy helps to explain how discourses are established as hegemonic by winning the consent of the majority, and provides additional theoretical weight to Fairclough’s (1992; 1999) use of Gramsci’s hegemony concept. I also argue that the Business Case text was both socially structured by, and worked to reproduce, the ideological function of the IC policy discourse. Following Chouliaraki and Fairclough (1999), as well as building support, integrated care as a hegemonic IC policy discourse perpetuates neo-liberalism by smoothing over any contradictions and complexities to reducing funding to the service, whilst also leading to improvements in patient care.

In section 5.3, utilising the ontological position set out in the DRA, I argue that the material reality of funding cuts and continued fragmentation had a socially structuring effect on the way in which LPIs constructed the CBIC. This led them to draw on the ‘empty oppositional status’ (Glynos *et al.*, 2015) of integrated care to reformulate the CBIC from *‘transformational’* service change integrating health and social care, to intra-organisational integration and changes to professional roles. This reformulation also saw efficiency savings created by greater integration of services, now attributed to reducing demand through patient self-management.

In section 5.4, I move on to discuss the way in which the discourse realised linguistically within LPI texts may be dialectically transformed into practice within implementation. The specific areas of empirical focus were integrated working between community nursing and community rehabilitation teams (particularly generic roles), covered in section 5.5, and the implementation of self-management, covered in section 5.6. I draw particularly on Fairclough's (2002; 2005; 2008) focus on the way in which discourse can be operationalised as materiality, identities, and ways of (inter)acting. However, in order to help me explain the way in which LPI's seek to guide staff and patients to act on themselves to reproduce the ideological work of the IC policy discourse, I borrow from Foucault's (1991b) work on governmentality and Miller and Rose's (1990; 2008; 2010) extension of these themes, to show how the conduct of individuals is shaped to further neo-liberal governmental aims through responsibilised, empowered and enterprising subjectivities. The specific empirical areas were chosen, firstly, due to the discursive attention they were given in the texts. Secondly, given the critical focus of this study and following Fairclough's (2001a; 2008) analytical framework, which focusses on social problems of a semiotic nature, I proposed that the dialectical transformation of this discourse could potentially lead to representational or needs based problems for health professional and/or patients. These potential problems are explored in the development of critical programme theories.

5.2 Dialectical relationship between LPI texts, social practice, and structure

In chapter 2, I set out how the IC policy discourse articulated within the HSCA 2012 and FYFV (NHS England, 2014) context, was constructed through the ‘horrifying scenario’ of fragmentation (Glynos *et al.*, 2015), the threat posed by the ageing population to the welfare system (Hughes, 2017; Carey, 2018), financial instability, and hospitals overwhelmed by patient admissions (Hughes, 2017). I also argued that alleviating fragmentation through the development of patient owned care plans, and a focus on ‘patient centred care’ and ‘empowerment’ allows IC to act as a conduit for fears about lack of patient power and choice over their own care (Glynos *et al.*, 2015; NIHR CLAHRC Greater Manchester, 2019; Coleman *et al.*, 2020). Below, I set out how the Business Case situated the CBIC as enacting national policy through intertextual links and by constructing the CBIC through many of the solution/problem pairing within the IC policy discourse.

5.2.1 Intertextual links between CCG texts and national policy

Intertextuality is how texts enter into dialogue with other texts by bringing other voices into what is being said (Fairclough, 2003). The Business Case can be seen as incorporating intertextual links to ‘voices of authorization’ as a legitimation strategy for the proposed CBIC service change by stressing its compatibility with national policy (Aggerholm and Thomsen, 2016, p. 200). The Business Case includes intertextual links to the HSCA 2012, the FYFV, and the BCF. However, compatibility with the FYFV is particularly emphasised, with 7 intertextual links. The desire to legitimise the CBIC in this way is made explicit when its alignment with the

FYFV is said to ‘provide the CCG’s Governing Body with the appropriate level of assurance to proceed with the project’ (p. 11). Later (p. 15) the text provides more detail on how the CBIC’s aligns with the FYFV, including its focus on prevention and greater patient control. The text explicitly frames the CBIC as an example of a multi-speciality community provider model (MCP), which is detailed within the FYFV (NHS England, 2014) as one of the new models of care designed to drive through greater integration between community, primary and social care. By aligning the CBIC with the MCP model, the Business Case is not just claiming to be consistent with national policy, but implies it is a direct enactment of the FYFV and the new models of care.

The Business Case also provides 6 intertextual links to the BCF. Section 2.5.6 of the text is explicitly titled *‘Alignment with the Better Care Fund’* claiming that a significant proportion of the BCF for the area will fund CBIC services, including social care services, such as reablement. The BCF was one of the government’s flagship integration policies during this period and adopted a top down approach with the key aim of reducing hospital admissions (Humphries, 2015). The text claims that the *‘Fund is intended to be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change’* (p. 38). It also claims that *‘the CCG is working with the County Council to deliver the key Better Care Fund outcome of a reduction of 3.5% in emergency admissions’* so explicitly relating the integration of health and social care within the CBIC to national policy goals of reducing hospital admissions.

5.2.3 Central problematisations

In this section, I show how the Business Case was constituted within and reproduced the IC policy discourse within discursive practice.

a) Poor public finances

The horrifying scenario of financial unsustainability is constructed in the extract below:

‘This level of increasing demand is placing significant strain on the sustainability of the local health and social care economy. The CCG is projecting a financial shortfall of some £80 million over the next five years. Meeting this level of challenge will require a system wide, transformational change in the way that services are commissioned and delivered for our residents. Doing nothing will mean that our health and social care economy no longer remains sustainable, impacting on the services we can commission for our population.’ (p. 3)

In the first two sentences, the relationship between the increasing level of demand and the financial shortfall is presented as though it is apolitical. It is stated that ‘*The CCG is projecting a financial shortfall’* which is attributed to increased demand. However, CCGs are allocated their funding pot by NHS England out of the total NHS budget, which is set by a central government decision (NHS England, 2021). The agency of central government is, therefore, silenced, preventing the solution to this financial shortfall being assigned to increased funding. This will instead be solved by the *‘system wide, transformational change’* which enhances the beatific dimension of the service change by presenting ‘a fullness to come once a named or implied obstacle is overcome’ (Glynos and Howarth, 2007, p. 147). The centrality of cost containment within this quote also positions the CBIC within the neo-liberal context in which the IC policy discourse is constituted (Maniatopoulos *et al.*, 2020). The horrific dimension to this fantasy is ‘*doing nothing*’ which will result in the service not being sustainable. This works to energise the need for the CBIC by presenting it as the only way to overcome the threat of financial unsustainability.

b) Ageing population

In the extract above, the political agency responsible for the misalignment between increasing demand and financial support is silenced. However, the text goes on to clearly attribute responsibility for increasing demand to an ageing population with multiple conditions.

‘As highlighted throughout this document, the CCG is facing a ‘tidal wave’ of demand for services, especially amongst older people with multiple long-term conditions. This is placing unprecedented pressure on the financial sustainability of the local health and social care system. Our patients and service users have also told us that they require more personalised and integrated services that keep them well at home, and prevent them from needing care in hospital’ (p. 8)

Demand for services from elderly people with long term conditions is described using the metaphor of a ‘*tidal wave’* facing the CCG, implying it is about to be overwhelmed. The use of ‘*tidal wave’* is a metaphor used to create an image of a force of nature that is ready to destroy whatever is in its path. This characterisation places the elderly population in a negative subject position, due to the threat they pose in overwhelming the health service. This links to the 'fantasy of demography' inherent within the IC policy discourse that positions the ageing population as a major threat to the welfare system (Lindberg and Lundgren, 2019, p. 6). The third sentence shifts position dramatically when the same patient population that are about to hit services with a tidal wave through their demand, are now described using a possessive pronoun '*our*' to indicate that they belong to the CCG and it is their responsibility to look after them and take their needs into consideration. The extract both inherently problematises this patient group due to their age and condition, whilst at the same time claiming to be focussing on their expressed wishes relating to care. The elderly population are therefore both responsible for a horrifying scenario, as well as those who require saving, highlighting an apparent contradiction inherent with the IC policy discourse and its conflicting problematisations.

c) Fragmentation

We are told that patients and service users '*require more personalized and integrated services that keep them well at home'*, but what does it actually mean for services to be more personalized and integrated? Drawing on the IC policy discourse, the Business Case describes the CBIC as the solution to the current system of '*fragmented*' services.

'Traditionally, health and social care has sometimes been commissioned around the needs of the service, rather than the needs of people. This has led to people receiving fragmented care, delivered by many different professionals. Some care has been duplicated. Some care has been missing.' (p. 9)

The horrifying scenario of fragmentation (Glynos *et al.*, 2015) is presented through threats of care being '*duplicated'* and *'missing'*. The CBIC is again constructed as providing 'a fullness to come' once fragmentation is conquered (Glynos and Howarth, 2007, p. 147) through its aim to '*transform the delivery of physical, mental health, and social care services'*. The level of change created by the CBIC is therefore implied to be grand scale, with '*transformational*' used 7 times to describe the redesign of the health and social care economy.

d) Hospital admissions and pressure on GP practices

In chapter 2, I demonstrated the extent to which integrated care was framed within policy and research as a solution to reducing hospital admissions. Although not linguistically constructed within the Business Case as a 'horrifying scenario' in the same way as fragmentation, financial unsustainability, or the ageing population, reducing hospital admissions was cited as one of the central aims of the CBIC. For example, the text stated the following:

'People with long-term conditions, and their carers, are supported to be independent in their own homes and avoid hospital admissions; through effective, personalised and integrated community based services' (p. 4)

The central mechanism for reducing hospital admissions was presented as patients either being more independent at home or receiving care in their homes or a community setting. Care delivered in a home/community setting was also framed in the text as providing wider system benefits including less ‘‘*bounce backs’ to General Practice’*. The assumption here is that care delivered outside of formal settings will be privileged within the CBIC.

e) Lack of patient power and control

As discussed in chapter 2, integrated care can be seen as a conduit for discourses of ‘patient-centredness’ (Speed and Gabe, 2020) and ‘empowerment’ (Salmon and Hall, 2003; Ellis *et al.*, 2017; Jones, 2018b) that relate to greater choice and autonomy (Glynos *et al.*, 2015; Carey, 2018). Within the Business Case, greater patient ‘empowerment’ and control over health care is described as a central element of the CBIC service change.

‘(CBIC) will empower patients to develop the knowledge, skills and confidence to take control of their own care, working in partnership with health and social care professionals as active partners in planning and managing their own care. Every person with a long-term illness or disability will have a personalised care plan suited to their needs. They will have been involved and instrumental in the development of that plan, to ensure that it reflects their personal circumstances, needs, choices and aspirations for improving their health. CBIC aims to provide a health and social care professional workforce that is appropriately skilled to support and promote self-care and self-management (pg.68)’

This quote draws explicitly on an empowerment discourse through its claim that this care delivery model will *‘empower patients’* to become ‘*active partners in planning and managing their own care*’. This implies that the traditional power asymmetry between clinicians and patients is being reversed with interactions based on partnership and collaboration. Patients are also positioned as becoming ‘responsible’ citizens in relation to their health (McDonald *et al.*, 2007; Jones, 2018b). In the above extract, empowerment is discussed in relation to two elements of practice. Firstly, care plans are to be created around the needs of patients, which works to link the development of care plans to both concerns about fragmentation and lack of patient control. The empowerment ethos will ensure that they are developed in partnership with patients and based on their needs. In the last line of the extract, the empowerment ethos also encapsulates self-care and self-management, which relates to patients having greater responsibility for their actual healthcare. This quote, therefore, works to tie together concerns about lack of patient involvement in care plans and lack of patient involvement in actual healthcare tasks. As a result, this has the effect of discursively linking self-management within a wider integration narrative.

5.2.4 Ability of integrated care to meet a range of problems

In the above section, I have demonstrated how the CBIC was constructed as a solution to a range of problematisations, working to reproduce the IC policy discourse at the level of discursive practice. By presenting these problematisations as horrifying scenarios and emphasising the beatific dimension of IC, these solution/problem pairings are energised by fantasy (Glynos and Howarth, 2007; Howarth, 2010). By drawing on the hegemonic policy discourse, the Business Case text worked to garner support and allegiance for the service change from the CCG’s governing body, who gave final approval, whilst situating it in a system of meaning that has widespread support across integrated health and social care practice.

The ability of the CBIC to meet numerous co-existing problems within the health service, is presented consistently throughout the Business Case text. There are several examples of where the CBIC is claimed to provide a solution to both high public expenditure and poor patient experience, such as:

'The CCG will commission joined up services based around the needs of the individual. As well as improving the quality and experience of care, this will enable the best use of budgets and resources for the benefit of the people of (Greenfay and Hallstone), both now and in the future'

In other places, the Business Case also directly links making cost savings with reducing fragmentation, unplanned hospital admissions, and activity taking place in the acute sector. The frequent claims that the CBIC will meet both patient needs and desires, and create efficiencies and cost savings, works to reproduce the narrative that integrated care can harmoniously meet a wide range of issues within the health service. The relationship between the clauses in the above quote, and other examples in the text, are additive, as opposed to explanatory, and so description of how the CBIC would work to achieve these aims, tends to subsume complex processes into explanations at a high degree of abstraction. This is what Fairclough (2003) calls providing the logic of appearances, as opposed to explanatory logic. Similarly, to that found by Hughes (2017), this works to reduce any contradiction and conflict within this explanation, and present consensus around integrated care as the only and inevitable solution to multiple problems within the health service, therefore perpetuating its hegemonic status.

At the interdiscursive level, the problematisations of patient demand and poor public finances, necessitating the need for cost containment and efficiency, frame the CBIC within the economic logic of the neo-liberal state focussed on withdrawing public provision of health and social care (Speed, 2016). Below, I discuss my analysis of LPI documents produced during the contracting process and interviews I conducted with LPI's, to show how this ideological work of the IC policy discourse began to be operationalised further through the evolving construction and shaping of the CBIC.

5.3 Reproducing neo-liberal austerity through the CBIC contract

I will now go to argue that the positioning of the CBIC within this discursive frame was more about legitimising moving services out of the acute hospital and into a community setting and re-contracting out community services within a severely reduced financial envelope, than representing any profound change to the way that services would be delivered within the health and social care arena. Despite the claims of *'transformational change'* to the delivery of health and social care services, a graphic within the Business Case, provided specific detail of which services were to be included in the plans. At the time the Business Case was published, the confirmed services to form part of the CBIC were a range of community health services (i.e. community nursing, therapies, continence, stroke rehab, etc) and some voluntary sector services. The contract also included some services that were moving out of the acute into a community setting, such as outpatient physio, pain management, etc. Reablement, which is part of social care, is included within the graphic. However, within the small print it reads '*procured by (County Council). To be novated to (CBIC) at earliest opportunity'* indicating that these plans still needed to be finalised. The graphic also indicates that community mental health services are to be integrated into the CBIC in phase 2 of implementation.

By the time, the CBIC was put out to competitive tender and contracted in April 2016, reablement no longer formed part of the contract. It was reported to me by, ex CCG CEO, Michael, that this was because the County Council were unable to break up their social care provision across the region, and so reablement remained within their responsibility. The CBIC was therefore funded purely through NHS budget, with no money coming from the BCF to fund the social care component (Bev, OCC Senior Manager). Regarding mental health, this was eventually dropped from phase 2 of implementation because, as was reported to me by CCG senior manager, Shirley, the tariff for mental services could not be migrated to the community, creating difficulties with configuring the contract. The comparison to the MCP model within the FYFV also became more debateable. The MCP model aims to combine the delivery of primary care and community services, normally through 3 different arrangements. 1. Provider and commissioning contracts are bound together by an 'alliance' agreement 2. Contracts are made between the MCP and GPs to facilitate operation integration 3. Full integration with a single whole-population budget for all primary and community service (NHS England, 2016b). However, there were no contractual or formal arrangements between the lead provider and GP practices within the locality. Michael also made it clear in his interview that this is not the model that was pursued in the CBIC, as there was no appetite for this from primary care at the time. This was despite the argument presented in the Business Case that the CBIC was aligned with the FYFV through the MCP model, and the claims made by the CCG Senior Manager, Jill, that ‘*we didn’t realise we were designing multispeciality community provider at the time we were designing it’*. The remaining inter-organisational aspect contained within the contract was for 1% of the total budget ring fenced for work with voluntary sector organisations.

The *‘transformational’* and ‘*system wide’* change was therefore reduced to a contract based mainly on the provision of community health services, with the expectation it could still help towards compensating for the *‘£80 million shortfall’* facing the CCG over the 5 years post Business Case publication. The CBIC contract contained substantial financial efficiency savings, with OCC Senior Manager, Bev, telling me that there was specific ‘*year on year efficiency within the contract’* which were on top of existing expected NHS efficiencies. A graph contained within the health coaching training manual, which will be discussed in full in chapter 7, indicated that the contract value fell from approx. £33.8m to £32.8m from 2017-18 financial year to 2018-19 financial year, and then from £32.8m to £32.3m between 2018-19 and 2021-22. OCC CEO, Vicky, also highlighted to me the level of inevitability and passive receptiveness felt by OCC to a commissioning decision that would have left the organisation unsustainable if they’d failed to win the tender. She told me that they would have lost roughly 2/3s of the business, emphasising that ‘*I don’t think it would have survived*.’ It was within conditions of little contractual integration between community services and social care/mental health/primary care and funding depreciation, that LPIs had to shape managerial and organisational practices that attempted to deliver ‘integrated’ care and meet efficiency savings. Following the critical realist approach to discourse analysis employed within this study, I presume that this material reality can have a socially structuring effect on discourse articulated through texts (Fairclough *et al.*, 2002).

5.4 Dialectical relationship between the moments of practice within CBIC

In the remaining sections of this chapter, I focus my analysis on texts produced within the socially structuring context described above. These texts include those developed as part of the contracting process (tender document) or during the early stages of implementation (staff training video) and data collected from interviews with LPIs. This analysis places importance on the role of LPIs, as mediators within the dialectical relationship between social structure, social practice, and social action.

On a theoretical level, I draw on Fairclough et al (2002) to argue that the material reality of the financial context and continued structural fragmentation in the contract had a socially structuring effect on the way which LPI's drew on certain discursive frames to both reformulate the CBIC into a much more limited form of 'integration' and the way in which they individualised problems to be overcome at the level of clinicians and patients. I then borrow from Foucault's governmentality (Foucault, 1991b) and work extended by Miller and Rose (2008) to help explain the way which LPIs seek to shape clinicians and patients into certain ethical subject positions that will ultimately deliver financial efficiency. Governmentality refers to the way of governing through rationalities, which are 'ways of rendering reality thinkable' so that the population are 'amenable to calculation and programming' (p. 16). Various forms of technologies (techniques/instruments) are used to then act upon the conduct of individuals in line with these rationalities. Although this theory is based on a post-structuralist ontology in which reality is constituted through rationalities, I employ these concepts in a more limited way through the DRA to help me explain the way in which mechanisms that seek to guide the conduct of individuals and organisations are linked to wider neo-liberal political objectives through ‘action at distance’ (p. 21). In this context, guiding the conduct of individuals involves them coming to see their own desires and needs in line with governmental aims.

Foucault (1988) sets out the way in which individuals engage in ‘practices of the self’ in which they ‘monitor, test, improve and transform’ themselves through moral codes to produce themselves as an ‘ethical subject’ (pp. 26-28). Within neo-liberal society, this ethical subject is one who is ‘responsibilised’ meaning they are autonomous, empowered to take personal responsibility, and making reasonable decisions about their life (Miller and Rose, 2008, p. 18). In the context of public service provision, this requires that citizens take greater personal responsibility for their welfare and health (Trnka and Trundle, 2014). In the context of work, this concept has been applied to workers being ‘empowered’ to take on tasks previously the responsibility of their superiors, or for labour problems (Mackenzie *et al.*, 2020). Du Gay (1996, p. 845) talks about these neo-liberal workers as ‘enterprising’ subjects who are ‘self-regulating productive individuals’. As will be demonstrated below, LPI texts push these subject positions through integrated care practices and so, at times, appeals are still made to improvements in patient care through greater joined up working and holistic care.

5.5 Generic working within integrated care teams

The tender written by the lead provider, OCC, as part of the CCG's competitive tendering process, set out a vision for what was described as '*Multispeciality Teams'*, in which OCC services would 'integrate' with external agencies on a non-contractual basis. These teams would include a range of health professionals internal to OCC and practitioners from external services, such as mental health, housing, voluntary sector, reablement and social care, which would either *'link or base representatives'* within these wider teams. It was also claimed that each GP practice in the area would have designated members of the multispeciality team to form a '*team around the practice*' to work alongside them to meet the needs of the practice population.

One year into service delivery, I was told in interviews with OCC Senior Managers that the geographic region had been split into 4, what was now termed, 'integrated care teams' across 4 localities (East Hallstone, West Hallstone, East Greenfay, West Greenfay). The integrated care teams included community nursing and community rehabilitation/therapy staff who visited patients in their home for those particular geographic areas. A range of other services were then hosted in these localities, i.e., speech and language therapy, stroke early assisted discharge. I was also told that members of the integrated care teams were attached to specific GP practices, as part of the team around the practice concept, and that the vision remained for external services to hot desk within the integrated care offices.

5.5.1 Framing generic roles within the IC policy discourse

Discursive attention was mainly given, however, to changes at the level of individual roles for health professionals. What was described as ‘integration’ between teams became synonymous with the actual roles of co-located community nursing and therapy staff becoming more generic through joint competencies. At this stage, LPI’s also articulated the desire for community nurses and therapists to incorporate low level mental health and social care tasks within their role. Within the interviews, LPIs often discussed changes to professional roles and integration between the teams interchangeably.

Senior Manager, Mary, described the aims of bringing the teams together below:

‘So, in terms of the overall philosophy and what we’re trying to do is to say this integration is purely within OCC. So that’s really about more than anything else organisational reorganisation in a way to bring those teams together to be co-located in physical premises together, which to me is quite important. To when we were trying these bring these teams together, it was really about saying we know from a patient perspective what they identify is that they’ve got all these different people. Some of which are OCC services that you might have you going in one minute, half an hour later, I might pitch up to do a nursing duty. You might have already been in to perhaps show them how to walk or to help them prepare a meal. We may also then have social care doing similar things, and medical staff from GP practices, etc. So, our overall aim is to get our own house in order so that our teams are talking

together and so that we can start to say actually, if you're going out and I'm going out is there any generic elements of that that we can bring into one visit.'

The first line reflects both the socially structuring context of the limited contract and the local deployment of the IC policy discourse when constructing the CBIC. Here, Mary frames '*integration*' as purely intra-organisational, in contrast to the *'transformational'* change outlined in the Business Case which saw community health, social care, and mental health brought together on a contractual basis. She stresses the importance of the co-location of teams. However, this is framed as a facilitator to role blurring between community nurses and community therapists, as opposed to simply the sharing of information or collaboration. The horrifying scenario of fragmentation is appealed to through *'all these different people'* who are visiting patients from a range of different services, including nursing, physiotherapy, social, and primary care. However, she is clear that *'our overall aim is to get our own house in order so that our teams are talking together'*, suggesting that organisational focus is concentrated on internal processes and changes at the level of individual health professionals to alleviate this fragmentation.

In the quote below, CCG senior manager, Jill, also discursively constructs 'generically trained' staff within a broader integration narrative, when she discursively links this workforce model with *'greater integration between teams'*.

'So, I think from a bottom-up perspective, it's greater integration between teams. So breaking down things like the physical and mental health barriers, so people are more generically trained. We've got mental health first aid, even if they're a

community therapist doing princably physical services, so we can treat the patients holistically. Using a more dynamic workforce model to satisfy patient need so you're not repeatedly having staff going into a patient's home when actually one person with some generic training could do that. So, a more efficient model.'

Similarly, to Mary, Jill links generic roles with the alleviation of the kind of fragmented care that results from numerous visits from different services for comorbid patients. She also draws on the minor discourse of holistic care, which is often linked with integrated working in the literature (Ventegodt *et al.*, 2016; Santos *et al.*, 2018; Brighton *et al.*, 2019). Holistic care is referred to as a way of understanding a patient's experiences and building this into the way care is delivered. It is claimed this would involve taking the 'physical, psychological, social and spiritual needs of individual patients, and their families or carers' into account' (Brighton *et al.*, 2019, p. 271). It is argued that delivering holistic care is facilitated by coordinating and integrating care across multiple service (Ventegodt *et al.*, 2016). In the same way as Mary, Jill is construing performing different types of tasks (mental health first aid, physio, taking blood) within one visit, as being of benefit to patient experience.

In addition, Jill couples *'a more efficient model'*, with delivering holistic care, and satisfying patient need. Similarly, to the assumptions within the IC policy discourse, generic roles are conceived as a harmonious solution to a wide range of issues. The linguistic coupling of both process efficiency and holistic care within Jill's description therefore works to reduce contradiction or inconsistency within this explanation and presents the same logic of appearances that I argued was present in the Business Case (Fairclough, 2003).

The training video given to staff in the early stage of delivery goes further in placing patients at the heart of the generic workforce changes by referring back to them as the primary agents of this problematisation, through intertextual links such as, *‘patient’s tell us that they find the current set of services disjointed and confusing’, and ‘the reason that they state for this that they often see different clinicians from different teams coming and pretty much focussing on one part of the patient’s care’.* There are no references to efficiency or time wasted, which could more likely be described as organisationally or policy driven problematisations. The focus is solely on patient’s perspective. When the presenter in the video says *‘patients tell us’* the text is providing an intertextual link to patient voices. However, this is done by reporting what patients have told them without reference to direct quotes or detail. This works to abstract away from what may be a diverse range of opinions amongst the patient population (Fairclough, 2003). The desire here is to build consensus and reduce difference around the service change, in a way that works to legitimise it. If the speaker had said that some patients find care delivery disjointed and confusing, but others also prefer the comfort of having health professional conducting tasks they were specifically trained for then the legitimacy of the claim that generic roles are in patient’s interests would have been called into question. The lead provider also has an interest in constructing its efficiency goals in line with the demands of patients to ensure legitimacy for the service change.

5.5.2 Generic workers as enterprising and responsiblised

Within Jill's quote presented in section 5.5.1, clinicians who successfully fulfil this workforce model are constructed favourably through the use of the descriptor *'dynamic'*, implying they are flexible, versatile, and can adapt to changing circumstances, placing them in a positive subject position. This is reflective of an 'enterprising' identity in which virtuous workers are 'self-regulating productive individuals' (Du Gay, 1996, p. 119). For staff to be able to deliver this *'dynamic'* care they will, as suggested by Jill above, need to receive some level of training to be able to put these competencies effectively into practice. The actual task of delivering multiple aspects of care was constructed as something easy and common-sense by LPIs. Senior OCC Manager, Bev, describes the process of a nurse taking on additional therapy and social care tasks in the following quote.

'I think what we're looking for is you get a better outcome for patients, but it reduces down on the duplication, so I might deploy a nurse, but the next week or in the same day a therapist might go out and then a social worker goes out, well actually completely wasting every bodies time, so it might be better to say the overarching needs of patient is nursing but the nurse can deliver some lower level therapy, and she's got enough to know about social services to act on behalf on social care. So, she wouldn't be making all of the decisions but she could coordinate the care as opposed to having three people go out doing what 1 person could do.'

Different visits from 3 different professionals is described as *'completely wasting every bodies time'*. Use of the word *'completely'* stresses the categorical nature of the time wasted, with no reason as to why different visits might be needed. Bev's focus on reducing *'waste'* also draws on the discourse of lean working, which centres organisational practices around increasing value and reducing wasteful processes (Waring and Bishop, 2010; Rees and Gauld, 2017). Uniprofessional staff are therefore wasteful, in contrast to the generically trained nurse who is skilled, knowledgeable, adaptable, and proactive. She *'can'* deliver low level therapy, and *'she's got enough to know about social services,'* with a slight mitigation that *'she wouldn't be making all the decisions'*, but regardless she could coordinate the care. Here Bev, is constructing generic health staff in the same enterprising subject position as Jill. The nurse is also empowered through her additional competencies to be responsibilised for co-ordinating the patient's care. The last claim that *'she could coordinate the care as opposed to having three people go out doing what 1 person could do'*, implies that this is perfectly within her power and capabilities, that it is common sense, and inevitable. The modality within this quote is categorical, indicating that the speaker has a strong affinity to this statement, which works to reduce doubt about its validity claims. Overall, the potential complexities of nurses adopting an enterprising and responsiblised subject position and putting this into practice during patient interactions is reduced. This silences out any potential contradictions or conflict that might arise from having to develop a variety of new skills outside traditional remit, and the time and resource for her to so easily conduct in one visit what it would normally take 3 people to do. The presentation of this process as easy also works to cement the idea that generic roles can achieve both process efficiencies and improved patient care in a harmonious manner.

5.5.3 Generic workers as moral

LPIs have constructed generic roles through the IC policy discourse, by positioning them as a solution to poor patient experience arising from fragmented care and inefficiency. In making this case they have also drawn on constituent discourses of holistic patient care and lean working. In actualising these roles, generic workers are flexible and responsible for a variety of patient need. Within this discursive context, those assistants who resist the change to generic roles were placed in a negative subject position. I argue through my analysis below that barriers to implementation are individualised at the level of resistant employees. Firstly, this works to render their problematic attitudes amenable to change in a way that more complex issues are not. And secondly, they provide an easy target of blame which deflects from any other organisationally or managerially driven difficulties. As such, this problematisation provides a legitimising function to the service change by attributing blame to either the moral failing of health professionals to live up to their caring duties to vulnerable patients, or their self-interested objection to having their roles changed against personal preference for work.

I asked Henry, a senior manager within County Council, whether he thought there were any issues associated with asking staff to take on additional tasks without extra resource, with the following response:

‘Yes. I think everybody in the public sector, any in any organization, will probably say that they're already overworked. There's a lot of resistance, by the way, to integration across the board from primary care, with GPs basically saying, "We are overworked.

We can't do the job as it is. How on earth do you expect us to be doing all this preventative work and outreach work, et cetera?" That definitely is an issue. On the other hand, sometimes some of the tasks are really small and really common sense. For example, let's say I was a nurse and I popped round, and I'm giving the medication to somebody, but I noticed that the person maybe needed a bit of a clean-- Maybe even their dinner putting in a microwave, or something, because, for a lot of frail people, they're struggling to clean themselves. They're struggling. Rather than go and send them, which has just wasted somebody else's time, travel time and the waiting time as well for somebody to get out, you'd think, don't you? Common sense, "What could I do? How could I do it?" If it's a big task then, yes, but—'

He begins with *'Yes. I think everybody in the public sector, any in any organization, will probably say that they're already overworked'*, which works to minimise new claims that staff are being overburdened, given this is the normal default position for staff in the NHS. However, he does go on to acknowledge that for GPs this may be a genuine issue. The ability of nursing staff to take on extra duties, however, is defended on the basis that *'sometimes some of the tasks are really small and really common sense'*. Repetition of *'really'* works to emphasise the apparent insignificance of these *'common sense'* tasks and reinforces Bev's construal of the easy implementation of generic roles. His use of *'popped round'* implies that nurses are not in a hurry when conducting these visits, instead they pop round in the way that you might pop round to a friend's house. He then adds that they *'maybe needed a bit of a clean-maybe even their dinner putting in the microwave'* with the repetition of *'maybe'* also working to reduce the significance of these tasks. Frail patients are described as *'struggling'*, in the sense that those health professionals who fail to also pick up the social care element are reneging on their duties as a carer to a vulnerable person. Similarly, to Bev, he also described how this member of staff would be guilty of wasting another's time when it would just be common sense to complete the social care work. In the face of these moral obligations to both colleagues and vulnerable patients, Henry places agency squarely with the health professional with his use of confronting questions, *'What could I do? How could I do it?'*. Here, Henry is asking those individuals to engage in 'practices of the self' (Foucault, 1988, p. 28) to look inside themselves and reflect on their behaviour in light of these obligations.

Here, we see the moral imperative of integrated care identified in Stocker et al (2018) and Eyre et al (2017) at the more abstract level recontextualised to the level of individual staff who fail to fit in with the aims of what is constructed as 'integration' at the level of roles. Again, this can be seen as a way of individualising the problem context and placing blame on health staff who are potentially struggling under heavy workloads to complete the visits within their caseload, whilst also attempting to provide elements of social care, such as heating dinners up and cleaning patients.

Further work to individualise any dissent from employees was found in the way CCG Senior Manager, Jill, attributed agency to individual staff for not conforming to the generic role model.

'Any change is challenging and not every discipline feels that the move to a generic model is satisfying for their own professional development or what they set out, what their schema of work was, or vision for them as a therapist when they trained. So, it does require coaching as to how you approach that change model. I think OCC did a

very good job of engaging their staff as to why the change was required and the sustainability of the model. But it's nevertheless challenging and particularly when you've got one group of staff in the hospital who are able to keep their definition in their role, and then the community staff who are being asked to do more generic roles. Some people will approach it as an opportunity and see that it's really broadening their skill set and some would see they are losing definition. So, there will always be a challenge around that.'

In this quote, agency is attributed to the health professional for resisting change due to personal interests. This is amplified by repeated use of the word *'they' 'their' 'them'*, placing emphasis on challenges arising from threats to professional identity and need. Jill presents a binary scenario in which *'people will approach it as an opportunity and see that it's really broadening their skill set'* or *'some will see they are losing definition'*. Resistance or acquiescence towards this workforce model is therefore based on role preference and nothing more. Staff who are accepting will be empowered and responsibilised for additional work through new opportunities that are *'really broadening their skill set'*. Potential issues identified earlier regarding competency, practicality, resource pressures and varying patient desires are silenced in this construction.

Giving discursive attention to potential complexity, training, resource, and time required to enable the transition to new roles would work against the broader sustainability objectives of the service change and the efficiency savings within the contract. If LPIs individualise the problem context as employee preference for role definition, then this works to increase the legitimacy of enforcing the change and directs blame towards individual employees and away from management. Ultimately, the positioning of clinicians, within the CBIC, as enterprising, responsibilised and empowered (Du Gay, 1996; Miller and Rose, 2008) reflects the economic logic underpinning the IC policy discourse.

5.5.4 Critical Programme Theories

Using insights from academic literature, I will now move on to develop CPTs, which help to think through how the discursive work described above may be enacted and operationalised through the implementation of generic roles within the CBIC. Generic roles are both constructed in relation to meeting the needs of patients, as well as reducing waste and duplication and therefore increasing efficiency. This works to encapsulate generic roles in the broader IC policy discourse, whilst also drawing on minor logics of holistic care and lean working. The subject position delineated within this discursive mix is that of the neo-liberal employee centred on being responsibilised, enterprising and empowered. Those who resist are by contrast blameworthy for failing in their moral duties to patients and allowing their self-interested preferences to dominate.

What are the potential consequences if these discourses are enacted and operationalised at the level of practice? Firstly, organisational discourse which emphasises the need for staff to fulfil duties to both patients in terms of their holistic needs and their obligations to other members of staff through reducing waste may be internalised within a clinician’s professional identity and ways of (inter)acting in their professional practice. Rees and Gauld (2017) have discussed how lean working in the health service, involves job redesign, bundling of tasks, and the development of multiskilled teams, which can act as an intensifier by increasing the pace and number of tasks, and reducing time or space between tasks. Other recent work (Mackenzie *et al.*, 2020) exploring the automotive industry, has positioned lean within neo-liberal capitalist economies in which seeking efficiency dominates. In this study the adoption of responsibilised subject positions through lean led to staff taking on additional work that increased intensification and exacerbated workplace stress. The positioning of responsibilised health professionals within both this discourse and the needs and preferences of patients through holistic care, adds substantial pressure to caring professionals to intensify their work. If health professionals engage in 'practices of the self' (Foucault, 1988, p. 28) in the way asked by Henry, then management may have succeeded in shaping desirable subjectivities. These health professionals may be more inclined to take on additional tasks without the subsequent resources that reduce their caseload, leading to substantial intensification and workplace stress.

On this basis, I have developed the following CPT, which was explored further in phase 2 data collection.

1. *If health professionals inculcate the requirements of an enterprising and responsibilised identity into their professional practice then they may put pressure on themselves to deliver additional tasks within visits, which they have not been given additional time or resource for. This could satisfy the efficiency aims of the service change, but result in substantial intensification and stress for staff*

Some staff, however, may resist internalising this discourse, instead retaining their professional attachment to their current role and identity. Professional identity is built up through professional education and socialisation and is considered a relatively enduring form of identity that enables professionals to demarcate themselves from other professional groups, in terms of status, values and self-image (McNeil *et al.*, 2013). It has been found that professional identity, as a pre-existing contextual factor, influences the way in which nurses respond to attempts to make their role more generic, with those who occupied their previous roles for longer being more resistant (Elliott *et al.*, 2015). Both Jill and Henry construct these types of resistant health workers in negative subjective positions based on failing duties to both colleagues and patients by pursuing their own self-interest. We might firstly raise the issue that the ability to hold a level of self-determination about the type of job that we hold represents a fair claim on behalf of employees. Stigmatising those who resist as selfish or self-centred may also place an undue burden on those employees, given how professional identity can be a key determiner of an individual's self-worth (Drevdahl and Canales, 2020). McNeil et al (2013) argue that those expected to move to generic health roles can also experience it as assimilation, insult and humiliating action, as it is perceived to devalue their current role.

Research within the sociology of professions (Allen, 1997; MacNaughton *et al.*, 2013; Huby *et al.*, 2014; Xyrichis *et al.*, 2017; Comeau-Vallée and Langley, 2020) has drawn on theories of boundary work (Abbott, 2014) and negotiated order (Strauss *et al.*, 1963) to explore the way in which clinicians working on multidisciplinary teams seek to negotiate and defend their professional boundaries (field of knowledge and tasks) in the face of threats to their positions by routinely advancing jurisdictional claims. This means that in the face of with competition from other professional groups, professions embark on a range of tactics to lay claim to a specific field of knowledge (Abbott, 2014). Redefining professional boundaries, in terms of making roles more generic, also involves a strong interactional component, as for one health professional to extend their role, there must be another willing to delegate the task or collaborate so that this is actualised in the delivery of care (du Bont, 2016). It has been found in certain contexts, however, such as hospital wards (Allen, 1997) and intensive care units (Xyrichis *et al.*, 2017) that open face to face negotiation is less prevalent, with professional boundary blurring instead being ‘accomplished’ through staff simply taking on additional tasks, as part of day to day work (Allen, 1997, p. 503). Within community and primary care settings, the potential for power struggles through open negotiation over professional boundaries has nevertheless still been identified (MacNaughton *et al.*, 2013). Following McNeil et al (2013), if health professionals asked to take on a generic role experience it as assimilation, insult or humiliating action then this can lead to further interprofessional conflicts, during this process of boundary work.

On this basis, I have developed the following CPT:

2. *If resistant health professionals are construed as less morally favourable then this may cause them to feel insulted or humiliated, leading to further interprofessional conflicts between members of the integrated care team when they attempt to defend their professional boundaries*

Research findings from the academic literature shed some doubt on this process being as easy and common sense as LPIs would describe. Some studies have in fact suggested that health professionals are being asked to take on tasks that stretch their capabilities in a way that could compromise patient care (Belling *et al.*, 2011; Gray *et al.*, 2011; Hannigan and Allen, 2011). A study by Gray et al (2011) found that community nurses who were asked to take on additional roles as part of the move to a generic model built up 'atrocity stories' (p. 1701) that described how fulfilling these roles without adequate experience or training could mean that patient care could be compromised. Hannigan and Allen (2011) also highlight in their study of role blurring in community mental health teams how these sorts of roles are encouraged within conditions of austerity, as the bundling of activities can act as a cost saving. They warn against the potential for interprofessional conflict and health professionals taking on tasks that stretch their capabilities. This research evidence supports my earlier analysis that construing generic working as easy and common sense, may work to minimise the potential complexity and difficultly of putting these new competencies into practice. This may mean that resources introduced to staff in relation to training and mentorship are inadequate. This is particularly compounded by conditions of austerity, when the resource needed for adequate training would offset the efficiency gains of bundling tasks.

On this basis, I also explored the following CPT.

3. *If the difficulties associated with the generic workforce model are minimised then inadequate training or support may be given, meaning staff will not*

> *develop the confidence and skill to fulfil their role, which may result in poor patient care and high stress for staff*

5.6 Self-management

In chapter 2, I argued that the IC policy discourse can act as a conduit for minor discourses of ‘empowerment’ and ‘patient centred care’. In section 5.2.3, I discussed how the CBIC Business Case linked self-management discursively within the integration narrative by claiming that patients will have greater choice and autonomy through jointly developing care plans with their care co-ordinator and patients taking a more active role in the management of their condition. Similarly, those texts produced by the lead provider (tender document and staff training video) also frame integrated care delivery through these same minor discourses. The lead provider’s tender document (section 4.1 Overarching Model) claims that through an *‘empowerment approach’*, *‘patients and carers will be treated as experts in the design, delivery and evaluation of their care’.* Care will then be tailored to patient’s *‘goals, appetite and capabilities’*. *‘Empowerment’* is then wrapped within the wider integration narrative, by placing the role of the care co-ordinator and its associated concerns with fragmentation, as central to delivery of this approach. Patients are to work collaboratively with their care co-ordinator to develop patient owned care plans, with care coordinators playing a key role in facilitating care across physical, mental health, social care, and the voluntary sector, and supporting patients *‘to discharge and self-management’*. Within both the tender and the staff training video, the care co-ordinator is presented as central to working with patients to set self-management goals and expected discharge dates, with all staff to be trained in *'health coaching'* and *'patient activation'* to facilitate this process.

Criticism of the empowerment discourse has focussed on the individualistic behaviour change model implicit within the discourse, which neglects structural factors that influence both the determinants of health and resources to self-manage a condition (Salmon and Hall, 2003; Jones, 2018b). Other criticism has arisen from those who see the empowerment discourse as still being constituted within the biomedical model, through the extension of the Foucauldian gaze into people's personal lives (Wilson, 2001; Fox *et al.*, 2005), and the ability of medicine to withdraw responsibility from problematic areas such as chronic disease (Salmon and Hall, 2003). Others have examined the implementation of self-management through the lens of Foucauldian governmentality to explore the way in which 'responsiblised' and 'enterprising' identities are constructed for patients through empowerment and self-management discourses, to encourage them to make well informed and self-sufficient decisions about their health (McDonald *et al.*, 2007; Jones, 2018b; Petrakaki *et al.*, 2018; Waring and Latif, 2018). These identities are underpinned by an economic rationality of maintaining the financial sustainability of the health service through increased individual responsibility (Petrakaki *et al.*, 2018). In addition to government policies that encourage patients to take on a more active role in their own healthcare, Jones (2018b) argued that these policies seeks to shape health professionals through 'pastoral subjectivites' that will guide patients into this behaviour (p. 4).

Below, I argue, following the DRA, that the funding depreciation within the CBIC contract had a social structuring effect on the discourse realised linguistically by LPIs. This meant that the LPIs gave little mention in their interviews of the *‘collaborative’* and *‘empowering’* conversations that were espoused in the Business Case and official texts produced by the lead provider. Nor did they give much discursive attention to greater patient control through co-developed care plans, with focus directed instead at the patient’s role in management of their condition. Instead, self-management was constructed mainly through an economic rationality of ensuring financial sustainability through the creation of responsibilised identities. In this sense, self-management began to be dislodged from its framing within practices advocated as leading to improvements in patient care, and instead to be frame within its ability to reduce demand from the service.

5.6.1 Financial sustainability

The link between self-management and the need to make financial savings was made explicit by several LPIs. Senior OCC managers, Bev, and Mary, as well as Jill, senior manager within the CCG, all spoke explicitly about the link between self-management and its necessity in ensuring the financial sustainability of the service. Bev told me of the specific *‘year on year efficiency within the contract’* which are on top of the *‘efficiency savings that come down from the centre’* already contained within NHS contracts. She then explicitly linked these savings with increased self-management, which she elaborated as *‘better management of the population, so better self-care which enables people to then be more resilient at home and to prevent or reduce cost further down the in the pathway*’. The use of the word *‘better’* implies a positive value judgement, with *‘better management’* also suggesting a unidirectional approach in which patients are being managed and directed into a particular type of care, which will ultimately reduce cost.

The unidirectional and imposing nature of self-management was illuminated in comments made by Jill who said:

‘The self-care agenda is critical not just to this contract’s sustainability. It’s critical to the system’s sustainability, so I would suggest that that’s a necessity whether it had been done in this contract, or had been done in any others’

Her reflection that self-care was *‘a necessity whether it had been done in this contract, or had been done in any others’*, implies this is something to be unilaterally imposed, regardless of context, based purely on financial sustainability. There is no sense that the CBIC patient group is predicted to receive special benefit from this model of care delivery, in fact the patient perspective is completely silent here.

Mary, too, expressed this unilateral imposition when she said the following.

‘If we do not get to a place where people take more onus on looking after themselves, or their community looks after them more, or the voluntary sector looks after them more, then as a model it can’t survive because of the reduced financial envelope’

Her listing of different sources of care emphasised that whatever form it takes, another source must simply look after these patients otherwise the service simply cannot survive. This echoes the sentiment expressed by Jill that it is not really about who is *best* positioned to care for patients, or considering this in relation to the different age, condition, and severity of the patients in question, it is simply about reducing pressure on the service to such an extent that financial sustainability is assured.

What can be seen here in both Jill and Mary's statements, was self-management beginning to be dislodged discursively from its association with the delivery of patient owned care plans, care co-ordination, empowerment, and placed purely within an economic narrative. There is no sense of achieving self-management through 'collaborative' and 'empowering' conversations, in which goals are developed as part of care plan with a care co-ordinator. This reflects the central argument in this thesis that the economic logic underpinning the IC policy discourse, which problematises poor public finances and demand, takes precedence through implementation. This also represented a discursive shift from cost savings attributed to reduced fragmentation and shifting the cost of care from the acute into the community, to one in which individuals become the targets of power in the form of responsibilisation. The financial efficiencies acting as a material reality, set a backdrop for why ideas around treating patients as experts, providing choice in how care is delivered and collaborative decision-making, associated with empowerment discourse featured relatively little in the interviews. Whilst, as argued by Jones (2018b) and Petrakaki (2018), the empowerment discourse is still used to shape responsibilised patient subjectivity, the enactment of the empowerment discourse involves working dialogically with patients and takes time to implement, with results not necessarily meaning a reduction in service use that accommodates the financial savings needed.

5.6.2 Central problematisations and the construction of desirable and undesirable subject positions

LPIs constructed several problem contexts which acted as barriers to achieving self-management. These included the nursing professional identity which was seen as overly paternalistic, staff's reasoning and decision making which needed to be regulated by systems and processes, and patients who are too dependent on health services. These problematisations involve constructing certain desirable and undesirable subject positions that furthered the political and normative aims of reducing resource pressure and reformulating the distribution of responsibility between the health service and patients. These problematisations provided legitimacy to the CBIC by individualising the problems to be overcome, rendering them at least potentially amenable to change.

5.6.3 Nursing Identity

The first part of the work to construct the nursing identity as problematic was to position it relationally to a favourable therapy identity. The therapy identity was considered to embody those positive principles of *'asset based'* care which support patients to achieve their goals. Bev described the differing professional approaches below:

‘Certainly in the nursing services. I think what we’ve got in therapy services is a much more proactive approach to asset based. I’m not here to do for you. I’m here to support you to achieve the goals that you want to achieve and at some point I’ll be walking away, and I think that’s what we’ve got to instil in our nursing staff. So actually doing it in this way, it’s not a bad thing because we’ve got some real test cases and case studies within therapies that actually we can support our nurses to get round the concept’

The failing is clearly within the nursing staff as a profession, and this is placed in contrast to therapist who are described as *‘proactive’*. Therapists are those who use their initiative to support others to achieve their goals, and so inculcate an ‘empowerment’ approach into their care. This was one of the few instances in which the empowerment discourse was drawn upon in the LPI interviews and seemed to be used mainly in problematising the nursing profession. Bev also says that this approach to care involves at some point *‘walking away’*, which is reflective of emphasis on supporting patients *‘to discharge and self-management’* found in the tender and training video. The assumption here is that care should also be orientated towards discharging patients and *‘that’s what we’ve got to instil in our nursing staff’*. The use of the word ‘*instil*’ has disciplinary connotations, such as instilling good behaviour in children, and implies that this way of thinking needs to be firmly embedded within the minds of nurses who are currently not focussed enough on discharging patients. Therapists can then be used to ‘*support our nurses to get round the concept’*, which almost implies that nurses may struggle to understand what for them is a difficult idea. The use of the possessive pronoun *‘our’* in relation to nurses, implies a level of ownership and protection, in the sense that they need looking after and educating as to the right way of delivering care, which may hold similar childlike connotations. This all works to position the nursing identity as problematic and relationally lower in the hierarchy compared to therapists, but in a way that emphasises lack of knowledge, as opposed to wilful neglect.

Professional practice within therapies is positioned relationally higher to nursing. However, it is also assumed that this style of care is easily transferable to a nursing context. The only barrier to be overcome is the nursing mindset and attitude to care. The patient-clinician interaction described in the quote presents a form of responsibilisation where both patient and clinician are active and responsible for their own behaviour, with therapists supporting patients to achieve their goals, but at some point walking away. In this sense, both clinicians and patients are fulfilling the neo-liberal ends of government through their personal behaviours (Miller and Rose, 2008; Pyysiäinen *et al.*, 2017).

The workload differences between nurses and therapists and how this may impact on their ability to set goals and case manage patients is alluded to by Senior OCC Manager, Mary, but this again is secondary to the need for mindset change.

‘I believe as well we are quite a long way short of our own staff and other people outside of OCC staff really understanding what case management means. That’s not so obvious, in terms of the therapy staff. They have managed cases better and for longer. They’re much better at working with patient goals and actually agreeing with patients what their goals are. The district nursing service in particular over quite a long period of time now has been very focussed on getting out there doing

something to a patient and then coming back. Their workloads are very much much higher than the therapy staff, and so what you've got is a district nurse having a rota of seeing between when we set off between 25 people a day and so they literally went bump, bump, bump. That's were we've got a really big challenge to come in terms of focussing spending a bit more time thinking about the preventatives, thinking about the interrelationships with other stuff that's out there. They are very much in the mindset of still, in I go, sort it out, out I come.'

Again, Mary privileges therapy staff through their ability to be *'much better at working with patient goals'*, with her praise of goal setting drawing on the active and self-motivated elements of the empowerment discourse. Whilst at the same time, stressing the extent to which nurses have a higher workload than therapist by using *'very'* and then repeating *'much'*. This higher workload is described as necessitating their visits being conducted in a short amount of time, continuously, and in quick succession, indicated by *'bump, bump, bump'*. However, responsibility for not being able to effectively set goals and draw in links with other services is placed back on the nursing *'mindset'*, despite acknowledgement of these factors.

5.6.4 Problematising staff decision making

Whilst the discursive focus in the quotes above centred on encouraging nurses to inculcate the empowerment discourse into their professional identity and ways of (inter)acting in their role, there was some indication that due to the difficulty of aligning the nursing mindset with organisational aims around self-management, more was needed in terms of systems and processes which would guide them into the *'right'* way of doing things.

'So, we've got to have the systems and our processes lined up that intuitively makes staff do the right thing. So, we're just about to embark on this in terms of scheduling. So historically, district nurses pretty much have referrals come and this patient will need with no intention of discharging that patient or no real clear plan, unless there's a very specific, patients come in they might have had a really big operation and the district nurses are going in for a very discrete piece of time to care for their wounds or whatever. At some point that patient will heal and they'll be off the books. The other scenario is the patient that might come onto the books who has got really horrible leg wounds, or they might be a diabetic, insulin dependent diabetic whose housebound. And I think what we've done historically is well I'm going to be with this patient forever. Where actually what we should be doing is educating the staff, educating patients and the system. But also setting about the process of patient comes into the system. We deploy a member of staff and at that first appointment you might give them a two-hour appointment, reduce it down over time so actually staff don't need to think about it, intuitively they are forced into the right way of doing things, and all of that needs system change. It needs education of the staff and the population so it's massive (Bev, OCC Senior Manager)'.

The first line in the quote above, *'we've got to have the systems and our processes lined up that intuitively makes staff do the right thing'* suggests that on their own, staff may have difficulty in coming to see their own professional desires, preferences, and practices in line with organisational discourse, in a way reflective of governmental power. To reinforce this idea, a binary is presented between keeping someone on the books forever, which sounds extreme and potentially undesirable and the right way of acting which is reducing the appointment down. Ensuring that staff *'don't need to think about it'* and that visits are automatically scheduled so that time is reduced, is the most effective way to achieve the right course of action in relation to care. In this sense, it is still nurse's reasoning and decision making, i.e. their mindset, that is problematic, but it is assumed that due to the difficulties of ensuring they engage in 'practices of the self' (Foucault, 1988, p. 28) to align with organisational aims more invasive forms of organisational control need to be implemented, in addition to influencing nurses through training or organisational culture.

5.6.5 Problematising national culture

In section 5.6.1, I argued that the primacy placed on achieving financial sustainability through self-management, saw LPIs begin to discursively dislodge self-management from its associated with improvements in patient care, construing it purely within the underlying neo-liberal economic logic of the IC policy discourse and the empowerment discourse. In section 5.6.3, Bev and Mary made some reference to the need for nurses to inculcate 'empowerment' within their professional identity and practice. However, discussion of problematic dependent patient behaviour discussed below, drew solely on responsibilisation, once again moving self-management away from placing patients in positions of power and control. Firstly, patients were construed as part of a national culture that is overly dependent on public services. However, problematic national culture was also mixed in with the personal failing and defective behaviour of patients themselves, where is it clear that they also hold a level of agentic responsibility for being too dependent on the care being delivered to them.

The OCC CEO, Vicky, describes the situation in which those who are suffering from pain want to see a consultant and to be referred for surgery, but are unhappy when they are referred to the community physio service instead.

‘So, if you look at people with long term chronic pain. People who’ve had it for years and years and it’s really difficult for them to manage. We’re trialling different ways of dealing with that. So, we actually encourage people to come along to group sessions where they meet other people with the same conditions and actually, I can get a complaint in. We’ve had a few around pain particularly because they go to their GP and they might say well I’ll refer you to the consultant. They come into the system and we then bring them into a group and they’re saying I thought I was going to see a consultant and instead I saw a physio. And I thought I was going to be put on a waiting list for some sort of surgery and actually you’re making me attend some group sessions and it’s not necessarily what I want. So, it is complicated, and I think we’ve grown up in an NHS where people expect solutions. They expect quick fixes really and with some of these things there aren’t any. It involves effort on an individual’s part and that can be quite difficult to swallow sometimes’

She identifies a national culture in the UK, deriving from the NHS which involves the expectation of solutions. However, there is also a negative construction of the lack of individual patient responsibility in that *‘they expect quick fixes’*. They are also unwilling to accept the *'effort'* that needs to be put in, as this *'can be quite difficult to swallow sometimes'*. This implies that their expectation of '*quick fixes*' is unjustified, and fault lies with them for not putting in the required *'effort'*. Whilst acknowledging that some of the responsibility for this 'problematic' patient behaviour arises from the NHS itself, the language used to describe patients clearly assigns agency and responsibility to the patient themselves. Patient's inability to put in the effort required and their resistance to this through finding it *'difficult to swallow'* has the implication that they are lazy and lacking in personal motivation. Patients are therefore framed within a negative subject position that is rooted in dependency on public services and are blameworthy on these grounds.

CGG manager Jill, also places some of the responsibility on the way in which services have previously been delivered when she says, *'I think we've conditioned our patients to expect a maternal/paternalistic delivery of services where they are quite passive in them.'* Responsibility for resistance to the self-management model of care then shifts to the patient themselves. She described self-management as *'uncomfortable for some people. It's not what they believe they pay their taxes for. You know they want to be cared for, rather than having to do it themselves. Or they want to be medicated.'* Similarly, therefore, to Vicky, Jill identifies an issue with the way that the NHS has moulded patients into this passive position, and then switches to place responsibility firmly with patients. She also repeats the pronoun *'they'* and *'their'* to provide emphasis on where responsibility falls. Her comments about patients wanting *'to be medicated'* creates an image of a passive docile patient on the receiving end of medication in which they put no effort in themselves.

5.6.6 Ways of interacting between clinicians and patients

So far, LPIs have problematised the current nursing identity as paternalistic, whilst encouraging them to inculcate the *‘asset based’ ‘empowerment’* approach associated with the therapy profession into their professional identity and practice. They have also constructed the patient population as part of national culture which is overly dependent on public services. Despite the reference to *‘empowerment’* through a focus on goal setting, this appeared to perform most discursive work in problematising the nursing profession, with LPIs making no reference to *‘treating patients as experts’*, *‘collaborative decision making’*, and tailoring *‘input to their needs, goals, appetite, and capabilities’* articulated within the Business Case, tender, and training video. Instead, self-management was framed within the economic logic underpinning the IC policy and empowerment discourse that presented it as a solution to poor public finances and demand. Within this context, the interactional dynamic encouraged between health professionals and patients is one in which patients are convinced through *‘difficult conversations’* to adopt responsibilised subject positions.

In the below quote, Vicky, describes the scenario where health professionals *‘go in, encourage them, help them do it for themselves, or take some responsibility for what they’re doing’*.

‘It’s quite easy to go in, do something to somebody and then come out. Rather than go in, encourage them, help them do it for themselves, or take some responsibility for what they’re doing. That can be more labour intensive at the start rather than the

straight-forward treatments. So, we've got a long way to go. I don't think we're anywhere near understanding which conditions really benefit from self-care and which outcomes are better against others that may not show any improvement. And also, sometimes especially with the older patients, they're quite happy to be done to, and so you have to convince them that them doing it themselves is the right route.'

Vicky's description of this interaction differs from the claims made in the tender where *'Patients and carers will be treated as experts in the design, delivery and evaluation of their care'*, which implies that the ideas and decisions arise from the patient themselves. Vicky's scenario is, instead, a unidirectional intervention where the health professional is doing something to the patient, i.e. getting them to take responsibility. She admits that they do not have a clear understanding of *'which conditions really benefit from self-care'*. This contrasts with her assertion that *'sometimes especially with the older patients, they're quite happy to be done to, and so you have to convince them that doing it themselves is the right route'*. Being unclear about whether self-care generates any benefits to patients, switches in the next line to having *'to convince them that doing it themselves is the right route'*. Similarly, to Bev's comment relating to *'better'* management of the population, a positive value judgement is made that this *'is the right route'* despite no clear indication that this provides a positive outcome for patients. Given the lack of indication about which conditions benefit from self-care, *'the right route'* appears to be a normative claim about patients taking a greater level of responsibility to meet the sustainability aims outlined in section 5.6.1.

Within this, health professionals are being encouraged to shape responsibilised subject positions through their interactions with patients, which were described by LPIs as *‘difficult conversations’* requiring *‘resilience’* and *‘confidence’* from staff. Vicky said that *‘you have to convince them that them doing it themselves is the right route’*, whilst Jill talked about how *‘it’s difficult to persuade people to make the changes’*. Mary added that *‘we recognise we’ve got a massive challenge in changing the minds of those people who’ve had it done to them for a long long time’*. The central premise is that patients need to be convinced, persuaded, or have their minds changed to adopt favourable subject positions through patient-clinician interactions.

5.6.7 Critical Programme Theories

So far, I have analysed the way in which LPIs linguistically constructed self-management within their interviews and how this language drew on discourse at the interdiscursive level. Through this analysis, I have begun to demonstrate the way in which favourable professional identities, subjectivities and ways of interacting were delineated within this discourse. By drawing on the DRA, I view these discourses realised linguistically, as being both socially structured by the discursive and material context, as well as having the potential of being dialectically transformed into materiality, identities, and ways of (inter)acting at the level of practice. On a theoretical level, I have borrowed from studies of neo-liberal governmentality to argue that if operationalised, discourse realised linguistically, could shape health professionals and patients through ethical subject positions that work to reproduce governmental aims. Based on the above analysis and findings from the academic literature, I will now develop critical programme theories, which help to think through how these discursive assumptions may be enacted and operationalised within implementation of the CBIC.

In the analysis above, LPIs dislodge self-management from its discursive linkage with care co-ordination and empowerment to construe it purely within its neo-liberal economic rationality. Within this discursive frame, the nursing professional identity and the patient population are delineated as problematic in their paternalistic and dependent attitudes, respectively. At the level of implementation, the assumption that the professional identity of nurses and therapists can be standardised into a more independent and responsibilised form, leaves out consideration of certain contextual differences between the professions that may create problematic implementation effects.

Firstly, community nurses provide care largely in people's homes to housebound patients, but they also treat patients in care homes and clinics. They perform a range of nursing duties, such as administering injections, palliative care, wound, catheter and continence care, and medication support. Their patients include those who have recently been discharged, or those with chronic, long term conditions (QNI, 2021). By contrast, those in the community rehabilitation team deliver both physiotherapy and occupational therapy in people's homes to support patients to able to perform daily living activities, usually following injury or surgery (CSP, 2021) meaning that the types of care interventions differ quite considerably between the teams. High workload, staff shortages and burnout are also highly prevalent in community nursing (Drennan, 2019; Lalani *et al.*, 2019; Dall'Ora *et al.*, 2020), with lack of time being found to be one of the main barriers to nurse's implementing self-management (Young *et al.*, 2015; Van Hooft *et al.*, 2016; Lenzen *et al.*, 2018). High caseloads have also been found to lead nurses to feel overburdened which dampens morale and quality of care (Lalani *et al.*, 2019). Focussing on mindset change deflects attention away from these barriers and allows nurses to be treated as blameworthy, whilst being placed in a negative position compared to therapists. Following the link between professional identity and self-worth (Drevdahl and Canales, 2020) and McNeil et al's (2013) argument that professional identity threat can occur if one profession experiences differential treatment to another, I have developed the following CPT:

4. *If nurses are on the receiving end of resources that diminish their professional identity or professional practice and place it in a lower hierarchical position to therapists, they may experience considerable professional identity threat and alienation from their work*

Jones (2018b) explored training for frontline health staff on how to conduct 'motivational interviewing' with patients and Waring and Latif (2018) studied GP/Pharmacist interactions with patients to improve medication self-management through the lens of Foucauldian governmentality and pastoral power. In both studies, health professionals are to act as the conduits for governmental discourse by adopting 'pastoral subjectivities', which seek to shape and guide patients into making responsible choice for their own health. Despite criticism in the critical self-management literature (Wilson, 2001; McDonald *et al.*, 2007; Jones, 2018b; Petrakaki *et al.*, 2018) of the neo-liberalism inherent within the empowerment discourse and its deployment in justifying a withdrawal of state intervention, as well as my argument in chapter 2 that discourses of ‘patient-centredness’ have themselves been linked with political agendas around increasing choice, competition and cost-cutting (Speed and Gabe, 2020), there is evidence to suggest that these kind of self-management patient-clinician interactions can have a positive impact on patient experience.

These benefits include increasing motivation and reducing stress for those suffering with multimorbidity (Abadi *et al.*, 2021). This can occur when patients feel they have established a personal relationship with the clinician/health coach, that goals are developed collaboratively (Obro *et al.*, 2020), they are able to gain more knowledge about their condition, they can seek information, they feel supported and encourage and they experience kindness (Wang *et al.*, 2018). Furthermore, if the discursive attention to financial sustainability, at the expense of care co-ordination and case management, is operationalised, then there is little chance of improvements in patient care, with Hudon et al (2017; 2020) finding that for case management to be effective in increasing patient empowerment, improving communication, access, coordination, involvement in decisions and efficient healthcare transitions, case managers must ensure patients feel supported and respected through in person contacts. They must also be experienced, calm, dedicated and trusted case managers that have buy in to the process, whilst involving patients in the development of the care plan, considering their needs and prioritising what they want to address.

However, clinician-patient interactions in LPI interviews are constructed as clinicians imposing the need for patients to take responsibility for their care through '*difficult conversations'* that '*convince them that them doing it themselves is the right route'*. These conversations then have the explicit aim to ensure financial sustainability. Waring and Latif (2018), who argue that pastoral power operates at the 'nexus' of discipline and subjectification (Waring and Martin, 2016; Martin and Waring, 2018), characterised GP-patient interactions in their study as taking a 'discipling form, involving instructive orders and surveillance', whereas Pharmacist-patients interactions represented a 'softer, more subjectified form of pastoral power based on self-reflection, individualised guidance and the shaping of patient behaviours' (p. 1078). Even in the latter, the authors reported resistance from patients to these attempts. This suggest that the interactions described by LPIs, may either generate greater resistance from patients or simply failure to self-manage through lack of collaborative working and buy in on behalf of patients. This interactional dynamic could be exacerbated if health professionals accept that resistant patients are problematic on the basis of dependency, meaning they fail to appreciate wider contextual factors which have been identified in the literature as barriers to self-management, such as socioeconomic background, multimorbidity, lack of knowledge, and financial resources (Kousoulis *et al.*, 2014; Khairnar *et al.*, 2019; Hardman *et al.*, 2020). This could potentially stigmatise those from lower socioeconomic backgrounds, those with fewer resources and those suffering with multimorbidity, who have been found to have greater barriers to self-management, and lead to negative patient-clinician interactions that do not express the kindness and the personal relationships, found by Wang et al (2018) and Obro et al (2020), to be valued by patients.

On this basis, I have developed the following CPTs:

5. *If health professionals accept the instrumental goal of using self-management to achieve efficiency savings and increased patient responsibility within their professional identity and practice, then their conversations and interactions with patients maybe unidirectional and imposing, resulting in poor experience for patients and not having their views and opinions taken into consideration*

6. *If health professionals accept that patient behaviours and attitudes are problematic due to their lack of responsibility then this could engender negative attitudes towards patients and increase the chances of difficult interactions, resulting in a worse experience for patients*

Furthermore, given the contextual factors that influence patient self-management (socioeconomic background, multimorbidity, lack of knowledge, and financial resources) and the types of interactions that have been found to facilitate the process (feeling supported, kindness, working collaboratively, establishing personal relationships), if the problematisation of nurse' decision making is enacted through 'systems' and 'processes' which influence discharge decisions, then individual circumstances and needs may not be considered and worked through, which may facilitate self-management. This could result in an even more unilateral and imposing implementation of patients taking on responsibility for healthcare. On this basis, I have developed the following CPT:

7. *If visit times are automatically scheduled so the length and number of visits is automatically reduced then the ability of nurses to make professional judgement over patients and to take their individual needs into account is reduced. This may result in reduced ability to treat patients holistically*

5.7 Discussion/Conclusion

In conclusion, this chapter has discussed the way in which LPIs at the meso level of IC policy implementation, had discursively constructed a community based integrated care service. Analysis of the CBIC Business Case was used to explore the dialectical relationship between social action (of which texts are a part) within the CBIC case study, health and social care integration practice and wider politics and structure. I demonstrate how the CBIC was linguistically constituted and worked to reproduce the IC policy discourse which is hegemonic within health and social care practice. This discourse was constituted within a neo-liberal austerity structural context, which views health and social care in terms of economic cost and benefit, whilst also making claims to improve patient care. Continued fragmentation between community, social care, primary and mental health, resulted in a contract containing existing community services and some additional services that were moved out of the acute into a community clinic setting (i.e. pain management, outpatient physio). As such, I argue that the IC policy discourse was drawn on to legitimate putting community services out to competitive tender within a contract that contained year on year funding reductions. Therefore, working to reproduce the neo-liberal austerity structural context that the IC policy discourse was constituted within.

I then moved on to analyse LPI texts in terms of the potential ways in which the discourse (systems of meaning and ways of representing) realised linguistically through the texts may be dialectically transformed at the level of implementation into resources, responses in the form of identities/subject positions adopted, ways of (inter)acting, and effects for staff and patient experience. I argue that within the socially structuring context of the contract, LPIs gave most discursive attention to ‘integration’ at the level of professional roles and self-management as a way of reducing demand and dealing with funding constraints. Within these two examples, some appeals are made to providing improved patient care through reducing the number of fragmented homes visits experienced by multimorbid patients, as well as through having care tailored to their priorities and co-ordinated across a range of services. However, ultimately desirable subject positions, constructed by LPIs, for both staff and patients were based on neo-liberal ideals of being responsibilised, enterprising and empowered. This would work to drive through funding reductions and reproduce neo-liberal austerity at the level of practice. Finally, I propose through the development of CPTs how attempts to shape identities and ways of (inter)acting along these lines has the potential to lead to needs based and representational problems. In the next three empirical chapters, I build on these initial CPTs to develop explanations of what happened at the level of micro level implementation, when IC policy and its constituent discourses when enacted and operationalised within the practice of the CBIC.

Chapter 6 - Generic Working within Integrated Care Teams

6.1 Introduction

In chapter 5, I discussed how integration within the CBIC was centred on co-locating community therapists and community nurses into integrated care teams, delivering care within a particular locality. The vison expressed within LPI interviews and the tender documents was for members of these integrated care teams to be linked with GP practices within a *'team around the practice'* and for voluntary sector, mental health, and social care staff to eventually be linked within the teams. The vision was also expressed for all patients to have a named care co-ordinator, who would jointly develop care plans with patients, support them towards self-management, and conduct a single assessment across physical, mental health, and social care. In chapter 5, I developed CPTs focussed on the adoption of generic roles within the integrated care teams and self-management, as these were given most discursive attention and had the potential for needs based and representational problems to arise. However, as outlined in chapter 4, I kept my data collection in phase 2 broad enough to be able to capture these wider efforts, so as not to miss any theoretically and analytically significant findings within micro-level implementation. As it turned out, the dominant findings emerging from phase 2, reflected very closely those areas given most discursive attention by LPIs. Section 6.2 provides a summary of my findings in relation to integration between community, social care, mental health, and primary care before moving on to main focus of chapter, which is the implementation of generic roles for band 3 rehab and nursing assistants.

In the previous chapter, I demonstrated that generic roles were constructed by LPIs within the broader IC policy discourse by discussing them interchangeably with integration at the level of teams. They were also positioned as a solution to fragmented and disjointed care, as well generating process efficiencies. Through the articulation of these problem-solution pairings, LPI texts drew on minor discourses of holistic patient care and lean working. However, whilst LPIs still referred to integration between community services and social care at the level of generic roles, by the time I entered the field to conduct the main phase of the empirical work, any reference to community staff taking on social care tasks had been dropped, reducing the scope of what was construed as *‘integration’* even further. Furthermore, LPI texts had remained ambiguous about which staff would adopt generic roles, with references made within the CBIC training video, to *‘nurses’*, *‘physiotherapists’* and *‘community therapists’*. However, within micro-level implementation, organisational and managerial focus was instead placed on rehab assistant practitioners and nursing assistant practitioners at the band 3 level being trained in joint competencies to produce generic staff, whilst those with professional registration (band 5 and above) retained their existing professional boundaries.

In this chapter, I show how within micro-level implementation, generic roles were framed through textual resources within both the narrative of *‘integration’* and lean discourse. However, the construal of generic roles as providing benefits to patients by LPIs, remained as ‘empty words’ and references to *‘integration’* remained ambiguous (Chouliaraki and Fairclough, 1999, p. 29). Managerial resources introduced to frontline staff were instead, a direct enactment of lean discourse and its focus on identifying and reducing *‘waste’* from patient care. This I argue, is due to the economic logic underpinning the IC policy discourse and the ideological work it performs in furthering austerity. At the representational level, the CBIC Business Case drew on the IC discourse, which promises a wide range of benefits including improved patient care, to smooth over controversy with funding cuts and continued fragmentation between services. However, at the level of practice, the socially structuring effect of this material reality led the IC discourse to be enacted and operationalised through shaping health staff into professional identities and ways of (inter)acting that are focussed on driving through efficiency and cost cutting, whilst dislodging concern over improvements in patient care.

In section 6.3, I present my discourse analysis of two semiotic ‘points of entry’ (Fairclough, 2008) into my analysis of the organisational practice of generic roles within the CBIC. These include the September 2018 staff newsletter outlining the Transformation Projects and the integration meeting that I observed in the Greenfay locality, participated in by middle management and senior clinicians. In section 6.4, I evidence, using my interview and observation data, the managerial resources that were introduced to frontline staff. These resources focussed on eliminating *‘wasted intellect’* within rehab assistant practitioners, by using them to plug the gap in nursing provision. Training and resource were then directed towards retraining rehab assistants to acquire nursing competencies, especially insulin administration. Some nursing assistants received training in rehabilitation but only a small number were allocated rehab visits. Middle managers also sought to shape rehab assistants into adopting the subject position of the *‘ideal integrated worker’* by explaining the benefits and providing support. This support, however, was time limited before staff were expected to become compliant. In this section, I draw on theory from Waring and Martin (2016), Martin and Waring (2018) who have sought to expand the study of neo-liberal governmentality by drawing on Foucault’s pastoral power. In this way they show how intermediary professionals and managers within the health service take on the role of ‘pastors’ to encourage new subjectivities in target actors. They argue that the techniques they employ operate at ‘the nexus between subjectification and disciplinary power’ (Waring and Martin, 2016, p. 136). Pastors seek to use tools of observation and surveillance to get actors to internalise these subject positions, whilst using normalising judgement to punish or correct deviations from organisational norms. At the same time, they also employ subjectifying forms of power that encourage them to regulate and act upon their own identity in line with dominant discourse. I apply this theory to the role of middle managers who adopt the role of ‘pastor’ when employing both forms of power when engaging with rehab assistants.

In section 6.4-.6.7, I evidence through the context-mechanism-outcome heuristic how when these managerial resources were introduced into a context in which assistants, although not holding professional registration, held a strong attachment to their professional identity, they exhibited strong resistance to inculcating generic working into their identity, whilst in practice carrying out this role as part of day to day working. The perception of injustice response fired most strongly in rehab assistants because of the greater requirements to change their role. However, some nursing assistants reported perceiving that their skills were wasted on carrying out rehabilitation.

The CMO is displayed as follows:

1. In **contexts** where many of the rehab and nursing assistants have worked within the service for many years and/or have a strong attachment to their professional identity **managerial resources** which seek to eliminate 'wasted intellect' within the integrated care team by retraining assistant practitioners into generic roles are met with a perception of injustice **response** from staff, which results in loss of job satisfaction, workplace stress, alienation, and little positive change in patient care

In section 6.8, I discuss the findings presented in the chapter in relation to the CPTs developed in chapter 5.

6.2 Integrated care teams

During phase 2 fieldwork, community nursing and community rehabilitation had come together in what were termed '*integrated care teams'* across 4 localities (East Hallstone, West Hallstone, East Greenfay, West Greenfay). The 1% of the total CBIC budget ringfenced for work with the voluntary sector was used to fund two members of staff from Clearhedge Voluntary Support (CVS), who hot-desked in both Greenfay and Hallstone once a week, to liaise with OCC staff and take referrals into a social prescribing scheme (directs individuals to services, clubs, or support to meet their needs, such as loneliness and isolation). At the time of fieldwork, no other members of staff from external organisations were co-located.

At a semiotic level, the term ‘*integrated*’ was used to the describe the teams as well as two of the middle managers, whose titles were ‘*Integrated Care Manager’* for either Greenfay and Hallstone. From my observations in both offices, signs were placed above the desks, which indicated the locality followed by ‘*Integrated Care Team Hot Desks’*, which could discursively give the impression staff sat in different places at different times and in locations occupied by differing professional mixes. However, although co-located in the same office, both the community nursing and community rehabilitation team sat consistently in their professional groupings. Internalisation of this semiosis into actual working practices between the teams, although not unaltered, struggled to move beyond this discursive labelling and the physical co-location of the teams within the shared office space. Some senior clinical staff (band 6) reported that communication and collaboration over patient care had improved across the rehab and nursing team, with quicker patient referrals being actioned. Members of the community rehabilitation team at the band 4 associate level and band 6 physiotherapists/occupational therapists, reported some advantages from the nursing related questions on the new holistic assessment, as this enabled them to identify pressure sores on patients, who were then referred to through the nursing service. However, it did not appear that working practice had changed substantially within the teams, and many staff reported having very little interaction with the other professions, which I also found during my observations of the Hallstone and West Greenfay offices. Many staff even reported not knowing who the therapists/nurses were within their integrated care team. I often asked staff during interviews whether they felt like they were part of an ‘*integrated care team’* to which the answer was almost unanimously ‘*no*’.

The *'team around the practice'* concept had largely been disbanded. However, I discuss this, and integration with GP practices, further in chapter 8. Resources to facilitate greater integration with social care and mental health through the CBIC were limited, with staff discussing pre-existing barriers between closer working and patients being passed between social care and community, due to disagreement over budget allocation. I was told by frontline staff about the detrimental impact that lack of both resources and co-working with mental health and social care was having on patients. Matron, Adele, reported that when some of her patients hit crisis point she is left with no other option but to admit them into hospital because there is no social care available to support them in their homes.

Supporting my argument made in chapter 5 and the discursive attention given to these areas by LPIs, there was little change to the way in which community, social care and mental health was delivered, with the main resources being directed towards changing staff and patient behaviour in line with delivering efficiency savings. In the remaining part of this chapter, I therefore focus my analysis on resources introduced to create 'integration' at the level of individual roles, with the aim of expanding on CPTs 1, 2, and 3.

6.3 Textual resources

6.3.1 Transformation Projects: September 2018 staff newsletter

1. What is the purpose of, and context behind, this specific communicative event?

The *‘transformation team’*, made up of senior and middle managers, held *‘Service Redesign Workshops’* on 30th and 31st August 2018, where senior clinical staff (band 6) were invited to discuss possible ways of saving money. 5 *‘transformation projects’* were developed out of these workshops called *‘facilitated health and wellbeing project; model team; agile working; effective technology; and managing supplies’*. Information about the service redesign workshops and the transformation projects was communicated to the organisation more widely through the staff newsletter published in September 2018. The aims and intention of the work streams were also communicated to staff during two meetings that I attended during my time conducting observations in the Hallstone office. A suggestion box was placed in the office in which staff were encouraged to add cost saving ideas relating to the work streams. Noticeboards were put up in the office, which management claimed would be populated with the ideas that had come through from staff. The below analysis relates mainly to the September 2018 staff newsletter, as this was of most relevance to the implementation of generic roles.

2. What is going on specifically within the text and how do the linguistic features within the texts draw on discourses (ways of representing) at the interdiscursive level?

The transformation projects articulated through the textual resources all draw on a managerialist discourse of lean working (McCann *et al.*, 2015). Lean philosophy is concerned with implementing organisational practices to reduce waste and create value through processes to ultimately reduce cost (Waring and Bishop, 2010; McCann *et al.*, 2015; Rees and Gauld, 2017). It was communicated through all three textual resources that the 5 transformation projects were underpinned by *'waste watchers'* philosophy, with staff asked to be active in this process by becoming a *'Waste Watcher'* themselves. Encapsulating all 5 work streams of the transformation projects within the discourse of lean, served to group together a range of workplace issues under the banner of potential waste removal, including, as described in the newsletter, *'intellect, surplus stock or excess travel'*. The connotations of *'waste'* is that there are unwanted or excess processes in relation to these areas that can be removed. Once removed, it was claimed that this will add value and *'have a positive impact on our overall cost savings'*. The application of *'waste watching'* to these specific transformation projects reflected the narrow application of lean 'specific tools or techniques' identified by Radnor et al (2012), as opposed to a system-wide philosophy within the CBIC.

On page 6 of the September staff newsletter, the title *'Transformation and Innovation: Removing Waste, Transforming Care'* is followed by a paragraph summarising the projects. The word *'waste'* is repeated 6 times which provides emphasis to the reader on both the prevalence of this waste and the need to remove it. One of the five projects, called *'Model Team Project'* claims to use *''waste watcher' philosophy'* in the aim of *'reducing waste of staff intellect by ensuring that tasks are carried out by the most suitable individual'*. Although not a great level of detail is given here, identifying *'the most suitable individual'* is reflective of OCC Senior Manager, Bev's comments, discussed in section 5.5.2, that *'I might deploy a nurse, but the next week or in the same day a therapist might go out and then a social worker goes out, well actually completely wasting every bodies time'*. The *'most suitable individual'* is the clinician who conducts the first visit, with the additional visits creating a *'waste of staff intellect'*.

3. What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

The problematisation here is the *'waste of staff intellect'*, with *'tasks carried out by the most suitable individual'* removing professional attachment from tasks. There is no reference to the patient experience in this description, implying that the primary consideration is maximising output and reducing waste in process, regardless of impact on care.

4. What ways of (inter)acting between patients and clinicians are framed within these discourses? 5. What patient/clinician identities/subject positions are delineated within these discourses?

There is no explicit reference to the types of patient-clinician interactions enacted through lean discourse. As mentioned above, the patient experience is completely absent in this framing of generic roles within the newsletter, suggesting that the application of *'waste watcher'* philosophy in this way, will remain unimpactful from a patient perspective. In terms of health professional identity, we are told across all transformation projects that staff should adopt the role of *'waste watcher'*, suggesting staff are expected to be active in this process of identification. Within the *'model team project'* we are also told that *'This project will also create upskilling opportunities for staff, supporting career development'* suggesting that adopting the role of *'waste watcher'* in this context may require staff not only to be active in this process, but to perform a more advanced role. This text therefore begins to hint at the responsibilised (Miller and Rose, 2008) and enterprising identity (Du Gay, 1996) articulated for generic staff by LPIs in chapter 5.

6.3.2 Integration meeting

1. What is the purpose of, and context behind, this specific communicative event?

During fieldwork, I observed a meeting in the West Greenfay office, involving two middle managers (Michelle and Claire), senior band 6 nurse (Kath) and three band 6 physiotherapists (Kimberley, Addison, and Rebecca). I was told by Michelle that the purpose of the meeting was to review progress on integrated working across the rehab and nursing assistants and to plan future training for both West and East Greenfay.

2. What is going on specifically within the text and how do the linguistic features within the texts draw on discourses (ways of representing) at the interdiscursive level?

This meeting was titled the *'integration meeting'*, implying that at least discursively, generic roles were being tied within the integration narrative. Within the Greenfay locality, generic roles were also explicitly referred to as *'integrated roles'* and multiple references were made by attendees to those assistants with joint competencies as being *‘integrated’*, i.e. *‘I know they’ve all got to be integrated’*, *‘she has really good integrated experience’*, and *‘she’s the ideal integrated worker’*. However, this construal of integrating working was dissimilar to LPI texts, in that there were no appeals to improved patient experience through holistic care, with *‘integrated’* referring to simply the acquisition of additional competencies outside one’s traditional boundaries. Despite the linguistic references to integrated care, the discussion, which focussed on how best to increase the competencies of assistant practitioners, was more reflective of strategies to reduce *‘wasted staff intellect’* found within lean discourse. Similarly, to the staff newsletter, there was little mention of the impact on patient care, or the way in which these tasks could be combined to reduce the *‘disjointed’* and *‘confusing’* care that the CBIC training video claimed patients were experiencing.

The exception to this came from an exchange between me, Claire, and Michelle that took place just before the meeting officially began. The following fieldnote was taken detailing the exchange:

‘I took the opportunity to ask Michelle if she could assist with recruiting patients into the study. She asked which types of patients and I said I was trying to speak to those who access both the nursing and therapy service. She said they can identify this through looking at their clinical audits. But added that because of the auto-allocation system (Cbernet) they are not able to always to capture those patients who could be seen for both issues (both nursing and therapy) in one visit. Michelle said they are managing to identify about half of these case and the other half are being missed. Claire added that even for those who need both insulin and bloods, where both need to be done in the morning and both are within core nursing duties*, ‘sometimes insulins are being done and 10 minutes later someone else is doing the bloods’.* She turned to Claire and said *‘we really need to look into that actually’.* I asked *‘so is this issue exacerbated by Cbernet?’* They both responded that *‘yes, it is’.* Claire said *‘it’s not very easy to do an overview of what you’ve got’.* And Michelle followed with *‘sometimes you realise you’ve just missed one and it’s very frustrating.’*

Despite the linguistic construal of generic roles as *‘integrated’* working and the title of the meeting being the *‘integration meeting’*, these observations, which indicated that the Cbnernet system was working in antithesis to delivery of joint tasks in one visit, were not raised during the meeting with the other staff members. Furthermore, this revelation from middle management seemed to arise only because of my prompting. Michelle’s comment to Claire that ‘*we really need to look into that actually*’, suggested both an awareness of the original justification for the role change, whilst also reflecting a lack of attention to ensuring its implementation.

3. What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

At the beginning of the meeting, Michelle wrote up the names of 5 rehab assistants and 4 nursing assistants who have already begun the process of retraining in joint competencies. Most discursive space was taken up in the meeting by discussion relating to two areas 1) identifying additional tasks that those assistants can be retrained in and 2) deciding amongst the attendees, additional assistants suitable to begin the retraining process. The problematisation inherent within this process was spare capacity within these assistants and therefore the *‘waste of staff intellect’*. Linguistic attention was then focussed on identifying and setting in place plans to eliminate this waste through *‘upskilling’*.

This process of identifying wasted *‘staff intellect’* predominantly, although not exclusively, identified *‘waste’* within rehab assistants, as opposed to nursing assistants. The greater variety of nursing tasks compared to rehabilitation, lent itself to the continual addition of tasks put up on the board next to the names of rehab assistants. I observed that suggestions for additional competencies for rehab assistants sometimes appeared quite ad hoc, with Claire at one stage saying, ‘*you know in Hallstone they’re doing continence assessments too?*’, prompting the development of plans for continence training in Greenfay rehab assistants. Another example came when Kath and Claire advised that a requirement of fulfilling the late shift is to be trained in catheter care, which prompted another plan for those 5 rehab assistants to begin catheter care training. This ad hoc approach developed through linguistic exchange during the meeting seemed to be reflected of the ‘quick wins’ approach found by Radnor et al (2012) in their study of lean in the English NHS.

Silent in the meeting, and reflective of the managerialist and process orientated assumptions implicit in lean discourse (Waring and Bishop, 2010), was the impact of these workforce changes on patients. One reference to potential impact on patient care was made by band 6 physiotherapist, Kimberley, in relation to plans for rehab assistants to complete the late shift. However, this was quickly dismissed by the nursing middle manager Claire. I made the following field note:

'Kimberley (who is quite softly spoken and non-combative in manner), referring to plans for rehab assistants to complete the late shift, says that *'this needs to be looked at because exercise programmes have a set number of exercises during the day that need to be completed, so we would need to check capacity'.* She adds *'It's just something we need to be mindful of'* hedging her comment here, so as not to appear objectionable. Middle manager Claire responds very quickly with *'well if nursing are up and running then that would compensate for that'.* The speed and manner of her response serves to shut down this conversation. Kimberley responds with an *'ummm'* and the conversation moves on*.'*

This exchange served to highlight that more nuanced discussion and consideration of the role changes in ways that challenged the dominant organisational narrative of identifying wasted intellect in the rehab team was not given discursive space at managerial level.

4. What ways of (inter)acting are these discourse trying to enact between patients and clinicians? 5. How do these discourses try to shape patient and clinician identity?

During the discussion of identifying appropriate assistant practitioners to begin '*upskilling*', the main criteria expressed by attendees was those who can act as '*positive examples'*. In response to a suggestion made by Kath, Michelle responded, *'I'm just a bit reluctant to go with her because she's a bit negative in the office and she's always moaning'*. Evident in the process of seeking out '*positive examples'* and avoiding '*negative*' staff, was a favourable subjectivity in managerial terms, characterised by being compliant and even enthusiastic about holding a range of multiprofessional skills. At one stage, the group discuss a new starter who is described by Claire as '*very good'* with '*integrated experience'*. When Claire tells the group that she '*has worked for reablement and has social care experience*' the rest of the attendees look at each other nodding to indicate their approval of this person. Whilst going through the list of assistants, Kath says '*We almost need another Candice to be a positive role model because she was so enthusiastic'*. Candice is described as the '*ideal integrated worker*' as she can do all tasks and she has '*everything*' written next to her name on the board, in terms of competencies. In this sense, Candice is '*the ideal integrated worker*' because of the extent to which, and her enthusiasm for, being *'upskilled'* in nursing tasks with less of her intellect being wasted. The '*ideal integrated worker*' in this sense is reflective of the responsibilised neo-liberal subject in which staff not only take greater responsibility for additional tasks, but they come to see their own professional desires in line with dominant discourse in a true display of governmentalising power (Miller and Rose, 2008).

6.4 Managerial resources

6.4.1 Training implementation strategy

Similarly, to analysis of the *'integration meeting'* above, some middle managers still sought to frame generic roles within the narrative of integrated care within their interview responses. In particular, middle managers within the West Greenfay locality, explicitly described generic staff as 'integrated roles', '*We've got six staff that are now fully integrated that can do both roles'* (Zoey, middle manager). However, this framing within the integration narrative represented ‘empty words’ in relation to concern for improvements in patient care (Chouliaraki and Fairclough, 1999, p. 29) and was not internalised within managerial implementation strategy. Within the socially structuring context of resource pressure, resources introduced to frontline staff internalised the discourse of lean realised linguistically in the textual resources analysed above. These resources focussed on identifying and eliminating *‘wasted’* intellect in the rehab team that could be used to compensate for resource pressure in the nursing team. Managerial decisions were therefore made to focus their training strategy on rehab assistants acquiring nursing competencies, with little managerial focus on how these tasks could be put together during visits for the benefit of patients.

Middle manager, Katherine, describes below the way this was enacted through their implementation strategy:

‘Again, it's about every contact counting. When we started looking at this our first point of call was to up-skill our community therapist, the core. The core services as opposed to the hosted services. The core and it was let's get the therapy unregistered staff delivering competent in giving insulins, because it's the insulins that when you've got so many to do morning and evening, if you've got more people that can do it, if you've got more people who can get on with the rest of the jobs. That didn't come out of any logical, so you're getting a community rehab member staff going to see someone who's had a hip replacement and they need their clips removed. We didn't do the clips first or the wound care, we did the insulin because it was more about our pressure as opposed to what was logical. That was the start off. We will just do this and they did it’

It is clear from this quote that Katherine is aware that the strategy to upskill rehab assistants (referred to here as ‘therapy unregistered staff’) in insulin administration, does not reflect the original aim outlined in LPI texts, discussed in chapter 5, when she explains ‘*That didn't come out of any logical, so you're getting a community rehab member of staff going to see someone who's had a hip replacement and they need their clips removed’*. She goes on to say that the reality of pressures within the nursing service to deliver insulin injections was the principle driving force behind this strategy. What this demonstrates is how the material reality of the resource pressure placed on the nursing service had a structuring effect on the way in which lean discourse was enacted as organisational strategy on staff training. Her reference to ‘*every contact counting’* could easily relate to joint tasks within one visit in the way articulated by LPI, Bev, as eliminating ‘waste’. However, the organisational context operating within the CBIC and pressure within the nursing service meant that lean discourse was dialectically transformed into training rehab staff to deliver insulin injections.

This implementation strategy of eliminating *‘wasted intellect’* in rehab assistant practitioners to plug the gap in nursing provision was something also described by Michelle:

‘It was, yes. It was a difficult start. Also, we decided to start with a quick win, a quick task that we could help with. Actually, this was not so much about integration really. It was more about the pressures on nursing, with the insulin injections. They were constantly struggling to manage all of the insulins in the time period that it's supposed to be in, which is an hour to an hour and a half, from 8:30, and particularly at the weekends. It was felt that it was something that was easy to learn. Once you

did the classroom course, you could go out and do some competencies. It wasn't something that needs that little bit more time to develop, the reasoning behind it. You have a task, you were given it, and you do it thing.'

That was what was chosen, I think, from above us as something that we've all tasked to do, the rehab assistant practitioners. I think that didn't really help with that perception because that wasn't really true integration. That was helping with the nursing pressures. It was starting to upskill. Actually, it's very rare that you'd be seeing rehab patient at the same time that you are going to be giving them their insulin. If it was at the extremes of the day. Then, we had a kickback really from the assistant practitioners that felt that they were just being used for capacity.'

Michelle explicitly describes the reframing of generic roles from *'integration'* to relieving *'pressure on nursing'*. Furthermore, she casts doubt on the whether the practice of joint tasks is even applicable anyway, '*Actually, it's very rare you'd be seeing rehab patients at the same time that you are giving them their insulin'* suggesting not only, that the move to generic roles was less about reducing fragmentation of care and more about reducing resource pressure. But, that the problematisation of fragmented and disjointed care described in the LPI texts used to justify generic working, i.e. '*what we know is that patients tell us that they find the current set of services, disjointed and confusing*' worked more in terms of legitimation, as opposed to having an actual impact on patient care.

Although both Michelle and Katherine frame the emphasis on dealing with nursing capacity as something that occurred in the early days of implementation, further fieldwork highlighted that emphasis on relieving pressure in the nursing service continued through the progressive implementation of generic roles. Generally, resource mechanisms introduced to frontline staff were focussed on assimilating rehab assistants into nursing assistants. Although it was the case that 4 nursing assistants within West Greenfay had been retrained and were being allocated rehab visits. Firstly, by the nature and variety of tasks performed by the nursing service, changes to rehab assistant roles were much more onerous and extensive. Whereas nursing assistants had to be trained how to assist patients with fairly simple rehabilitation exercises, rehab assistants were learning how to do all or some of the following: administering insulin injections, treating wounds, taking blood, performing eye care, and conducting continence assessments. Furthermore, during the time of fieldwork, rehab assistants working hours were changing to be in line with nursing assistant practitioners, to enable them to be available to complete tasks across the 24/7 nursing service. This involved a staggered approach in which the hours were changed to include 8.30am to 5pm from 1st July 2018, 1.30pm-10pm from 1st January 2019, and the night shift of 9.45pm to 7.30am from 1st August 2019 (OCC hours consultation document).

6.4.2 Shaping favourable subjectivity

It was demonstrated in section 5.5.3 in the discussion of LPI texts that those who resist the move to generic roles are problematised in terms of their self-interested preferences and failure to fulfil their duties to vulnerable patients. CPTs 2-3 expressed concern that enactment of these assumptions could be problematic in respect of creating resentment, intensification, and professional identity conflict for health professionals. Given the way generic roles were largely dislodged from their association with delivering ‘holistic’ care within micro-level implementation, middle managers placed less emphasis on duties to vulnerable patients, and in the main presented resistant assistants as problematic in terms of exhibiting self-interested preferences, their age, and their confidence levels. As identified within analysis of the *‘integration meeting’* presented in section 6.3.2, the *‘ideal’* assistant practitioners was construed as someone who is flexible and enthusiastic about holding a range of multiprofessional skills. The data from my interviews with middle managers revealed that they used a range of strategies, to try to shape assistants into adopting this subject position, whilst individualising any barriers to implementation at the level of frontline staff. This worked to move responsibility for implementation issues away from organisation/management, reflective of concerns expressed in CPT1, legitimising inflexible implementation with the hope that resistant assistants would simply leave to make way for a newer more compliant workforce.

Despite the training resources directed towards assistants dislodging concern for improvements in patient care from the notion of *‘integrated roles’*, there was evidence that middle managers, taking on the role of ‘pastor’ (Waring and Martin, 2016; Martin and Waring, 2018) sometimes drew on the power of the IC policy discourse when attempting to shape and guide assistant practitioners into adopting favourable subject positions. In the quote below, Hallstone middle manager Denise, describes how through ‘*explaining the benefits’* band 3 assistant practitioners move from their resistant position based on self-interested preference, to the right and moral position of appreciating the wider patient benefits generated by *‘integration’*.

‘So they might..it’s normally quite unambiguous really, so they’ll say well I’m a physio and that’s what I wanted to do. If I wanted to do x,y,z, I’d have trained to do x,y,z. If I wanted to be a nurse, I’d have trained to be a nurse. This is why I went in. This is my profession. That is what I want to do. But by explaining the wider system and explaining how health care needs to work across the health economy and explaining the benefits of (CBIC) and integration they are gradually coming to terms with it and as time’s gone on, they have understood and appreciated first-hand the benefits that that can have for a patient. So instead of working in a silo by being able to add more value to their visits. They’ve seen the value of that now first-hand’

Denise describes the journey taken by the assistant practitioners from a position of objection, which was *‘quite unambiguous really’*, implying it is not open to interpretation or nuance. She illustrates this position using a series of comparative clauses that presents their justification as arising from fairly simplistic reasoning, ‘*if I wanted to be a nurse, I’d have trained to be a nurse’*. Her repetition of the pronoun ‘I’ reinforces the idea that this reasoning arises from purely self-interested motivations and is reminiscent of LPI Jill’s construction of self-interested resistant assistants. These objections are positioned as arising from preference for work or professional boundaries, reasons which are not considered legitimate. Denise emphasises her pastoral role through by ‘*explaining*’ the benefits to frontline staff in terms of patients and the wider health economy.

Staff on the receiving end of these explanations ‘*have gradually come to terms with it’*. The movement from the self-interested and simplistic perspective to one in which the benefits of integration in terms of patient care are accepted takes time.

Emphasising the subjectifying nature of Denise's interactions with her staff, they are also described as having '*understood and appreciated first-hand the benefits that that can have for a patient*'. The process described by Denise, is therefore, one in which staff are focussed purely on their own needs and preferences to one in which they are then able to move beyond their own self-interested desires to consider the benefits for patients, acting upon themselves in line with an ethical subjectivity (Foucault, 1988). The weight of this argument comes from the moral force of putting one's own desires aside to consider the needs of others and adopting one's own professional practice in line with the ethical frame of integrated care.

In another part of her interview, Denise problematises the older staff as struggling most with the changes.

'But I would again in the unqualified bandings, the APs, we have certainly had staff who are older, who have been just one role for a long time and are not willing change and they can't appreciate that change and then they decide to leave. So we haven't always won'

Denise presents these older members of staff, in opposition to those she discussed earlier, as those who have not been able to get past their self-interested position to the moral position that provides most benefit for patients. The end result is that these staff have left and the organisation '*haven't always won*' in their attempts to shape assistants into adopting favourable subjectivity. The sentiment that middle managers are willing to take on a supportive 'pastoral' role in shaping favourable subjectivity, but only to certain point, was also reflective in comments from Fiona, who works as middle manager alongside Denise in Hallstone:

'*Again, it's something that Denise and I have worked really really closely, and we are very much in agreement that they need to get on with it. Because it's a confidence thing and if they don't push themselves to do it then there will always be something that's stopping them doing it. They've always got someone they call, so it's just about reinforcing to them, 'you're fine, you're doing ok' 'If you don't understand something, just say'*

Similarly, to Denise, Fiona also presents management in a 'pastoral' role through being available on the phone to offer advice and support, *'if you don't understand something, just say*'. However, she also indicates that ultimately it is the responsibility of the assistants to '*push themselves to do it'*. Whilst also suggesting that there is a time limit to managerial patience and that assistants '*need to get on with it'*. Both Denise and Fiona suggest that there were no issues with the level of support and training that assistants had received. Instead, choosing to frame any barriers in individualised terms by problematising clinician's '*confidence*' and '*age*'. The 'pastoral' role adopted by Denise and Fiona represents a governmentalising form of power in which they seek to encourage staff to adopt generic roles through their own will (Martin *et al.*, 2013). In this sense, assistant practitioners become responsibilised and empowered by adopting their professional practice in line with the ethical demands of integrated care and pushing themselves to overcome their confidence issues.

Greenfay middle manager, Michelle, also individualises barriers to assistants successfully taking on the generic role by constructing objections to generic working in terms of preference for work. In the below example, an assistant who is happy to do venepuncture (withdrawing blood) but has a severe stress response to wound care is characterised as exhibiting a preference. This works to delegitimise workplace stress as an acceptable objection to a change of job role.

'She's happy to do that but she's pushed back a lot saying, "Is there any way that I can be excluded from it? I really hate it. I never wanted to work with wounds. I find it disgusting. It makes me sick. It's making me feel really stressed." She's got eczema and said that her eczema was getting worse and she was getting stressed out I think. With her, I just said that "Look you've got the opportunity to go to occupational health, you can self-refer." I said, "If you feel that really strongly, you can speak to an HR advisor about it.

She did approach the HR about the role and ask if she could be excluded. Now, they spoke to me and said "Is there any way that this can't happen? I said, "It really--" If we exclude one person just because of a preference, we can't really, we can't really allow that. Otherwise, other people, they would be able to come also and say "I can't do this. I can't do that." It would really be difficult '

The use of '*preference'* is indicative of a slight like or dislike and so agency is placed on this employee for choosing not to want to fulfil that aspect of the role, enabling their claims to be more easily dismissed by management. It is true that we are in part in control of our stress responses due our inner dialogue. However, we would not normally characterise a severe stress response that exacerbates an existing medical condition, as a preference or even a choice. This is a discursive move that problematises the individual and allows an equity claim to be made on behalf of those staff who have retrained. It also works to silence any claim that the clinician may have to be exempt from that particular task and moves responsibility away from management to deal with the issue in any flexible way. The managerial enactment of individualising this barrier is that Michelle is able to take a hard line in not allowing an exemption for wound care. The assistant is advised to go to Human Resources or Occupational Health indicating that dialogue on a managerial front has been exhausted and that options for the assistant are narrowing. Here, the assistant is encouraged to become responsibilised for her stress response and any difficulties associated with the role change. But Michelle employs her 'pastoral' role in a discipling form by assessing and judging the assistant's *'preference'* for not fulfilling the generic role, as not adhering to the favourable subject position of the '*ideal integrated worker'* who is enthusiastic about eliminating their *'wasted intellect'*. She then declines the request limiting the assistant's options going forward. This reflects what Foucault (1991a) described as 'hierarchical observation' (p. 170) and 'normalising judgement' (p. 177) in which subjects are first gazed upon, assessed and then punished for infractions from the norm.

6.4 CMO - 1

In **contexts** where many of the rehab and nursing assistants have worked within the service for many years and/or have a strong professional attachment to their role **managerial resources** which sought to eliminate 'wasted intellect' within the integrated care team by retraining assistant practitioners into generic roles are met with a perception of injustice **response** from staff, which resulted in loss of job satisfaction, workplace stress, and alienation, and little positive change in patient care **(outcome)**

6.4.1 Contextual factors relating to professional identity and role

The context that the training implementation strategy and attempts to shape favourable subjectivity were introduced into was one in which many of the rehab assistants had worked for the service for many years. Having reported enjoying their previous role and displaying a strong professional attachment to the rehab team, these members of staff reported a strong perception of injustice to the changes and the way they were being implemented. The nature of the nursing service is that the types of care and tasks delivered are more complex and intimate than rehabilitation, so the requirements were much more demanding for rehab assistants than for nursing assistants. Rehab assistants had also previously enjoyed a lower workload than nursing assistants (8-10 visits compared to 15-20 visits). Nursing assistants also expressed a strong attachment to their professional identity and the nursing team but given that the demands to change their role were more limited, they did not express the same level of resistance. By contrast those that did resist felt their skills were being wasted on rehab.

6.4.2 Response mechanism - perception of injustice

The perception of injustice characterises a wide-spread response from the assistant practitioners interviewed in this study who strongly rejected adopting the role of the *‘ideal integrated worker’* who was empowered and responsibilised to eliminate wasted intellect through *'upskilling'*. Specifically, rehab assistants rejected being responsibilised for taking on the burden of *'integration'* and for the difficulties associated with the role change. Instead, they described feeling anxious and disorientated whilst carrying out these duties and sought to reaffirm their previous professional identity, with nursing assistants viewing generic working as wasting their expertise.

a) Taking on the burden of 'integration'

Some rehab assistant practitioners reported that they felt that they were taking on the burden of what was considered *'integration'* in the organisation.

'It was frustrating first of all when we went through that and I think, as well, when we started doing the insulins it was like we were sold this as integration, but all that we could see was us integrating, we couldn't see anybody else doing anything back. I don't know whether that would have sort of softened the blow, but you kind of thought, "Why is it just us?" (Diana, AP)

This quote from Diana expresses her response to the discursive shift in the way that generic roles were framed within the organisation. In Diana's view *'integration'* requires reciprocal behaviour from the other members of the integrated care team. Note how Diana's response indicated a greater concern with parity of process, as opposed to impact on patient care. Nevertheless, Diana experienced the managerial resources she was on the receiving end of as a confusing interdiscursive mix between integration and the elimination of wasted intellect on the rehab team. Her reference to being *'sold this as integration'* may refer to middle managers *'explaining the benefits'*, as described by Denise. This speaks to the disconnect between framing generic roles as *‘integration’* and the implementation strategy described in 6.4.1, which generated a perception from assistants, such as Dianna, that they are being unfairly burdened with the requirements of *‘integration’*.

Laura describes below a similar feeling of injustice that rehab assistants have been both disproportionately and negatively affected by the changes.

‘I know everywhere is changing within the care industry, and job roles are changing. It's got to change, I know, but it's the way it's been done because I think the APs-- and I know people higher up have been through stuff, but the APs have really took a hammering with this (CBIC). We lost our palliative of care, then we lost our weekends. We lost our lates and stuff like that. Then all of a sudden, now you've got to do it again. Now you've got to do this. Now you've got to do that, and that's all we've heard right through the whole-- We've had to reapply for our jobs, we've had to-- It's so much like someone at the top has made a really bad- made a decision, but not thought it through so the ones at the bottom are the ones that have suffered. Oh no, I forgot that, we need to add that in. I've got to do this, and I just feel like each time it's been the assistant practitioners have got the blunt end of it (Laura)’

She emphasises the extent and the rate of changes they as rehab assistants have had to endure through her repetition of ‘*now you’ve got to do it again. Now you've got to do this. Now you've got to do that*’. Her description that the assistant practitioners were taking a ‘*hammering*’ and getting ‘*the blunt end of it’* presents her experience of the ‘inequitable implementation’ resource through violent imagery. It also suggests she perceived rehab assistants to be under disciplinary and punishing tactics employed by management, as opposed to being guided and persuaded. Certainly, her perception of the ad hoc nature of the changes and the lack of a strategic vision is reflective of my impressions when observing the integration meeting and the ‘quick wins’ approach found by Radnor et al (2012). The identification of potential wasted intellect within the rehab team, in the form of potential nursing tasks that could be added to their repertoire, was being done on a reactive basis, as and when, waste was identified. This operationalisation of lean discourse exacerbated Laura’s perception that they, as rehab assistants, have been unfairly burdened and responsibilised for the CBIC service change compared to other members of staff.

b) Breaking the terms of the agreement

For rehab assistants, there was a general perception that it was simply unfair that they should have to change their role when they had not applied for a role in nursing. This sense of unfairness meant that they resisted becoming the *‘ideal integrated worker’* and instead reaffirmed their current professional identity.

Erin describes below her dissatisfaction on a basic level with having to change her role. The first line indicates what she perceives to be her powerlessness in the face of the workforce changes, before going on give her main objection in a speech pattern very similar to that presented by middle manager Denise, *‘If I’d wanted to be a nurse, I would have trained to be a nurse’*. This unambiguous statement provides a firm rejection of inculcating nursing into her identity.

‘Well, yes, but I just feel we're told anything just because that's what's going to happen. Nothing we can do about it really. I do feel, I think we all feel that obviously, this is not what we signed up for either. We're being /nurses, and nurses do a lot of training, and I think we're not getting adequate training really for what we're asked to do. If I'd wanted to be a nurse, I would have trained to be one. It is a totally different job role’

For middle managers, whilst expressing some sympathy, objection on the basis that this was not the job role they applied for, was not considered legitimate as justification for exemption. For assistant practitioners, however, this was a feeling of injustice that was hard to move beyond. Despite being without professional registration, many of the rehab assistants had a strong attachment to the therapy professional identity and the rehab team they belonged to. An unexpected change to this role for which they had not applied for felt like an affront and an unjust course of action by management. Laura provided a very specific example of the terms of the agreement being broken when she describes the move she made from working in West Greenfay to East Hallstone.

‘I had to come for an interview, I had to apply for the job in Hallstone, and I went for the interview and I went for a rehab interview because I belong to rehab. I’m an assistant practitioner which is rehab. I then got a phone call about two weeks before I was due to transfer over and the phone call said, "Don’t panic, but there's a consultation going on. We'll bring you over but under nursing, but you'll be in rehab, but what it is, is we can’t take any more on rehab at the moment, but we'll sit you under nursing, but you'll definitely be in rehab." I said, "Well I don’t mind, as long as I can come," thinking that I would be rehab. When I got here, I was then told, "Now you're

nursing". Then I kicked up bit of a fuss and said, "Look if that was the case, I'd have just stayed where I was".

Hannah: *You made the choice to come from Greenfay over here?*

Laura: *Yes, so I said if that was the case, I said, and I'd have known that I would have actually been a nursing assistant when I came here, I wouldn't have come. I said I'd have stayed where I was and then they gave me two days rehab because they were short on rehab, and then three days nursing. Then they brought me in again and said I can't have the two days rehab, I've got to do five days nursing. I was absolutely gutted, I must admit, I felt like I had been brought over on false pretences'*

Laura emphasises her attachment to her professional identity through her repetition of the fact she belongs to rehab, '*I went for a rehab interview because I belong to rehab. I'm an assistant practitioner which is rehab*.' It was also notable that she spoke in the present tense, despite now being a member of the nursing team. Her attachment to her professional identity acts as a contextual factor in which her perception of injustice response fired so strongly. However, it is also the case that Laura's articulation within the interview suggests that she experienced managerial action as an extreme form of *'waste watching'*. The sequence of the events she describes sees management moving Laura between teams and professional duties based on identification of where her *'intellect'* is most needed, with little reference to her expressed wishes or prior agreement. The language she uses demonstrates the level of injustice that she feels about this managerial action, which left her *'gutted'* and feeling like she '*had been brought over on false pretences*'.

c) Fear of incompetency

Middle managers had been keen to emphasise to me in interviews that assistant practitioners were well supported in their change of job role, in terms of the training and ongoing support from senior clinicians. Barriers to them fulfilling the role were individualised at the level of the assistants themselves, in terms of preferences, age and confidence, which provided legitimation for management to place a time limit on how long they were willing to accept resistance. However, assistant practitioners reframed barriers to generic working through a '*fear of incompetency'* response, which located responsibility at the level of the organisation through inadequate training and the disorientation and anxiety experienced during their ways of (inter)acting with patients.

Below, Candice, who Kath described as the *'ideal integrated worker'* in the integration meeting, discussed the difficulties with the *'upskilling'* required within her new role, where she '*constantly got to keep on thinking on your feet all day long*'.

'*You feel a bit pressured I suppose, because I feel like I have to be quite relaxed to take blood. If I'm all stressed out, I can't really do it and then things end up taking longer than they would do normally. Quite often we've rehab visits they quite often stipulate not in the morning and then you've got that to contend with it as well as all your other work to do. You might also get triage phone and say, there's a blocked catheter and as you're there can you go and do that as well? There is a lot to think about. You constantly got to keep on thinking on your feet all day long. You might sit there in the morning thinking, I'll do that in that route, but it could change*.

Diana emphasises her insecurities below in performing nursing duties when describes feeling like ‘*a bit of a fraud’*. Her use of the word *‘fraud’* also implies the extent to which performing nursing duties is in such incongruence with what she perceives her professional role and expertise to be. Her reference to not being signed off, is explained in another part of her interview where she tells of performing some tasks for which she not been signed off by the senior band 6 nurse. Nevertheless, she was given the ‘tick’ against her name and so was allocated these visits.

‘I’ll just try think of a word, what it's like? You just feel a bit of a fraud to be honest. That’s the one, forget how I'm feeling, that’s the way I look at it, I think of that poor patient and I’ll be honest. I haven’t ever said to a patient, "I’m not signed off." I’ve said I’m only recently trained, as you do get, how long have you been a nurse? I say 'I’m not a nurse'. And then I explain it's part of this integration, and you’ll be seeing a few more faces. I’ve said to them, "I’m I more than capable of doing it."

Initially, first of all I suppose it was a bit frightening really, I was thinking Christ, we just kind of thought, what’s the one dressing that you can put on someone. We worked that out amongst ourselves, that's not going to cause any harm. Might not necessarily be good, but what’s the one dressing. Once we had worked that all out. I suppose perhaps with time, confidence has grown, but no, not first. First of all it was horrible but it wasn’t, you were competent, so you had to tick against your name, so you got many visits but it was just’

Her fear of incompetency during the early stages of performing this role is exemplified most strongly through finding it *‘frightening’* and working out which dressing is *‘not going to cause any harm’*. Her reference to how they ‘*worked that out amongst ourselves*’ also suggests a lack of support and/or training in fulfilling the role, which directly challenges managerial problematisation based on simply a *‘preference’* or *‘confidence’*.

In a similar way to Diana, Celia also describes anxiety about interactions with patients and fear that their lack of competency would be exposed through the direct question, *‘do you know what you’re doing?*’

‘I'm quite happy as I say to do whatever they ask me to do as long as I'm competent and I've got the right care plan and I know what I'm doing. My big fear is going into somebody and somebody saying, "Do you know what you're doing?" And that is my biggest biggest fear because dressings are a very involved sort of thing’

These quotes present a strong reframing and objection to managerial discourse (realised through LPI texts, organisational texts, and managerial resources), which construe generic workers as being empowered and enterprising during their interactions with patients, acting upon patient need through their newly acquired skills. Instead, assistants feel anxious and disorientated, whilst being left to figure things out on their own.

d) Feeling skills are wasted

The nursing assistants, although lacking the anger and dismay reported by the rehab assistants, described a feeling of pointlessness towards completing the rehab tasks. In contrast to rehab assistants who were challenged by the greater difficulty and responsibility of having to take on nursing tasks, nursing assistants described rehabilitation as lacking the interest and variety of their nursing duties, with nursing assistant Leah describing rehab as both *‘boring’* and *‘monotonous’*. In this sense, they felt that their nursing skills were being wasted to fulfil tasks that they did not see as important and lacked any congruence within their professional identity. Amber explains below:

‘Even now, [chuckles] I don't like to sound horrible but I do the rehabs and I think, "I've got so much more better stuff to be doing with my time." I know this person needs a rehab service but compared to the nursing, how simple it seems. I feel like my time is being wasted, the services, money is being wasted by me doing it. I know that sounds horrible because someone's got to do that job and obviously, I go and do it, but it just feels a very unskilled job.’

In the above quote, Amber is performing her own form of *‘waste watching’* by asserting her skills are being wasted by performing the generic role, as well as challenging the notion that this is form of *‘upskilling’* by describing rehab as *‘a very unskilled job’*. Despite carrying this out in practice, *‘I go and do it’*, Amber views this purely as a distraction from her nursing role.

In addition to resisting inculcation of generic working into their professional identity, nursing assistants and more senior nursing bands expressed some animosity towards the therapy service due to their lower workload. Leah expressed this ‘perception of injustice’ in the below quote:

‘Yes, I feel like therapists, they're not run under like we are. They get paid the same as us. I feel like it's very unfair. It's in bad faith. It's really unfair that they do exercises all day and get paid band three. We're out there running around like no tomorrow and we're paid exactly the same’

Leah claims explicitly that it is unfair that rehab assistants get paid the same as nursing assistants to ‘*do exercises all day’* which works to emphasise her perception of the lack of skill involved. In opposition to work conducted by LPIs to frame generic working as integration at the level of teams, there was evidence that increased exposure to the therapy role through generic working within the integrated care teams worked to enhance interprofessional conflict. Nursing Assistant, Pheobe, expressed frustration that band 4 Associate Practitioners were not also taking on nursing tasks.

If we're integrating work and we're firefighting because we haven't got no capacity, we could see that maybe someone from therapy has got time to be able to support us. They've not all been brought obviously for the training for whatever reason. It's not working for me in that respect. When you put yourself forward and you're doing everything that's been asked, it's frustrating that you're working as hard as you are and putting in masses of input and you're seeing others that are not.

Her reference to ‘*seeing others that are not’* in her opinion ‘*working as hard as you are’* highlights the heightened visibility of other profession’s workloads, within the wider integrated team. In this sense, Pheobe also takes on the role of *‘waste watcher’* by identifying *‘wasted staff intellect’* within the wider rehabilitation team, which has created its own perception of injustice because of pressure on the nursing service.

6.4.3 Outcomes

a) Loss of job satisfaction and stress

It was reported that at least two rehab assistants had left the organisation in response to the generic workforce change and that one was currently looking for work elsewhere. Most of the remaining rehab assistant had, nevertheless, adopted the generic workforce model in practice. However, it was evident that they had not adopted into their identities or ways of (inter)acting an enterprising and empowered subjectivity, in which they were active in the identification and removal of wasted intellect. On the contrary, they held a strong attachment to their existing professional identity, feeling they either lacked the competency to carry their additional duties, or that these additional tasks wasted their skills. In this sense assistants had undergone a form a responibilisation for the resource pressures in the service and the difficulties associated with the role change.

Interview responses indicated that the outcome was a substantial loss of job satisfaction, workplace stress, and what could be described as an alienation from management and their employer, with assistant Celia telling me *‘I used to enjoy my* *job. Not anymore'*. The level of grievance felt by these assistants was substantial and it was presumably due to their age (some were nearing retirement), experience, and geographic location (Greenfay in particular is a more isolated coastal area, with limited other similar roles to apply for) that they remained in their roles. In that sense, from an organisational perspective they had managed to in large achieve compliance from the workforce, although staff had certainly not come to view their own interests and desires in line with organisational discourse in any governmentalising sense. Interestingly, the *'ideal integrated worker'*, Candice, who was praised in the integration meeting, told me in her interview that her enthusiasm for the generic workforce model arose because her interest lay with nursing and she had seen it as opportunity to transition from rehabilitation into the nursing team. This suggests that even those seen by management as adopting favourable subjectivity had not adopted this way of working into their identity. Furthermore, despite the framing of generic roles as a synonymous with integration at the level of teams by LPIs, retraining of assistants into generic roles seemed to create a greater level of animosity between the professions.

b) No improvement in patient care

At the patient level, it appeared that care delivery had not improved in any positive way. Middle managers claimed that joint tasks had been on occasion performed within one visit. However, although this may have happened on a few occasions, this was not taking place in any consistent way. The extent to which the concept of joint tasks within one visit was even compatible or desired by patients was also challenged by frontline staff and some middle managers. Nursing assistant, Amber, told me that nursing and rehab tasks do not often fall together in the same visit. The time sensitive nature of insulin injections (delivered at 9am and 5pm) was one barrier. However, staff also reported that patients would often refuse multiple tasks performed in the same visit because it was too painful or uncomfortable.

None of the patients I spoke to had received joint tasks in one visit. However, I asked some patients on a hypothetical basis how they would feel about this approach to care. Maureen, who had visits from both nursing and rehab clinicians following knee surgery, described the level of pain from having her surgery clips taken out, as making her think she ‘*was going to die*.’ Marie, who similarly had visits from both nurses and rehab staff, reported passing out when she had surgery staples removed. When I asked Maureen her views on the nurse taking her through the rehabilitation exercises within the same visit. Her response was as follows:

‘It would have been good because I would have said, "Let's have a cup of tea," or something. Hopefully, she'd got that time because pain, God, it's like when you stab yourself with a sewing needle. You know you've done it and you've got to go through that bit, and it was going through that bit with every single staple. They were staples, that's what they were. No, that would have suited me personally. I'm only talking about me.’

Despite the pain, Maureen was supportive of the idea, if there was sufficient time allowed between the tasks. Marie also said she would have been happy for the nurse to have taken her through some of the exercises, as this would have provided her with some confidence that the stitches would not split. Dorothy, who accessed the service following knee surgery, also said she liked this idea, despite the acknowledged pain. Interestingly, both Dorothy and Maureen had no issue with having multiple visits to the house from different clinicians. Instead, viewing joint tasks as a way of *‘saving the NHS money’*.

A central requirement from my patient interviewees (Marie, Maureen, Dorothy, and Susan and Dave) who I posed the hypothetical to, was that they would need assurance that clinicians were adequately trained in all areas. Marie, for example, displayed particular reticence to the suggestion that someone specialising in physiotherapy would have sufficient expertise to take the surgery clips. When speaking about the nurses who removed her staples, she said:

‘She knew what she was doing. She had been trained and if something could go wrong because the nurse was originally, "Look, we're going to start past these bottom ones because I'm not sure. Let's see how the other ones hold up before we take those bottom ones out." Now it might be that the physiotherapist didn't have that experience or that knowledge. It's a knowledge thing.’

Dave and Susan also expressed some concerns about the loss of specialism, i.e. *‘I don't want anybody to just walk in and say well I’ve come to do the physio’*. However, Susan also reflected that if this was performed by a particular clinician, such as their practice nurse, Kerry, who knew how to motivate Dave, then these concerns were lessened. It may be the case that once assured of the level of competence of the clinician, these patients and carers would have had their concerns allayed. However, their comments bring into sharp focus some of the worries expressed by rehab assistants about their competency to carry out nursing tasks, stressing the need for adequate training and support.

Regarding whether nursing and therapy tasks are compatible within one visit, there is indication from the patients interviewed that this would be welcomed. Although it is important to consider that differing levels of tolerance for pain may create variation here, and patients appear to balance their acceptance for generic working with their desire for specialism. It is also still the case that due to time sensitive nature of insulin administration it appears infeasible to conduct rehabilitation at the same time. What was apparent from the patients in my study was that none of them perceived numerous visits from different health professionals as a problem. It is also the case, however, that most of my patient interviewees, apart from Dave, remained within the service for a short period, unlike those suffering from long term multimorbidity who may be more greatly impacted by numerous visits.

Instead, the patients in my study problematised ‘fragmentation’ in the form of lack of coordinated working between the professions/services, and not on the basis of tasks performed by different professionals. For example, Marie reported that ‘*there's no coordination at all between the different departments. Or even between their own departments. Some of the physiotherapists didn't know the other physiotherapists and every physiotherapist had a different opinion and a different way which was odd. No continuity at all’*. Susan and Dave also expressed their frustration and confusion about the way which the services they access work together. Susan told me ‘*he's diabetic, he's got health problems, he's got vascular problems as well. You're under so many different people on you really. [laughs] But, no, they don't communicate.*

Definitely, they don't communicate.' These concerns were the most visible in my interview data, suggesting the problematisation of the number of visits was more organisationally and politically driven.

6.8 Discussion/conclusion

6.8.1 Relationships of findings to CPTs

In chapter 5, I argued that generic roles were framed by LPIs within the IC policy discourse through explicit description of this workforce model as 'integration'. Generic roles were also framed within the same solution-problem pairing found within the IC discourse through claims that they alleviate fragmented and disjointed care and produce process efficiencies. I also argued that in the articulation of these solution-problem pairings, LPIs drew on minor discourses of holistic patients care and lean working. Within these discursive frames, health professionals inculcating generic roles within their identity and professional practices were construed in positive ethical positions as responsibilised, empowered and enterprising. Those who were resistant to this change of role were instead blameworthy on the grounds of failing in their moral duties to patients and through their own self-interested preferences for work. Within these subject positions, any barriers to implementation were individualised. I raised concerns, in line with critical research on lean working, that there was potential for intensification if health professional acted upon on their own subjectivity in line with this ethical framing. By contrast, and following literature within the sociology of professions, the high chance of resistance to this change may lead to professional identity conflicts. Finally, individualising barriers may be enacted through inadequate resources to support the retraining process. As such, I developed three CPTs to be explored further within phase 2 of fieldwork:

1. If health professionals inculcate the requirements of an enterprising and responsibilised identity into their professional practice then they may put pressure on themselves to deliver additional tasks within visits, which they have not been given additional time or resource for. This could satisfy the efficiency aims of the service change, but result in substantial intensification and stress for staff

2. If resistant health professionals are construed as less morally favourable then this may cause them to feel insulted or humiliated, leading to further interprofessional conflicts between members of the integrated care team when they attempt to defend their professional boundaries

3. If the difficulties associated with the generic workforce model are minimised then inadequate training or support may be given, meaning staff will not develop the confidence and skill to fulfil their role, which may result in poor patient care and high stress for staff

Within phase 2 data collection, I identified that generic roles were construed linguistically within an interdiscursive mix that drew on both the wider narrative of *‘integration’* and the discourse of lean with its focus on removing *‘waste’*. The *‘ideal integrated worker’* was constructed through this discursive mix as being those that enthusiastically and proactively adopted their role as *‘waste watcher’* to eliminate wasted intellect by applying their generic skills to patient care. However, references to *'integration'* referred to the acquisition of joint competencies, but not to staff applying these during patient visit to deliver holistic care.

The dialectical transformation of this discourse into managerial resources, dislodged concerns of fragmentation and poor patient care, to enact generic roles purely within their economic logic. This logic used generically trained rehab assistants to plug the gap in nursing provision. These managerial resources manifested in two main ways 1) managerial decisions were made to focus their training strategy on rehab assistants acquiring nursing competencies with little managerial focus on how these tasks could be put together 2) when faced with staff resistance, middle managers adopted their pastoral role using a range of subjecting and disciplining tactics to try to encourage staff to take responsibility for the difficulties with the role change.

As such, the resources did not create responsibilisation that led to the intensification concerns expressed in CPT 1. Instead, the enterprising and responsibilised element of the subjectivity desired by middle management, was one in which they took on responsibility for difficulties associated with the role change and filling the resource gap, leading to a perception of injustice response expressed through the following CMO:

1. In **contexts** where many of the rehab and nursing assistants have worked within the service for many years and/or have a strong professional attachment to their role **managerial resources** which seek to eliminate 'wasted intellect' within the integrated care team by retraining assistant practitioners into generic roles are met

with a perception of injustice **response** from staff, which resulted in loss of job satisfaction, workplace stress, and alienation, and little positive change in patient care **(outcome)**

The perception of injustice response and the negative outcomes for staff and patient experience were more reflective of concerns expressed in CPTs 2 and 3 that staff would experience insult and humiliation and they would not develop the confidence to fulfil their role, resulting in high stress and poor care. However, my findings did not reflect theorising with CPT 2 that conflict could result from the interactional component of the role change. As will be discussed further in chapter 8, the auto-allocation scheduling system, Cbernet, removed this dimension from role blurring. However, I did find within the perception of injustice response that some nurses developed animosity towards therapists. This was created through greater visibility of workload that arose through generic working within the integrated care teams.

Chapter 7- Self-Management

7.1 Introduction

It was demonstrated in chapter 5 that LPIs individualised both the problems and solutions to patients self-managing their condition. The central problematisations identified were the nursing professional identity, staff decision making and national culture, with the solution for health professionals to convince and persuade patients to take more responsibility during patient-clinician interactions. These problem-solution pairings served to locate problems within the minds and behaviours of both health professionals and patients, whilst ignoring wider structural and systemic issues that may delegitimise the aims of the service change. I argued that LPIs were seeking to construct ethical subjectivities for both staff and patients to perpetuate governmental and managerial aims. I then proposed through the development of CPTs some potential problematic implementation effects if these discursive assumptions were enacted and operationalised at the level of implementation.

In section 7.2 of this chapter, analysis of textual resources introduced to staff as part of the health coaching training (produced at the beginning of the contract) demonstrates how they drew mainly on an empowerment discourse. However, two years into CBIC delivery, the material reality of resource pressure within the service had the socially structuring effect that self-management came to be framed within the managerial discourse of lean working. The discourse of lean working was articulated through texts communicating the *'transformation projects'*, aiming to eliminate *'waste'* from the organisation. This reframing of self-management reflected a similar discursive shift between the Business Case and lead provider documents and LPI interview data. In both examples, self-management came to be dislodged from its inculcation within the empowerment to focus purely on its ability to reduce to demand. Within the discourse of lean working, health professionals are asked to adopt the position of *‘waste watchers’*, whilst the patient subject position is one of potential waster of clinician time and intellect.

In section 7.3, I will demonstrate using evidence gathered from interviews and observations how the discourse of lean working was dialectically transformed into organisational resources that created pressure on staff to discharge patients through either self-management or the housebound condition. Again, I drew on Waring and Martin (2016) and Martin and Waring’s (2018) work on pastoral intermediaries to help explain how power operated through this organisational resource. This reflects the central argument within this thesis that the IC policy discourse worked ideologically to smooth over any inconsistencies and contractions with making funding reductions, whilst also claiming to improve patient care. This enabled economic austerity to be mobilised through implementation of the CBIC when semiotic references were made to *‘empowerment’* and *‘integration’*, whilst the material reality of resource pressure dislodged concern for improving patient care from actual practice.

In section 7.4, I evidence through the context-mechanism-outcome heuristic, how when this organisational resource is introduced into a context of substantial resource pressure in the nursing service in comparison to the therapy service, nurses will more readily adopt their role as ‘*waste watcher’*, resulting in a disempowering experience for both nurses and patients and patients being bounced between services. The CMO is displayed as follows:

2. In **contexts** where members of 'integrated' care teams hold differing professional identities, professional practice, and workload pressures, **resources** which seek to encourage health professionals to discharge patients through self-management mean that nurses **respond** by more readily adopting *'waste watcher'* identities than therapists and enacting conflictual and antagonistic patient-clinician interactions. The **outcomes** of this are disempowerment for both patients and clinicians and the possibility of vulnerable patients being discharged under the housebound condition

In section 7.5, I demonstrate how when the organisational pressure to discharge is introduced into a context of an elderly, vulnerable patient population, often suffering co-morbidities then health professionals must negotiate this '*waste watcher'* identity so as not to reduce the holistic nature of care or risk harm to patients. This resulted in work intensification due to the difficultly of reducing the caseload in line with the financial modelling within the contract.

The CMO is displayed as follows:

3. In **contexts** where members of the 'integrated' care team treat patients with high levels of frailty, comorbidity and dementia, **resources** which seek to encourage health professionals to discharge patients through self-management mean that health professionals must negotiate their *'waste watcher'* identity considering this vulnerable patient population **(response)** with the **outcome** of potential harm to

patients if they are discharged and intensification for staff when patient’s capability for self-management does not align with reduced budgets

In section 7.6, I discuss the findings presented in the chapter in relation to the CPTs developed in chapter 5.

7.2 Textual Resources

The textual resources analysed below are semiotic elements of practice relating to self-management within the CBIC and represent channels of communication from senior management to middle managers and frontline staff. The organisational ambition, stated in the LPI interviews and the CBIC tender document, was for all staff to undergo health coaching training. These resources were developed as part of the early development of the CBIC. As discussed in 6.3.1, the transformation projects, which were led by senior management, were communicated through a series of mediums two years into the contract: service re-design workshops, the monthly stand-up meeting in Hallstone, monthly nursing and therapy team meetings, and the staff newsletter emailed to all staff. Analysis of the textual resources discussed below provides evidence of the way in which an empowerment and lean discourses were linguistically realised through texts introduced to staff within micro level implementation.

7.2.1 Health coaching training

1. What is the purpose of, and context behind, this specific communicative event?

It was specified within the CBIC tender document that all staff would be *'trained in developing the skills and commitment to person-centred care including activation, health-coaching, and person-led care planning'*. The health coaching training that I observed was part of this strategy and was one of numerous training sessions that were running on an ongoing basis. The training manual and the presentation given can be presumed to have been of a similar format to the other training sessions delivered. The specific training content was developed in-house by the lead provider, with the overall health coaching approach developed by both the lead provider and the County Council. Analysis of both the training manual and the verbal communications given by the trainer, assisted by a PowerPoint presentation, can therefore be seen as representative of the discursive messaging that was being communicated to staff who attended the health coaching training sessions. These texts therefore represented a semiotic aspect of self-management practice within the CBIC, as well as a 'semiotic 'point of entry'' into the analysis (Fairclough, 2008, p. 169).

2. What is going on specifically within the text and how do the linguistic features within the texts draw on discourses (ways of representing) at the interdiscursive level?

The introductory part of the training manual clearly links *'health coaching'* conversations between clinicians and patients to 'self-management' of health conditions. It is, therefore, made clear that the purpose of 'health coaching' within this context is orientated around those patients who have existing health conditions that require management, as opposed to self-care, which is focussed on individuals doing more to look after their general health, i.e., diet and fitness. LPIs sometimes used *'self-care'* and *'self-management'* interchangeably in their interviews. However, I found no evidence that community nurses/therapists were encouraged to engage with patients about general health.

Clinicians and patients are described as '*working in partnership*' where the aim is '*to empower them (the patient) to build up the knowledge, skills, confidence and resilience to be responsible for and manage their own health and well-being and to access appropriate care and support as required'*. '*Working in partnership'* through patient directed goals, represents a shift from what would be considered the medical model in which scientific knowledge is prised over the experiences of patients in a hierarchical dynamic. As articulated in the empowerment discourse (McDonald *et al.*, 2007; Jones, 2018b; Petrakaki *et al.*, 2018) this partnership approach works to *'empower'* people to be '*responsible*' for managing their health. To '*empower*' people suggests that power will be redistributed back to patients. However, this empowerment is clearly defined specifically around the power to becoming a 'responsibilised' citizen, as opposed to other patient orientated forms of empowerment, such as coming to terms with their condition and managing threats to their identity (Aujoulat *et al.*, 2008).

Nevertheless, we are then told that '*self-management support respects equally the knowledge of the healthcare professional and the person living with condition- no longer about seeing the professional, 'who knows best'*.' This sentence positions the health professional and the person living with the condition in equal status. The decision to use '*the person living with the condition'*, as opposed to '*the patient'* works to emphasise a holistic view that respects the whole person and does not just view individuals purely through their medical status. During the introductory dialogue, the trainer goes further than this by telling us that ‘*patients are experts in the care they require’*. Describing patients as ‘*experts’* implies that they have additional knowledge to that held by health professionals, developed through individual lived experience of their disease (Wilson *et al.*, 2007).

It has been argued by Petrakaki et al (2018) that the empowerment discourse is governed by an economic rationality, which is articulated clearly within the health coaching training manual and presents a contrast to the above discussion of *‘working in partnership*’ and treating patients as ‘*experts*’. We are told on page 3 that the health coaching approach has been developed by the lead provider and County Council as a ‘*new approach to managing demand’*. Those ‘*expert*’ patients are now framed as ‘*demand*’ that needs to be reduced, suggesting a conflict internal to the empowerment discourse, which implies that the same patients occupy both positive and negative subject positions. The sense of urgency in reducing this demand via self-management is emphasised when it is described as *‘a critical part of (OCC’s) organisational strategy’*. The ‘*critical*’ and ‘*urgent’* nature of self-management to organisational survival was echoed in the interview responses of LPIs Bev, Jill, and Mary, highlighting the pervasiveness of the economic rationality within organisational discourse.

The financial demands within the contract and their association with self-management are further emphasised with the use of a graph and accompanying text on page 4. The text ‘*The (CBIC) contract value decreases over the lifetime of the* *contract. Cost improvement plans are in place, but we also need to reduce demand on our service through self-management'* is positioned next to a graph with the title *'(CBIC) base contract value'*, which indicates that the contract value falls from approx. £33.8m to £32.8m from 2017-18 financial year to 2018-19 financial year. The observed training session took place in September 2018, and so the financial necessity of self-management for participant's present working lives is given immediate focus through this timeline. The use of the pronouns *'we'* and *'our'* places responsibility and ownership on the clinician to instrumentally reduce demand on the service through self-management, with a clear visual representation of the extent to which this is required. The trainer and training manual do not present financial savings as a positive by-product of '*empowerment*' and treating patients as '*experts'*. Reducing demand on the service is in fact *'critical'* to achieving £1 million of cost savings, with the contract value decreasing regardless. Concepts of '*empowerment'* and treating patient as '*experts*' imply a greater level of control and a reshaping of the unidirectional nature of interactions between clinicians and patients. However, the financial imperative of reducing demand on the service implies that the empowerment discourse is still constituted within the biomedical model (Wilson, 2001; Salmon and Hall, 2003; Fox *et al.*, 2005), with power placed in the hands of clinicians to use '*empowerment'* instrumentally to reduce demand.

3. What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

The problems that were construed as barriers to implementing self-management were focussed mainly on patient mindsets and behaviours and reflected criticism in the literature of individualistic behaviour change model that underpins the empowerment discourse. This is said to neglect structural factors that influence both the determinants of health and resources to self-manage a condition (Salmon and Hall, 2003; Jones, 2018b). Similarly, to the overly dependent patient population constructed by LPIs, the trainer tells us during the session that '*people become overly reliant on us'* and 'some patients will say '*I've paid you to care and look after me. I've paid into the NHS'.* This non-specific group of '*people*' works to homogenise the population who are overly reliant and dependent. The trainer is therefore reinforcing to attendees that this overly dependent and problematic patient behaviour could apply to a wide and varied spectrum, and it is '*us*', i.e. the attendees, as health professionals, who are on the receiving end and potentially burdened with this problematic dependency. The trainer emphasises the individualistic nature of this barrier by articulating the patient perspective using the first-person pronoun 'I've' followed by simplistic reasoning on why the patient expects care to be given.

4. What ways of (inter)acting between patients and clinicians are framed within these discourses? 5. What patient/clinician identities/subject positions are delineated within these discourses?

The 'health coaching conversation' is constructed as a new genre (semiotic way of interacting), in contrast to a traditional patient/clinician consultation. The premise underpinning this genre is an egalitarian exchange based on the development of patient-centred goals, as opposed to hierarchical patient-clinician consultations, in which power is held in the hands of health professionals. Page 12 tells us that through the health coaching conversation, the coach '*expects coachee to take ownership and responsibility for their issues'*, suggesting patients are expected to adopt responsibilised subjectivities implicit within the empowerment discourse (McDonald *et al.*, 2007; Jones, 2018b; Petrakaki *et al.*, 2018) by taking charge of their own healthcare. The role of the coach articulated within the training manual reflects the 'pastoral subjectivity' identified by Jones (2018b) and Waring and Latif (2018) in shaping and guiding the development of this 'self-governing' responsibilised subjectivity. The coach is expected to '*encourage the coachee to take ownership of their decisions'* and to '*guide coachee through any experiences'*. We are also reminded by the trainer that self-management does not involve '*forcing things on people that they're not necessarily wanting'* and '*respecting that person as an individual, as everyone's needs are different*'. The emphasis placed on guiding, encouraging and respecting individuals is reflective of the 'pastoral' nature of this interaction, as opposed to using formal authority or '*forcing things on people'*. However, given, as previously discussed, the clear economic rationality underpinning empowerment to ensure financial sustainability through responsibilised patients, the pastoral subjectivity to '*guide'* and *'encourage'* is used instrumentally to instruct patients into behaviours to achieve political objectives of reducing demand. Here, we see the health coaching conversations as seeking to influence the actions of the individuals, as part of the wider apparatus of neo-liberal government (Foucault, 1988; Foucault, 1991b; Miller and Rose, 2008).

The lack of discursive attention paid to the characteristics or diversity within the patient population that may serve to delegitimise or challenge the assumptions underpinning the self-management drive within the service, not only presents a homogenised patient population who vary only in motivation levels, but also a homogenised identity for frontline staff who are constructed as delivering similar types of care to similar types of patients, regardless of their professional groupings. During the discussion on goal setting, the trainer says '*most therapists work with goal setting*' as if to reassure the group that there was familiarity to the training. However, no mention was given to the application of this concept to nursing. This may have been due to the lack of nurse participants. However, none of the training content made any differentiation between the different types of patients and care delivery across the professions. The material delivered remained at a high level of abstraction and discussed the goal setting approach as if it could be extracted and applied within any context. Reflective of the problematisation of the nursing professional identity that I identified in my analysis of LPI interviews, the health coaching textual resources furthered this work in attempting to enact a homogenised and standardised professional identity, in which patient-clinician interactions can operate in similar ways despite varying patient types and care delivery.

7.2.2 Transformation Projects

1. What is the purpose of, and context behind, this specific communicative event?

The below analysis relates to three communicative events that took place during the time I was conducting observations within the Hallstone Integrated Care offices. These events, the stand-up meeting, staff newsletter, and community rehab team meeting all involved communicating information to frontline staff about the transformation projects that were in progress during the time of field work.

2. What is going on specifically within the text and how do these linguistic features within the texts draw on discourses (ways of representing) at the interdiscursive level?

As discussed in section 6.3.1, the transformation project textual resources all draw on a managerialist discourse of lean working and its focus on reducing waste and adding value (McCann *et al.*, 2015). Under the '*Facilitated Health and Wellbeing Project'* this '*waste watcher'* philosophy is specifically applied to '*reducing the time that patients are in OCC's services by giving them the necessary tools to self-manage their care.*' The implication here is that if patients remain on the service any longer than necessary, then this considered wasted time and therefore wasted intellect of the clinicians who are treating them. Using self-management to reduce waste is in contrast to the empowerment discourse discussed earlier, which centres on egalitarian patient-clinician exchanges that empower them to set their own goals. Constructing self-management within lean discourse, brings its underlying economic rationality to the fore and strips away any notion of 'empowerment' being used instrumentally to serve the goal of reducing demand.

3. What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

The main problematisation constructed within the staff newsletter, is the time and intellect wasted when patients spend too long on the service. What is not discussed is which patients have a legitimate claim to the time and intellect of health professionals and which should be eliminated through *'waste watching'*. This opens the potential that all patients should be held under suspicion as potential wasters of resources. Similarly, to that discussed earlier under the empowerment discourse, lean also works to homogenise the patient population, so that all are potentially amenable to removal through reduction of waste.

The air of suspicion held over the patient population and the potential waste they create may imply blameworthiness. However, this was made explicit during the stand-up meeting when middle manager, Katherine, was discussing the '*Facilitated Health and Wellbeing Project*' and described the following patient response, ''*I've got diabetes. My toe will drop, oh well'*. Her advice to the clinicians listening was that '*we need to be saying, look is there something we can do with that…..moving responsibility back onto the individual'*. This implies that not only are patients not taking on responsibility for themselves for their condition, but they remain unbothered by the potentially serious consequences of their health of conditions, such as diabetes. This narrative casts blame onto the patients who may be wasting resources through their own defective or negligent attitudes, and so mixes ideas of neoliberal responsibilisation with the mangerialist discourse of lean working.

4. What ways of (inter)acting between patients and clinicians are framed within these discourses? 5. What patient/clinician identities/subject positions are delineated within these discourses?

Within the staff newsletter the process by which patients will achieve self-management and the agency involved with doing so is left unclear. It is claimed that '*Facilitated Health and Wellbeing also aims to enhance patient care by giving patients the tools they need to better manage their health and wellbeing'.* In this example, the agent who will be '*giving patients the tools'* is left unclear, instead being described through the name of the project '*facilitated health and wellbeing'*. Responsibility for this process is therefore unclear, as is the causal process for this being achieved. How exactly patients will be given the tools to be able to manage their care is not specified, potentially implying that this process lacks complexity. Although the agent is unclear, the use of *'giving'* implies that this is something that patients are on the receiving end of and moves us away from notions of shared decision making and goal setting within the genre of 'health coaching'. Patients as recipients of self-management was echoed in the comments made during the stand-up meeting, *'we need to be saying, look is there something we can do with that…..moving responsibility back onto the individual*'. Repetition of the pronoun '*we*' suggests this is something that is directed by the clinician, and that responsibility is something that is moved back onto the individual by the choice and command of the health professional, reflecting a genre more akin to the bio-medical model.

Lean discourse attempts to inculcate the *'waste watcher'* identity within health professionals, whilst viewing patients as potential wasters of resource. Favourable subjectivity for health professionals therefore involves being enterprising through embracing their role of being alert to, and monitoring patients, for potential wasters of time and intellect. Similarly, to the *'ideal integrated worker'* the neo-liberal subject is animated specifically through the lens of *'waste watching'* within self-management.

Once the ‘*waste watcher’* identity is accepted they must then go about shaping the conduct of patients through monitoring, surveilling, and making the decision to begin ‘*moving responsibility back onto the individual’*. This is reminiscent of the disciplinary GP-patient interactions described by Waring and Latif (2018). Contrasting with the softer subjectifying forms of pastoral power focussed on ‘guiding’ and ‘encouraging’ patients (Jones, 2018b; Waring and Latif, 2018) found within the health coaching textual resources. The economic rationality of enabling demand to be reduced through responsibilised patients integral to the empowerment discourse, is also present here. However, the ways of interacting and identities enacted through lean discourse strips away any reference to ‘empowerment’ or changes to traditional interactional dynamics that have been widely criticised as disempowering for patients (Gill, 2020).

7.3 Organisational Resources- organisational pressure to discharge patients

Analysis of interview and observation data found that the discourse of lean realised linguistically through the transformation project texts was dialectically transformed into organisational resources more prominently than the empowerment discourse. Similarly, to that found within generic roles, these resources exercised power ‘operating at the nexus of discipline and subjectification’ (Waring and Martin, 2016, p. 136). I argue that self-management practice within the CBIC, provided another example of where the socially structuring material reality of funding cuts to service meant that reference to improvements in patient care were dislodged in favour of ‘waste watching’. This illustrates the ideological work of the IC policy discourse to mobilise economic austerity through the implementation of integrated care services.

7.3.1 Discharge via self-management

Firstly, at the time of fieldwork, the process of staff undertaking health coaching training was still ongoing and so not all interviewees had taken part. Those staff who had participated in the training reported in interviews and informational conversations that they did not feel it was very practical for their day to day working lives, due patient contextual factors. The example below is an informal exchange between me and Speech and Language Therapist, Roxie, who attended the training session I had observed.

***Hannah**: Oh, you were in the training yesterday? How did you find it?*

***Roxie:** a bit tedious (pulls face). I mean I think it was good. I understood the principle, but I think it might be difficult to put into practice.*

***Hannah:** how so?*

***Roxie**: Well, most of our patients have degenerative diseases so ultimately they're going to die so they have no interest in caring for themselves and you can understand that. It sounds a bit morbid but it's true.*

Others appeared confused when asked what they though the purpose of the training was.

'I don't really know. I think it was just something that we all had to do, so we all just did it really' (Aubree, band 6 physiotherapist).

Two other members of the community rehab team reported that they appreciated the empowerment and goal setting approach embedded within the training, but that this was part of their existing professional practice and was not brought about because of the CBIC service change.

Data collected through fieldwork revealed that organisational resources most dominantly internalised lean discourse, which sought to shape health professionals into adopting the *'waste watcher'* identity with the ultimate aim that they would discharge patients via self-management. For rehabilitation staff at the band 4 associate level, adopting the '*waste watcher'* role meant discharging patients from the service after 4 weeks, as opposed to the previous 6-week maximum period.

As explained by band 4 Associate Practitioner, Abbie below:

'It was roughly about six weeks, but they wouldn't start pressuring you if it started going on to eight weeks or anything. They wouldn't put a huge pressure on you. Now you've got to flag it up and it all turns red when you've had them for three weeks, and then Leanne in admin will come in with the sheet, with all different colours on, saying, "You've had your patient for four weeks, you need to discharge them." You just say, "Well, I'm not ready to discharge him," but you've got to. It's a big difference. It's a big difference'.

Here, Abbie describes how the RAG rating system that has been adopted creates pressure to discharge patients through disciplinary means. The RAG rating makes clinicians who have not successfully fulfilled their role as *'waste watcher'* by discharging patients within the designated time visible and amenable to observation. This then alerts the admin team, who Abbie describes as assisting with exercising 'normalising judgement' (Foucault, 1991a, p. 177) through her attempts to correct this deviation from the organisational norm. Middle manager, Denise, told me that if clinicians do not wish discharge patients at 4 weeks then they must move them into either the yellow or red caseload depending on the case and then ask approval from her for an extension of time, '*So yeah it's just about just clearing it with myself, or sometimes it's a band 6 that can authorise that. Just to keep them on just a little bit longer*.' However, it was also clear from another band 4 therapist, Alice, that the four-week period is considered to be an enforceable timescale- *'You have it for a week and then you got to reduce it, so they've become really quite strict with us and even our timescale. It's four weeks. Four weeks and you're done.'* She goes on to say '*You may get an extension if you talk to Denise, but that would be up to six weeks and then you're done. That's hard to swallow when from before, I've had all the time in the world and this is just from a therapy point of view.'*

Within the nursing service, discharge dates remained a clinical decision, but staff described a general organisational environment which engendered discharging patients from the service. Nurses described the organisational push to discharge patients, not as an overt command from management, but as frequent subtle reminders or suggestions. These subtle reminders and suggestions came from all levels within the organisation. This suggests that once staff had adopted the *'waste watcher'* identity, they also adopted a pastoral role in seeking to guide and shape their colleagues. The key role played by senior band 6 nurses in particular was also present in the data. In the quote below, band 5 Nurse Cheryl, describes it as *‘a little nudge’* from the senior band 6 nurses in the West Greenfay office.

‘Yes, every now and again, there'll be a little nudge. You walk into the office and it will be like, you know whoever is walking into the office at that time it will be, "Today, we're going to get some patients off”, for something’

The use of ‘*every now and again’* implies that she does not perceive the suggestions to be too frequent or overbearing, but just enough so that staff are made aware that this is the intention. However, the use of ‘*today, we’re going to get some patients off’* suggests that although this may be infrequent, the message is overt and unambiguous in its communication of the need to discharge patients and as urgently as ‘*today’*.

This was echoed by senior band 6 Nurse, Lucy, who explains that although there is not an overt directive to discharge a certain number of patients, there is *‘a massive drive without a shadow of a doubt’*. She also told me at another stage in the interview that she had attended the transformation project workshops, which may reflect her experiences of the ‘*massive drive’*. The way in which more senior clinicians also experience direct communication from senior management in the way that more junior staff would not, may suggest why band 6 nurses seemed to play a key mediation or ‘pastoral role’ (Waring and Martin, 2016) in attempts to shape more junior staff into ‘*waste watchers’*. Lucy’s indicates that this ‘*massive drive’* does not manifest as a specific target to discharge a certain number of patients. Lucy does express some frustration, however, if these nudges are perceived to be too frequent, due to the difficult nature of discharging patients.

‘Do you know what? It becomes a little bit frustrating when it's spoken about quite a bit because you just think-- Do you understand?

This may suggest that there is a balance to be struck on the managerial side of not aggravating staff with too much overt pressure, as getting staff to view their own identity in line with *‘waste watching’* is vital to meeting organisational aims.

In another quote, band 5 nurse Cheryl, further emphasises the idea that she does not experience the drive to discharge patients as a command. In fact, in some cases this is a co-constructed process.

‘If I was to say to them, for argument's sake, "I can't see why we're going in to Mrs. So-and-So when her daughter lives with her or something." Then the managers will say, "Yes, get her off, get her off. Why isn't the daughter helping? Why isn't she--?" It's all about trying to get people off our books or managed in an appropriate manner to free us up a bit more so we're not in somebody's more than we need to be’

In this hypothetical example, Cheryl first approaches one of the middle managers because she believes that a patient’s daughter could take on responsibility for the patient’s care. She describes what she views as their typical response, which is one of encouragement and almost excitement. This is emphasised by the repetition of *‘get her off’* and the repetition of the question ‘*why isn’t the daughter helping? Why* *isn't she?*'. This indicates that sometimes the suggestion is made by the frontline staff themselves, with enthusiastic encouragement from middle management in a co-constructed process.

So far, the quotes from respondents reflect the influence of comments from either management, senior nurses, or administrators, either spontaneously or in response to an initiated conversation from one of the frontline members of staff. Matron, Adrienne, however, describes how this messaging can exist beyond the specific interaction.

'I just think there's sometimes that pull of, like that little someone in your ear of you've got to discharge all these patients, and they've all got to be self-caring'

The '*little someone in your ear'* implies this messaging follows her around when she is delivering care to patients and acts as a source of pressure for her to enact her role as '*waste watcher*'. This suggests that she is beginning to act upon herself in line with dominant organisational discourse, without the need for crude enforcement. However, her reference to '*all these patients'* and '*they've all got to be self-caring'* gives the impression that she perceives the expectation to be demanding and potentially unachievable. This provides evidence that the organisational resource is operating on occasion through disciplinary means as internalised surveillance, rather than acting on Adrienne's own will in the governmentalising sense (Martin *et al.*, 2013).

I also observed examples of where junior staff reinforced this message amongst each other. The following fieldnote was recorded during the Hallstone observations.

‘A few band 5s and HCAs are chatting with some nursing new starters. One of them says to the new starter ‘*we have to try to encourage patients to take more care of themselves*’’.

This highlights that messaging around patients taking more responsibility for their own care has seeped into organisational consciousness where staff encourage each other to perform these sorts of duties. Note again the way in which the patient population is homogenised, representative of both empowerment and lean discourse, through ‘*we have to try and encourage patients’*, implying that the focus is trying to get as many as possible to ‘*take more care if themselves’*. The organisational pressure to discharge, therefore, can be represented as a dominant organisational discourse that has been enacted via organisational resources which draw on both subjecting and disciplining forms of power to encourage discharge through self-management.

7.3.2 Discharge via housebound criteria

Although not articulated as an official aim of the CBIC, I found that lean discourse was also operationalised through practices of discharging housebound patients. This involved attempts to shape health professionals into ‘*waste watchers*’ meant through identifying patients who were wasting ‘*time and intellect*’ because they did not fulfil the housebound criteria. It became apparent during interviews with nurses and whilst conducting observations of the open plan office that determining whether patients meet the housebound criteria occupied a central focus in the day to day working lives of the community nurses in this study. Moreover, determining whether patients are housebound and discharging them on this basis also came to be discursively linked with the self-management agenda. I noted during interviews that sometimes when I would ask interviewees about self-management, they would respond by talking about the housebound criteria.

This is highlighted in the following exchange between me and senior nurse Lucy:

‘**Hannah:** *With the self-management aspect, you said there's that group of people who are capable of doing it, but they've had their expectations raised by the hospital. Are there any examples of where it's a success? Where you do get somebody to self-manage?*
Lucy: *Yes you do. Certainly not as many as you'd like to. I think the thing is, it's not even a success, is it? Most of them that you'll find are not housebound. So, the success is you've discharged them back to the appropriate service’*

This, I would argue, was inevitable given the dominance of the lean discourse within the organisation and the focus on reducing demand and solving resource pressures. Despite both lean and the empowerment discourse having an underlying economic rationality, for self-management to be distinguished from the housebound criteria in the minds of managers and frontline staff, assumptions within the empowerment discourse, such as joint decision making, egalitarian conversations, and working together towards mutually agreed goals would need to be dominant at the level of implementation. If self-management is seen as just one way of identifying ‘*waste’* and instrumentally reducing pressure on the service, then discharging a patient under the housebound criteria is simply another way of achieving this aim. For those health professionals acting as *‘waste watchers’*, patients who are deemed capable of self-managing and those deemed physically capable of making it to GP appointments, are both wasters of the ‘*time and intellect’*, whilst they remained on the service.

Middle manager, Zoey, explained how she had communicated the housebound criteria to her staff during a team meeting.

‘*I explained it to my staff in the last team meeting. You don't go into a shop and pick up your shopping and pay for half and walk out with the other. You only get what you've paid for. For community nursing and under (CBIC), we're only paid to do X,Y and Z. We're only paid within out contract to see housebound patients. If we're seeing patients that are going out, which we do at times, and find out. We need to have those conversations. That's really hard from a caring professional nurse’*

The above example highlights how staff were encouraged and guided through managerial communication to take up their role as ‘*waste watcher’*. This involves encouraging health professionals to ‘*find out’* if these patients are wasting not only the time, intellect and in this case money of the service, and if so, discharging them. Zoey’s quote also highlights how the material reality of the funding constraints within the CBIC contract has rendered the need to identify those patients creating this waste more acute.

There was also evidence from fieldwork that the pastoral shaping of nurses into adopting the ‘*waste watcher*’ identity and applying it to the housebound criteria within the open plan office existed in a similar, if not more stringent manner, to self-management. During my observations, I heard frequent references made to housebound patients, and the question ‘*are they housebound*?’ was asked between clinicians on numerous occasions. In one example, a junior nurse was asking a senior nurse for advice on a patient to which the senior nurse replied *‘I don’t care if her fucking cat needs to go to the vets. She’s not housebound!*’ providing one example of the type of hard-line messaging that more junior staff were receiving from senior nursing staff.

7.4 CMO - 2

The following CMO theory was developed to explain what happened when this resource mechanism was introduced into the integrated care teams within the CBIC:

In **contexts** where members of ‘integrated’ care teams hold differing professional identities, professional practice, and workload pressures, **resources** which seek to encourage health professionals to discharge patients mean that nurses **respond** by more readily adopting ‘*waste watcher*’ identities than therapists and enacting conflictual and antagonistic patient-clinician interactions. The **outcomes** of this are disempowerment for both patients and clinicians and the possibility of vulnerable patients being discharged under the housebound condition

7.4.1 Contextual differences in professional identity and workload

Interview responses from members of the community rehab team reflected an attachment to an empowerment and goal setting approach to their professional practice that was not present in nurses. All band 4 associate and band 6 physiotherapists/occupational therapists told me of the importance of setting patient owned goal that they would work towards with patients. Physiotherapist Aubree, who had struggled to articulate the exact purpose of the health coaching training was very clear of the benefits an empowerment approach could bring to patients:

‘It's, I should say, just changes their mental attitude. Doesn't it? It's like, "Yes, we can do this. There's nothing that is out of my control anymore. I know that if I do this, this is going to happen. This is going to impact my life. I'm going to be able to go to the shops. I'm going to be able to go out with my daughter in the car. I'm going to be able to do this", do some gardening or whatever it is they want to do. I think it's good. We push people, we are risk takers. That's what we do, because we want people to be the best they can be. I think that is empowering, isn't it? Just seeing someone's potential and giving them the tools to reach that potential’

Although Aubree’s comments could be open to criticism on the basis of the implied individualistic behaviour change model, they also reflect an empowerment approach that has been found in some studies to increase motivation, meaning and purpose in life, and reduce stress for those suffering with multi-morbidity (Abadi *et al.*, 2021). Furthermore, community rehab staff described the benefits this approach could bring to patient’s lives, with no reference to the advantages of enabling patient discharge. This approach to care was inculcated within their pre-existing professional identity and did not reflect the instrumental use of empowerment to fulfil political and managerial aims.

The workload difference between community therapists and nurses highlighted by LPI Mary and pressures facing community nursing identified in the literature (Drennan, 2019; Lalani *et al.*, 2019; Dall'Ora *et al.*, 2020) was also reflected in my interview and observation data. Both frontline nurses and middle managers were open about the workload pressures facing the community nursing team. In section 6.4.2, I reported comments made by nursing assistants that they were '*running around like no tomorrow'* and '*firefighting because we haven't got no capacity'*. The sense that nurses were *'firefighting'* was also echoed by middle manager, Zoey. With middle manager, Katherine, explaining that modelling conducted on the community nursing team by an external agency '*shot us beyond what we should have and ditto our own efforts. It just always comes out as you need more than we've got'* emphasising the organisational awareness of capacity issues within the team.

These professional contextual factors provide the background as to why nurses much more readily accepted their role as *'waste watcher'* than therapists when on the receiving end of the organisational pressure to discharge resource. It is, however, important to note that the workload pressures within the community nursing team were also a result of the CBIC contract, and so the material reality facing frontline staff and the encouragement to discharge patients worked symbiotically. Detailed analysis of this response mechanism and the way in which it interacted with these contextual factors is discussed in the following section.

7.4.2 Response mechanism - adopting the *'waste watcher'* identity and enacting conflictual interactions

a) Self-management

Analysis of fieldwork data revealed that nurses generally were more accepting of adopting the *'waste watcher'* identity than therapists. This was because therapists saw the reduction in time before discharge as conflicting with their professional practice by not providing enough time to empower patients to self-manage. The quotes from band 4 Associate Practitioners, Abbie, and Alice, discussed in section 7.3.1 above indicated their frustration at having to discharge patients at 4 weeks when they do not feel they are ready. In other parts of their interview, they both expressed a level of panic when the four-week period was approaching and they were either going to have to discharge or ask middle manager, Denise to extend the time-period.

Alice told me:

'It's very difficult. I got a patient at the moment, I saw her for the first time, that would be Wednesday. End of last week, she told me her pain was 9 out of 10 on the pain scale so I'm already starting at a really reduced level. Now, I'm starting to think, "Four weeks, where am I going to get her to at four weeks? What can I do with her for four weeks?" I'm already starting to think in my head about discharging and if she doesn't reach where she's going to go, wherever she wants to go, what can I do with her to refer her or can I refer her to anybody else? Can I speak to Denise already and say, "Look, this lady may need an extra couple of weeks so that may take me to six weeks.'

This quote indicates a level of panic when Alice is asked to fulfil her role as ‘*waste watcher’* by discharging a more complex patient after 4 weeks. Her repeated self-questioning reflects her level of worry as to how to ensure that the patient does not fall through the cracks in response to organisational pressure to discharge patients. Both Alice and Abbie’s interviews indicated a level of professional satisfaction gained from working with patients for longer to ensure full rehabilitation. This suggests that they were resistant to the framing of patients as potential wasters of time and intellect and often hoped to be able to extend the 4-week period.

Similarly, physiotherapist Aubree, who I highlighted in section 7.4.1 as expressing a strong professional attachment to the empowerment approach, too expressed concern with how patients manage beyond the four-week period, saying that ‘*it would be nice if we could just keep them and just go and see them once a week, just to make sure that they're just ticking over’* and to prevent patients coming ‘*back around just like swinging doors’*. This sentiment was echoed by Abbie who expressed concern over patients coming back through the ‘*revolving door’*, adding *‘because we used to be able to have them for longer and really get them through their rehab*.’ This suggests that Abbie and Aubree view quicker discharge as ultimately more wasteful because of patient bounce-back to the service, representing a counter discourse to organisationally defined ‘*waste’*.

By contrast, the caseload pressure on the nursing service meant that nurses were keen to identify and eliminate *‘waste’* when they deemed patients to be capable of self-management or they did not fulfil the housebound criteria. Many nurses expressed frustration at patients who they felt could fulfil healthcare tasks themselves but resisted. It was evident in the data that many nurses had adopted their own neo-liberal enterprising and responsibilised subject positions (Du Gay, 1996; Miller and Rose, 2008) animated specifically through ‘waste watching’, in which they were self-regulating and active in their responsibility to seek out and responsibilise patients to take on a greater role in administering healthcare tasks.

‘Yes. I think it's getting patients to admit that they've got a personal responsibility. I think it's quite an old school view that health services are there to provide everything, and they're not used to having to take responsibility for their own health. It's always just been done for them’ (Adrienne, Matron, West Greenfay)

Adrienne is clear here that it is part of her role to get ‘*patients to admit they’ve got a personal responsibility.*’ However, in her example below, she describes how this can generate resistance and conflict in her interactions with patients.

‘Not all of them respond very well. I had a lady last week, and I case manage her husband who went and bought eye drops over the counter because she had a sore eye and wanted the district nurses to go out and do her eyedrops four times a day. She doesn't like doing them herself, but you know the argument that you get is, "I've paid my taxes all my life. Why shouldn't I have a nurse come out and do that for me?" That is the general argument, is, "I've paid my taxes. Why shouldn't I?" It's just explaining that we can't, we just can't. You have to take responsibility for your own health’

The above quote is Adrienne’s reporting of the interaction and not something I directly observed. However, Adrienne’s construes the position of the patient and herself as diametrically opposed. Both the patient and Adrienne are presented as giving simplistic arguments on either side of the debate, with little consensus or common ground achieved. The patient’s repetition of ‘*I*’ gives the impression that they are being overly demanding, and Adrienne’s ‘*we can’t, we just can’t*. *You have to take responsibility for your own health’* is issued as a command. The interaction described is more akin to a parent-child dynamic, where the child makes demands and the parent says no. This does little to move patient care away from the hierarchical dynamic within the medical model.

Several senior nurses reported that the less experienced junior staff can find it more difficult to engage in conversations about self-management with patients, due to the hostile reaction this can provoke from patients. Below, band 5 nurse, Penny who qualified two years before describes her difficulties when trying to encourage a patient to take over his insulin injections.

Penny*:* *‘Well, when it really snowed, I had to walk to this patient to do his insulin and I just thought, "You can do it yourself. I'll be here. I've got time this morning, I can encourage you, I can teach you, supervise you, blah, blah. ‘Oh well you've been doing it for X amount of months, years so you can carry on. It's your job. That's what I get. It's your job. It’s your job. Well, actually no, it's not my job. You can do it yourself but yes, that's the sort of thing that comes up. You've done it for so long. Why is it changing? No one likes change do they, but yes—'*

Hannah: *What do you say in response to that?*

Penny: *I was just pissed off, so I just left it there if I'm honest. Well, I've just walked here in the snow, I'm not going to have this conversation with you now. But yeah I don't know whether they'd be more accepting to like speak with a specialist, diabetic nurse, but obviously there's only like one***,** *so you can't have everyone go out to them but I do try, but it's just timing, isn't it?*
When someone gets their back up, like, "But you've been coming to me for years, what's changed?" I just think, "Well, actually I don't really have an answer for that." I can't really say, "Well we're really busy." But at the end of the day, it is that and you can self-manage, so you should be doing it.'

In the quote, Penny describes a difficult interaction in which she comes up against considerable resistance from a patient when she tries to suggest that he take on his own insulin administration. She exhibits favourable subjectivity in managerial terms through her rejection of what might be considered the traditional nursing role when she says '*well, actually no. It's not my job*.' Her quote in fact displays an acceptance of her role as teacher as opposed to care giver, marking a shift from what LPIs problematised as the '*do to'* paternalistic nursing mentality. Penny adopts the role of '*waste watcher'* through her assessment that the patient is capable of administering insulin, and so is therefore wasting the time and intellect of staff. She then makes a consequent attempt to get rid of this waste by suggesting to the patient that she teach him how to administer his own insulin.

Although in this instance Penny chooses to withdraw from the conversation, as opposed to engage in what would likely be a conflictual interaction. The patient-clinician dynamic enacted is similar to that expressed by Adrienne above. The clinician and patient are diametrically opposed in their positions with little consensus or common ground between the two parties. Most likely due to Penny's reluctance to engage, the patient is described as in more control of the interaction in contrast to Adrienne's description, with the patient commanding '*it's your job. It's your job'*. However, when Penny describes what she would have liked to have said in response, '*you can self-manage, so you should be doing it'* she resumes the role of the 'parent'.

One of the telling aspects of Penny's example is when she admits that she struggles to know how to justify the change to patients, "*Well, actually I don't really have an answer for that"* whilst then acknowledging that she can't say "*Well we're really busy.*' This demonstrates the difficult and uncomfortable position that frontline staff are being placed in with their interactions with patients, as well as highlighting how the material reality of pressures within the nursing service enhances her adoption of this subject position. Given the efficiency and waste reducing assumptions within lean discourse, the patient-clinician interactions enacted do not even provide the guise of empowerment or goal setting, leaving clinicians stuck with how to justify this change to care delivery. The result is a negative and adversarial interactional experience for both clinician and patient. This experience appeared particularly unpleasant for Penny who describes being left feeling *'pissed off'*. Furthermore, her experience level may have left her less equipped to deal with conflictual interactions that are enacted when clinicians attempt to adopt their '*waste watcher*' identity.

b) Housebound criteria

As highlighted above, the operationalisation of lean discourse into organisational pressure to discharge patients was inculcated in practices around discharging patients under the housebound criteria. Analysis of fieldwork data revealed that, similarly to the implementation of self-management, nurses exhibited favourable managerial subjectivity through their acceptance of their role as '*waste watcher*' when identifying those who they perceived to have physical capacity to make it to GP appointments. Also reflecting the enterprising nature of wasting watching, nurses spoke about the process of '*catching people out'* or '*finding out'* that people were not housebound through nurse's active engagement and acceptance of the role. Whilst the requirement for community nursing to be restricted housebound patient predates the CBIC, there appeared to be encouragement of stricter application of this criterion, due to resource constraints and caseload pressures in the nursing team. Similarly, to self-management, the pressure placed on the nursing service from the material reality of funding cuts, I would argue, led them to act upon themselves more readily in line with the *'waste watcher'* identity. Similarly, to that highlighted with the self-management analysis above, adopting this subject position often resulted in conflictual interactions between themselves and patients. Nursing assistant, Leah describes below a telephone call between one of the senior band 6 nurses and a patient who had called through to the office:

'We had a man call in about a leg dressing. One of the band sixes called him back and said, "Look, are you housebound? Because we're so short on capacity that we don't have time to see non-housebound patients." So every patient now, we're ringing up saying, 'are you housebound?, are you housebound?' She got an

absolute mouthful. It was horrendous, apparently. He was really abusive. People do get offended, because they're too lazy. Some of them. This is really niche. Some of them are too lazy to get to the GP surgery. It's easier for somebody to come to them.'

The relationship between the pressure on the service and determining whether patients are housebound is made very apparent through the rationale provided directly to the patient, i.e. '*Because we're so short on capacity that we don't have time to see non-housebound patients'*. Leah also claims that every patient is being called up to determine whether they are housebound or not, which draws on the assumption that all patients are kept under suspicion as potential wasters of resources. Nurses, acting as '*waste watchers'* then seek out and determine which of these patients is wasting time and intellect, so this '*waste'* can be removed. Again, this data example involves the retelling of an interaction by the interviewee and not a conversation that I witnessed and recorded first-hand. Regardless of whether this exact wording was spoken to the patient, it exemplifies the sentiment within the nursing team that part of their role involves seeking out and determining whether patients meet these criteria or not. The nature of the interaction is also described as *'horrendous'* and '*abusive'*, highlighting the possible conflictual nature of the dynamic between the health professional and patient, when clinicians embark on their role as '*waste watcher'*.

For Leah, however, this interaction clearly does not represent the neutral implementation of housebound criteria. Patient behaviours and attitudes are clearly problematised when she describes them as '*too lazy'*. She goes on to explain her frustration when patients try to resist being discharged from the service when she presents a stereotypical exchange between her and a patient:

‘Well, if we're discharged to the GP surgery, means that we’ve got to go out. And we say ‘well, yeah’. Well, we prefer if somebody would come here." "No, you can't. You can't do that. It's just a waste of resources." You're battling up against that. Some people just don't like being discharged. They just get offended, don't like it’

In this quote, Leah is encouraging the patient to become ‘responsibilised’ by making their own way to the GP surgery, as opposed to having a home visit. She expresses her frustration of resistant patients with her repetition of ‘*no, you can’t. You can’t do that’*. This is issued as a command to patients who are exhibiting a preference for being visited at home. She then draws directly on the discourse of lean working by explicitly describing these patients as ‘*a waste of resources’*. Her quote clearly implies that the dynamic between patients and clinicians can be antagonistic when clinicians are trying to both identity and remove *‘waste’* from the service. CPT 6 expressed concern that if health professionals internalise a negative perception of patients, then this may exacerbate the potential for negative interactions. This is not to say, that health professionals should take responsibility for all abusive and argumentative responses from patients. It is to say, however, that a perception of patients as ‘*lazy*’ or wilfully wasting resources sets a pretext for a high probability of hostile and antagonistic interactions if patients are resistant to being discharged.

Not only was antagonism between nurses and patients relating to the housebound criteria evident within the research data, nurse’s also reported increased conflict with other agencies, such as GP practices and the acute hospital. Given that the CBIC's stated aim was to increase collaborative working with external agencies, including GP practices, in order to reduce fragmentation and improve patient care, resources which encouraged discharge were leading to greater hostility. This largely arose because patients who do not qualify as housebound were being bounced between community services and GP practices who claimed they lacked the facilities or skills to treat the patient. As explained by the middle manager, Fiona, below:

'Yeah, it raises problems all the time. So, if you've got someone who requires insulin, there's nowhere else for them to go to have it done if they're not housebound. Same with more of the specialist ones. So, for example yesterday we had a 35 year-old lady referred into the service for a drain. Well, she's definitely not housebound, but the surgery are saying they don't know how to do it. So, we have actually refused that, but eventually it will bounce back because there's no one else to do it.'

This example represents interorganisational relationships between community and primary care that is the antithesis of claims made in the Business Case that the CBIC would result in less 'bounce backs' to General Practice'. In Fiona's example, the patient has been passed between the GP and community and is left waiting for care.

7.4.3 Outcomes

a) Disempowerment and poor experience for both staff and patients

I found little change to the hierarchical patient-clinician interactions based on the medical model. Acting as a ‘*waste watcher*’ produced adversarial interactions if patients exhibited resistance to self-managing their condition or attending GP appointments, as opposed to having home visits. These interactions had the potential to be disempowering for both clinician and patient. I did not speak to any patients who had experienced conflictual interactions over self-management or the housebound condition. However, one patient, Margaret, and her friend Sally who also took part in the interview, did report sensing that the community nurse was irritated by being called out, with Sally reflecting ‘*she probably thought, "Well, why can't she have gone for surgery?"*’ And Margaret, perceiving ‘*You couldn't relax with her. You felt you were holding her up*.’ This highlights that even if patient-clinician interactions do not result in outright conflict, patients are able to sense they are being viewed as wasters of staff time and intellect.

There was some evidence from my interviews with nurses and patients that on some occasions patients had been receptive to self-managing their condition. This was based on greater convenience through not having to wait for home visits. I captured the following exchange between Jonathan and his wife Christine, which suggest some patients are also active in this *‘waste watching’* activity and would be happy to take on responsibility for aspects of their care.

Jonathan: *It's just wasting time. There are just big gaps in-between when you should be doing stuff. That's why you end up, that's cheaper to do it yourself because you get it done when you want to get it done.*

Christine: *Well, like you say, they're wasting time on you when you probably could do that yourself is what you said one day, did you, to me?*

Jonathan: *Well, yes.*

Christine: *"If we could learn to do it ourselves," you said, "that's as wasting their time where they'd likely go with people who are really ill," like some of the elderly-- well, more elderly than the-- He does his bag and everything himself so he said perhaps we could do that. We will probably ask again if somebody can show us that to see if he can do it, because there are people who do their own, we know people who do their own*

Firstly, Jonathan refers to the convenience that would be obtained through being able to '*get it done when you want to get it done'*. Christine, whilst referring to a prior conversation between herself and William, is supportive of managerial discourse by construing Jonathan as '*wasting their time'* by comparison to more vulnerable patients. In these contexts, where patients do not consider themselves vulnerable and have substantial support from family members, they may experience the opportunity to fulfil healthcare tasks themselves positively. However, what the operationalisation of lean discourse through 'waste watching' does not provide is a way of explaining or engaging with patients who offer resistance. The consequence of which is the type of disempowering experiences described by clinicians in section 7.4.2.

b) Patients being bounced between the service or falling through the cracks

Stricter application of the housebound criteria resulted in patients being bounced back to the GP practice or falling through the cracks of the service, in the way described by Fiona. Some evidence provided by some of the senior nurses within West Greenfay suggested that there could be some negative psychological and physical effects from discharging certain patients who did not meet the strict housebound criteria but were also too frail to visit the GP surgery.

'I've got one particular lady that if she really had to, she could get in a taxi and go out, but the repercussions on her mobility for four days after because she's got such a bad rheumatoid arthritis, is terrible. And that's no..when she's got to go out once a week for a 15-minute injection, if that, but then she's suffering for four days after that trip. There's no quality of life, and we need to look at things like that (Adrienne, Matron, West Greenfay)'

From a patient perspective, I did not speak to anyone who reported being discharged under the housebound condition. However, Dorothy described complaining to the hospital sister when she was advised that she would have to go her GP to have her stitches out, on the basis that her mobility was too poor following surgery. Dorothy describes how the sister '*got on to them (community nursing team) again and had a bit of an argument with them. 'This patient's got to have someone to come out to see her stitches' and in the end, they agreed and they made the appointment.*' Dorothy's described this process of arranging her care as '*ridiculous*' indicating the lack of clarity and delay to having her stitches out was a negative experience.

7.5 CMO - 3

The following CMO demonstrates how the response mechanism differed in the context of more vulnerable patients.

In **contexts** where members of the ‘integrated’ care team treat patients with high levels of frailty, comorbidity and dementia, **resources** which seek to encourage health professionals to discharge patients mean that health professionals must negotiate their *‘waste watcher’* identity considering this vulnerable patient population **(response)** with the **outcome** of potential harm to patients if they are discharged and intensification for staff when patient’s capability for self-management does not align with reduced budgets

7.5.1 Contextual factors within the patient demographic

The patient population within the community nursing service are primarily housebound patients who exhibit poor mobility, eyesight, and dexterity (middle manager, Zoey). The Greenfay area in particular has a very high rate of elderly people suffering with long term conditions, including dementia, with this being above the regional and national average (see appendix 3). My nurse interviewees explained how these patient contextual factors can influence their ability to administer their own insulin. Band 5 nurse Cheryl, told me the following:

‘*Maybe their dexterity or just their ability. Some patients just do not have the ability to remember all the steps of giving an insulin injection. If it's put in for six weeks, they're* *still forgetting to do the air shot, holding it for 10 seconds once they've given it to them. You just think actually maybe they do need some ongoing support*'

Band 5 nurse, Raquel also explains below how most insulin dependent diabetics have ended up on the service because of an issue with their ability to correctly self-administer.

'*Normally, they've actually proven that they can't do it because they've had hypos, hypers, ended up in hospital, they've been found on the floor or whatever. There's normally been some drama that has led to us coming into their lives. Quite often it is protracted, very poor control of their glycemic levels because they either don't bother to take the insulin, they don't take enough of it, they forget to take it, they forget to eat or whatever. Normally they go into hospital, some they've been found on the floor and they've been found in a terrible state. People have got to the bottom of it and it's because they haven't been able to accurately and reliably give themselves insulin. There's nobody that we see that could do it, but just doesn't fancy it*'.

Raquel is highlighting the vulnerabilities in their patient population, which mean that safely transferring responsibility for insulin injections to those patients would present many complex challenges. Raquel's point, which was supported by middle manager Zoey in her interview, is that community nursing patients, by definition, exhibit a high level of frailty to qualify for the service. It is these very frailties that mean transferring responsibility for care they have already demonstrated they are at risk from administering themselves, renders the concept of self-management potentially problematic.

Both Cheryl and Raquel's explained the way in which patients fail to administer their insulin correctly, i.e. '*forgetting to do the air shot, holding it for 10 seconds once they've given it to them'* or *'very poor control of their glycaemic levels because they either don't bother to take the insulin, they don't take enough of it, they forget to take it'* highlighting how it is the particular technical element of insulin administration that becomes challenging within this patient context, with the consequences of incorrect administration being 'hypo- and hyperglycemia, wide glycemic excursions, and diabetic ketoacidosis' (Trief *et al.*, 2016, p. 25), which can lead to serious health consequences, such as chronic diabetic complications (Al-Rashed *et al.*, 2020) and cardiovascular disease (Standl *et al.*, 2011; Saisho, 2014).

The patient population typically coming under the rehabilitation service are those that have been discharged following surgery or struggling with their mobility in their home. Although there is not a specific requirement that these patients must be housebound, they are often elderly with long term conditions, and so need to be visited at home. There was some indication from staff that these factors exacerbate the ability of patients to self-manage their condition. However, physiotherapist, Addison, explained how she perceived self-management in therapy to be different to interventions performed in nursing '*because we are not doing any manual handling anyway, so most of our activities would be the patient self-managing because even when we are there, we are just telling them what to do*'. The different types of interventions performed in nursing and therapy was also considered my nurses to exacerbate the application of goal setting within their care. As explained by middle manager, Zoey, below.

‘Actually, nine times out of ten their goal will not be around anything that you're there for. Their goal could be, they just want to see a family member or they want to be able to go one more walk along the beach or something like that. We have to recognize that but it's not achievable within our service we deliver. It would be then making an onwards referral. It is really hard and that is the bit that community nurses struggle with because it's all about their goals. Their care plan would be around their nursing activity that we're seeing, and we meant to do that in partnership with the patient. But nine times out of ten these patients don't want to know what we're putting on their wound, because we're the nurses and we'll dress it how they feel is best for nurses to dress it.’

7.5.2 Response - negotiating the *‘waste watcher’* identity

As discussed within CMO 2, most nurses exhibited favourable subjectivity in terms of their willingness to actively adopt enterprising neo-liberal subject positions, which were animated specifically within the CBIC through the ‘*waste watcher’* identity. However, it was also the case that many, including middle manager Zoey, acknowledged the difficulties of this approach to nursing and drew a clear dividing line between those that simply could not take on this responsibility due to either their physical or cognitive abilities. In these cases, nurses were clear that they had a duty of care to the patient. Most commonly, nurses highlighted the patient factors discussed above in section 7.5.1, such as dexterity and memory loss, as barriers to them instigating self-management with patients. However, the reasons given for maintaining their caring role did not appear to represent the paternalistic attitudes described in the LPI interviews, in which nurses were constructed as arbitrarily wanting to continue to ‘*do to’* the patient, and instead presented clear reasons as to why patient safety may be compromised by withdrawal of nursing care.

In the below quote, Matron Adrienne, who as discussed in section 7.4.2, was keen to take on the role of *‘waste watcher’* and to encourage patients to become responsibilised, expressed fears over the impact of applying self-management unilaterally and not considering the patient as a whole person.

‘*Yeah generally, the district nurses have only ever done injections for those patients that were really complex or just couldn't do their own insulin. I think over the years, some have slipped through where they could do it themselves. It's just they don't like the idea of doing it themselves. Those patients definitely do just need to do it. You can't just have the excuse of, "I don't like the thought of injecting myself." It's for your own benefit, you need to have that responsibility for your health. Those ones that you feel they can physically push a pen, but there might be other stuff going on. So, sometimes that part is lost where the more holistic side of it, I suppose. Some are just really task-orientated. I think that's a shame if that's-- I don't want nursing to go into that way of all being around the task. It's got to still remain around the patient’*

Adrienne is expressing concern that the drive to discharge patients to self-administer insulin can result in task-orientated patient-clinician interactions that do not consider the whole of range issues that may be impacting on a patient’s life and their ability to self-manage. This is expressed as ‘*they can physically push a pen, but there might other stuff going on’*. What is potentially lost is investigation into the ‘*other stuff’*, which represents potential social, cognitive, or mental health related issues.

Adrienne's comments suggest that adoption of '*waste watching'* into nursing professional identity creates potential for nurses to take less consideration of the whole range of physical, social, and mental issues that may be operating in their life, which may render self-management difficult.

Concern was also expressed by some nurses about the impact of applying the housebound criteria unilaterally on patients. For these nurses, identifying those patients who constituted '*waste*' in relation to the housebound criteria was a grey area. Patients may be able to physically leave the house, but the impact on their physical and mental wellbeing maybe considerable. Acting as *'waste watcher'* can therefore be complicated by the gradients of what can be considered housebound, meaning that the determination of what counts as a *'waste'* of time and intellect must be balanced against potential harm to patients from leaving their house for appointments.

Healthcare assistant Sonia, a junior member of staff in terms of banding, but someone who was older in age and had worked for the provider for many years, told me the following:

'Erm (long pause) erm yeah, I guess it does, but I just feel a great deal of the patients that we see will never be able to self-manage, you know. I know there's a big thing about housebound at the moment. Housebound patient, you know "Tell me what is a housebound patient?" You know. I find it quite difficult and I'm not the toughest on that sort of thing, but basically if they can get in a car, they're able to get

to the surgery by taxi whether they've got the money or not because it's not our concern. I do struggle with that a bit'

Interestingly, the question I had posed to Sonia related to self-management, which she begins to discuss before switching seamlessly to the housebound criteria, demonstrating the discursive link between the two for many community nurses interviewed. Her question, '*tell me, what is a housebound patient?*' suggests that the criteria is, nevertheless, not always straightforward to apply. She describes finding it '*quite difficult',* whilst adding '*I'm not the toughest on that sort of thing'.* This implies she is not actively seeking out 'waste' and stringently enforcing the criteria, suggesting resistance to the *'waste watcher'* identity and its associated way of (inter)acting.

Similarly, to Adrienne's concern that the '*other stuff going on'* may not be taken into consideration when judging appropriateness of self-management, Sonia's reference to '*if they can get in a car, they're able to get to the surgery by taxi whether they've got the money or not, because it's not our concern'* suggests she views this criteria as both overly simplistic and reneging on their duties and obligations to the patient. Just determining whether someone can get into a car may not account for other issues that may be having an impact on the situation. Her criticism of not caring whether someone in fact has the money to attend GP appointments by taxi, also feels like an attack on neo-liberal ideas of personal responsibility and withdrawal of state intervention. A mitigation to the neglect of wider contextual issues by staff members came from CVS worker, Lottie, who told me that her attendance at the Leg Club provided an example of benefit to patients when the voluntary sector, focussed on social issues (i.e. alleviating loneliness), and the nursing team, focussed on clinical issues, work together, as, she reported, some patients wish to stay within the service, due to loneliness. It could be argued that contractual integration with the voluntary sector legitimised consideration of wider systemic issues that moved the dialogue away from purely individualising barriers to self-management, which often place blame onto individuals, whilst ignoring wider contextual factors.

In section 7.3, I discussed the key role taken on by senior band 6 nurses in encouraging frontline staff to discharge through either self-management or the housebound criteria. However, I also collected data which provided evidence of a counter 'pastor' role played by senior nurses in encouraging more junior team members to adopt a more nuanced approach to their *'waste watching'* identities, whilst reaffirming their caring role. Adrienne expressed concern to me that some junior members of staff were unilaterally enforcing the housebound criteria and will *'just discharge without telling the lead nurse, or anything'* saying that she tries to advise staff more junior to her that '*it's a guideline'* and '*we need to use our initiative'*. The fieldnote below describes a conversation I overheard between senior nurse (band 6) Kath and one of the lead band 5 nurse, Cheryl, in the West Greenfay office. This conversation exemplified the concern expressed by the senior nurses that some frontline staff are discharging patients under the housebound criteria, without taking into the account the whole person.

'*Kath (senior band 6 nurse) is having a conversation with Cheryl and telling her about a phone conversation she has just been having with a patients' daughter. Kath started off by saying 'I mean she does have some fair points'. The patient is being* *treated for leg wounds by the service, but is also going to the hospital once a week to have blood transfusions and these are keeping her live. She also says 'she's a palliative patient'. Kath tells Cheryl that when the nurses hear about this they rightly say 'well you're not housebound then'. Kath goes on to say that 'we need to have some flexibility with these kinds of patients. We need to be treating them on an individual basis. So, I've said to her that we'll still go out and see her as she's really poorly and palliative.*

Cheryl replies: *'people are just applying it so rigidly to everyone and we need to treat people individually.'*

Kath: *I know they need to be treating each patient at a time. I mean especially if they're palliative. I mean they're going through enough as it is. We just need to make sure that no one else says to the daughter that her mum's not housebound. I think one more time and it'll tip over the edge*.'

Kath's position provides a mitigation to the *'waste watcher'* identity by rejecting an overemphasis on identifying and getting rid of '*waste*' from the service that can result in decisions that do not view patients holistically. The enactment of this mitigation is that Kath has overridden the discharge decision made by the nurses who have engaged with the patient previously and reinstated the patient within the care of the nursing team.

7.5.3 Outcomes

a) Impact on patient care

There was not much evidence that patients are being discharged to self-manage and coming to any long-lasting harm. Nurses reported that given the risk associated with patients not administering their own insulin correctly, they do not withdraw support if there is potential danger. They also said that patients who struggle, following a self-management discharge, will soon bounce back to the service. However, it is also the case that the risk level for these nursing patients is higher than those therapy patients who fail to self-management, given earlier discussion in section 7.5.1 on the impact of poor glycaemic control. The difficulty level of correctly administering injections can result in incorrect application and high levels of stress.

I did not speak to any patients who were administering their own insulin, but Maureen did describe to me the difficulties she had doing her post-operation clexane injections.

‘I did come out with it and I said I would try and I did try. I know, I suppose, I ruined about three of those things. They weren’t three nights on the trot. I thought, “Blow it, a day or two doesn’t matter.” If anything went wrong, it would have been my fault, but about three. I think you had to do it for two weeks, I can’t remember. So about three out of those for two weeks I did ruin. Just luck of the draw. I was covered in bruises. You had to get a hold of your tummy between two fingers and stab yourself. Some days I didn’t stab hard enough, another time, I stabbed so hard I bent the needle back.’

This example from Maureen provides an example of the patient experience of struggling with attempts to self-manage injections, i.e. ‘*Some days I didn’t stab hard enough, another time, I stabbed so hard I bent the needle back’.* This provides an insight to difficulties facing nursing staff when attempting to discharge through self-manage when patients are at risk of not administering correctly.

b) Work intensification

The main staff level outcome was that the level of patients deemed unsafe or resistant to self-management meant that demand on the service far outstripped resource, given the financial modelling within the CBIC contract. This resulting in work intensification, as explained by Greenfay middle manager, Zoey below:

‘I've constantly got vacancies, then you've got sickness on top of that, unfortunately due to financial pressures, community nursing, there was some hours removed from my budget for qualified nurses which has been really detrimental to my team, my staff. I've got staff working extra to meet demand. Because of the CBIC vision, that we'd have this self-care model and push forward with it, with this area in particular, which is one of the most deprived areas in (the region) and that's one of my wards that I cover, primarily Orlake, patients are not-- They don't self-care, they're at the age, they're vulnerable, they haven't got the knowledge or skills or had the education to understand that.’

Zoey articulated how the difficulties of self-management within a deprived patient population (Orlake is consistently ranked as the most deprived small area in England (Ministry of Housing Communities & Local Government, 2019)) means that demand has not reduced in line with funding reduction, resulting in *'Firefighting as in, staffing level sometimes don't reflect our demand. We are all working what I would say over and above'*. She also emphasised to me that they as nurses have a '*responsibility to that patient'* if they do not feel self-management is safe or applicable. Her comments relating to '*firefighting'* are also reflected in comments made by nurses across the empirical chapters. Middle manager, Katherine, also explained to me that in response to the resource pressure in community nursing '*the nurses make do and I think that they're very resourceful at making do*-- *We work a lot on people's goodwill, I think'*, suggesting, in support of Zoey's comments, that the service survives through nurses working extra and being responsibilised for the financial efficiencies in the contract.

7.6 Discussion/conclusion

7.6.1 Relationship of findings to CPTs

This chapter has built theory on what happens within micro-level implementation when self-management is framed within managerial discourse of lean and its focus on the removal of 'waste'. I have demonstrated within chapter 5, how LPI meso level texts developed prior to, and at the initial stage of contracting (Business Case, Tender, Staff training video), framed the implementation of self-management within the IC policy discourse and its constituent discourses of empowerment and patient centred care. I argue that the socially structuring effect of the funding pressure within the CBIC contract meant that there was discursive shift between this and the LPI interviews where self-management became dislodged from patient related problematisations (i.e. lack of patient power, disjointed care) and instead became construed purely within its neo-liberal economic logic. Within LPI interviews, self-management was positioned as essential to ensuring financial sustainability and meeting the efficiency savings within the contract, with LPIs attempting to shape patients and nurses into responsibilised subjectivities. Through engagement with the academic literature, I developed three CPTs that are relevant here. These formed propositions of how needs-based problems may be created if this discursive work was dialectically transformed into practice. These were as follow:

4. If nurses are on the receiving end of resources that diminish their professional identity or professional practice and place it in a lower hierarchical position to therapists, they may experience considerable professional identity threat and alienation from their work

5. If health professionals accept the instrumental goal of using self-management to achieve efficiency savings and increased patient responsibility within their professional identity and practice, then their conversations and interactions with patients maybe unidirectional and imposing, resulting in poor experience for patients and not having their views and opinions taken into consideration

6. If health professionals accept that patient behaviours and attitudes are problematic due to their lack of responsibility then this could engender negative attitudes towards patients and increase the chances of difficult interactions, resulting in a worse experience for patients

Analysis of phase 2 data found that nurses were not on the receiving end of organisational/managerial resources that diminished their professional identity in relation to therapists. Although I found that the health coaching training, drawing heavily on the empowerment discourse, was delivered from a therapy perspective, data analysis revealed that the health coaching textual resources did not have a great impact on the day to day working lives of therapists or nurses. Both therapists and nurses were instead on the receiving end of organisational resources operationalised from lean discourse. These employed power operating at the nexus of subjectification and discipline to encourage staff to discharge patients as wasted time and intellect. I argue that the move between empowerment and lean within micro level implementation, represented a similar discursive shift found between official documents and the LPI interviews, arising from the same socially structuring material reality of resource pressure. The shaping of the *'waste watcher'* health professional represented a specific articulation of the responsibilised and enterprising neo-liberal subject position constructed by LPIs. Through analysis of phase 2 data, I developed the following two CMOs, which expand CPT 5 and 6, as well as integrating findings on professional roles, referred to in CPT 4, as a contextual factor.

2. In **contexts** where members of 'integrated' care teams hold differing professional identities, professional practice, and workload pressures, **resources** which seek to encourage health professionals to discharge patients mean that nurses **respond** by <u>more readily adopting '*waste watcher*' identities than therapists and enacting conflictual and antagonistic patient-clinician interactions</u>. The **outcomes** of this are

disempowerment for both patients and clinicians and the possibility of vulnerable patients being discharged under the housebound condition

3. In **contexts** where members of the 'integrated' care team treat patients with high levels of frailty, comorbidity and dementia, **resources** which seek to encourage health professionals to discharge patients mean that health professionals must negotiate their '*waste watcher*' identity considering this vulnerable patient population **(response)** with the **outcome** that discharging patients through self-management and the housebound criteria becomes difficult when balanced with responsibility for patient care, resulting in intensification for staff when patient's capability for self-management does not align with reduced budgets

Conversely, to what I had proposed through CPT 4, it was nurses who more readily took on their role as *'waste watcher'* compared to therapists, due to the need to reduce their caseload pressure. I therefore built this professional contextual factor into CMO 2 to show how inculcation of lean discourse into professional identity occurred when workload pressures were high, and the removal of *'waste'* would have a material benefit on their day to day working lives. Building on CPTs 5 and 6, I found that nurses were therefore accepting of their role in using self-management to reduce caseload pressure by shaping responsibilised subjectivity in patients. However, as suggested in CPT 5 and 6, evidence from my interviews with nurses found that conflictual patient-clinician interactions occurred when patients resisted. Nurse's acceptance of their *'waste watcher'* identity also had to be negotiated carefully when dealing with their largely elderly and frail patient cohort, as those discharged from the service could potentially come to harm. However, the main outcome arising from this context/response mechanism interaction was that the level of patients able to be discharged through self-management/housebound criteria did not match the financial modelling in the contract, leading to work intensification for nurses.

Chapter 8 Auto-allocation Scheduling System

8.1 Introduction

Chapters 6 and 7 sought to expose the way in which the managerialist discourse of lean was operationalised through managerial and organisational resources to shape health professionals and patients through neo-liberal responsibilised and enterprising subject positions, animated specifically within the lens of *‘waste watching’*. At the semiotic level, references were made to integration and empowerment narratives within micro-level implementation. However, the ideological work of the IC policy discourse smooths over contradictions and inconsistencies in the claim that resources can be reduced whilst also improving patient care, allowing austerity to be mobilised through IC implementation. This had a dislodging effect on concerns for improvements in patient care. The socially structuring context of funding cuts allowed the constituent discourse of lean to achieve organisational dominance, which was operationalised through attempts to shape clinician and patient subjectivity in line with *‘waste watching’* within the CBIC practices of self-management and generic roles.

This chapter will seek to demonstrate through the empirical example of an auto-allocation scheduling system, called Cbernet, how the operationalisation of lean discourse through this technology had a similar dislodging effect when it came to case management and treating patients holistically. Auto-allocation for community health visits tries to optimise resources by privileging the number of face-to-face contacts with patients each clinician undertakes. It also seeks to minimise the amount of time spent doing activities which were not considered legitimate parts of a clinical role or were considered to exhibit personal preference or potential human error. However, it will be demonstrated through the empirical findings presented in this chapter that this efficiency maximising health professional interacts negatively with the type of behaviours and ways of working that are associated with integrated care. These include engaging with the same patients over time, reviewing their progress, taking their whole needs into account beyond their professional boundaries, having sufficient knowledge of individual patients to be able to discuss at multidisciplinary team meetings, and basing their engagements on genuine human interaction.

In section 8.2, I present my discourse analysis of three semiotic ‘points of entry’ (Fairclough, 2008) into my analysis of the organisational practice of auto-allocation scheduling within the CBIC. These texts, including the Cbernet website, promotional poster, and promotional video, draw heavily on lean discourse by stressing the ability of the new system to reduce waste and add value and efficiency to the allocation process. The system is also presented as having an empowering and liberating effect for staff who will be freed from burdensome administrative work that inhibits their professional practice.

In section 8.3, I discuss the way the discourse realised linguistically through these texts was operationalised as a technological resource that had a direct influence on the day to day working lives of frontline staff. This resource exerted disciplinary power (Foucault, 1991a) through a) the physical presence of a list with the order of visits, journey route and average number of minutes per visits allocated to staff b) a gatekeep system operating over the scheduling system.

In sections 8.4 to 8.6, I present the context-mechanism-outcome theories that seek to explain what happened when this resource mechanism was introduced into varying professional contexts and a largely frail elderly patient cohort. These CMOs are as follows:

4. In **contexts** where health professionals have a greater level of professional discretion over the allocation of community visits, **resources** which exhibit greater surveillance and control over their decision-making processes will reduce their ability to use professional judgement and skill **(response)** therefore reducing continuity, care co-ordination and ability to participate in case load reviews with external agencies, such as GP practices **(outcomes)**

5. In **contexts** where band 3 assistants who have been trained to deliver care beyond their traditional boundaries have a high daily volume of visits, consisting largely of elderly, vulnerable patients **(resource)** greater control over visit allocations and time restrictions **(response)** diminish human relationships and authentic patient-clinician interactions, resulting in the continuation of task orientated and non-holistic care **(outcome)**

6. In **contexts** where there is a patient population of largely elderly, frail individuals with comorbidities **(resource)** exercising surveillance and control over swapping visits with colleagues or making adjustments to visit times can result in health professionals internalising this discipline **(response)** meaning that health professional’s role is intensified through them taking on the burden of completing work in their own time **(outcome)**

In section 8.7, I discuss the findings presented in the chapter in relation to the CPTs developed in chapter 5. In relation to the wider IC policy discourse, the central argument presented here is that the ‘ideal’ efficiency maximising health professional is at odds with the type of health professional who can deliver greater continuity, care coordination, and multidisciplinary working. This type of care requires time to build up patient relationships, to review progress and determine the links with other services beyond their professional boundaries. This evidence, therefore, works to expose the inherent contradiction and ideological work within the IC policy discourse, which seeks to smooth over any conflict between the Government’s austerity agenda and the delivery of integrated care and any benefits for patients.

8.2 Textual resources

8.2.1 Cbernet website, promotional poster and video

1. What is the purpose of, and context behind, this specific communicative event?

The textual resources analysed in this chapter, include text within the Cbernet website presenting a case study of OCC, the promotional poster which was placed in the Hallstone office, and the promotional video created by OCC and Cbernet. All three textual resources were created by both the provider and Cbernet as an advertising tool to promote the technology. The way in which auto-allocation is construed linguistically therefore represents the way these organisations would like auto-allocation to be promoted to an external audience. However, the promotional poster was displayed within the Hallstone office in the hallway so it would be clearly visible to staff as they entered the office, indicating that the poster was also an organisational messaging tool.

Similarly, the promotional video, which was posted on YouTube, OCC's Facebook page, and the Cbernet website was made with participation of staff and included staff testimonials of their experiences with the system. However, it is important to note that I have treated the staff testimonials as organisationally promoted discourse within the analysis. I was alerted to the video's existence by a member of staff and I witnessed staff watching this video, demonstrating that this was also a resource co-created and consumed by frontline workers. All three textual resources draw on the same discursive frame, so I have combined my analysis below, under the same question headings.

2. What is going on specifically within the text and how do the linguistic features within the texts draw on discourses (ways of representing) at the interdiscursive level?

The main discursive frame drawn upon linguistically through the texts is the managerialist discourse of lean, which I have discussed in depth in chapters 6 and 7. Through the discourse of lean, auto-allocation of community health visits is construed as reducing waste, adding value, and creating efficiency. The waste created by the previous system of manual allocation was articulated within the promotional video through the voice of senior band 6 nurse, Sandra:

‘It was really hard work, really frustrating, spending hours allocating the work, getting the right people in the right place at the right time. It was just really frustrating as we needed to be out on the ground doing the work that we’re trained for and we were spending time doing admin work’

The quote stresses how much time was wasted through reference to the ‘*hours*’ and *‘time’* spent ‘*allocating work’* and ‘*doing admin work’*. Having this *‘waste’* articulated by one of the senior nurses, as opposed to management, works to reinforce the authenticity that is claim is professionally as opposed to managerially owned. The negative impact that this *‘waste’* has on her as a clinician is also emphasised through her repetition of the adverb ‘*really’* to describe how *‘frustrating’* this waste was and the level of ‘*hard work’* it required. Her use of the pronoun *‘we’* instead of ‘*I*’ also suggests that this wasted time applies to all senior nurses collectively and is not an isolated issue.

The text used on the Cbernet website directly draws on the language of waste when it is claimed that manual allocation is resulting in *‘thousands of hours of senior nursing time being wasted each year.’* The idea that manual allocation adds no value is categorically expressed when it is described as ‘*being needlessly convoluted, complex and time consuming*’, with ‘*needlessly’* emphasising the pointlessness of using this process. The value added by the scheduling system is also expressed using this level of categorical modality when it is claimed it has been ‘*proven that by using the scheduling system instead of the clinical system, Senior Nurses can schedule and book over 100 patient appointments in just 20 minutes.*’ The claim that is has been ‘*proven*’ is unequivocal and presents this assertion as fact.

In addition to an emphasis on eliminating waste and adding value using the auto-allocation scheduling system, the texts also draw on the discourse of lean in their rejection of the ‘logic of professionalism’, in replace of the ‘logic of managerialism’ (Waring and Bishop, 2010, p. 1333). For example, in the promotional video, middle manager, Fiona, says, ‘*We needed some sort of technology to help with this scheduling problem’* before discovering Cbernet who ‘*were already solving problems of logistics in the commercial industry’*. Here, she draws a direct link to the way in which solutions developed in the private sector can be applied to the healthcare context, in the way assumed within lean working (Radnor *et al.*, 2012).

3. What is the representational function of the discourse being drawn upon in these texts? In what ways are problems constructed? What is silenced? What are the underlying assumptions?

By drawing on the discourse of lean, which prises managerialist solutions to problems, the texts construed nurses making allocation decisions and any time spent away from face-to-face interaction with patients as problematic. Speaking on the promotional video, Fiona describes the ‘*moving of visits, changing of visits, cherry picking’* that was being conducted through the manual scheduling process. ‘*Cherry picking’* was described in interviews as clinical staff showing particular preference for certain patients, due to home setting or personal connection. The assumption here is that nurses were employing personal discretion in the allocation of visits for inappropriate and non-clinical reasons. Taking this a step further, the Cbernet website describes the previous scheduling system as relying on ‘*nurses’ experience and intuition’* compared to the ‘*in-built decision support’* within the automated system.

In this example, even professional '*experience and intuition'*, which would normally be considered as positive attributes are problematised in terms of '*inefficient schedule and increased risk of human error'*, with '*human error'* resulting in '*missed visits'*. This was contrasted with the claim on the promotional poster that there had been '*0 missed visits*' since the introduction of the scheduling system. The auto-allocation scheduling system is therefore constructed as increasing standardisation and removing professional discretion by restricting allocation decisions to those based purely on competency, minutes left in the day, and geography, with the result of increased efficiency and patient safety.

In a similar vein, the auto-allocation system was also construed as being able to better plan the visit schedule and journey route compared to health professionals themselves. On the promotional video, nursing assistant Samantha, is featured saying the following:

'So, what I love about it is that all of the patients are listed on my phone, and they're listed geographically so I know which route to take. Because I've followed it geographically my list is done quicker so I've visited my patients a lot quicker.'

Again, including this statement from a member of frontline staff, works to provide a level of authenticity that clinicians themselves are in agreement with managerial discourse. Samantha uses the word '*love'* as opposed to '*like*' to indicate a strong emotional response to the scheduling system. She also places herself in a passive, incapable position, problematising her ability to plan her own schedule and route to take, by suggesting that she would not know which route to take if it was not for the scheduling system.

As well as problematising nursing input into allocation decisions and their ability to plan their schedule and route, time spent away from face-to-face interactions with patients was not construed as legitimate nursing work. Sandra's reference to *'we needed to be out on the ground doing the work that we're trained for*' indicates that the allocation of visits is not considered part of the nursing professional role. The main strapline on the promotional poster placed in the Hallstone integrated care office also read *'how we avoided fines and got our nurses back to nursing*'. Time away from conducting patient visits is therefore problematised as pulling nurses away from their legitimate duties.

The decision-making capability of the auto-allocation system was linked directly with cost savings. Costly fines, due to failure to attend pressure ulcer visits, were linked with manual scheduling. A senior manager speaking on the promotional video tells the audience *'missed visits around pressure ulcer care can result in a fine of £10,000 per pressure ulcer, and in one financial year we wracked up fines of a £120k'*. It is then claimed later in the video that 2 ½ years on from the initial implementation of scheduling system there have been no missed visits and no pressure ulcer fines. This cost saving is therefore directly linked with minimising the human error that results when nurses do their own allocations, further working to problematise any aspect of human decision making. The Cbernet website also claims that the scheduling system can achieve 10% productivity gains and a reduction in the cost of delivering the service, highlighting the monetary gain that it is claimed can be derived from an increase in automation.

Given the promotional nature of the textual resources, it is unsurprising that there is little focus within the textual resources on what might be lost from moving from a manual to an automated system. The textual resources analysed are designed to project the auto-allocation system positively to those consuming them. We might, therefore, consider what is silenced within this presentation of an automated allocation system, and whether by diminishing the human element within the process there are any negative impacts on patient care. Speaking on the promotional video, the managing director of Cbernet, Jamie, provides the only discussion of the '*human*' element that goes into scheduling community health visits.

'*When we first came to OCC, we brought with us what we thought was a good technology with our experience of scheduling. But then we realised that actually there was a lot more to it with community services. A lot more clinical rules and you have to be more patient focussed. For example, each patient is very individual so the duration of visit may not work across visits. You have to be flexible. Some visits may be longer for certain patients, also around insulins that was very important to make sure you don't put anything in between insulins. So, lots of little things like that, with a human they would know that straight away. We had to teach a system to learn that'*

The above quote provides the first example of where human decision making is seen as beneficial within the allocation process. It is highlighted that when working with patients, flexibility is needed due to the individual nature of patient care. This means that some patients will require visits that last different lengths, and that some visits are more urgent than others, such as insulin visits. The need is therefore to teach the system to learn the aspects that '*with a human they would know straight away'*. Previously, flexibility has been associated with introducing personal bias, human error, and inefficiency. In a slight discursive shift, it is acknowledged that when dealing with community health patients, flexibility is in fact needed to account for the individual nature of patient care. The question then becomes whether a system premised on the benefits of removing flexibility in visit allocation decisions has the capability to deal with individual nature of patient care.

4. What ways of (inter)acting does this discourse trying to enact between patients and clinicians? 5. How do these discourses try to shape patient and clinician identity?

As found in my analysis of lean discourse in chapters 6 and 7, the patient voice or experience was largely absent. Concern is expressed about missed visits. However, this was framed through the potential for resulting financial penalties and not in terms of improved patient experience. Any change to patient-clinician interactions is therefore silent, which works to imply that patient care will remain unchanged or potentially improved through quicker processes.

The Cbernet textual resources, reflecting recent work on worker subjectivity constituted through lean discourse (Mackenzie *et al.*, 2020), situated nurses in positions of freedom and constraint. Nurses were on one hand, liberated and unburdened by unnecessary administrative work through use of auto-allocation scheduling, empowering them with the freedom to complete the work they were trained for. On the other, nurse's predilection for human error, bias, and the inefficiency created by their intuition and experience, necessitated standardisation of professional practice. In this sense, the ideal health professional is one that maximises efficiency and constrains their personal preferences and inclinations, whilst exercising freedom in activities considered as legitimate professional practice, such as face to face patient contacts.

8.3 Technological resource mechanism

The analysis discussed above provides evidence of the way in which lean discourse was realised linguistically through textual resources, which sought to communicate the Cbernet system to an internal and external audience. However, lean discourse was also dialectically transformed into a technological resource in the form of the auto-allocation scheduling system. This was introduced to staff as a material reality that had a direct influence on their professional roles and their day to day working lives, in a way that goes beyond its linguistic representation.

In its efforts to reduce waste, and to combat the perceived problem of time spent on allocation and the problematic aspects of health professional decision making, the auto-allocation system enacted a certain level of control over day to day working through a) the physical presence of the allocation list and scheduled visit lengths on staff's phones and b) a gatekeeper system operating over changes to visit allocations. Power operating through this technological resource was therefore more directly disciplining (Foucault, 1991a) through its ability to make staff visible through ‘hierarchical observation’ (p. 170) and ‘surveillance’ (p. 171), whilst being assessed and corrected against a norm through ‘normalising judgement’ (p. 177).

a) Physical presence of a list with the order of visits, journey route and average number of minutes per visits allocated to staff

The managerial logic underpinning lean discourse assumes that the Cbernet system can more efficiently plan the order of visits, journey route and visit times, compared to health professionals. Community nurses band 3 & 5 and community rehab assistants band 3, receive their allocated home visits on their mobile phone. This list sets the order of patient visits and uses a satnav system to work out the route to take to drive between visits. Each health professional has a total of 390 minutes to complete for the day and visits are allocated out on this basis, with average visit times pre-decided based on the type of visit, i.e. insulin, wound care, etc. These average visit times also include time spent on travelling between homes and admin time to add patient notes onto SystmOne.

Under the previous system, visits would be added manually onto staff’s SystmOne leger, which could be accessed using an employee’s laptop. Length of time for visits were allocated on the previous system, but staff reported that there was a greater level of flexibility and that these could be changed, dependent on their experience with the patient. Length of time for visits was also set separately to Travel, SystmOne, and Management (admin) time (TSM). Staff reported that Cbernet’s use of average times, including travel and admin, resulted in insufficient time to complete all aspects of the visit (care delivery, travel, admin). It also meant that the next visit would be allocated immediately after the last one, regardless of the length of time it would take to drive from one patient home to the next. These average times had a normalising and homogenising function (Foucault, 1991b), which made health professionals visible when deviating from the norms, working to exert pressure on them to complete their patient list within unrealistic time frames.

b) Gatekeeper system operating over access to Cbernet

Access to Cbernet was restricted to certain members of staff (management, senior band 6 nurses, and those performing the role of duty nurse on a particular day), which in effect limits the ability of frontline staff to alter or swap visits with their colleagues. Senior band 6 nurses had responsibility for maintaining surveillance of patient allocations and making any alterations. Under the manual system, it was possible for frontline staff to make alterations to visits to respond to events arising throughout the day. During an informal conversation with two nurses who were working on triage duty in the Greenfay office, I was told that '*there was more flexibility with SystmOne because if the visit took longer you just logged on and changed the time yourself and extended it*'. During additional fieldwork it became apparent that there was also an interactional dimension to movement of visits. Nurses claimed in interviews that they were able to swap visits with each other to allow for flexibility.

'Whereas before, when we had our ledges, we knew roughly what patients were where and we'd say, "I'll do that for you. You take one of mine." And we kind of worked well as a team, whereas now we can't really work as a team, because Cbernet does everything. We're not able to step in and help each other.'

Due to the level of restricted access, frontline staff must now call through to the office to get the visit time altered by a senior band 6 or triage nurse, which ensured hierarchical observation over staff who wanted to extend their visits. Although this allowed an avenue of flexibility, overall, it appeared that attempts to increase standardisation and to remove professional discretion within lean discourse was enacted through this gatekeeper who could then decide on the acceptability of the request through normalising judgement.

8.4 CMO - 4

In **contexts** where health professionals have a greater level of professional discretion over the allocation of community visits, **resources** which exhibit greater surveillance and control over their decision-making processes will <u>reduce their ability to use professional judgement and skill</u> **(response)** therefore reducing continuity, care co-ordination and ability to participate in case load reviews with external agencies, such as GP practices **(outcomes)**

8.4.1 Contextual factors relating to professional role and skill level

The reduced ability to use judgement and skill response fired most acutely, although not exclusively (discussed further in CMO- 5), within professional contexts where staff had higher level skills, meaning the process of automation was more impactful on their role. Previously, band 5 lead nurses managed a list of patients, conducted the initial visit, decided how many visits they needed, and then allocated these out to other members of the nursing team. They would then review the progress of these patients. As an enactment of lean discourse, the Cbernet system sought to eliminate this *'waste'* by allocating visits to band 5 lead nurses in the same way as other staff members and removing responsibility for managing their case list. Responsibility for keeping an overview of patients in the area passed to senior band 6 nurses. Introducing a greater level of control over this process in a professional context exhibiting higher level skills and greater previous discretion, triggered a level of resistance and objection from nurses.

8.4.2 Response mechanism - reduced ability to use professional judgement and skill

The lead band 5 nurse role was effectively diminished as they no longer managed a caseload and allocated out the visits to other band 5 nurses and nursing assistants. I had this exchange with newly appointed lead nurse, Penny, which highlighted how this role had largely become defunct.

Hannah: *Do you take on the role of care coordination?*

Penny: *No, that's the band 6. I don't really know why they have a lead nurse, but I've been appointed it so I'm going to sit on it. It's more if, say, the healthcare assistants or anything have questions, they can ring me. If I don't have the answer, then they can ring band six. Other than that, I don't really know.*

Through attempts to eliminate waste from the allocation process, those nurses who had occupied the lead nurse role prior to Cbernet, reported that the technological resource removed their ability to apply their professional skill to patient care.

As band 5 nurse Cheryl explains:

‘Yes, that's right, that's how it used to be. We would decide for ourselves as a trained nurse, "Yes, that's fine, but it doesn't need another RN for perhaps two weeks. It's okay for the HCA to go in and we'll review them fortnightly." I'm just using that as an example, whereas even that now doesn't happen. I've been into somebody this morning, and I thought, "Well, he definitely needs twice-a-week this gentleman," but when I've looked, he's actually already down for twice a week, so I said, "Oh well, that's good, I haven't got to do anything about that’

Cheryl describes the process of selecting visit frequency as deciding for *‘ourselves as a trained nurse*’, which implies that this decision required a level of professional input that is no longer present. This contrasts with senior nurse Sandra’s comments in the promotional video that allocation work was wasted time, which prevented nurses from getting out and doing the work they were trained for. Cheryl is therefore presenting a challenge to organisational framing of waste, by drawing on a discourse of professional autonomy (Mackenzie *et al.*, 2020) and rejecting the inculcation of this new way of (inter) acting into her professional identity.

In Cheryl’s example, she indicates that the patient was ‘*already down for twice a week’* which aligned with her recommendation and required no further action. However, her involvement with the patient’s care implied less control and order over the process. Her realisation that *‘Oh well, that's good, I haven't got to do anything about that’* suggested that her professional judgement was being applied in a reactive and less structured way.

Below, nursing assistant, Amber also describes the lack of professional ownership over patients experienced by band 5 lead nurses, as result of auto-allocation.

‘Cbernet makes it better that it does an automatic booking system. It doesn't take that, book this visit, book that visit. It's there and it has to be sorted. But before, by us booking them [sic] visits, we were going through them a bit. The nurses would quite often review those patients, even if they just looked at the last injury just so they had a more of a know what's going on. That's all been taken away and I know that a lot of the nurses were quite upset at the beginning because they didn't have a lead role no more. They were being given visits, they had no update on what was happening with their patients. As areas, we were given them to look after and try and heal, and developing that. That all got taken away and it was just, whoever could go when.’

The professional input into reviewing these patients is described as being *‘taken away*’, indicating a loss in application of judgement and skill, leaving nurses ‘*quite upset’*. They are then placed in the passive position of being ‘*given visits’*, with ownership lost once this visit is completed and ‘*no update on what was happening with their patients’*. The operationalisation of lean discourse through standardisation of care and limited professional discretion, was exemplified within Amber’s reference to ‘*it was just, whoever could go, when’*. This implies that experience and continuity with the same patient is not considered, whilst availability to conduct the visit is. As discussed within section 8.2.1, lean discourse construes legitimate nursing practice as face-to-face visits, with additional activity considered as waste.

The *‘whoever could go, when’* approach was picked up by Cheryl below when she describes ‘*coming to work and getting these jobs done’* through professional activity that is ‘*a bit like piecework’*.

‘I don't blame Cbernet as such, because I think OCC have allowed this way of working to happen. And it's not ideal, it really isn’t. Don't get me wrong, I love my job, I love my patients, and I enjoy coming to work, but saying that, I don't feel-- How can I put it? I don't feel like a trained nurse anymore. I just feel like I'm just coming to work and getting these jobs done. It’s a bit like piecework. I don't know how old you are, but years ago you used to have piecework, where it's like a production line-. You used to get paid for how many gadgets you could make during the day. Basically, it's the same with the way we are working now.’

Reiterating on her earlier point, Cheryl is suggesting here that the skill and judgement that she acquired through her training has been stripped out of the job, i.e. ‘*I don't feel like a trained nurse anymore’*. This also indicates that the changes Cbernet has made to her role are not inculcated within her professional identity as a nurse. She describes her interactions with patients as akin to producing products on a production line and compares her visits with getting ‘*paid for how many gadgets you could make during the day*.’ This suggest she not only sees her nursing role as being watered down to something that requires less thought and judgment, but also that the human and interpersonal element of role is now lacking. She therefore displays strong resistance to this new way of acting and interacting, challenging the managerial representation of stripping out unnecessary admin time so that nurses could be freed to ‘*get nurses back to nursing’*.

Within the textual resources, not only was time spent on manual allocation of visits construed as an inefficient waste that adds no value, but nurse's allocation decisions were also problematised in terms of exhibiting personal bias based on inappropriate or non-clinical reasons. In the below quote, Raquel provides a challenge to this framing, by demonstrating how removal of professional discretion within the practice of allocation by band 5 lead nurses can represent a loss of judgement and skill.

'(Previous lead nurse) She was very good. We used to talk on the phone constantly, some of that's a personal thing, but some of that was also professionally advantageous because she would phone me up and say, "Raquel, you know, that woman you saw last week? Why don't you go see her again? You know, she's on my list but let's swap her off. So, you see her again because I know you got on really well with her or whatever so you can see if that wound has improved, or whatever.'

Here, Raquel describes a situation where the lead nurse made judgements on what allocation would result in a better experience for both staff and patient. Below, she makes reference to the '*human component'* to allocation which comes from the knowledge built up through the experience of close working with a small number of team members and patients.

'There was a human component to it, which is absent in the way the band 6s triage. Well, not all of them, they seem to have a pathological hatred of triaging because it's a very stressful job. And I think the stress they are under, the pressure they are under, the first thing that would go, would be any knowledge of continuity. Particularly if it's outside of the auspices of their own team. I mean, they're not going

to know that one of the team members in my team actually cannot abide one of the patients on our caseload. They don't know that but Julie would have known that. Julie would have kept the two of them apart, things like that. That softer skill set is the first thing that's lost when people are under pressure, but also when people are dealing with such a wide and large number of patients'

In managerial terms, the above allocation decision would be labelled '*cherry picking'* because it is based on personal issues between clinicians and patients. However, here the concept of cherry picking is reframed to account for inevitable personality clashes that may occur and to ease the interactional process of engaging with patients.

8.4.3 Outcomes

a) Negative impact on care co-ordination and case management

Written into the CBIC tender response was a claim that '*named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey'* would be assigned for each patient (p. 39). The process described above did not represent the form of care co-ordination described in the tender response, which entails co-ordinating a patient's care across multiple services. However, movement away from a lead band 5 nurse monitoring a specific group of patients, suggested that the service was deviating even further away from this goal. Within the new process, senior band 6 nurses technically took on this care coordination role. But this seemed poorly defined, with band 6 nurses expected to fulfil that role across a large number of patients. Senior nurse Emily, explains below:

‘That's what they used to do. As far as I know, they used to block out time and they used to have time in their week to be able to allocate all the visits to the staff in their team and themselves. Then they would caseload review, look over them, plan, see what was going on. That doesn't happen anymore. We caseload review as a whole once a month. You can task Cbernet and say, “All right guys. If I wanted to go and see someone particularly, I could have tasked them that but whether or not that would stay, I don't know’

Similarly, to the description given by Cheryl above, the process described here sounds more ad hoc (‘*I could have tasked them that but whether or not that would stay. I don’t know*’), and lacks the sense that patients are being closely managed by a named care co-ordinator. Instead, caseload reviews, at least within the West Greenfay area, take place as a whole team, with band 6 nurses keeping an overview through that mechanism. Both Emily and Lucy, Hallstone senior nurse, described the difficulty of holding these meetings, regardless, because lead nurses are not familiar enough with their patients to participate effectively. Lucy told me:

‘It's good to know your patients because you know what, we're meant to do caseload reviews. And you know the girls have really enjoyed doing them. At the moment, to be fair, we haven’t and I will be totally honest, we haven't been able to do them because we haven't got the staff and time, because you're taking out a team at a time. Before, I could just take- I could take a lead, say like let's sit down but when if you've just got one lead there and they haven't always seen their patients because they haven't allocated those visits, how can they sit and talk about that patient that they don't know’

Here, Lucy makes a clear link between the reduced ability to use judgement and skill response and the impact on conducting caseload review meeting. If face-to-face contact time is privileged over other activities that are considered ‘administrative’ then nurses are never building up relationships with patients to the extent that they are able to discuss their progress during meetings.

From a patient care perspective, my conversation with Dave and his wife and carer Susan, highlighted their perceived importance of having a named point of contact to help coordinate Dave’s care across a variety of services, as well as someone who knows Dave well. Below, Susan describes some of the confusion experienced because Dave accesses numerous social and health services and how having one contact would alleviate some of this confusion.

‘Because there's so many like the social services, the carers. I don't know who fits with who. I think if you had that one person there, I'd know that you all came under that one person or that one person could say, "They're joined up to this," without me guessing. Yes, I think it would be a good idea.’

She also described the positive experience they have with their practice nurse, Kerry, who visits Dave daily and knows him well. Kerry is described as *‘absolutely brilliant’* with Susan saying that ‘*I can get most information out of her, what I need. I suppose, really, if I needed to find out something, medically for him, I would talk to Kerry’*. She then goes on to say how Kerry’s familiarity with Dave, eases the process of care delivery.

‘You can see what sort of like character Kerry is, she comes in sort of thing and she knows what the blank look and everything. She knows she can read him. Then when he's really not good, she's seen him like that as well. She's got a good understanding of Dave’

Dave and Susan’s experience highlight the importance, from the patient perspective, of having a key contact who is familiar with the patient and their conditions. Senior nurse, Emily, said she did not feel that patients were getting ‘*continuity of care like they used to*’, whilst also raising concerns that lack of ownership over patients may mean that ‘*things could get missed’*.

b) Disintegration with GP practices

The team around the practice concept put forward in the LPI texts discussed in chapter 5, was largely disbanded by management by the time I had begun phase 2 data collection. However, frontline staff and senior nurses expressed regret at the loss of this idea and were still making some efforts to operationalise it. In the below quote, Lucy expresses disappointment at how she felt the links with GP practices were being lost.

‘*It's just quite hard at the moment, isn’t it? Because you know how it could work, and actually do you know what, I think the whole (CBIC) idea that was portrayed to me, from my old leaders. It was a good idea, working under the GPs which sort of then gave the idea, I interpreted it as, was it also gave the GP, ‘we know that's our named nurse and that was the impression and I think that makes the GPs feel that they've got this nurse that they can turn to improve relationships and get good links with’*

Emily also describes how they were trying to hold on to the lead nurse role, so that they could work to forge links with GP practices. She describes the benefits of making the lead nurse *'feel valued'* and as being '*good for morale'*. However, she reiterates how it is difficult for nurses to fully engage in caseload review meetings with GP practices, because they do not hold patient specific knowledge gained through the management and review process.

'If there was a lead nurse, like we're trying to say that the three of them are lead nurses. We're trying really hard to get the lead nurses to get into the surgeries, introduce themselves and to set up regular RN meetings. I have that in one of my surgeries. We had one at surgery X the other day and that really helped because the RN that came with myself and Kath, it's part of her role. It makes her feel valued and it's good for morale and knowing that she's able to speak about patients. But even in there, we spoke about some people she's like, "I don't know who that is." She used to and that's what they're all saying, that's what was so different. They used to all know their patients and now they don't'.

In relation to patient care, nurses cited advantages of close working between GP practice and community health, such as, faster processes, more accurate referrals, and additional input into medication and care reviews.

8.5 CMO - 5

In **contexts** where band 3 assistants who have been trained to deliver care beyond their traditional boundaries have a high daily volume of visits, consisting largely of elderly, vulnerable patients **(resource)** greater control over visit allocations and time restrictions **(response)** diminish human relationships and authentic patient-clinician interactions, resulting in the continuation of task orientated and non-holistic care **(outcome)**

The diminished human relationships and authentic patient-clinician interactions response manifested itself in two main ways:

i) health professionals unable to act upon whole personal health needs
ii) inauthentic interactions where staff feel a sense of dread about time pressures and interactions are robotised

8.5.1 Contextual factors relating to professional role and patient demographic

Building on the analysis discussed in Chapter 6, the Cbernet technological resource was introduced into a professional context in which nursing and rehab assistants had been retrained into generic roles. I have already argued that managerial resources, which focussed on eliminating waste, paid little attention to the way in which these skills could be used for the benefit of patient care. Within this CMO, I will demonstrate how within this context, the increased control over allocation of visits and visit times, exacerbated patient-clinician interactions that were task orientated and did not allow them to act on whole person health needs. This was intensified further by a patient population composed of largely elderly and vulnerable patients whose varying issues mean it is not always easy to predict the nature and length of visits.

8.5.2 Response mechanism- diminished human relationships and authentic patient-clinician interactions

Band 3 assistants with joint competencies described how the greater control exerted over allocation and time restrictions did not engender an environment where their joint competencies and skills can be brought to bear in patient-clinician interactions. Points raised in chapter 6 about how this would likely only apply on a case-by-case basis was supported by band 3 assistants who described how joint skills can be utilised in a more spontaneous and ad hoc way through discovering patient need during visits. However, as described by Nursing Assistant, Candice, below, the scheduling system manages out the ability to think beyond the allocated task.

'I mean maybe, it's kind of where they've made the Assistant Practitioners... The word I want to say is like minions. "There we go. There's that skill. You can do that. You can do that." Then, we're on a computer and it's just a computer sorting things out, but I think maybe if in areas one, two, and three they perhaps had their own physio and OT because I don't know if that's done like that or not. Then, maybe if I went somewhere and saw something, say someone needed a grab rail, I would say, I would know where to go because I think I don't really always know where to go. I'm part-time as well. That probably has a lot to do with things.

Hannah: *You said about the band 3s as minions with a different tasks. That's quite a very strong word. Are you able to just talk more about that?*

Candice: *It almost feels like, I've got all these hats in my pocket, a therapist's hat and a nursing hat. I'm in a computer generator.'*

Candice uses the word '*minions*' to describe the position of band 3 assistants, implying they are in a position of servitude, carrying out the tasks they have been instructed to follow. Her description implies a total lack of agency on the behalf of assistant practitioners who have been instructed what skills to have and then allocated out visits by a computer. Her use of '*we're on a computer and it's just a computer sorting things out*' implies the assistants have been robotised in their roles. She then imagines a scenario with greater interaction between her and the physio team, in which she is able to use her reasoning and decision making to view the needs of the patient more holistically, whilst drawing in other specialisms. She is implying here that the task orientated allocation system disconnects her from other members of staff, leaving her to interact with a faceless, instruction giving computer screen.

Similarly, to Candice, Band 3 nursing assistant, Amber, describes below the process in which she is allocated tasks as at the will of organisational demand and lacking personal agency when she says '*They know what I can do, and they need this, so I get that. Do you know what I mean?*'. Whilst also acknowledging previously discussed concerns about compatibility, she then also goes on to explain how even in those contexts where she could apply her multi-professional skills, the rigid allocation process with tightly controlled time restrictions impacts on viewing patients holistically and introducing her full range of skills within patient interactions.

'They know what I can do, and they need this, so I get that. Do you know what I mean? Generally speaking, they don't overlap much. Again, back to time, for what you're allocated to do, that service, you can open a whole can of worms if you start

delving into what you're not there for. If you're there for rehab, you've got a service to do and then, you've also got a list of other patients to see. You'll deal with what's needed then and there, but I could go into a whole nursing head and had to do a whole nursing assessment. I've not got the time. Everything is timed. We were told with CBIC service change that they wanted us to be less task orientated and they wanted us to go more holistic with our care, and we just lost all the time. Not that we've really had the time before, but we just don't have the time. We lost the time, I think, in just our caseload expanding’

Candice’s comments here challenge managerial discourse articulated through the textual resources, that efficiency gained through greater control over the visit scheduling process can also retain the flexibility required to treat patients and their care needs on an individual and holistic basis. If this allocation process is introduced into a context of elderly, frail patients whose behaviour is not always easy to predict, then this can work further to reduce the authenticity of patient-clinician interactions. This is because if patients do not behave in a uniform and formulaic way, then the visit will not fit into the allocated spot, creating both a fixation and an anxiety for clinicians about how long visits will take. This is reflective of the way some staff internalised the normalising requirements of Cbernet that created a ‘rule of measurement’ (Foucault, 1991a, p. 184) for visit times that staff must monitor themselves against.

Rehab Assistant, Erin, describes below the different unexpected issues that can arise during visits, due to the patient context. She links this to the way in which average visit times allocated to clinicians, which include both admin and travel time, exert pressure on staff to complete visits in unrealistic time periods.

‘I think it sort of makes you into a robot or makes the patient's life a bit like a robot because you're meant to follow it as-- but they're human beings. You go to them and you turn up. They don't know you're coming that time. They might want the toilet. They might want this. They're elderly. Cbernet gives you 20 minutes to get in there, do your rehabs, do your systemone, and get out. Then your next visit is there, it might give you five minutes to get from A to B. Because of Cbernet, it makes you look like you can do more visits in the day, which-- [laughs] Because the times are not really right’

Attempts to eliminate waste through auto-allocation sought to standardise human behaviour and reduce interactions down to a controlled process. As put by Erin, ‘*it sort of makes you into a robot or makes the patient's life a bit like a robot because you're meant to follow it as-- but they're human beings*’. Similarly, to Amber and Candice, Erin is emphasising how the scheduling of visits does not allow the flexibility required to take individual patient need into account.

Anxiety about time is described by rehab assistant, Dianna, in the quote below. Here, she describes how patients are potentially missing out on the care they have been assigned, due to time constraints.

‘Well you rush it. There's no-- you know if I've got a full day. I would never rush it to the point of being unsafe. I've definitely said, I've raised this in meetings, I've said to

people, "We'll leave the standing exercises for today and that is due to my time constraint." I'll write that down on their record that that was unfortunately not carried out. A lot of our patients sometimes could take ten minutes to get to the door. I was never like that before, but I feel like I'm so aware of time, all the time.

Dianna also described in another part of her interview a feeling of dread when she sees some patients on her list because she knows they are more complex patients or have frailty issues, such as arthritis, which may require a greater amount of time. This provides an example of how authentic clinician-patient interactions are being diminished when clinicians come to view their patients, in terms of the time they take up and their ability to fit within the norm facilitated by Cbernet, as opposed to their care needs.

8.5.3 Outcomes

a) Loss of job satisfaction

The outcome of these types of patient-clinician interactions is a likely reduction in holistic patient care delivered to patients, as the inability of staff to react spontaneously to health needs during visits is diminished. Although, as detailed in chapter 6, assistant practitioners largely rejected the inculcation of generic working into their professional identity, there was some evidence from nursing assistants cited in this chapter that they also objected to the standardisation implicit within auto-allocation scheduling that prevented them from drawing on a range of skills to meet patient need in a more spontaneous manner. This suggests that clinicians will more likely accept generic working and experience improved job satisfaction if they can see a clear benefit to patient care. Whilst less concerned with multi-professional care, rehab assistants also rejected what they saw as a robotisation of their roles that diminished the authenticity of their interactions.

b) Poorer patient experience

Like staff, patients revealed they sometimes perceived their interactions with health professionals to be rushed, leaving them craving a greater human component to their visits. Dorothy, who had received care from rehab and nursing staff following knee surgery, told me the following:

‘When they came, "Are you ready? Ready to do your exercises?" They wanted you to get on with them, get them done, and then, "Yes, you're progressing really well," and then write something on their computer, say bye. I didn't actually time how long they were here, any of them, but that was the impression I got. They had too much work to do.’

When I asked her how in ideal terms, she would like care to be delivered, she said she wished they would *‘Keep treating you as a person, not as another job. Yes. They don't connect, and because they're in such a hurry, you couldn't offer them a cup of tea or coffee or anything like that. It was all too rushed.’* Similarly, Margaret also reported experiencing this disconnect between the clinician and herself, when she said that the nurse ‘*didn't really warrant her attention’* and that her ideal form of care would ‘*make you feel that you're not wasting their time’*.

The outcome from the context/mechanism interaction discussed here is that the through attempts to eliminate waste by allocating order of visits, journey route and average visit times, the Cbernet system worked to manage out an interpersonal dynamic that is favoured by both staff and patients. This also meant there was less chance for staff with multi-professional skills to delve into other health needs that were within their professional capability.

8.6 CMO - 6

In **contexts** where there is a patient population of largely elderly, frail individuals with comorbidities **(resource)** exercising surveillance and control over swapping visits with colleagues or making adjustments to visit times can result in <u>health professionals internalising this discipline</u> **(response)** meaning that health professional’s role is intensified through them taking on the burden of completing work in their own time **(outcome)**

The internalising discipline response manifested itself as staff being reluctant to call back to the office to subject themselves to the hierarchical observation and normalising judgement of either the senior band 6 nurse, or the triage nurse, in order to get approval to swap or move around visits, due to their schedule overrunning or difficulty completing visits in the allocated time. The following reasons were cited 1) previous experience of triage nurse or band 6 persuading them that it is too difficult to move visits 2) previous experiences of confrontational interactions with either triage nurse or band 6 nurse back at the office 3) internalising guilt about not being able to fulfil the visits on the list and consequently causing more work for colleagues.

8.6.1 Contextual factors

As detailed in CMO 5, the patient population are composed of largely elderly and vulnerable patients whose varying issues mean it is not always easy to predict the nature and length of visits. Attempts to standardise patient-clinician interactions were also enacted through the introduction of a gatekeeper system to reduce flexibility in changing visit times. This patient context increases the unpredictability of visit lengths meaning that clinicians are operating in a context where they must take on personal responsibility for completing visits in their own time.

8.6.2 Response mechanism - internalising discipline

Band 5 nurse, Cheryl, describes her previous experience of ringing back to the office to try move visits that she was struggling to complete. She explains how continual resistance met from the office left her exacerbated (‘*oh why bother!*’), to the point where this from of subtle control is internalised into her way of acting by incorporating visits into her own time.

‘It would be, "Oh well, Cheryl. We haven't got the capacity, we've got no one we can move any visits to." Or "You've left here a bit late in the day. We can't move anything now." In the end, you just think, “Oh why bother!" So, you end up working through your lunch and working late, just to get it all in. It's never a true picture on that Cbernet, basically, you know of your day. It might tell you that you've seen 18-20 patients. It says on there, "Yes. You've seen them within 390 minutes, but you haven’t because you’ve worked through your lunch break, you started early, you finished late."

Cheryl's comment again provide challenge to claims made in the textual resources that the Cbernet system can achieve 10% productivity gains. Cheryl argues that beneath the surface of the data, which says that 18-20 patients have been seen in 390 minutes, staff are working beyond the number of minutes that have been allocated, suggesting that at least part of these productivity gains are attributable to staff behaviour and not efficient allocation.

Rehab assistant, Diana, who works within Cheryl in the West Greenfay integrated care team, described how previous experience of confrontational interactions with either the triage nurse or a senior band 6 nurse prevents her from asking for extra time or for her allocation to be changed.

'Yes. That stuff, if I have a problem with my computer which I have. I can't get emails on Outlook. I say that as if I understand it, but luckily one of my patients was cancelled yesterday, but I spent 45 minutes on the phone to IT. But none of that.. Admittedly, I can hear them saying, "Well just go over to the desk." No, I'm not getting my ear bitten off for asking for a bit of extra time'

In this example, Diana describes her reluctance in attempting to access the gatekeeper system for time allowances, when unexpected events, such as IT issues arise, for fear of getting her '*ear bitten off*'. In another example, she describes a visit taking double the allocated time due to a patient's mobility issues but explains that after having '*a mouthful too many times'*, she did not call through to the nursing desk.

Dianna's description of interactions with the senior nurses is much more conflictual than that described by Cheryl. Cheryl describes her experience, as one of being cajoled by the nurses into submission, whereas Dianna says she's had her '*ear bitten off'* or she's had '*a mouthful'* reflecting specific punishment for deviating from the norm. The types of interactions between therapy assistants and nurses, and between nurses on the same team are both likely to be different in actuality, as well perceived differently. Elsewhere in the interview Dianna describes a difficult relationship with nurses within the integrated care team who she perceives as hostile to her, due her position as a therapy assistant. A contextual factor relating to professional boundaries may therefore lead to more hostile interactions between therapist and nurses, or at least a perception that these interactions are hostile. However, both conversational styles and manner of engagement work to the same effect here by triggering a similar behavioural response in frontline staff. Both Dianna and Cheryl are discouraged from calling back to the office to ask for her extra time, due to their previous experience engaging with the band 6 or triage nurses on duty (interviewees did not specify although often band 6's are performing the triage role).

A subtle form of control is being exercised here. Firstly, the gatekeeper system, on the surface, provides an avenue for flexibility. However, through making it either uncomfortable or futile to ask the gatekeepers to alter visit allocations, frontline staff internalise this discipline and do not phone back to change visits that they are struggling to complete.

In contrast to Cheryl and Dianna, band 5 nurse, Raquel, does not site previous resistance from other staff members for her reluctance to call back to the office.

Instead, she says that if she did call back to the office and asked for visits to be taken off her list then ‘*they would. I know they would’*. Raquel puts her hesitancy down to her own perception of inadequacy, as she explains:

‘The thing is it’s not a draconian organization. I bring a lot of my problems upon myself. If I phoned up somebody and they said, "It's 3:00 o'clock. I've got 10 visits that I haven't done yet. Please take some off my phone list." They would. I know they would. I'm not saying that they wouldn't, but it's just the expectation as per Cbernet that you should be able to do all of this. Makes you feel really bad if you can't. It adds to the burden, it adds to the stress because you're far less likely to put your hand in the air and say, "Well, actually please can you take one of these visits away from me because there's no way I'm going to get it done." You look at your system and like, "Well, I should. According to this, I should be able to get it done, so what's wrong with me?"

The provider is described as ‘not a draconian organisation’, whilst it is Cbernet that creates unreasonable expectations *‘that that you should be able to do all of this’*. Raquel’s distinction between the organisation on one hand and Cbernet on the other is interesting in that the expectations enacted through the technological resource arise from the managerial assumptions and problematisations contained with lean discourse. This false separation may work to further emphasise her perception of her own inadequacy through not attributing the expectations within her patient list with any level of managerial agency.

Ultimately, it is the surveillance and normalisation exercised through the physical appearance of the visits on her list that has the disciplining effect that leads her to perceive that she '*should be able to get it done'* and then to question, '*so what's wrong with me?'*. This last sentence represents a powerful form of self-questioning of her own adequacy to get the job done and motivates her to work to complete the list and not ask for assistance. Here, she has internalised the normalising function of Cbernet to ensure that she pushes herself to complete the list. Here, Raquel is producing her own subjectivity in line with organisational aims to create productivity gains, which means taking on the burden of an unmanageable caseload within her day to day working practice.

8.6.3 Outcome

a) Work intensification

The outcome of this context/response mechanism interaction reflects previous criticism of lean working found in the literature that it leads to work intensification (Rees and Gauld, 2017; Mackenzie *et al.*, 2020). By completing visits in their lunch hour and after work, health staff were using their own time to compensate for the *'waste'* that it is claimed that Cbernet had eliminated through more efficient allocation. This means that responsibility for completing the patient caseload had shifted from the provider to individual staff. This represents a process of responsibilisation for completing work out of paid hours and in essence taking on the burden of funding cuts to the service.

8.7 Discussion/Conclusion

8.7.1 Relationship of findings to CPTs

In chapter 5, it was argued that LPIs individualised problem contexts which focussed on the behaviour and decision making of actors (health professionals and patients), to both legitimise the service change and to try to influence responsibilised subjectivity in those actors, in line with efficiency aims. The legitimising function arose from focussing on individual factors that were potentially amenable to change, given continued structural division between health and social care services and resource constraints. However, to drive through efficiency savings, the 'ideal' health professional also needed to be shaped in such a way that engendered their ways of working and professional identities in line with these aims. Analysis of LPI texts provided some indication that due to the difficulties of getting ways of working and identity to align with organisational aims, more invasive forms of organisational control need to be implemented.

The following CPT was developed as a theoretical proposition of how this might be enacted at the level of implementation.

7. If visit times are scheduled so the length and frequency is automatically reduced, the ability of nurses to make professional judgement over patients and to take their individual needs into account is limited. This may result in reduced ability to treat patients holistically.

Analysis of data collected through phase 2 fieldwork, demonstrated how the assumption that through systems and processes staff can be '*forced into the right way of doing things' (LPI, Bev)* was operationalised through a technological resource, called Cbernet, that auto-allocated community health visits. I argued that this technological resource operationalised managerialist discourse of lean working and its focus on reducing 'waste' and increasing efficiency in process. As a material reality facing frontline staff, Cbernet facilitated greater control over day to day working. These findings supported speculation in chapter 5 that due to the difficulties in getting staff to adopt responsibilised subject positions and ways of interacting with patients that would drive through efficiency savings, more invasive methods would be needed. Findings in this chapter demonstrate how instead of relying on staff to come to see themselves through the *'waste watcher'* identity, more disciplinary methods were employed through technology to exert control over the timing and scheduling of visits. CMOs 4 & 5 expand on concerns expressed in CPT 7 that greater level of control over visits may negatively influence ability for professional judgement when introduced into varying professional and patient contexts.

4. In **contexts** where health professionals have a greater level of professional discretion over the allocation of community visits, **resources** which exhibit greater surveillance and control over their decision-making processes will reduce their ability to use professional judgement and skill **(response)** therefore reducing continuity, care co-ordination and ability to participate in case load reviews with external agencies, such as GP practices **(outcomes)**

5. In **contexts** where band 3 assistants who have been trained to deliver care beyond their traditional boundaries have a high daily volume of visits, consisting largely of elderly, vulnerable patients **(resource)** greater control over visit allocations and time restrictions **(response)** diminish human relationships and authentic patient-clinician interactions, resulting in the continuation of task orientated and non-holistic care **(outcome)**

Findings within CMO 4 & 5 demonstrated that staff at different levels objected to attempts to standardise their professional practice, in favour of being able to bring their skills to bear on patient care and to engender authentic human interactions with patients. I argue that attempts to shape efficiency maximising health professionals through technological control worked in antithesis to patient care promised within the IC policy discourse that was co-ordinated across different services and based on their needs and the views of frontline staff and patients. I argue that the IC policy discourse worked ideologically to smooth over contradictions and inconsistencies in the claim that these improvements could be made, whilst also reducing demand and funding, enabling austerity and neo-liberal structure to be reproduced through IC implementation.

CMO 6 below expands on the argument made in section 7.5 of this thesis concerning the potential for work intensification. If health professionals begin to internalise this discipline then this may lead to them becoming responsibilised for the resource pressures in the service.

6. In **contexts** where there is a patient population of largely elderly, frail individuals with comorbidities **(resource)** exercising surveillance and control over swapping visits with colleagues or making adjustments to visit times can result in <u>health professionals internalising this discipline</u> **(response)** meaning that health professional's role is intensified through them taking on the burden of completing work in their own time **(outcome)**

Chapter 9- Discussion/Conclusion: New Insights into Integrated Care Policy Implementation using the Dialectical Relational Approach

9.1 Introduction

In chapters 6-8, I presented my data analysis of the three empirical themes within this thesis: generic working within integrated care teams, self-management, and auto-allocation scheduling. This analysis was presented through the CMO heuristic and was related back to the initial CPTs developed in chapter 5. Using the theory expressed through the CMO, I explored the dialectical relationship between structure and social action within the CBIC, and between semiosis and social relations, power, materiality, organisational/managerial practices and value, beliefs, and desires within social practice. To help explain the connection between neo-liberal structure and attempts to shape health professionals and patients through neo-liberal responsibilised and enterprising subject positions, animated specifically through the lens of '*waste watching*', I drew on studies of neo-liberal governmentality.

In section 9.2, I will present my findings explicitly in relation to answering my research aim and research questions. In the process, I will demonstrate how these findings contribute to the integrated care policy literature I discussed in chapter 2, as well as critical literature on lean working and self-management introduced in the empirical chapters (5-8). I argue that I make a unique contribution to the literature by demonstrating how the IC policy discourse, constituted within the 2012-2016 context, worked ideologically through the meso and micro levels to mobilise economic austerity and reproduce neo-liberal structure. Specifically, I show how this was achieved through a series of textual, managerial, and technological resources that sought to shape both health professionals and patients through the lens of '*waste watching*'. In doing so, I also contribute to the critical literature on lean working in healthcare (i.e. Rees and Gauld (2017), McCann et al (2015), Waring and Bishop (2010), Radnor et al (2012)) by demonstrating how its enactment negatively interacts with many of the healthcare practices (care co-ordination, case management, continuity) that are evidenced as improving care both in the literature and in my research interviews with patients. I was also able to demonstrate how when '*waste watching*' subject positions are enacted through self-management, staff move beyond the 'pastoral' role found in the critical self-management literature (Jones, 2018b; Waring and Latif, 2018), to engage in conflictual patient-clinician interactions. Finally, I present the normative and explanatory critique developed within this thesis.

In section 9.3, I present an argument for why pushing Foucauldian concepts of disciplining and governmentalising power through the DRA, helps to provide more nuanced analysis of the way in which neo-liberalism is perpetuated and resisted through organisational practices and the subject positions adopted by health professionals and patients, than those adopting a purely Foucauldian analytical framework. In section 9.4, I argue that from a methodological perspective, combining CDA textual analysis with the initial programme theory concept and the CMO heuristic from RE, provided me with a coherent research design to bring these theoretical considerations to bear in answering my research aim and research questions. I then place this methodological development in response to literature that is critical of CDA methods (section 9.4.2), those that attempt to combine CDA with other qualitative methodologies (section 9.4.3), and those that criticise RE for its rejection of some central critical realist tenets (section 9.4.4).

The CBIC case study within this thesis is positioned within the legislative context of the HSCA 2012, and policy initiatives articulated though the FYFV, and the new models of care. In section 9.5, I set out the implications of my findings for current integrated care policy in England and what this means for potential avenues of future study. In section 9.6, I discuss the recommendations I have developed for the lead provider, OCC, who commissioned this study. In section 9.7, I highlight some of the limitations with my research and how further research could account for these limitations. Finally, in section 9.8, I provide a summary of thesis and main contributions.

9.2 Empirical Findings

9.2.1 Contributing to the research aim

The aim of this study was to investigate how the IC policy discourse was operationalised through implementation within a community based integrated care (CBIC) case study at the level of commissioners, providers, frontline staff, and patients. In chapter 2, I set out the case for viewing integrated care as a dominant policy discourse, constituted within a neo-liberal austerity context, that performs political work. It was argued that the problematisations of demand from the ageing population, poor public finances, and hospital admissions (Hughes, 2017) renders health and social care within an economic logic of cost and benefit (Speed, 2016).

This study uniquely contributes to the integrated care policy literature by demonstrating how the integrated policy discourse was operationalised ideologically through implementation at the meso (LPIs) and micro (organisational/frontline staff/patients) levels to mobilise economic austerity within my case study.

Specifically, I demonstrated how at the initial stage of development and contracting, the CCG drew interdiscursively on the IC policy discourse and intertextually on integrated care policy statements (FYFV) and flagship initiatives (new models of care and BCF) to provide legitimacy to contracting out community services with reduced funding. Once contracted, I show how within the socially structuring context of financial pressures and the subsequent removal of mental health and social care from the contract, the economic logic underpinning the IC policy discourse and its constituent discourses was put to work. In this way, LPIs sought to individualise problematisations and shape the subject positions of responsibilised actors operating within the health and social care arena.

Within micro level implementation, I argue that despite semiotic references to '*integrated*' care and *'empowerment'*, the economic logic and ideological function of the IC policy discourse was exposed. The material enactment of funding cuts meant that lean discourse and its focus on reducing waste and increasing efficiency emerged as dominant within CBIC practice. As such, textual, organisational, managerial, technological resources sought to shape the subject positions of both health professionals and patients through the lens of '*waste watching'*, when attempting to enact integrated care. This had a dislodging effect on concerns for improvements in patient care and experience and resulted in work intensification, and disempowerment for staff and patients.

This thesis moves the study of integrated care away from viewing it as an apolitical intervention designed to meet objective problems to one in which the policy discourse of integrated care works ideologically to obfuscate the implementation of further austerity. It was argued by Hughes (2017) that the IC policy discourse positions integrated care as the solution to wide ranging and varied problems within the health service, including poor patient care. In this way, it provides some discursive cover for continued austerity and structural fragmentation between services. It has been demonstrated in this thesis that this discourse was operationalised as a series of organisational and work practices that sought to construct health professionals in line with delivering financial savings. These practices worked in antithesis to treating patients holistically and managing their care across a range of services. The underlying ideological aims included furthering the neo-liberal state by both moving responsibility for the cost of health and social care into the unwaged realms of the home and community, as well as onto frontline staff through work intensification (Speed, 2016).

Calls from the policy implementation literature (Miller and Glasby, 2016; Exworthy *et al.*, 2017; Goddard and Mason, 2017; Harvey *et al.*, 2018; Coleman *et al.*, 2020; Raus *et al.*, 2020) to ensure greater clarity and consistency within integrated care policy aims as a route to successful implementation, fail to explain the structural conditions that shape these conflicting and vague policy aims. The argument put forward in this thesis would not disagree with Glasby (2016; 2017) that integrated care has become part of the problem if it has lost its focus on achieving better outcomes for patient's lives and Coleman et al's (2020) argument for meaningful bottom-up change, as opposed to 'quick results to satisfy the political needs of the programme' (p. 13). However, by directing critique at the structures that frame health and social care in terms of economic cost and benefit (Speed, 2016) this thesis engages with the ontological level that reflects the underlying cause of the findings identified in the policy implementation literature. This reflects the benefit of the study's critical realist approach, which seeks to generate social explanation by exploring partially hidden mechanisms/structures at the level of real (Bhaskar, 1979; Bhaskar, 2013).

A number of studies have discussed integrated care implementation in terms of the austerity context it is operating in (Erens *et al.*, 2016; Exworthy *et al.*, 2017; Goddard and Mason, 2017; Round *et al.*, 2018; Starling, 2018; Erens *et al.*, 2019; Maniatopoulos *et al.*, 2020). My thesis, however, is the only study, to the best of my knowledge, to demonstrate how an integrated care contract drew on the IC policy discourse to legitimise a reduction in contract value, and then to trace how this discourse was deployed within this socially structuring material reality to mobilse austerity. In this study, austerity is not simply a context that IC is being introduced into, but actively works to shape the lingustic, material, technological and managerial practices that are operationalised through the implementation of integrated care. Whilst those studies (Glynos *et al.*, 2015; Hughes, 2017), drawing on critical discourse theory, view integrated care as a discourse constitued within its neo-liberal context, their analysis focusses on the way in which the IC discourse operates through governmental and grey literature to ease the passing of neo-liberal policy.

This thesis is unique in tracing the policy discourse through its interaction with materiality, mangerial practices and social relations to produce outcomes. It also places a unique focus on the shaping of subject positions/identities and ways of interacting between clinician and patients within integrated care policy implementation and the reproduction of neo-liberal austerity.

9.2.2 Research Questions

This section discusses the empirical findings in relation to the research questions.

1. How have local policy implementers (CCG/lead provider/County council) constructed a community based integrated care service (CBIC)?

2. What are the potential implications for frontline staff and patients if this discursive work is operationalised into practice?

Research questions 1) and 2) were answered within chapter 5. The findings presented in this chapter contribute to the integrated care policy implementation, evaluation, and discourse literature, discussed in chapter 2, by demonstrating the mediating role that LPIs play at the meso level, between on one hand wider health and social care practice (including the dominant IC policy discourse), politics and neo-liberal structure, and the linguistic, material, technological and managerial resources introduced to frontline staff within micro level implementation in the reproduction of this structure.

We knew from quantitative evaluations of IC flagship policies (Davis *et al.*, 2020; Morciano *et al.*, 2020) that monitoring from NHS England was preventing vanguard providers from collecting broader outcome measures relating to patient centred data or locally defined measures of success. Governmental priorities of reducing admissions and cost savings were therefore influencing provider behaviour in line with these concerns. Qualitative integrated care policy evaluations of vanguards and integrated care pioneers identified conflicts between cost saving and patient related priorities for those at the macro level (NHS England) and meso level (commissioners, local authority, provider) (Erens *et al.*, 2016; Stocker *et al.*, 2018; Maniatopoulos *et al.*, 2020), as well as between those at the meso level and the micro level (frontline staff) (Eyre *et al.*, 2017). CCG managers and vanguard leaders reported struggling with the pressure placed on them to achieve efficiency savings and to reduce hospital admissions, with this severely hindering progress on local initiatives and damaging opportunities for shared learning (Coleman *et al.*, 2020; Maniatopoulos *et al.*, 2020). However, despite this there was also evidence that allegiance to the overall IC narrative was maintained when meso level actors viewed integrated care as a ‘moral imperative’ (Stocker *et al.*, 2018, p. 3), ‘the right thing to do’ (Eyre *et al.*, 2017) or the status quo as untenable (Erens *et al.*, 2016; Maniatopoulos *et al.*, 2020). Combining these findings with the argument made in section 2.5 that an IC policy discourse, underpinned by an economic logic, had achieved hegemonic status within policy and practice, led me to express concern that lying beneath the surface of the policy discourse was the potential for social practices that were problematic in their lack of priority for patient care improvements. Moreover, I was also concerned that the separation given to IC rhetoric and implementation by Miller Glasby (2016) and Exworthy et al (2017) ignored the active role that the policy discourse may play in perpetuating these problematic practices.

By viewing the interview responses and texts produced by LPIs as semiosis working in dialectical relationship with structure and social practice, I moved beyond existing literature discussed above, which served to report the experiences of senior managers within commissioning and provider organisations during implementation. Instead, by considering LPIs as active mediators in relation to both wider structure and implementation resources, this allowed me to demonstrate how the conflict between cost savings and patient care directly shaped the way in which they constructed the implementation of the CBIC. These conflicts, that the IC policy discourse seek to smooth over, are not simply something experienced by LPIs, but they have a socially structuring effect on the way integrated care is constructed and enacted through the implementation chain, in which these actors play a central role.

The Business Case text constructed the CBIC through solution-problem pairings energised by the 'beatific dimension' of creating '*transformational change'* in response to the 'horrifying scenario' (Howarth, 2010, p.322) of '*doing nothing'*. This is similar to the way in which enthusiasm for IC was maintained by viewing the status quo as untenable by meso-level actors in Erens et al (2016) and Maniatopoulos et al (2020). However, I advance these findings by demonstrating how constructing the status quo as untenable, worked as a form of discursive practice to both legitimise the CBIC service and to reproduce the political work of the IC discourse. Within the legislative context of the HSCA 2012 and its emphasis on greater competition within the health service (Player, 2013), I argue that positioning the status quo as untenable worked more to legitimise moving several services out of the acute hospital and into a community setting and re-contracting out community services within a severely reduced financial envelope, than representing any profound change to the way that services would be delivered within the health and social care arena.

In Allen et al's (2017) study of how 4 CCG case studies used competition and collaboration between 2013-2015, they found that commissioners were all attempting to move care out of hospital into the community to try to save money. Although exploring the option of outcome-based commissioning and lead provider models to try to remove cost pressures, none of the case studies were attempting to use competition to achieve this, instead focussing on using contractual levers with existing providers and assessing performance. Whilst Allen et al (2017) suggests that competition was not always used to achieve these aims, I build on their findings by demonstrating how the IC policy discourse was deployed through the process of competitive tendering to legitimise saving money when contracting out community services. Comments made by OCC's CEO about the organisational survival imperative to bid for the contract also support health providers within Allen et al (2017) who reported being under the power of the CGG through threat of losing their contract. Therefore, even at the point of contracting the IC discourse was already beginning to perform work in reproducing neo-liberal austerity within my study.

When it came to describing the development of the service, LPI texts stressed the compatibility of the CBIC with the policy direction set out in the FYFV and the new models of care. FYFV called for efficiency savings of £22bn to be made by 2020 (Kerasidou, 2019), with the new models of care, which focussed on different ways of integrating primary, secondary, community and voluntary sector services, as key to these savings and making improvements to fragmentated and disempowering patient care (Hammond *et al.*, 2019). Analysis within Chapter 5, demonstrated how the need to meet financial savings, reduce demand and make improvements in patient care, within the context of little structural change to the organisation of health services, led LPIs to move from ‘transformational’ and ‘system wide’ change to a more limited deployment of the IC policy discourse. In addition to that found by Davis et al (2020), Morciano et al (2020), Maniatopoulos et al (2020), Erens et al (2016), Eyre et al (2017), Coleman et al (2020), that meso level actors were dominated by cost saving, I show how those actors constructed integrated care implementation and the subject positions of staff and patients in line with these aims.

I focussed my analysis on the way in which these subject positions were pushed through both self-management and ‘integration’ at the level of professional roles, as these were given most discursive attention and had the potential to generate needs based and/or representational problems when operationalised into practice. CPTs were developed which expressed concern that if the semiotic work expressed within the texts was dialectically transformed into practice, then this could result in poorer patient care not based on their priorities, negative patient-clinician interactions, work intensification, and alienation and identity conflict for health professionals. This theory development provided the initial work in responding to my research aim, as well as contributing to the integrated care policy implementation, evaluation, and discourse literature. This occurred through linking the operationalisation of the IC policy discourse through the implementation chain with potentially problematic implications for health professionals and patients at the level of lived experience.

3. How has the IC policy discourse and its constituent discourses been enacted and operationalised within a community based integrated care service?

4. What are the outcomes and implications for patient care and staff experience?

These research questions were answered within chapters 6-8. In answering these questions, I split my analysis into 3 themes, with a chapter dedicated to each theme. Two themes (self-management and generic working within integrated care teams) originated from the CPTs developed in chapter 5 and one (auto-allocation scheduling) emerged through data collection and analysis within phase 2. The construction of the CBIC as a solution to a range of problematisations within the IC discourse (poor public finances, ageing population, fragmentation, pressure on secondary/primary care, lack of patient power and control) worked ideologically through the meso level to legitimise a reduced financial contract. However, this in turn had a socially structuring effect on managerial and organisational practice at the micro level of CBIC implementation, in which problems of demand and poor public finances came to dominate. Within this context, I used these empirical examples to show how practices framed by LPIs within the integration narrative, became dominated by the managerialist discourse of lean working, within micro level of implementation.

Using the DRA, I was able to demonstrate how semiotic references were made to *‘integrated care managers’ ‘integrated roles’*, and *‘integrated care teams’*, as well health coaching training material that drew on an empowerment discourse. However, it was the managerialist discourse of lean working that was dialectically transformed into managerial, organisational, and technological resources introduced to staff.

These resources sought to shape the subject position/identity of clinicians and patients through the lens of *'waste watching'*. I argue that *'waste watching'* cut through CBIC practices, having a dislodging effect on any potential improvements for patient care. The IC policy discourse, therefore, worked ideologically by smoothing over contradictions in the claim that patient care would be improved whilst also cutting funding, allowing austerity and neo-liberal structure to be mobilised through IC implementation. This occurred through micro-level implementation where frontline staff were responsibilised for difficulties with role changes and lack of resources, and patients through self-management or lack of improvements in care.

Within chapter 2, I argued the case for a study that was able to link the political work of IC policy discourse, identified by Hughes (2017) and Glynos et al (2015), and the generative power of this discourse to be operationalised through implementation to prioritise reducing costs and demand, over improvements in patient care, as suggested in Davis et al (2020), Morciano et al (2020), Maniatopoulos et al (2020), Erens et al (2016), Eyre et al (2017), Coleman et al (2020). In this thesis, I have been able to meet this research gap by demonstrating through explicit empirical examples (generic roles, self-management, auto-allocation scheduling) how priorities of reducing demand and costs, shaped practices, and identities/ways of (inter)acting within integrated care implementation. We now have greater knowledge of when the IC policy discourse is deployed ideologically in the reproduction of neo-liberal austerity, it can create problematic implementation effects for frontline staff and patients, such as workplace stress, loss of job satisfaction, and negative patient-clinician interactions.

The benefit of the approach taken within this thesis is that I was also able to capture the emergence of constituent discourses within integrated care policy implementation and to theorise their contribution towards effects at the level of lived experience. In this way, I have also been able to add to the critical literature on the application of lean within healthcare. Previous research has raised concerns about the application of lean within healthcare, in what has been termed the ‘managerialisation of healthcare’ (Waring and Bishop, 2010, p. 1334). Within Waring and Bishop (2010), clinicians criticised the prioritisation of efficiency and productivity over improvements in patient care and experience. This issue arose due to the focus within lean on the elimination of waste and the addition of value to processes when the definition of value to patients, commissioners, and government may differ (Radnor *et al.*, 2012). This thesis extends concerns about the negative effects of lean on patient care to the realm of integrated care practice.

For example, in chapter 5 I discussed how the CBIC tender response drew on the IC policy discourse in its claims that the CBIC would implement care co-ordinators who would jointly develop care plans with patients, manage their care across physical, mental health, social care, and the voluntary sector, and tailor care and self-management to patient need and capability. I also discussed how whilst discourses of ‘patient-centredness’ and ‘empowerment’, have been criticised in the literature for justifying the withdrawal of the state (i.e. Speed and Gabe (2020) & Petrakaki et al (2018)), there is also evidence that these healthcare practices can lead to benefits for patients if case managers engage in multidisciplinary care planning, reviewing and monitoring of care plans, frequent and long visits, they consider patient need, prioritise their interests, allow patients to gain knowledge on their condition, and they experience kindness (Wang *et al.*, 2018; Hudon *et al.*, 2020; Obro *et al.*, 2020). I argue that the *‘waste watching’* identities and interactions enacted within the CBIC were the antithesis of the types of behaviours and interactions found in the literature to produce better outcomes for patients. For example, my findings on the technological enactment of lean discourse reflected the ‘heavy standardisation, rigid principles, tight statistical control and the driving out of employee discretion’ that was identified by McCann et al (2015, p. 1560) as being integral to lean practices. In this way, auto-allocation inhibited practices, such as visiting the same patients over time, reviewing their progress, taking their whole needs into account beyond their professional boundaries, having sufficient knowledge of individual patients to be able to discuss at multidisciplinary team meetings and basing their engagements on genuine human interaction.

Similarly, evidence from chapter 6 suggested that the application of generic roles to performing joint tasks within one visit was nuanced and dependent on patient preference, and pain and discomfort levels. This suggests it would need to be applied on a patient-by-patient basis through discussion and negotiation with the patient. However, exacerbated by auto-allocation scheduling, rehab assistants were allocated single tasks to plug the resource gap on the nursing teams with little to no organisational or managerial focus on how their skills could be applied in a nuanced way to patient care. The emphasis on retraining rehab assistants, compared to nursing, also supported McNeil et al (2013) that those required to take on a generic role can experience it as differential treatment, assimilation, insult and humiliating action. The responsibilisation of these staff for difficulties with the role change, by deflecting issues of competency and confidence onto the individual and away from the organisation, also supported existing literature that generic working can stretch staff beyond their capabilities in a way that can damage patient care (Belling *et al.*, 2011; Gray *et al.*, 2011; Hannigan and Allen, 2011). The implementation of generic roles through auto-allocation scheduling also advances work in the sociology of professions to highlight the negative consequences when boundary blurring is technologically enforced, as opposed to being negotiated or accomplished (Allen, 1997; Xyrichis *et al.*, 2017).

The findings presented in chapter 7 have contributed to the critical literature on self-management in the following ways. Firstly, I have expanded Jones' (2018b) and Waring and Latif's (2018) work on the role of health professionals as 'pastors' in 'conducting the conduct of patients' (p. 988) through discourses of empowerment. I have advanced on Jones (2018b) by moving beyond analysis of the formal training delivered to clinicians in my case study and shown how the socially structuring effects of resource pressure, led 'pastors' to be construed as '*waste watchers'* through lean discourse. Exploring the enactment of discourse through the DRA allowed me to demonstrate how the empowerment discourse remained unactualized beyond its linguistic realisation within the health coaching training sessions. When self-management came to be construed through managerial discourse focussed on '*waste watching*', the 'pastors' identified by Jones who are 'responsible for shaping and guiding' (p. 991), through 'collaborative endeavour', are now focussed on identifying and eliminating 'wasted staff time and intellect' on patients who are deemed capable of self-managing their condition. I demonstrated how organisational resources introduced to frontline staff during their day to day working, sought to encourage staff to take on this role. In their study of GP/Pharmacist interactions with patients to improve medication self-management, Waring and Latif (2018), do show how these interactions can take disciplining forms ‘involving instructive orders and surveillance’ (p. 1078). However, the findings in this thesis show these interactions can move beyond the traditional hierarchical-patient dynamic to one which is conflictual and antagonistic if patients resist.

9.2.3 Normative and explanatory critique

The normative critique put forward in this thesis is based on needs-based problems that arose for staff and patients when discursive representations where enacted and operationalised through CBIC implementation.

In chapter 6, I illustrated that the subject position of the *‘ideal integrated worker’* did not appear to value the experience and expertise of long-standing employees and difficulties with the role change were too easily placed within the responsibility of these staff members, creating stress and loss of job satisfaction. Framing self-management within the managerialist discourse of lean working removed concern for improvements in patient care as the end goal, meaning that those patients who are accepting of self-management are a positive by-product, whilst conflictual interactions are created when patients resist. This created negative experiences for both clinicians and patients and is the antithesis of the claims made in the IC policy discourse about making improvements in patient care. Furthermore, the IC policy discourse champions patients receiving care inside their homes, therefore taking pressure from other agencies such as GPs and the acute sector. However, reducing financial support from community nursing under the guise that these patients would be empowered to self-management has resulted in stricter implementation of the housebound criteria. This meant more pressure placed back on GP surgeries and patients being denied their preference for being treated at home. Within the example of auto-allocation, I demonstrated how this technological operationalisation of lean discourse cut through IC practices, creating lost application of skill, and dislodging professional practice centred on improving patient care. This included reduced ability to gain patient knowledge to identify need and collaborate with other members of staff on patient care.

Based on these findings, I therefore argue that the practice created within the CBIC did not live up to the values we would take to be fundamental for good working conditions within healthcare, such as demonstrating a clear priority for staff's psychological health (McLinton *et al.*, 2018) and for providing education, training, and on the job support that enables staff to deliver high quality care (Ward and Wood, 2000; Sarre *et al.*, 2018). Moreover, nor were visions of good patient care and experience upheld, such as compassion, continuity of care, agency, empowerment and being viewed a whole person (Greenfield *et al.*, 2014).

The explanatory critique developed is that IC policy discourse, as the dominant discourse governing health and social care, worked ideologically in smoothing over the passage of funding cuts to the CBIC, creating the socially structuring environment for lean discourse to emerge as dominant within organisational practice. Within implementation, references to *'integrated teams'*, *'integrated roles'* and *'empowerment'* appealed to wider concerns around fragmented care and poor patient experience. This worked to give the impression that changes were being made to benefit of patient care, when concerns about costs cutting and demand came to dominate. The construction of empowered subject positions for staff also worked as an opaque operation of power when actually they experienced a greater degree of control over their working lives, whilst being responsibilised for the difficulties of the service change. If we take neo-liberalism, following David Harvey (2007), to be a political project that works to restore and perpetuate the power of economic elites, then the explanatory critique developed here is that the IC discourse works as a mechanism to perpetuate false beliefs that benefit dominant groups over others (Fairclough, 2001b).

9.3 The Dialectical Relational Approach and its contribution to governmentality

Theoretically, I drew on the DRA as a way of explaining, from an ontological perspective, how different mechanisms worked together to produce effects within integrated care policy implementation. As a theory of discourse that helps explain both the dialectical relationship between social action, social practice, and social structure, and the internal relationship between the mechanisms operating within social practice, the DRA provided me with a framework to connect the macro level (neo-liberal austerity politics, national integrated care policy), meso level mediation, and micro-level implementation of community based integrated care.

However, whilst providing me with the tools to connect these ontological levels, the DRA is not a social theory and so did not could provide the conceptual tools to help explain the specific connection between these types of subject positions that were being shaped within micro-level implementation and neo-liberal structure. For this purpose I borrowed from Foucault’s (1991b) work on governmentality and the extension of this work by Miller and Rose (2008) and Du Gay (1996) to help explain how within neo-liberalism individuals become active in its operation when encouraged to become responsiblised, empowered, and enterprising. This provided me with the conceptual tools to help explain how neo-liberalism at the structural level worked through the levels of implementation within integrated care to produce subjects that worked to reproduce neo-liberal austerity, as opposed to achieving improvements in patient care. In this sense, it was claimed that auto-allocation would have a freeing and empowering impact on nurses who would be liberated from administrative work that was preventing them from carrying out their legitimate nursing duties. Generic working was framed as ‘upskilling’, whilst having similarly liberating effects through clinician’s no longer having their time wasted. Self-management would be ‘empowering’ for patients and free up time for health professionals. Reflective of other research literature examining lean working (McCann *et al.*, 2015; Mackenzie *et al.*, 2020), I found through my fieldwork that the actual resources introduced to staff within these three examples exerted a greater level of control over their day-to-day work, increasing standardisation of practice and reducing professional judgement. The shaping of these subject positions, therefore, worked to reproduce austerity and furthering the neo-liberal state by responsibilising health professionals for dealing with funding cuts through intensification, negotiating discharge decisions for vulnerable patients, and taking on responsibility for difficulties with role changes.

On a theoretical level, I have contributed to studies of neo-liberalism and its subtle effects on the subject positions and inter-relationships between clinicians and patients (i.e. Martin et al (2013), Martin and Waring (2018), Waring and Latif (2018), Jones (2018b), Petrakaki et al (2018)), and have applied this theory within the context of integrated care. Governmentality studies has been criticised for relying too heavily on the 'programmers perspective' and official texts, whilst assuming automatic assimilation into dominant discourse (Martin *et al.*, 2013; Martin and Waring, 2018; Mackenzie *et al.*, 2020). This led Martin and Waring (2018) and Waring and Martin (2016) to incorporate Foucault's concept of pastoral power to demonstrate how governmental discourses are mediated by professional and managerial intermediaries acting as 'pastors', who use methods 'operating at the nexus of discipline and subjectification' (p. 1304) to shape subjectivity of those 'target groups' on the receiving end (p. 1300). I used these theoretical insights to show how middle managers, senior clinicians, and sometimes those in lower bands, worked as a resource mechanism when trying to shape favourable self-governing subject positions in other staff members, whilst on occasion using more disciplinary methods.

However, I argue that examining the connection between wider structure, policy discourse and the shaping of subject positions through the DRA, as opposed to those that take Foucauldian governmentality as their overall analytical framework, aids with more nuanced exploration of the translation of policy discourse into implementation. As argued by Fairclough (2013), within post-structuralist analysis, discourse is articulated through language, actions and objects, whereas within CDA, discourse works through practices in combination with non-semiotic mechanisms. He argues that to study changing political and social phenomena, then it is essential to analyse shifting articulations of semiotic and extrasemiotic elements. By separating out discourse in its semiotic form from its differential retention into non-discursive practice, I was able to demonstrate the way in which the material reality of resource pressure within the CBIC led to the dominance of lean discourse within the managerial, organisational, and technological resources that were introduced to staff, in contrast to discourses of empowerment and holistic care. This was most acutely demonstrated through my analysis that the empowerment discourse articulated through the health coaching textual resources was usurped by lean discourse, when operationalised through organisational resources. In a similar vein, I was also able to demonstrate how pre-existing contextual factors led to the differential acceptance or resistance of discourse by frontline staff. For example, therapists exhibited greater resistance to the '*waste watcher*' identity than nurses because their pre-existing professional identity was linked more closely to an empowerment and goal setting approach. Nurses, however, were more accepting of acting as '*waste watchers*' when they deemed patients to be capable of self-management or visiting the GP surgery, as this allowed them to reduce their caseload.

By exploring the dialectical enactment of discourses realised linguistically through texts into managerial, organisational, and material practices, as well as embodied subjectivity and practices on behalf of clinicians, I was able to explore the way in which some discourse realised linguistically remained unactualized through their interaction with materiality and human agency. I was also able to explore the way in which different types of resources sought to act on health professionals attempting to shape their subject positions and ways of (inter)acting, from more subtle reminders and hints within the open plan office to more disciplining methods arising from auto-allocation scheduling. For example, in Waring and Latif (2018) they use Foucault's concept of pastoral power to explore doctor-patient and pharmacist-patient interactions through the New Medicines Service (NMS) The NMS aims to promote adherence to new medications prescribed to those with long term conditions. This study conducts textual analysis of health policies, training documents, and expert testimonials to understand the governing rationality of NMS. This analysis is not presented in the article, however, leading us to presume that the linguistic construction of NMS is consistent across these texts. The study then explores the different way in which in which doctors and pharmacists enact their pastoral practices during their consultations with patients. Their use of the pastoral power concept is useful in analysing how governmental discourses are translated through implementation, the variation between the ways doctors and pharmacists enact these practices, and the responses from patients. However, I would argue that the incorporation of the 'pastoral' mediator between governmental discourse and the public only goes part of the way in combatting the accusation that too much power is given to discourse in constituting subjectivities. This approach could have the consequence of not appreciating the semiotic and extra-semiotic articulations that lead 'pastors' to adopt, resist or reformulate this role, presuming a linear relationship between discourse and pastors. Furthermore, I would argue for a greater focus on the analysis of the differing and competing discourses realised within policy/organisational texts, so that through their interaction with the socially structuring features of material reality, we can explain why certain discourses are operationalised into practice and others are not.

As discussed in chapter 3, Fairclough conceptualises social relations as the subject positions/identities that agents adopt and their ways of behaving and interacting with the world and others. I also argue that separating out the two, as opposed to Foucault's (1982, p. 27) 'mode of subjection' in which subjects both recognise themselves in line with ethical conduct and then act upon this ethical self in their behaviour and relations with themselves and others, enables greater depth of analysis. For example, in chapter 6, I demonstrated how rehab assistants strongly reject inculcating generic working into their professional identity, whilst at the same time carrying out nursing tasks during their interactions with patients and becoming 'responsibilised' for the difficulties of the role change. This demonstrates how organisational control may lead frontline staff to adopt ways of interacting that reproduce governmental policy discourse, whilst internally remaining opposed and resistant. This, therefore, provides a way of providing more nuanced analysis of both the more disciplining and governmentalising power operating through actors.

9.4 Integrating realist evaluation and the dialectical relational approach

9.4.1 Answering my research aim and questions

In this section I will argue that combining CDA textual analysis with the initial programme theory concept and the CMO heuristic from RE, provided me with the methodological resources and a coherent research design to bring the theoretical considerations discussed in section 9.3 to bear in answering my research aim and research questions.

The development of CPTs using discourse analysis of LPI texts provided a way of exploring how the IC policy discourse was operationalised through implementation within a CBIC case study at the level of commissioners and providers, by positioning their texts in dialectical relationships with wider structure through interdiscursive and intertextual analysis. CPTs also provide discursive and theoretical links between the way in which policy discourse is interpreted and articulated by those at the meso level and the operationalisation of discourse at the micro level.

The CMO heuristic provided me with a way of structuring my data when investigating the way integrated care policy and its constituent discourses have been enacted and operationalised at the micro level for frontline staff and patients. The mechanism concept allowed me to clearly conceptualise the different types of resources introduced to frontline staff (textual, managerial, organisational, technological) and their responses (subject position/identity, ways of (inter)acting), and the way power was operating through these micro level processes in their disciplining and subjecting form. Interdiscursive analysis served to position the representational element of this practice in dialectical relationship with social practice and structure. The context element allowed me to explain how pre-existing semiotic and extra semiotic factors had a socially structuring and conditioning effect on the discourse that was articulated through texts, its operationalisation into resource mechanisms, and its reception through subject positions and interaction. Finally, the outcomes provided a means of theorising the effects of integrated care policy implementation within lived experience for staff and patients.

9.4.2 Responding to criticisms of CDA textual analysis

As well as helping me to meet my research aim and answer my research questions, I also argue that this methodological approach works to combat some of the criticisms that have been made against CDA and RE in the literature. CDA has been criticised on several fronts. Firstly, that it lacks a developed theory on the effects of discourse and its responses, presuming a linear relationship between text and the reader, without obtaining evidence on the effects (Breeze, 2011). Secondly, Hammersley (1997) argues that if CDA scholars acknowledge the influence their political perspective has on their research, then there is no particular reason why readers should accept CDA's political stance over another. In my methodological development, I have tried to avoid presuming a linear relationship between the effects of texts and the consumer/reader. Instead, I have presumed that the texts I analyse contribute towards general meaning making within the organisation, whilst working in dialectical relationship with the 'objectification' of discourse through materiality, technology, and managerial/organisational practice. The responses of health professionals are then judged to be responses to a combination of these resource mechanisms, with strict linearity impossible to determine from an epistemological level. The CMO theories instead offer postulations of causal processes, which will always remain theories within the transitive (reality mediated through the perceptions of actors) domain, as opposed to knowledge of the real structures and mechanism operating within the intransitive domain that we can never fully gain access to (Bhaskar, 1979). My approach also goes some way to combat Hammersley's (1997) criticism by not simply generating a critique on the basis of textual analysis of policy documents from a pre-decided perspective. In the initial stage of analysis, LPI texts are analysed discursively, and CPTs are developed on the basis of *potential* problematic effects. The problematic social practices described in the CPTs are just propositions of what might happen. Further fieldwork is used to explore these propositions by examining organsational texts, managerial practices, frontline staff responses, and opinions of patients. Critique of current structure, policies and practices relating to integrated care has only been made within this thesis based on this multi-layered analysis.

9.4.3 Combining CDA with other methods

Fairclough (2003) does acknowledge that in order to examine the role texts play in social life, textual analysis should be combined with ethnography, as part of transdisciplinary research projects. The limitation of viewing CDA purely in relation to textual analysis has been widely acknowledged with the development of CDA into the field of Critical Discourse Studies (CDS), to indicate a broader approach to research (Krzyzanowski, 2018). A special issue of the journal Critical Discourse Studies was devoted to studies (Barkho, 2011; Galasiński, 2011; Johnson, 2011; Krzyżanowski, 2011; Rogers, 2011) that combined CDA with ethnography. There have also been methodological developments, such as Krzyzanowski's (2018) Discourse Ethnographic Approach (DEA), which seeks to build on the Discourse Historical Approach (DHA) (Wodak, 2001) and its problem orientation and focus on textual mediation within a multilevel context.

The DEA involves defining and theorising the research problem, conducting ethnographic fieldwork, and then analysing data using Discourse-Historical analysis. The aim being to track interdiscursive relationships between discourses and the recontextualization of these discourses across practices. In doing so, this shows how findings from ethnographic data collection can be interrelated with discourse. Although the DEA comes closer to my approach in attempting to bring CDA on a more equal footing with ethnographic research, there is less explicit focus on how to systematically go about exploring the dialectical relationship between discursive and non-discursive mechanisms at the level of social practice and then relating this to macro analysis of power relations and enduring structures. Instead, DEA seems to still rely on analysing discourses and making inferences about practice from the same analysis. Therefore, not giving enough weight to the critical realist assumption that mechanisms, both semiotic and extra-semiotic (i.e., material/agency), contribute their own distinctive generative powers, whilst interacting dialectically to produce change (Chouliaraki and Fairclough, 1999). My integration of RE and DRA, however, provides a systematic methodology of how to explore the dialectical relationship between IC policy discourse, constituted within its macro structural level context, LPIs at the meso level, and micro level social action within the CBIC case study, whilst also accounting for the dialectical relationship between semiotic and extra-semiotic mechanisms within the meso and micro levels. I argue this was facilitated directly by the development of CPTs and later CMOs, which enabled me to structure my data analysis in terms of these dialectical relationships.

A further methodological development has been brought by Belfrage and Hauf (2017) who have sought to develop a form of Critical Grounded Theory (CGT), which aims to provide a systematic methodology for operationalising Cultural Political Economy (CPE) theory by integrating CDA and Grounded Theory. Exploring the relationship between discursive and material dimensions of social life is central to CPE, in the same way as the DRA, and so the authors argue that their methodology provides a way of analysing semiosis and the other material dimensions of social life that CDA cannot adequately fulfil on its own. CGT does share some similarities with the approach developed in this thesis, in respect of using both CDA textual analysis and ethnographic data collection in the process of continual theory development. However, Fairclough (2013) distinguishes the DRA from CPE and its ‘simple differentiation between semiosis and structuration’ (p. 182) with his focus on the *dialectical relationship* between semiosis and structures through the category of ‘operationalisation’. In the same way, the methodology developed within this thesis differs from the CGT approach in its ability to explore both the dialectical relationship between structure, social practice, and action, and between the mechanisms within social practice, by exploring the way discourse was dialectically *operationalised* as materiality, technology, and social relations etc. I therefore argue that the methodological integration of RE and DRA developed within this thesis, represents a contribution to how CDA can systematically be combined with ethnographic data collection in a research study.

9.4.4 The critical realist challenge to realist evaluation

By adapting RE’s initial programme theory concept and CMO heuristic within the DRA’s ontology, instead of scientific realism, I have responded to the criticisms from Alderson (2021) that RE inadequately engages with power asymmetries between stakeholders engaged in the service/intervention/policy under question, as well as failing to analyse deeper, partially hidden structures at the level of the real which account for the political factors driving change within the health service. Firstly, my adapted versions of initial programme theories into CPTs and CMOs enabled me to account for differential power held by LPIs, middle managers, frontline staff, and patients. Secondly, by drawing on the DRA, I was able to position the findings expressed within the CMO theory in dialectical relationship with wider discursive practice and structure, reflecting critical realism's focus on unearthing underlying causal mechanisms that explain empirical phenomena. Finally, Porter's (2015a) challenge that the maintenance of the fact/value distinction and rejection of the emancipatory elements of critical realism, leaves realist evaluators with the task of instrumentally explaining the objectives of policy makers, has been met by my incorporation of the normative and explanatory critique within the development of CPTs and the evaluation of CMOs.

9.5 Relevance for current integrated care policy and future research

I have situated my CBIC case study within the legislative context of the HSCA 2012, and policy initiatives articulated though the FYFV and the new models of care. These polices were governed by an IC policy discourse that was constituted within a neo-liberal austerity context and achieved hegemonic status within health and social care practice. Since the publication of the FYFV in 2014, integrated health and social care has retained its dominance as the organising narrative for health and social care and has emerged through a series of policy documents (i.e., *Delivering the Forward View (2015) , Next Steps on the NHS Five Year Forward View (2017), NHS Long Term Plan (2019), Integration and innovation: working together to improve health and social care for all (2021)),* and initiatives, including STPs and ICSs.

Hammond et al (2017) has positioned STP policy within the politics of austerity by arguing that they are a ‘strategy to increase control over health budgets by defining them in relation to specific places, exerting financial incentives for organizations to collaborate to address deficits, and ascribing responsibility to these places for any 'local' failures' (p. 224). Leys (2016) also criticised the way STPs divert responsibility to localities to deal with the contradictions between improving patient care and inadequate NHS budgets. The non-statutory nature of collaborative working between different elements of the health and social care system, has also raised concerns that it does not do enough to rectify historical fragmentation, which was exacerbated by the HSCA 2012 (Hammond *et al.*, 2017; Moran *et al.*, 2021). It was found by Moran et al (2021) that organisations within their case study STP did not feel accountable for the outcomes of the whole STP, suggesting a continuation of an intraorganisational focus.

Given these findings, it appears that STPs are operating in the same discursive and socially structuring material reality as the CBIC. The findings presented in this thesis, suggest that further research needs to explore the way in which the IC policy discourse has been further deployed to mobilise neo-liberal austerity at the micro level within STPs. The funding conditions that STPs have been working in and the development of neighbourhood teams predicated on collaborative and voluntary partnerships, means that they are likely coming up against some of the same difficulties as the integrated care teams in this study. If collaboration between community, social care, mental health, and primary care is little improved by the STP, in the same way as the CBIC, then the resource pressure could likely see the same targeting of power through individuals as responsibilised subjects, leading to similar work intensification, conflictual patient-clinican dynamics, and lack of benefits for patient care and experience. Further research must therefore be attuned to the neo-liberal austerity context in which integrated care policy is being constituted and enacted. Whilst, also seeking to develop further normative and explanatory critique if this discourse is serving to render these objectives opaque, benefitting economic elites and making relatively low paid frontline staff and the users of service pay the price.

Following the completion of my fieldwork, the NHS Long Term Plan (NHS England, 2019) was published announcing the expansion of STPs to Integrated Care Systems (ICSs) by April 2021. ICSs are envisaged as extended versions of STPs, where NHS providers and commissioners and Local Authorities work together to deliver care for the geographic area. ICSs currently have no basis in legislation. However, the publication of the white paper '*Integration and Innovation: working together to improve health and social care for all*' (2021), expressed the plan to place ICSs on a statutory footing from 2022. Under ICSs, the purchaser/provider split is to be abolished, with CCGs disbanded (King's Fund, 2021) By placing these systems on a statutory footing and giving NHS organisations and local authorities a duty to integrate, the structural environment governing provider organisational behaviour differs from the context in which the CBIC was operating. Attempts to operationalise integrated care policy will now also be operating in a COVID-19 context where frontline staff are still both battling COVID and suffering from extreme burnout (Jalili *et al.*, 2021; Manzano García and Ayala Calvo, 2021). It will therefore be expedient to use the DRA to explore the evolving IC policy discourse, its enactment, and differential retention into practice, dependent on its interaction with this new context. Critically orientated social research should seek to expose if the acquisition of sustainability and efficiency is dominating at the level of implementation and what the effects might be on staff and patients, as we move forward with the integration agenda in England.

9.6 Organisational recommendations

I have argued that the context of financial pressures and continued inter-organisational fragmentation led to organisational practices that were dominated by achieving efficiency savings, which had a dislodging effect on concerns for improving patient care. However, it is also the case that bringing these practices to light and exposing their effects on staff and patients can lead to organisational changes, even within this context. Firstly, both senior and middle management should ensure that their messaging on self-management is aligned with in-house training, in order to encourage principles of joint decision making, empowerment and equal partnership between health professionals and patients. Furthermore, additional training should be developed by the organisation, which is tailored specifically to the nursing profession who deal with a complex cohort of patients whose age and condition render the complexity of self-management considerable, compared to therapies. These changes would provide potential for improved patient experience through establishing a personal relationship with the clinician (Obro *et al.*, 2020). Patients would also become more knowledgeable about their condition, have the ability to seek information, whilst feeling supported, encouraged and experiencing kindness (Wang *et al.*, 2018).

Secondly, the organisation should ensure that it is reviewing efficiency gains derived from new technological developments with the aims of integrated care, such as continuity, care co-ordination and case management. Consideration should also be given to potential work intensification resulting from automation, as well as the way job satisfaction, professional fulfilment, and clinical judgment, are balanced in relation with efficiency gains. This would enable patients to benefit from improved communication, access, coordination, involvement in decisions and efficient healthcare transitions (Hudon *et al.*, 2017; Hudon *et al.*, 2020).

Thirdly, senior and middle managers should give thought on how best utilise the skills of generic staff to improve patient care. Greater acknowledgement from management that for some staff fulfilling nursing tasks was causing high levels of stress and dissatisfaction with their role, may also work to ease tensions between management and frontline staff. It should also be ensured that enough resource and time is being put into the training for these new roles, instead of pursuing a tendency to locate problems at the level of individual staff. This would ensure that patient care is not compromised by staff delivering care that they do not feel competent to carry out (Belling *et al.*, 2011; Gray *et al.*, 2011; Hannigan and Allen, 2011).

9.7 Limitations

A limitation with this thesis is that due to its position within the critical social science tradition, it is overly focussed on providing critique of social practices, as opposed to identifying the positive benefits of IC policy implementation. CDA, in particular, has been criticised for focussing too heavily on the oppressive elements of discourse and its opaque ideological aims (Martin, 2004). When developing my CPTs, I focussed specifically on the way in which the operationalisation of discourse could lead to needs based and/or representational problems. These CPTs were used to guide further data collection, which embedded this critical focus within the initial research design. This means it is possible that I neglected other organisational practices which could have led to benefits. For example, as summarised in section 6.2, there was evidence from frontline staff that co-location of therapy and nursing staff had improved the speed of referrals and enabled faster and more frequent communication relating to patient care, especially amongst more senior clinical staff. It could be argued that I failed to fully explore these kinds of positive findings within the building of CMO theory. However, I would assert that the central theoretical argument made within this thesis was enacted across a range of examples within the CBIC (generic roles, self-management and auto-allocation scheduling) and that this represented the most substantial and analytically interesting findings from the data I collected. It was also my intention within this thesis to contribute to the integrated care policy literature by demonstrating the ideological work performed by the IC discourse through implementation at the level of commissioners, providers, frontline staff, and patients. This provided a novel way of exploring the topic and, I would argue, a much-needed exploration of the position of integrated care implementation within austerity politics. This, therefore, involved focussing my analytical interest on the data that exposed this ideological reproduction of neo-liberal austerity and its negative effects for staff and patients.

As highlighted in chapter 3, this study was limited by lack of data from interviews with long-term housebound patients, meaning I was unable to determine how these patients had responded to being encouraged to self-administer their insulin injections. I was therefore left to rely on data collected from health professionals to develop my theory. Given that patient perspectives may differ from that of health professionals (Griffiths, 2009; Brookes and Baker, 2017), this input may have modified my analysis. For example, these patients may not have reported the level of resistance portrayed by clinicians. Another limitation is that I did not observe patient-clinician interactions, and so the portrayal in this thesis is skewed by the perspectives of clinicians. Future research would be useful to test out my theoretical developments by conducting observations of these interactions.

9.8 Thesis summary

This thesis presents a novel exploration of integrated care policy implementation in England, using a community based integrated care service case study. Data collection, using ethnographic methods, took place between April 2017 and April 2019 and involved analysis of key organisational texts, semi-structured interviews with LPIs within the Clinical Commissioning Group, County Council and lead provider, middle managers, frontline staff, and patients, as well as observations within the integrated care office space. I have positioned my case study within the legislative and policy context of the HSCA 2012, FYFV (2014) policy statement and the new models of care initiatives. Building on studies that present integrated care policy within this period, as a dominant discourse articulated through government policy documents and grey literature (Glynos *et al.*, 2015; Hughes, 2017), this thesis traces the IC policy discourse and its constituent discourses, through LPI texts at the meso level to its enactment and operationalisation at the micro organisational, workforce and patient level. In this way, the study shows how integrated care is not just an objective solution to a range of problems within the health service but constituted within a neo-liberal context and deployed in the mobilisation of economic austerity.

In this thesis, I demonstrate how the IC policy discourse is drawn upon at the meso level, as a legitimation strategy to justify moving services out of the acute hospital into the community and re-contracting them and existing community services with reduced funding. Within microlevel implementation, despite semiotic references to '*integrated care teams'*, '*integrated roles'* and '*integrated care managers'*, the socially structuring context of a CBIC contract with reduced funding and continued fragmentation between community, social care, mental health and primary care, led to the managerialist discourse of lean being internalised within organisational practice. The removal of '*waste',* central to lean discourse, positioned staff and patients as empowered and liberated through the additional time and skills they would acquire. However, the operationalisation of lean discourse in trying to shape clinicians and patients through the lens of '*waste watching'* cut through self-management, generic working, and care co-ordination practices to dislodge concern for improvements in patient care. As a result, this led to work intensification, disempowerment for staff and patients, conflictual interactions, and reduced ability for clinicians to apply their professional skill. This study, therefore, demonstrates how the IC policy discourse worked ideologically to actively obfuscate austerity policies that have a negative impact on patients and staff. Furthermore, this study provides caution to neo-liberal promises of the benefits of empowerment and responsibilisation, as in actuality both staff and patients were often more greatly controlled through the provider's attempts to shape them into these desired subject positions. This thesis also demonstrates how it was those with the least power that took responsibility for a neo-liberal political project that works to restore and perpetuate the power of economic elites (Harvey, 2007).

In summary, this study makes several empirical contributions. It responds to calls from the policy implementation literature (Miller and Glasby, 2016; Exworthy *et al.*, 2017; Goddard and Mason, 2017; Harvey *et al.*, 2018; Coleman *et al.*, 2020; Raus *et al.*, 2020) for greater clarity and consistency within integrated care policy aims as a route to successful implementation, by directing critique at the structural conditions that shape these conflicting and vague policy aims. Without altering the structural conditions that the IC discourse is constituted in, conflicting policy aims between locally defined patient related concerns and top-down focus on reducing costs and hospital admissions, will always result in an economic rationality emerging through integrated care policy implementation. I also contribute to the critical literature on lean working in healthcare (i.e. Rees and Gauld (2017), McCann et al (2015), Waring and Bishop (2010), Radnor et al (2012)) by demonstrating its enactment negatively interacts with many of the healthcare practices (care co-ordination, case management, continuity) that are evidenced as improving care both in the literature and in my research interviews with patients. I was also able to demonstrate how when *'waste watching'* subject positions are enacted through self-management, staff move beyond the 'pastoral' role found in the critical self-management literature (Jones, 2018b; Waring and Latif, 2018), to engage in conflictual patient-clinician interactions, which are disempowering for both staff and patients.

I have also made a theoretical and methodological contribution in my study of integrated care policy implementation. I have presented a case for pushing Foucauldian concepts of disciplining and governmentalising power through the DRA, to help to provide more nuanced analysis of the way in which neo-liberalism is perpetuated and resisted through organisational practices and the subject positions adopted by health professionals and patients, compared to those adopting a purely Foucauldian analytical framework (i.e. Waring and Latif (2018)). From a methodological perspective, combining CDA textual analysis with the initial programme theory concept and the CMO heuristic from RE, provided me with a coherent research design to bring these theoretical considerations to bear in answering my research aim and research questions, as well as contributing to studies that seek to integrate CDA with other qualitative and ethnographic methodologies (i.e. Belfrage and Hauf (2017)) and those who criticise RE for its scientific realism underpinning (i.e. Porter (2015b; 2015a)).

Finally, I have suggested that future research would need to explore the way in which the IC policy discourse evolves and is shaped through more recent policy iterations, such as STPs and ICSs, as well as within the COVID-19 context. This research should focus on engaging the most vulnerable multi-morbid patient groups who require long term care in their homes. This is particularly within the context of a policy discourse that emphasises greater community and at home care, whilst creating the environment for emphasis given on discharging these types of patients through self-management or back to the GP under the housebound condition.

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Appendix 1

Summary of key legislation and integrated care policy initiatives between 2012 and 2016

Health and Social Care Act 2012 (HSCA 2012)

The HSCA 2012 created a decentralised system of commissioning that abolished strategic health authorities and split commissioning responsibilities across CCGs, local authorities, NHS England and Public Health England (Checkland *et al.*, 2018). 152 Primary Care Trusts, which had previously been responsible for the commissioning of health services within England, were replaced with 207 CCGs, which are GP membership organisations. NHS England was created to oversee CCGs and to commission several areas of care, in particular primary care (Hammond *et al.*, 2019). The HSCA 2012 more firmly entrenched competition between providers into legislation, with the stated aim that this would improve quality and efficiency (Allen *et al.*, 2017). These reforms meant that different parts of the health and care system (primary care, social care, hospitals, mental health and community health) were commissioned and funder separately (Humphries, 2015). Following controversy over the passing of the bill, a ‘duty to integrate’ was placed on NHS England, Monitor, CCGs, and Health and wellbeing boards, with a similar provision for adult social care in the 2014 Care Act (Miller and Glasby, 2016).

Integrated Care Pioneers

The Integrated Care Pioneer programme ran for five years from 2013 to 2018. In November 2013, 14 Pioneers were announced in the first wave, followed by another

11 in January 2015 in the second wave. Pioneers were given some limited funding, initially £20,000 and then a further £90,000. The expectation from the Department of Health was that those adopting pioneer status would improve 'whole system integration involving health, social care, public health and potentially other public services, and the voluntary sector' leading to improvements in 'patient experiences, better patient outcomes and financial efficiencies' (Erens *et al.*, 2019, p. 15).

Better Care Fund (BCF)

The BCF created a single pooled budget across health and social care with the stated aim of increasing integration between the two areas. The fund was introduced in 2016 and required each local authority and CCG to submit an agreed plan of how they would spend the money. The plans were expected to include provision for 7 days a week care services, a named professional who coordinates each individual's care, better data and information sharing and joint assessment and care planning (Humphries, 2015). The central aim of the BCF is to reduce unplanned hospital admissions and length of stay (Harlock *et al.*, 2020).

Five Year Forward View (FYFV)

The Five Year Forward View (FYFV) was a policy statement published by NHS England in 2014 and set out a vision for how issues within the health service, such as poor patient care, fragmentation between service and inefficiency and poor public finances. Specifically, the FYFV called for efficiency savings of £22bn to be made by 2020 (Kerasidou, 2019). This would be met through the development of 'new models of care’ that would lead to innovations in integration across primary, secondary and community settings (Hammond *et al.*, 2019). The new models of care included the following models:

Multispeciality Community Provider (MCPs)- These aimed to develop extended primary care models, which would move specialist care out of the acute into the community. Integration would involve hospital, community and social care services to provide wrap around and coordinated services for patients (Sheaff *et al.*, 2018).

Primary and acute care systems (PACs)- These involve vertical integration of hospitals, GPs, mental health, and community services. One organisation takes accountability for the health needs of a list of registered patients, under a delegated budget (NHS England, 2014). MCP and PACS are similar population-based models aimed at moving specialist care out of hospitals into the community, and creating closer integration of General Practitioners, hospital, community and social care services (Morciano *et al.*, 2020).

Urgent and Emergency Care Networks (UEC)- The aim was to reduce demand on Accident and Emergency by implementing a new model of integrated urgent care accessed through NHS 111 and facilitating closer working between health and community and social care in discharge support (Marjanovic *et al.*, 2018).

Enhanced Health in Care Homes (EHCH)- This model aimed to ensure that people living in care homes have access to primary, community, mental health, social care, and specialist services to prevent the need for additional services. Budgets and incentives are aligned with the aim that these services work together in a multidisciplinary teams to improve health and wellbeing (NHS England, 2016a).

Acute Care Collaborations (ACCs)- These involve collaborations between hospitals and were based on 3 main types 1) hospital groups where providers work together under a single group structure 2) multi-service networks that work on a range of clinical and non-clinical area 3) single-service networks that work on specific service area (NHS England, 2018).

Vanguards

Leading from the FYFV, 50 Vanguard sites were selected in 2015, which were to test out and pilot the ‘new models of care’ (Coleman *et al.*, 2020). Of these 50, there were 14 MCPs; 9 PACS; 6 EHCH; 8 UEC and 13 ACCs (Morciano *et al.*, 2020). The vanguards had access to a £350 million Transformation Fund (Wilson *et al.*, 2021).

Appendix 2

Summary of integrated care teams

	Core Teams	**Patient Type**	**Location**	**Hosted Teams**	**Patient Type**	**Location**
East Hallstone	Community Nursing	Housebound (usually elderly) patients living in East Hallstone. Treatments include wound care, leg ulcers, injections, insulin management, catheter care.	Shared open plan office space in Hallstone	Continence	Patients requiring neurology, prostate, pads	Services ran out of clinics, but continence nurse also hot desks once per week in each locality
	Community Rehabilitation	Visit post op rehab patients, and those who have been referred by their GP for mobility issues in their	Shared open plan office space in Hallstone	Pain Management, MSK Outpatient Physio	Pain management/MSK is for all patients across both boroughs & Outpatient is all of Hallstone	Services previously ran out of acute hospital but now delivered out of separate clinics

		homes who live in East Hallstone				as part of CBIC contract
West Hallstone	Community Nursing	Same as above	Shared open plan office space in Hallstone	Tissue Viability	housebound patients, but also provide care in nursing homes, GP surgeries	Hot desk in both Greenfay and Hallstone office
	Community Rehabilitation	Same as above	Shared open plan office space in Hallstone	Early Supported Discharge Stroke Service, Speech and Language Therapy, Lymphedema	Patients across both boroughs that require these services	shared open plan office space in Hallstone
East Greenfay	Community Nursing	Same as above	East Greenfay office in Richfield	Cardiology, Pulmonary	Patients across both boroughs that require these services	Cardiology hot desk in shared office but deliver services out of clinics
	Community Rehabilitation	Same as above	East Greenfay office in Richfield	Outpatient Physio, Respiratory, Orthotics	Outpatient physio just East Greenfay patients. Respiratory and	Outpatient and Orthotics delivered in clinics and

					Orthotics is across both boroughs	respiratory is homebased
West Greenfay	Community Nursing	Same as above	West Greenfay office in Richfield			
	Community Rehabilitation	Same as above	West Greenfay office in Richfield	Outpatient Physio, Podiatry	Outpatient physio just the Richfield area. Podiatry patients across both boroughs	Delivered in clinics

Appendix 3

Case study demographic breakdown

Unless stated otherwise, the information below has been taken from the 2019 Strategic Needs Assessments conducted by the Greenfay and Hallstone Local Authorities. Not cited in full to retain anonymisation.

Population

The CBIC provides services to the population living in two local authority areas (Hallstone and Greenfay) in a region in the South of England. The population of Hallstone was approximately 192,523 in 2018 and 145,803 for Greenfay in 2017.

Age profile

Hallstone has a smaller proportion of older people aged 65+ compared to the region's average, whilst Greenfay has the highest proportion of residents aged over 65 across the region. Greenfay also has the equivalent of 1.8 working age person to every person aged 65 and over. This is significantly above the average for the region and for England. The average life expectancy for a child born in Greenfay is 81.5 years for females and 77.8 years, which is lower than the average for England and the region.

Socioeconomic variation

The average weekly income for a Greenfay resident working fulltime in 2018 was -13.7% below the average for the region compared to Hallston which was -8.45% lower than the average for the region. The most deprived small area (Orlake) in England is located within Greenfay. Greenfay is the 32th most deprived local authority area in the country, compared to Hallstone which is 181st. However, there are still pockets of deprivation in Hallstone (Ministry of Housing Communities & Local Government, 2019).

Service use

For emergency hospital admissions in 2018 for all causes, all ages, Greenfay has the second highest in the region and is above the national rate. Hallstone has the third highest in the region and is just below the national rate. Both areas have a rate of emergency hospital admissions due to hip fractures among persons over 65 higher than the regional and national rate.

Long term health conditions

Overall, there is a greater proportion of the Greenfay population suffering from long term conditions than in Hallstone. The proportion of residents suffering from long term conditions (i.e. hypertension, heart disease, MSK, dementia) in Greenfay is also higher than the regional and national average. For example, Greenfay has the highest prevalence of residents with dementia, with a proportion of 1.07%, which was the highest prevalence of dementia across the region (0.81%) and England (0.77%). The proportion of residents in Hallston was 0.67%, which is lower than the regional and national rate. In Greenfay, 47.7% of residents were recorded as having a long term musculoskeletal (MSK) problem, which was higher than the region rate of 33.5%. This is compared with 32% residents in Hallston who have a long-term musculoskeletal problem, which is lower than the region average and for England. For the area covering both Greenfay and Hallstone, the prevalence of diabetes is 6.8% which is higher than the average for England (6.5%) and the region (6.6%). Across both Greenfay and Hallstone, the rate of common mental health conditions (anxiety & depression) and severe mental health conditions (schizophrenia, bipolar, and psychoses) was higher than the prevalence across the region and England.

Appendix 4

List of texts analysed in phase 1 data collection

Organisational texts

Author	Date	Title
CCG	November 2014	CBIC Full Business Case
OCC	October 2015	CBIC Response to Tender
OCC	April 2016	CBIC Staff Training Video

Local Policy Implementer interviewees

Organisation	Role	Pseudonym	Date of interview
OCC	CEO	Vicky	19/04/2017
OCC	Senior Manager	Bev	19/04/2017
OCC	Senior Manager	Mary	06/06/2017
OCC	Senior Manager	Sandra	28/04/2017
OCC	Senior Manager	Sarah	06/06/2017
CCG	Ex-CEO	Michael	21/06/2018
CCG	Senior Manager	Jill	09/10/2017
CCG	Senior Manager	Shirley	23/05/2018
County Council	Senior Manager	Henry	30/05/2018

Appendix 5

LPI interview schedule

1. Please can you tell me about your role within (Organisation)?
    a. What is your involvement in relation to CBIC?

2. Can you tell me a bit about the background of CBIC?
    a. What is your organisation's role in relation to CBIC?
    b. Where did the idea for CBIC come from?
    c. What were the driving forces?

3. What influences have shaped the development of the CBIC?
    a. How has your organisation been involved in this?
    b. To what extent were patients and the public consulted in the development of the model?
    c. What were the policy drivers?

4. What do you see as the broad aims of CBIC?

5. Can you describe the key mechanisms within CBIC that you expect to lead to these aims?

6. How do you expect these mechanisms to lead to the desired outcomes of the model?

7. Who is involved in ensuring that the service will achieve change?
    a) Patients, staff, senior management, politicians

8. How will your organisation work in partnership with other organisations to deliver CBIC?

9. Can you describe the main barriers to CBIC achieving its aims?
    a. Organisational, cultural, demographic, workforce related, patient related, wider political backing/funding?

10. What do you think will help CBIC in achieving its aims?
    a. Organisational, cultural, demographic, workforce related, patient related, wider political backing/funding?

11. How will you know if CBIC has been successful?

Appendix 6

Textual Analysis Questions

Words

I. The vocabulary used; i.e. what experiential value do words have? What relational values do words have? What expressive values do words have? What metaphors are used?

Grammar

I. What experiential grammatical features are used? i.e. what level of agency or responsibility is ascribed to agents? Are nominalisations used? Nominalisation being a process converted into a noun, leaving the position of the agent's responsibility unclear. Are sentences active or passive? Passive agents leave causality unclear.

II. What relational values do grammatical features have? i.e. what types of mode are used? What features of modality are there? Relational modality being the authority of the speaker over another. Expressive modality being the speaker's evaluation of the truth, with categorical modality being a strong commitment to the truth. Are pronouns used and if so how?

III. How are simple sentences linked together? What logical connectors are used?

Text Structures

I. What is the overall structure of the text and how is it organised? (this applies to the secondary data sources

Interdiscursivity and Intertextuality

I. how do the linguistic and grammatical choices used within the text fit in to pre-existing systems of meaning and ways of representing (interdiscursive analysis) and other voices and texts that have been produced before (intertextual analysis)

Appendix 7

Example of moving from textual analysis to CPTs

Stages

1. Textual analysis
2. Interdiscursive analysis
3. Theoretical ideas about the enactment of this discourse
4. Initial ideas about how the CPTs relate to wider structure

1. The first step involved analysing the specific linguistic features of texts, such as the below example. Analysis described 5.5.3.

‘Yes. I think everybody in the public sector, any in any organization, will probably say that they're already overworked. There's a lot of resistance, by the way, to integration across the board from primary care, with GPs basically saying, "We are overworked. We can't do the job as it is. How on earth do you expect us to be doing all this preventative work and outreach work, et cetera?" That definitely is an issue. On the other hand, sometimes some of the tasks are really small and really common sense. For example, let's say I was a nurse and I popped round, and I'm giving the medication to somebody, but I noticed that the person maybe could, needed a bit of a clean-- Maybe even their dinner putting in a microwave, or something, because, for a lot of frail people, they're struggling to clean themselves. They're struggling. Rather than go and send them, which has just wasted somebody else's time, travel time and the waiting time as well for somebody to get out, you'd think, don't you? Common sense, "What could I do? How could I do it?" If it's a big task then, yes, but—'

2. I then linked the assumptions within the text to desired subject positions within neo-liberalism at the level of discursive practice. The desirable health professional in the extract above is described as responsibilised for taking on the work of other staff, as well as caring for vulnerable patients. They are also enterprising in the sense of taking initiative to seek out what additional care needs there are and acting on them before calling in a colleague. This process was completed by inferentially linking what I found within the text to the desirable neo-liberal subject described in the literature, i.e. Miller and Rose (2008).

3. I then began to use abduction (creative hunches and insight) to think about what would happen if the desire to shape health professionals within this neo-liberal subject position was enacted and operationalised. My first hunch was that the description given by Henry sounded overly simplistic and dismissive of the practical issues that may arise from this workforce model. Secondly, I felt his comments had moralistic and judgemental tone that could potentially make health professionals feel guilty for not fulfilling the role this manner. To then retroductively build on this initial hunch, I drew on ‘practices of the self’ (Foucault, 1988, p. 28) to think through how the moralistic dimension of Henry’s construction of a desirable subject position, could lead health professionals to act upon themselves in line with transforming themselves into ethical subjects. By drawing on findings from the academic literature, which demonstrate how the bundling of tasks can lead to work intensification, as

well as stretching the capabilities of staff, I was able to add more detail to what the practical implications may be of management silencing out the difficulties of the generic workforce model. Putting this together led me to propose that health professionals who act upon on themselves in line with this desirable ethical subjectivity, would more likely put pressures on themselves to stretch their capabilities and intensify their roles. This resulted in the following CPT:

If health professionals inculcate the requirements of an enterprising and responsibilised identity into their professional practice then they may put pressure on themselves to deliver additional tasks within visits, which they have not been given additional time or resource for. This could satisfy the efficiency aims of the service change, but result in substantial intensification and stress for staff

4. In order to connect what is going on within the CPT with wider structure, I drew on Fairclough's (2001b) analytical method of assessing the way in which discursive practice, identities and ways of (inter)acting either reproduce or transform structure. He maintains it is only by being occupied that subject positions delineated in particular discursive frames continue to reproduce this social structure. However, I still needed a way of conceptualising these subject positions and what structures they were reproducing. This led me to draw on studies of neo-liberal governmentality to provide theoretical assistance with connecting wider neo-liberal political projects of reducing state spending on public service provision with shaping of individual subjects who

would take on individual responsibility for their health or workforce issues, in the way described by Henry.

Appendix 8

Description of texts analysed in phase 2

Self-management

Health coaching training

Health coaching training manual/training session- whilst observing the health coaching training session I made notes both on the content of the session in terms of what the trainer was saying and how participants responded to the session. I also collected the health coaching manual which was handed to participants. The reason for selecting and analysing this session as a communicative event was that it provided evidence of the way in which discourse relating to self-management was being linguistically realised and introduced to frontline staff within the provider. The health coaching training had been developed at the initial outset of the CBIC and was distinct from the types of communication and resources staff were on the receiving end of during their normal day to day working.

September staff newsletter

I selected the September staff newspaper for analysis as a key text because the presentation of self-management drew on a different discursive frame to the health coaching training session and represented the change in organisational focus as the service moved forward in time. I was then able to explore the extent to which the discursive frames discussed in these texts were then actualised into material and managerial practice.

Stand up meeting in office

During the time I spent conducting observations in the Hallstone office, I observed the monthly team stand up meeting. The purpose of the meeting was for middle manager, Katherine, to provide an update to staff on what was happening in the organisation and Management Executive Meeting (MEM). I made notes on the meeting as management would be communicating central organisational messages to staff. However, before attending I was unaware of the exact focus. Upon attending there were some relevant communications relating to self-management, so I analysed this text within this theme.

Generic working within integrated care teams

September staff newsletter

The September staff newsletter also discussed integrated/generic roles. Again, however, the discursive frame in which these roles were discussed represented some changes from the way in which they had been constructed by local policy implementers. This therefore provided a good source of data as to the way in which discourse was being reformulated and recontextualised through the implementation chain.

Integration meeting

I was invited by a Greenfay middle manager to attend what was termed the ‘integration meeting’ taking place in January 2019. Although this was not a communicative event that was accessible to frontline line staff in the same way as a newsletter or training course, it provided a good source of data as to the way in which middle managers and senior clinical staff were discussing their ongoing implementation strategy for integrated roles. The way discourse was being realised linguistically within the meeting can therefore be analysed in terms of its relationship with material and managerial resources directly introduced to staff.

Auto-allocation system

The three texts below all provide evidence of the way in which auto-allocation company and the provider have constructed the scheduling system linguistically with a view to promoting it both internally and externally.

Company website

The scheduling system company website has a page devoted to the auto-allocation system within community health services and uses the lead provider as a case study, including quotes from managers. This provided a good source of data on the way in which the scheduling system was being constructed in terms of the problems it was trying to tackle and how it would work to provide a solution to these problems.

Poster

During my time spent hotdesking in the Hallstone office, a promotional poster created by both management and the auto-allocation company, which aimed to advertise the successes of the system was placed outside the main office in the hallway. I took a photo of the poster for analysis, as it provided a good source of data as to the way in which the provider was seeking to advertise and promote scheduling system to both the outside world and internally to staff.

Promotional video

I came across the auto-allocation promotional video whilst conducting fieldwork in the Greenfay office. One of my interviewees, Rachel SCN, informed me that the video had been posted on the provider's Facebook page.

Appendix 9

Frontline staff sampling breakdown

Community Nursing

East Hallstone

Area 1	Total	Attempted to contact	Consented	Date took place	Sampling Round
Matrons	1	1	1 (Adele)	15/08/18	1
Senior band 6	1	1	0		
Band 5 lead nurse	1	0 (had left provider at time of fieldwork)	0		
Band 5	2	1	1 (Penny)	20/11/18	4
Nursing assistant	2	1	1 (Leah)	14/08/18	1
Area 2					
Matrons	1	0			
Senior band 6	1	1			
Band 5 lead nurse	1	0 (had left provider at time of fieldwork)	0		
Band 5	2	1	1 (Amelia)	21/08/18	1
Nursing assistant	2	0			
Area 3					
Matrons	0				

Senior band 6	1	1	0		
Band 5 lead nurse	0				
Band 5	1	1	1 (Raquel)	12/12/19	4
Nursing assistant	2	1	0		

West Hallstone

Area 1	**Total**	**Attempted to contact**	**Consented**	**Date took place**	**Sampling Round**
Matrons	1	1	0		
Senior band 6	0				
Band 5 lead nurse	0				
Band 5	2	0			
Nursing Assistant	3	2	0		
Area 2					
Matrons	1	1	1 (Caroline)	21/08/18	1
Senior band 6	1	1	1 (Lucy)	04/10/18	2
Band 5 lead nurse	0				
Band 5	0				
HCA	5	0			

Area 3					
matrons					
Senior band 6	2	2	0		
Band 5 lead nurse	0				
Band 5	4	2	0		
Nursing assistant	5	1 1 snowballing	1 (Sonia)	05/10/18	2

West Greenfay

	Total	**Attempted to contact**	**Consented**	**Date took place**	**Sampling Round**
Matrons	3	1	1 (Adrienne)	05/12/18	3
Senior band 6	2	2	1 (Emily)	07/12/18	3
Band 5 lead nurse	4	4	1 (Cheryl)	19/02/19	4
Band 5	4	0			
Nursing assistant	15	3 (assistants performing generic roles)	3 (Amber, Candice, Phoebe)	03/12/18 04/12/18 04/12/18	3

Community Rehabilitation Team

East Hallstone

	Total	**Attempted to contact**	**Consented**	**Date took place**	**Sampling Round**
Band 6 physio	1	0			
Band 6 OT	1	1	1 (Camila)	31/08/18	1
Associate Practitioner	4	1 2 snowballing	1 (Abbie) 2 (Elizabeth & Alice)	28/09/18 03/10/18 05/10/18	2 2 2
Assistant practitioner	4	3 snowballing	3 (Celia, Laura, Erin)	04/10/18 26/10/18 23/11/18	2 2 2

West Hallstone

	Total	**Attempted to contact**	**Consented**	**Date took place**	**Sampling Round**
Band 6 physio	1	1	1 (Aubree)	14/08/18	1
Band 6 OT	2	0			
Associate Practitioner	2	1	1(Madelyn)	29/08/18	1
Assistant practitioner	2	1	1 (Naomi)	21/08/18	1

West Greenfay

	Total	**Attempted to contact**	**Consented**	**Date took place**	**Sampling Round**
Physiotherapy	3	1	1 (Addison)	29/10/18	3

OT	2	1	0		
Associate Practitioner	4	1	1 (Lillian)	09/10/18	3
Assistant practitioner	5	4 (1 not contacted as was not performing generic role)	1 (Diana)	09/10/18	3

Appendix 10

Staff interview schedules

Middle Manager Interview Schedule

Introductory questions

1. Can you tell me a bit about your role?
a) Typical day
b) Length of time employed by the provider

2. Can you run through the different teams that you hold managerial responsibility for?

3. What types of things that get escalated up to management?
    a) most difficult staff related issues that you deal with?
    b) most difficult patient related issues that you deal with?
    c) If there were one or two things that you could change to make your role easier, what would they be?

Coordinating care in collocated space

4. How are experiencing the co-located office space?
    a) What interactions do you have with the therapy and nursing leads? (informal chats in the office, meetings)
    b) How does that enable you to do your job?
    c) How are the teams responded to this? (collaborating, visual difference, impact on patient care)
    d) How have you as a manager responded to any issues?
    e) Are there any things you would change in terms of how care is coordinated between the therapy and nursing teams?
    f) What is it about the therapy/nursing professions that make it easy or difficult for them to collaborate?

5. How do the core teams work with the hosted teams to coordinate care? Or are there anyways that the hosted teams work together?
    a) Examples of where this is working well
    b) Examples of where this works less well

6. Can you describe any multidisciplinary team meetings that take place within OCC’s services?
a) which professions are involved and what is their role?
b) How do they impact on providing holistic care, or identifying patients at risk of admission?
c) Difficulties in implementing meetings? What is it about the teams that has meant this has been difficult to achieve?

Change to roles

7. There have been some attempts to train nurses to deliver low level therapies and vice versa for therapists?
a) How have the assistants responded to this?
b) How have you as a manager responded to this?
c) Has this reduced number of visits?
d) Conflict between quality and reduced visits
e) Mental health first aid?

8. All patients are allocated a named care coordinator to case manage care, how is this working in practice?

9. Staff are being encouraged to conduct holistic assessments on their first visits, how is this working in practice?
a) Time/workload pressures
b) Expertise
c) Difference to patients

10. Health professionals are being encouraged to take on the role of health coach, what is this trying to achieve in both nursing and therapy?
    a) How are health professionals responding- an idea that this is more difficult for nurses
    b) What is it about health coaching that leads to benefits for patients, if there are any?
    c) Is it anything lost to the delivery of care through adopting this approach (difference between nursing and therapy?

11. How do staff go about tailoring self-management to the individual?
a) PAM
b) Discussions with patient

c) What things might be going on in people's lives that make self-management difficult

12. How would you describe what it means to be a caring professional? This is changing in light of CBIC?

Integration with social care/primary care

13. How has the role of the community matron changed and what is the impact on integration with GP practices?
    a) Impact on case management
    b) Impact on risk identification

14. Can you describe how community nursing integrates with social care/mental health/housing?
    a) Meetings
    b) Phone calls

Assistant practitioner interview schedule- round 1

1. Can you start off by telling me a bit about your role?
    a) How long have you worked here?
    b) What is a typical day for you?
    c) Types of patients?

2. Are there things that you particularly like about your role?
    a) Things you don't like?

3. Can you tell me a bit about the team that you're in?

Changes to roles

4. What are the biggest changes to your role that you've noticed since the introduction of CBIC?
    a) Do you remember the way this was communicated to you?
    b) What training and guidance have you had for this?

5. Have you been asked to take on any additional tasks, such as delivering insulins/rehabilitation exercises, etc?
    a) How did you respond to this?
    b) Communicate feelings to management? What mechanisms are available?
    c) Can you describe any challenges/benefits?

6. Can you describe the way this has made you feel towards your role?
    a) Has this changed?

7. Have you been through the health coaching training?
    a) Can you describe how this has impacted on your role?
    b) Is it making any difference?

8. Can you describe what it means to you to be a caring professional?

Coordinating care in Co-located office space

9. Can you describe your experiences of working in the co-located office space?
    a) How does it compare to previously?
    b) If there was something you could change what would it be?
    c) Any disadvantages?

10. Can you describe what ways you interact with others in the community rehab team?
    a) In the office
    b) Team meetings
    c) What are the results of this collaboration?

11. Can you describe the ways in which you engage with community nursing?
    a) What would you do if you needed advice on a nursing issue?
    b) Challenges/barriers- ways this could work better?

12. Can you describe what you would do if you identified a social care/mental health need for one of your patients?
    a) Voluntary sector worker hot desks in the office

Associate practitioner interview schedule – round 1

1. Can you tell me a bit about your role?
    a) Typical day
    b) Length of time employed by the provider
    c) Types of patients

2. Can you tell me a bit about the team that you're in?
    a) What's your role in relation to the assistants?

Coordinating care in co-located office space

3. How have you experienced the move to a co-located office space?

4. Can you describe whether and how your location in the office impacts the way you work?

5. Can you describe the meetings that you have with colleagues to assist with the delivery of patient care?
    a) Difficulties in implementing meetings? What is it about the teams that meant this was difficult to achieve?

6. Can you describe any examples of when you may need to link in with the hosted teams?
    a) What advantages does this have for patients?
    b) Examples of where this has worked well?
    c) How could this work better?
    d) Do you ever link in with hosted teams that aren't based in Hallstone?

Change to roles

7. What are the main changes to your role that you noticed since CBIC? (Apr 2016)
    a) Do you remember the way these changes were communicated?
    b) What training and guidance were you given?

8. Can you describe the ways you have experienced conducting holistic assessments?
    a) Compare to previous assessment
    b) Advantages- examples where it is working well
    c) Disadvantages
    d) Ways this could work better

9. How is the named care coordinator working in practice?

    a) Can you describe the process of drawing up a care plan?
    b) How does this relate to goal setting?
    c) Any different to before?
    d) Impact on bringing in other services?

10. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
    a) Goal setting
    b) Self-management- what is this and what is the relationship to goal setting?
    c) Experience of training?
    d) What is it about heath coaching that is different from before?
    e) Balance between individual responsibility and responsibility of health professionals
    f) Interactions with patients

11. How do you go about tailoring self-management to the individual?

    a) PAM/PROMs
    b) Discussion with patient
    c) What things might be going on in people's lives that make self-management difficult?

12. Can you describe what it means to be a caring professional?

    a) Have any of the CBIC changes made you feel any differently about your role/professional identity?

Integration with social care/primary care

13. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well
    b) Difficulties and barriers to this
    c) Voluntary sector

14. Can you describe the way in which you would work with mental health when delivering patient care?

a) Examples of where this has worked well

b) Difficulties and barriers to this
c) Ways this could work better

15. Can you describe the way in which you would work with the voluntary sector when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

16. Can you describe the way in which you would work with primary care when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could be better

Band 5 nurse interview schedule – round 1

1. Can you start off by telling me a bit about role?
    - a) How long have you worked here?
    - b) What is a typical day for you?
    - c) Types of patients?

2. Can you tell me a bit about the team that you're in?
    - a) Interaction with nursing assistant?

3. What are the biggest challenges for you in your role right now?
    - a) Difficulties with financial constraints and staffing levels
    - b) Housebound conditions

Coordinating care in co-located space

4. How are you experiencing the co-located office space?
    - a) What interactions do you have with community rehab?
    - b) How does that enable you to do your job? Examples of where this has worked well?
    - c) Disadvantages of open plan office? (privacy, noise, etc)

5. How are the teams responded to this? (collaborating, visual difference, impact on patient care)
    - a) How have you as a manager responded to any issues?
    - b) Are there any things you would change in terms of how care is coordinated between the therapy and nursing teams?

6. How do you work with the hosted teams to coordinate care? Lymphodema, tissue viability, continence
    - a) Examples of where this is working well
    - b) Examples of where this works less well
    - c) How could this work better?

Changes to roles

7. What are the biggest changes to your role that you've noticed since the introduction of CBIC?
    - a) Do you remember the way this was communicated to you?
    - b) What training and guidance have you had for this?

8. Can you describe how you have experienced conducting the new comprehensive holistic assessment?
   a) Compare to previous assessment (therapy aspects, social care, mental health)
   b) Advantages/disadvantages
   c) Ways this could work better
   d) Care plan- what is the process?

9. Health professionals are being encouraged to take on the role of health coach, what is this trying to achieve in nursing? (goal setting, self-management, is it the same thing?)
   a) Is there any difference between what this is trying to achieve in nursing and therapy?
   b) What is it about health coaching that leads to benefits for patients, if there are any?
   c) Is it anything lost to nursing through adopting this approach?
   d) Balance between nursing role and personal responsibility?
   e) interactions with patients

10. How do staff go about tailoring self-management to the individual?
    a) PAM/PROMs
    b) Discussions with patient
    c) What things might be going on in people's lives that make self-management difficult

11. How would you describe what it means to be a caring professional?

12. Have any of the changes to your job spec made you feel any differently about your role or your identity?

Integration with social care/primary care

13. Can you describe any way that you work with GP practices?
    a) Examples of integration with primary care, or examples of where it's not working well
    b) Why has it been difficult to integrate therapies with primary care?
    c) Impact on case management
    d) Impact on risk identification

14. Examples of integration with voluntary sector?

17) Can you describe the way in which you engage with social care/mental health/voluntary sector?
    a) Meetings- what is it about them that makes a difference
    b) Phone calls (named contact to call through to)
    c) What is it about the Tending context that has enabled integration with social care?
    d) Barriers
    e) Ways this could work better

Community Matron interview schedule – round 1

1. Can you tell me a bit about your role?
   a) Typical day
   b) Length of time employed by the provider
   c) Types of patients

2. Can you tell me about the community nursing team?
   a) Do you have any line management responsibilities?

3. What are the main changes to your role that you've noticed since the CBIC? (Apr 2016)
   a) Do you remember the way these changes were communicated?
   b) What training and guidance were you given?

4. Can you describe how you have experienced conducting the new comprehensive holistic assessment?
   a) Compare to previous assessment
   b) Advantages- examples where it is working well
   c) Disadvantages
   d) Ways this could work better

5. How is the named care coordinator working in practice?
   a) Talk me through the process of developing a care plan
   b) How does this relate to goal setting?
   c) Any different to before?
   d) Impact on bringing in other services?

6. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
   a) Goal setting
   b) Self-management- what is this and what is the relationship to goal setting?
   c) Experience of training?
   d) What is it about heath coaching that is different from before?
   e) Interactions with patients

7. How do you go about tailoring self-management to the individual?
   a) PAM/PROMs
   b) Discussion with patient

   c) What things might be going on in people’s lives that make self-management difficult?

8. Can you describe what it means to be a caring professional?
   a) Have any of the CBIC changes made you feel any differently about your role/professional identity?

9. Can you describe the way in which you would work with primary care when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could be better

10. Can you describe how high-risk patients are identified and managed?
    a) In what ways do you work with primary care in this?
    b) Ways working well and not so well

11. One of the aims within the bid was to progressively integrate primary and community services, to what extent do you think that’s happening?

12. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well
    b) Difficulties and barriers to this
    c) Consequences if this is not happening?

13. Can you describe the way in which you would work with mental health when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

14. Can you describe the way in which you would work with the voluntary sector when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better
d) Voluntary sector

15. How are you experiencing the co-located office space?
    a) What sort of interaction do you have
    b) How does it enable you to do your job
    c) Disadvantages

16. Can you describe any ways that work with community rehab, or the hosted teams?

Nursing Assistant Interview Schedule- Round 1

1. Can you start off by telling me a bit about role?
    a) How long have you worked here?
    b) What is a typical day for you?
    c) Types of patients?

2. Are there things that you particularly like about your role?
    a) Things you don't like?

Changes to roles

3. What are the biggest changes to your role that you've noticed since the introduction of CBIC?
    a) Do you remember the way this was communicated to you?
    b) What training and guidance have you had for this?

4. Have you been asked to take on any additional tasks, such as therapy exercises, etc?
    a) How did you respond to this?
    b) Communicate feelings to management? What mechanisms are available?
    c) Can you describe any challenges/benefits?

5. Can you describe the way this has made you feel towards your role?
    a) Has this changed?

6. Have you been through the health coaching training?
    a) Can you describe how this has impacted on your role?
    b) Is it making any difference?
    c) Tailor self-management?
    d) Interactions with patients

7. Can you describe what it means to you to be a caring professional?

Coordinating care in co-located office space

8. Can you describe your experiences of working in the co-located office space?
    a) How does it compare to previously?
    b) If there was something you could change what would it be?
    c) Any disadvantages?

9. Can you describe what ways you interact with others in the community nursing team team?
    a) In the office
    b) Team meetings
    c) What are the results of this collaboration?

10. Can you describe the ways in which you engage with community rehab team?
    a) What would you do if you needed advice on a nursing issue?
    b) Challenges/barriers- ways this could work better?

11. Can you describe what you would do if you identified a social care/mental health need for one of your patients?

Physio/Occupational Health interview schedule- round 1

1. Can you tell me a bit about your role?
a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
   a) Do you have any line management responsibilities?

Change to roles

3. What are the main changes to your role that you noticed since CBIC? (Apr 2016)
   a) Do you remember the way these changes were communicated?
   b) What training and guidance were you given?

4. Can you describe the ways you have experienced conducting holistic assessments?
   a) Compare to previous assessment
   b) Advantages/Disadvantages
   c) Ways this could work better

5. How is the named care coordinator working in practice?
   a) Can you describe the process of drawing up a care plan?
   b) How does this relate to goal setting?
   c) Any different to before?
   d) Impact on bringing in other services?

6. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
   a) Goal setting
   b) Self-management- what is this and what is the relationship to goal setting?
   c) Experience of training?
   d) What is it about heath coaching that is different from before?
   e) Interactions with patients

7. How do you go about tailoring self-management to the individual?
   a) PAM/PROMs
   b) Discussion with patient
   c) What things might be going on in people's lives that make self-management difficult?

8. Can you describe what it means to be a caring professional?
   a) Have any of the CBIC changes made you feel any differently about your role?

Coordinating care in colocated space

9. How have you experienced the move to a co-located office space?
   a) Does your location in the office have any impact on the way you work?
   b) difference in physical proximity to the nursing team?
   c) Challenges and barriers- examples of difficulties
   d) Are there any things you would change in terms of how care is coordinated between the therapy and nursing teams?

10. Can you describe any examples of when you may need to link in with the hosted teams?
    a) What advantages does this have for patients?
    b) Examples of where this has worked well?
    c) How could this work better?

11. Can you describe the meetings that you have with colleagues to assist with the delivery of patient care?
    a) Difficulties in implementing meetings? What is it about the teams that meant this was difficult to achieve?

Integration with social care/primary care

12. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well
    b) Difficulties and barriers to this

13. Can you describe the way in which you would work with mental health when delivering patient care?

a) Examples of where this has worked well

b) Difficulties and barriers to this
c) Ways this could work better

14. Can you describe the way in which you would work with the voluntary sector when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

15. Can you describe the way in which you would work with primary care when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could be bette

Assistant practitioner interview schedule- round 2

1. Can you tell me a bit about your role?
a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
    a) How would you describe the team you're in?
    b) Has the way you think about the team that you belong to changed since CBIC?

Changes to roles

3. What are the biggest changes to your role that you've noticed since the introduction of CBIC?
    a) Do you remember the way this was communicated to you?
    b) What training and guidance have you had for this?

4. Have you been asked to take on any additional tasks, such as delivering insulins, etc?
    a) How did you respond to this?
    b) Communicate feelings to management (staff council)? What mechanisms are available?
    c) Can you describe any challenges/benefits?

5. Can you describe the way this has made you feel towards your role?
a) Has this changed?

6. Can you describe your experiences of the Cbernet scheduling system?
    a) How do you feel when you're out and about?
    b) Positive benefits
    c) Negative consequences

7. Can you describe what ways you interact with others in the community rehab team?
    a) In the office
    b) Team meetings
    c) What are the results of this collaboration?

8. Can you describe the ways in which you engage with community nursing?
    a) What would you do if you needed advice on a nursing issue?
    b) Challenges/barriers- ways this could work better?

9. Experience of teams
    a) Interaction with nursing, knowing who everyone is
    b) Location in office
    c) Difference
    d) In what ways could this work better?

10. Has it changed the way that you relate to other health professionals?
    a) Impact on patients (examples)

Associate practitioner interview schedule – Round 2

1. Can you tell me a bit about your role?
a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
    a) Relationship to the assistants
    b) How would you describe the team you're in?

3. Experience of teams
    a) how has this changed over the time you've been here?
    b) Interaction between the teams (core), knowing who everyone is
    c) Location in office
    d) Difference
    e) In what ways could this work better?

4. Can you describe any interactions with the hosted teams?
    a) Within office/outside the office
    b) Has it changed the way that you relate to other health professionals?
    b) Impact on patients (examples)

5. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well
    b) Difficulties and barriers to this

6. Can you describe the way in which you would work with mental health when delivering patient care?
d) Examples of where this has worked well
a) Difficulties and barriers to this
b) Ways this could work better

7. Can you describe the way in which you would work with the voluntary sector when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this

c) Ways this could work better

8. What are the main changes to your role that you've experienced?
   a) Do you remember the way these changes were communicated?
   b) What training and guidance were you given?
   c) If you have an issue, how do you express this?

9. Can you describe the ways you have experienced conducting holistic assessments?
   a) Compare to previous assessment
   b) Advantages/disadvantages
   c) Contexts where this works better than others
   d) Ways this could work better
   e) Use of PROMs/PAMs

10. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
    a) Goal setting
    b) Self-management- what is this and what is the relationship to goal setting?
    c) Experience of training?
    d) What is it about heath coaching that is different from before?
    e) Interactions with patients

11. How do you go about tailoring self-management to the individual?
    a) PAM/PROMs
    b) Discussion with patient
    c) What things might be going on in people's lives that make self-management difficult?
    d) Contexts where self-management works better than others

12. Can you describe what it means to be a caring professional?

13. Have any of the CBIC changes made you feel any differently about your role/professional identity?

Nursing assistant interview schedule- round 2

1. Can you tell me a bit about your role?

a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
   a) How would you describe the team you're in?
   b) Has the way you think about the team that you belong to changed since CBIC?
   c) Does it feel like an integrate care team?

3. How do you interact with the nursing team? What types of things do you talk about?
   a) In what ways do you need to interact with therapies? Examples of benefits?
   b) Location in office- effects of the changes in the office?
   c) In what ways could this work better?
   d) Difficulties of having different professions together

4. Can you describe any ways that you work with hosted teams?
   a) Within office/outside the office
   b) Are there ways this could be improved?

Roles

5. What are the main changes to your role that you've experienced?
   a) Do you remember the way these changes were communicated?
   b) What training and guidance were you given?
   c) If you have an issue, how do you express this?

6. Can you describe your experiences of the Cbernet scheduling system?
   a) How do you feel when you're out and about?
   b) Positive benefits
   c) Negative consequences

7. Can you describe the ways you have experienced conducting holistic assessments?

  e) Compare to previous assessment
  f) Advantages/disadvantages
  a) Contexts where this works better than others
  b) Ways this could work better
  c) Use of PROMs/PAMs

8. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
   a) Goal setting
   b) Self-management- what is this and what is the relationship to goal setting?
   c) Experience of training?
   d) What is it about heath coaching that is different from before?
   e) Interactions with patients

Integration with primary care/mental health/social care

9. Can you describe the way in which you would work with primary care when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could be better
d) Care homes- meetings at care homes?

10. Can you describe the way in which you would work with mental health when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

11. Can you describe the way in which you would work with the voluntary sector when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better
d) Community 360

12. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well

b) Difficulties and barriers to this
c) Consequences if this is not happening?

Self-management

13. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
    a) Goal setting
    b) Self-management- what is this and what is the relationship to goal setting?
    c) Experience of training?
    d) What is it about heath coaching that is different from before?
    e) Interactions with patients

14. How do you go about tailoring self-management to the individual?
    a) PAM/PROMs
    b) Discussion with patient
    c) What things might be going on in people's lives that make self-management difficult?

15. Can you describe what it means to be a caring professional?
    a) Have any of the CBIC changes made you feel any differently about your role/professional identity

Senior Community Nurse interview schedule – round 2

1. Can you tell me a bit about your role?
a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
    a) How would you describe the team you're in?
    b) Has the way you think about the team that you belong to changed since CBIC?

3. How do you interact with the nursing team? What types of things do you talk about?
    a) In what ways do you need to interact with therapies? Examples of benefits?
    b) Location in office- effects of the changes in the office?
    c) In what ways could this work better?
    d) Difficulties of having different professions together

4. Can you describe any ways that you work with hosted teams?
    a) Within office -Continence, Tissue viability, Lymphedema, speech and language, ESD
    b) Out of office-outpatient physio, pain management, podiatry, cardiology
    c) Are there ways this could be improved?

5. Have you been involved in training the rehab assistants in nursing tasks?
    a) What impact is the generic role having?
    b) How do you feel about therapists taking on nursing roles?
    c) What are the consequences?

6. Can you describe the ways your involved with scheduling through Cbernet?
    a) Advantages/disadvantages

Integration with primary care/mental health/social care

7. Can you describe the way in which you would work with primary care when delivering patient care?
a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could be better
d) Care homes- meetings at care homes?

8. Can you describe the way in which you would work with mental health when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

9. Can you describe the way in which you would work with the voluntary sector when delivering patient care?

a) Examples of where this has worked well
b) Difficulties and barriers to this
c) Ways this could work better

10. Can you describe the way in which you would work with social care when delivering patient care?
    a) Examples of where this has worked well
    b) Difficulties and barriers to this
    c) Consequences if this is not happening?

Self-management

11. Staff are being encouraged to engage in health coaching, can you describe what health coaching means to you in your role?
    f) Goal setting
    g) Self-management- what is this and what is the relationship to goal setting?
    h) Experience of training?
    i) What is it about heath coaching that is different from before?
    j) Interactions with patients

12. How do you go about tailoring self-management to the individual?
    a) PAM/PROMs
    b) Discussion with patient
    c) What things might be going on in people’s lives that make self-management difficult?

13. Can you describe what it means to be a caring professional?
    a) Have any of the CBIC changes made you feel any differently about your role/professional identity?

Nursing assistants interview Schedule- round 3

1. Can you tell me a bit about your role?
   a) Typical day
   b) Length of time employed by the provider
   c) Types of patients

Changes to roles

2. Have you been asked to take on any additional tasks, such as rehab exercises, etc?
   a) Do you remember the way this was communicated to you? Feelings?
   b) Communicate feelings to management (staff council)? What mechanisms are available?
   c) What training were you given?

3. Can you describe the challenges of this new workforce model when you're carrying out your day to day job? (switching between different mind sets, time differences between delivery of tasks)
   a) What are the different things that you have to consider when switching between the two?
   b) Can you describe any things you like about it?
   c) Impact on patients (different task performed to one patient?) are there certain types of patients were the delivery of two tasks works better?

4. Can you describe your experiences of the Cbernet scheduling system?
   a) How do you feel when you're out and about? Build up a picture of this
   b) How do you decide when to follow Cbernet and when to ignore it?
   c) Positive benefits
   d) Negative consequences

5. Can you describe the way this has made you feel towards your role?
   a) Has this changed?
   b) How would you describe the position of the band 3s?
   c) How much control do you feel you have over your working life?

Team interactions

6. Can you tell me a bit about the team that you're in?
   a) How would you describe the team you're in?
   b) Has the way you think about the team that you belong to changed since CBIC?
   c) Does it feel like an integrated team?
   d) What would integration look like?

   e) Is there a sense that your team is linked with the nursing (geographical) area?

7. Can you describe what you would do if you needed advice on a therapy issue?
   a) How would you make the decision on who to speak to?
   b) Challenges/barriers- ways this could work better?
   c) How would you describe your relationship with the therapy team compared to the nursing team?

8. Can you describe where you sit in the office?
   a) Does this impact on the way in which you interact with colleagues?
   b) Are there any difficulties with having different teams co-located? Visual differences between the professions.

Additional role questions

9. Can you describe how you have experienced conducting the new comprehensive holistic assessment?
   a) Compare to previous assessment (therapy aspects, social care, mental health)
   b) Does it change the way you think about the care you're delivering, or lead to different actions?
   c) Advantages- examples where it is working well
   d) Ways this could work better

10. Health professionals are being encouraged to take on the role of health coach, what is this trying to achieve in nursing? (goal setting, self-management, is it the same thing?)
    a) Is there any difference between what this is trying to achieve in nursing and therapy?
    b) How are health professionals responding- an idea that this is more difficult for nurses
    c) What is it about health coaching that leads to benefits for patients, if there are any?
    d) Is it anything lost to nursing through adopting this approach?
    e) Balance between nursing role and personal responsibility?
    f) Interactions with patients

11. Any positive examples of where someone has been enabled to self-manage?

Matron interview schedule – round 3

1. Can you tell me a bit about your role?
   a) Typical day
   b) Length of time employed by the provider
   c) Types of patients

2. Can you tell me a bit about the team that you're in?
   a) How would you describe the team you're in?
   b) Has the way you think about the team that you belong to changed since CBIC?
   c) Do you get the sense you belong to an integrated care team?
   d) What does it mean for the teams to be integrated?

3. Can you describe what you would do if you needed advice on a therapy issue?
   a) How would you make the decision on who to speak to? Is there a sense that there are therapists linked with your area?
   b) Can you describe what you would do if you needed advice from one of the hosted teams in the office?
   c) Are there ways this could be improved?
   d) Contexts where you would more likely interact with other professions?

4. Can you describe where you sit in the office?
   a) Does this impact on the way in which you interact with colleagues?
   b) Are there any difficulties with having different teams co-located? Visual differences between the professions.

Integration with social care/primary care

5. Can you describe any way that you work with GP practices?
   c) Examples of integration with primary care, or examples of where it's not working well
   d) Has this changed since CBIC?
   e) Impact on case management
   f) Impact on risk identification

6. Can you describe how you make decisions on whether to refer someone through to social care/mental health (health in mind)/voluntary sector? Examples
    a) What are the barriers and enablers to doing this?
    b) Ways this could work better
    c) Consequences of lack of integration, or positive consequences of integration?

Roles

7. Can you describe any changes to your role since the introduction of CBIC?
    a) Do you remember how the changes were communicated to you?

8. Can you describe how you have experienced conducting the new comprehensive holistic assessment?
    a) Compare to previous assessment (therapy aspects, social care, mental health)
    b) Does it change the way you think about the care you're delivering?
    c) Does it facilitate greater engagement with other agencies?
    d) Advantages- examples where it is working well
    e) Ways this could work better

9. Health professionals are being encouraged to take on the role of health coach, what is this trying to achieve in nursing? (goal setting, self-management, is it the same thing?)
    a) Is there any difference between what this is trying to achieve in nursing and therapy?
    b) How are health professionals responding?
    c) What is it about health coaching that leads to benefits for patients, if there are any?
    d) Is it anything lost to nursing through adopting this approach?
    e) Balance between nursing role and personal responsibility?
    f) Interactions with patients

10. How do staff go about tailoring self-management to the individual?

a) PAM/PROMs
b) Discussions with patient
c) What things might be going on in people's lives that make self-management difficult

11. Have any of the changes to your job spec made you feel any differently about your role or your identity?

a) How would you describe what it means to be a caring professional?
b) What impact are the capacity issues having? Impact of not having enough staff
c) What do you do if you're unhappy?

Senior Community Nurse Interview Schedule- round 3

1. Can you tell me a bit about your role?

a) Typical day
b) Length of time employed by the provider
c) Types of patients

2. Can you tell me a bit about the team that you're in?
   a) How would you describe the team you're in?
   b) Has the way you think about the team that you belong to changed since CBIC?
   c) Do you get the sense you belong to an integrated care team?
   d) What does it mean for the teams to be integrated?

3. Can you describe what you would do if you needed advice on a therapy issue?
   a) How would you make the decision on who to speak to? Is there a sense that there are therapists linked with your area?
   b) Are there ways this could be improved?
   c) Contexts where you would more likely interact with other professions?

4. Can you describe where you sit in the office?
   a) Does this impact on the way in which you interact with colleagues?
   b) Are there any difficulties with having different teams co-located?

Changes to roles

5. Can you describe any changes to your role since the introduction of CBIC?
   a) How was this communicated to you?
   b) Have you been involved with training the rehab assistants? Advantages/disadvantages
   c) How do you feel about rehab assistants taking on nursing roles?

6. Can you describe how the introduction of Cbernet has impacted on your role?
   a) What do you do differently now?
   b) Can you describe the scheduling process previously?
   c) What are the advantages/disadvantages?

7. Can you describe how you have experienced conducting the new comprehensive holistic assessment?

   a) Compare to previous assessment (therapy aspects, social care, mental health)
   b) Advantages- examples where it is working well
   c) Ways this could work better
   d) Are patients repeating their story less?

8. What is it about the area team meetings that make a difference to patients?
   a) Implication of not having these?

9. Health professionals are being encouraged to take on the role of health coach, what is this trying to achieve in nursing?
   a) Can you describe any differences between what this is trying to achieve in nursing and therapy?
   b) How are health professionals responding- an idea that this is more difficult for nurses
   c) What is it about health coaching that leads to benefits for patients, if there are any?
   d) Is it anything lost to nursing through adopting this approach?
   e) Balance between nursing role and personal responsibility?
   f) Interactions with patients

10. How do staff go about tailoring self-management to the individual?

a) Discussions with patient
b) What things might be going on in people's lives that make self-management difficult

11. Have any of the changes to your job spec made you feel any differently about your role or your identity?
    a) How would you describe what it means to be a caring professional?
    b) What impact are the capacity issues having?
    c) What do you do if you're unhappy? Staff council, suggestion box

Integration with social care/primary care

13. Can you describe any way that you work with GP practices?
    a) Examples of integration with primary care, or examples of where it's not working well
    b) Can you describe how you make decisions on whether to refer someone through to social care/mental health (health in mind)/voluntary sector? Examples
    c) What are the barriers and enablers to doing this?
    d) Ways this could work better
    e) Consequences of lack of integration

Band 5 Nurse interview schedule- round 4

1. Can you tell me a bit about your role?
   a) Typical day
   b) Length of time employed by the provider
   c) Types of patients

Changes to roles

2. Can you describe anyways you think your role has changed since CBIC? Have there been any changes to the lead nurse role?
   a) Can you describe any changes to your role following the Cbernet system?
   b) Can you describe the impact on your role because of this?
   c) What is the impact on patient care?
   d) What impact does that have on the way you feel about your role?

3. Can you describe how you would have scheduled your visits previous to Cbernet?
   a) What was the reasoning process? What factors did you take into consideration when scheduling?
   b) How does Cbernet compare to this?

4. Does Cbernet affect your role in any other ways?
   a) Can you describe what it feels like when you're out and about following the scheduling system?
   b) Any advantages?

5. One of the aims within CBIC was to have a named care coordinators for each patient, is that something that happens in practice?
   a) Do you have patients that you manage across services for the duration?
   b) What would it be about care coordinating that would make a difference to patients?
   c) Are there any contexts where this would work?

6. Can you describe how you have experienced conducting the new comprehensive holistic assessment?
   a) Advantages- examples where it is working well
   b) Ways this could work better
   c) Are patients repeating their story less

7. Health professionals are being asked to encourage patients to take on more responsibility for taking care of themselves, are you able to describe how that's being implemented in practice? (how this approached, what convos with patients)
    a) How do you feel about being asked to have those conversations with patients?
    b) What is self-management trying to achieve?
    c) Is there anything about self-management that leads to benefits for patients?

8. How do staff go about tailoring self-management to the individual?

a) Discussions with patient
b) What things might be going on in people's lives that make self-management difficult
c) What is the impact of demographic factors?
d) How do you feel when someone who you feel could self-manage but refuses to do so?
e) Interactions with patients

9. Can you describe any difference between what this is trying to achieve in nursing and therapy?

a) Is it anything lost to nursing through adopting this approach?
b) Balance between nursing role and personal responsibility?

10. Have any of the changes to your job spec made you feel any differently about your role or your identity?
    a) How would you describe what it means to be a caring professional?
    b) Have you been involved in training the assistants?
    c) What do you do if you're unhappy? Staff council, suggestion box

11. What impact are the capacity issues having? Impact of not having enough staff?
    a) Do you ever take on additional responsibilities when in patients' homes, i.e. social care?

Integration with social care/primary care

12. Can you describe any way that you work with GP practices?
    a) Examples of integration with primary care, or examples of where it's not working well
    b) Impact on case management
    c) Impact on risk identification

Appendix 11

Patient interview schedule

1. Can you please describe the usual care you receive?
   a) Condition type
   b) Number of visits and by whom
   c) Help at home (social care)

2. Can you describe the first visit that you had?
   a) Can you describe the process of drawing up your care plan?
   b) How involved did you feel?
   c) Did you set goals? How were these decided?
   d) Holistic assessment?

3. Can you describe the way in which health professionals are working together around your care?
   a) Do you get any sense that they are working together and communicating?
   b) The referral process? (seamless?)
   c) How often are you repeating your story?
   d) Do you have a care coordinator who is case managing your care?
   e) How important to you is this?

4. Can you describe how well you think community services are working together with external agencies?
   a) GP practices?
   b) Social care
   c) Mental health
   d) Voluntary sector?

5. Can you describe any differences you have noticed to the types of tasks performed by the health professionals who are visiting you and the number of visits you are receiving?
   a) Are you getting continuity in care?
   b) How would you feel if a therapist who came to do you rehab also took your clips out, or took blood?
   c) How would you like feel if the nurse who was taking your clips out/taking blood also did the rehab exercises on the same visit?

6. Can you describe any new responsibilities you’ve been asked to take on?
   a) Describe how this topic was broached? How did you feel?
   b) Can you talk me through an example of when you have found it difficult to fulfil these new responsibilities?
   c) Can you talk me through an example of when you have found it easier to fulfil these new responsibilities?
   d) Resources available, i.e. family/friends

7. Can you describe any changes made to the location of your care?
   a) Where would you prefer your care to be delivered? Home, GP practice, health clinic, hospital
   b) What impact have any changes to location had on you?

8. What does the delivery of good quality patient centred care mean to you?
   a) What are your priorities when receiving care? (location, staff, coordination)
   b) What would health care designed around your priorities look like?

9. How would you describe feeling empowered in relation to your condition?
   a) How would you describe feeling in control of your condition?

Appendix 12

University of Essex

University of Essex, PhD Research Project

A critical realist evaluation of community based integrated care policy

Please initial in box

Interview Participant Consent Form

1. I confirm that I have read and understood the information sheet v2 13/03/18 for participants for this study and have had the opportunity to ask questions and had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without conditions of employment or legal rights being affected ☐
3. I understand that if I choose to withdraw, my data may be used up and until the point of withdrawal ☐
4. I understand that my responses will remain confidential to the PhD researcher and supervisors ☐
5. I understand that my data will be stored in accordance with the General Data Protection Regulation (GDPR) ☐
6. I understand that during the study the researcher becomes concerned for patient or staff safety they have a duty to act on these concerns and confidentiality cannot be maintained ☐
7. I understand that only anonymised quotes will be used and published in the final report and that if an individual is mentioned, a pseudonym will be provided to protect the individual's Identity. However, if direct quotations are used in the research report it cannot be guaranteed that I will not be identified ☐
8. I understand that relevant sections of data collected during the study may be looked at by individuals from the University of Essex ☐
9. I agree to be audio-taped during the interview ☐
10. I agree to take part in the above study ☐

____________________	____________________	____________________
Name of Participant	**Date**	**Signature**
____________________	____________________	____________________
Name of Person taking consent	**Date**	**Signature**

Please note that one copy of this form is for the participant to keep and the second copy is for the research investigator

University of Essex

University of Essex, PhD Research Project

A critical evaluation of community based integrated care policy

Observation Participant Consent Form

Please tick box

1. I confirm that I have read and understood the information sheet for participants for this study and have had the opportunity to ask questions and had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without conditions of employment or legal rights being affected ☐
3. I understand that if I choose to withdraw, my data may be used up and until the point of withdrawal ☐
4. I understand that my data will remain confidential to the PhD researcher and supervisors ☐
5. I understand that my data will be stored in accordance with the Data Protection Act (1998) ☐
6. I understand that during the study the researcher becomes concerned for patient or staff safety they have a duty to act on these concerns ☐
7. I understand that only anonymised data will be used and published in the final report and that if an individual is mentioned, a pseudonym will be provided to protect the individual's identity ☐
8. I agree to being observed by a researcher during participation in training/meeting/office ☐
9. I agree to take part in the above study ☐

Name of Participant	**Date**	**Signature**
Name of Person taking consent	**Date**	**Signature**

Please note that one copy of this form is for the participant to keep and the second copy is for the research investigator

Appendix 13

University of Essex

Staff Interview Participant Information Sheet

Study Title: A critical realist evaluation of community based integrated care policy

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

What is the purpose of the study?

Oaklea Community Care (OCC) are sponsoring a PhD research project to evaluate their 'Community based integrated care' (CBIC) service. The aim of the study is to answer the following research questions:

1. How have local policy implementers (CCG/lead provider/Essex county council) constructed a community based integrated care service (CBIC) and what relationship does this have to the social and political context?
2. How have attempts to reconstruct health professional roles been implemented within community based integrated care and what impact is this having on patients and staff?
3. What consequences can be observed from the co-location of community based integrated care teams?
4. By what mechanisms are community services integrating horizontally with primary care, social care, mental health and the voluntary sector, and what are the outcomes?

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Further information and contact details:

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hk16201@essex.ac.uk
07824701919

University of Essex

Staff Interview Participant Information Sheet

Study Title: A critical realist evaluation of community based integrated care policy

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What is the purpose of the study?

Oaklea Community Care (OCC) are sponsoring a PhD research project to evaluate their 'Community based integrated care' (CBIC) service. The aim of the study is to answer the following research questions:

1. How have local policy implementers (CCG/lead provider/Essex county council) constructed a community based integrated care service (CBIC) and what relationship does this have to the social and political context?
2. How have attempts to reconstruct health professional roles been implemented within community based integrated care and what impact is this having on patients and staff?
3. What consequences can be observed from the co-location of community based integrated care teams?
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