The Organisational Dynamics of Integrating Neurology Services in an NHS Hospital Trust: A Systems Psychodynamic Perspective.

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Finally to Dad,
I haven't given up yet.

"Be strong and of good courage, and do it: fear not, nor be dismayed: for the Lord God, even my God, will be with thee; he will not fail thee, nor forsake thee, until thou hast finished all the work for the service of the Lord." (1 Chronicles 28: 20)

Abstract

Background: The factors driving NHS integration are captured in the Neurology patient population, characterised by increased life expectancy, alongside high incidence of complex, degenerative, and long-term conditions. Organisational change is a requirement of integration, with the potential to undermine clinical care. Merger is introduced as an existing form of integration, where relational understanding has been subjugated.

Literature Review: Research addressing professional views of organisational merger in NHS hospital trusts was systematically identified. A line of argument synthesis illustrates the distal influence of politics and place, borne out locally in assimilation, loss, and pragmatic progress.

Aims: To explore what could be learned about a local integration from a psychodynamic method of observation, and to hypothesise unconscious aspects of integration relevant to wider UK health systems.

Method: A philosophical and epistemological position consistent with the unconscious aspects of change in a public institution are set out in detail. This conceptual frame is operationalised into a three phase method of observation. Data generated from 6 in depth observations and reflective groups was analysed in line with reflective thematic analysis.

Results: A rigid hierarchy underpinned anxiety at uncertain boundaries, indicating the task and structure of integration split off painful feelings. Systemic demands to quantify integration were hypothesised to obscure the painful task of caring for patients with degenerative conditions. These defensive structures also appeared liable to semi-sudden collapse, risking the sudden return and contagion of disavowed feelings.

Conclusions: The capacity to flexibly contain painful feeling states is denatured by marketised competition and pressures to evidence quality. Associative forms of enquiry offer a means of integrating feeling states into the process of organisational change in the NHS. This form of knowledge is essential to integrate local systems, but is threatened by cycles of top down re-organisation, reverting power to the centre.

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Chapter One: Introduction

Chapter Overview

The National Health Service (NHS) in the United Kingdom (UK) has been subject to repeated organisational changes, since its political conception nearly eighty years ago. This introductory chapter conceptualises the quality of human interactions within this organisational history as inseparable from the primary task of clinical care within health systems. The current organisational change demanded of the NHS is framed by the integrated care agenda, which is defined as locating patient perspective and experiences as the organising principle of clinical service delivery. This is set in the historical context of organisational merger, an example of integration focussed on technical processes, methods and tools. The clinical realities driving integrated care are then set out in relation to the medical speciality of Neurology, with specific attention drawn to the implication of complex and long term neurological conditions, which require support from across highly specialised systems . The human impact on professionals who both enact and are subject to change is widely neglected in the design, implementation, and evaluation of integration initiatives. Qualitative approaches to organisational research within healthcare systems is introduced, with specific focus on a systems psychodynamic model of human behaviour. This posits humans as irrationally motivated by internal psychological factors, while simultaneously shaped by the dynamics of social groups. This theoretical frame is presented as and mode of enquiry.

Organisation of a National Health Service

The NHS was established in the UK in 1948, at a unique moment of societal change following the second world war (Sheard, 2011). Over the intervening 75 years, re-organisation of the NHS has been perpetual, driven by profound shifts in the socio-political and economic context of the UK (Klein, 2010). However, Nye Bevans vision for population

wide healthcare, funded through taxation, and free at the point of access has against all odds endured. At its heart the NHS contains a tension between centralised political control and the diverse peripheral systems which deliver care to local people. Lambert (2024) frames this as a question of whether the NHS is a top-down institution organised on a local level, or a subsidiary array of local systems administered by central government.

Lambert (2024) states this tension between ministerial oversight and clinical expertise has been ubiquitous, with the intersection of these opposing interests consistently located in an intermediary and shifting regional tier. Over time this intermediary structure has evolved to both drive and ameliorate central prioritises towards efficiency and performance. This includes the collaborative integration of regional services, while implementing a neoliberal agenda of marketisation, and centralised regulation of quality. The NHS survives through its capacity to balance these competing demands, including continuity and flexibility, centralisation and localism, and the reality of crises and underperformance, with its own idealised public myth (Klein, 2010).

Lambert (2024) further argues the spatial parameters of distinct geographical territories should be understood to exist alongside organisational structures, and relational ties. This means rather than a simple structural hierarchy with distinct regional forms, the NHS is better understood as an intersecting relational and spatial network (Allen & Cochrane, 2007). This intersection of organisational structure and human relationships places inherent tension at the heart of the UK's health system, which is a centralised national service delivered by subsidiary local systems. Compared to post war political consensus, the UK political landscape has shifted, notably represented by healthcare's devolved status since the end of the 20th century (Redhead & Lynch, 2024). Regardless of orientation, these regional sub-systems are under increasing pressure to integrate their services to meet the changing health needs of ageing populations.

Integrated care systems (ICSs)

The 20th century saw the emergence and proliferation of bio-medical and scientific progress in healthcare. This has inadvertently driven the concentration and specialisation of acute hospital care (Fulop et al., 2002). However, ageing populations characterised by complexity and chronicity are now undermining the rigid differentiation of medical specialities (Kellett, 2011). The structural integration of health and social care systems has been proposed as one means of addressing the organisational silos associated with specialisation and marketisation (Lorne et al., 2019). However, the division of labour in community healthcare systems according to bio-medical speciality is mismatched to the on-going needs of complex, long-term conditions (Hughes et al., 2020).

Government policy which requires the integration of multiple agencies across commissioning and clinical services has been an emerging priority for some time (Lavender, 2009). Aligned with the previous NHS long term plan (NHSE, 2019), the Health and Care Act (DHSC, 2022) formalised Integrated Care Systems (ICSs) under English law. These comprise Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), which seek to organise patient care and commissioning at the levels of system, place, neighbourhood, and person (Charles, 2022b). This legislative development marked a step change in the re-organisation of health and social care, away from mandatory competitive tendering set out by former health secretary Andrew Lansley (DHSC, 2012).

ICSs at their inception were mandated with statutory governance responsibilities, improving health and healthcare, addressing inequalities across outcome, experience, and access, and to ensure economic value. These priorities sat alongside a broader aim of contributing to societies wider social and economic development (Charles, 2022b). The scope of these functions highlights a need to balance centralised interests, including governance and accountability, alongside the needs of diverse stakeholders at the local level. This framing of

top-down and bottom-up interests highlights the continuity of competing and perhaps contradictory demands placed on health systems.

The integration of NHS services is being implemented at a time of societal upheaval (Montgomery et al., 2021), and long-term financial constraints which have been equated to the managed decline of public services (Cooksley et al., 2023). Centralised legislative frameworks which adequately address health inequalities at the local level are absent (Olivera et al., 2022). While the integration of care does require such top-down frameworks, policy and legislation alone does not determine local relationships and action (Charles, 2022a). Hughes et al. (2020) observed that isolated structural changes to complex healthcare systems often fail, meaning understanding of multifaceted and interrelated change is a growing need. Rather than simply presenting a polemic account, research into the social and relational aspects of organisational change could contribute to better understanding of complex systems change. In line with the principal of subsidiarity in integrated care systems, locally situated knowledge of how clinical services are integrated on a human and emotional, as well as technical level is an important need (De Molli, 2020; Pratt & Crosina, 2016). Localised research knowledge which addresses the human impact of organisational change requires collaboration across geographical, organisational, and professional boundaries, mirroring the task of structural reorganisation in the NHS (Parbery-Clark et al., 2024). One clinical field which captures the dissonance between centralised political structures, and the idiographic needs of local communities is the medical speciality of Neurology.

Long Term Neurological Conditions (LTNCs)

Human neurological conditions affect the brain, spinal cord and/or nervous system (Thakur et al., 2016). 1 in 6 people in the UK live with a diagnosed neurological condition, and they constitute a leading cause of disability in the general population, and account for

approximately 1 in 5 deaths each year (Brain Research, 2024). Many neurological conditions are lifelong, with far reaching implications for a person's quality of life across a range of functional domains (King & Tyerman, 2003). This burden on individuals, families and communities is also connected with a high economic costs (Humphreys et al., 2013).

Specialist neurological services such as rehabilitation are not a statutory requirement, despite significant evidence for their clinical effectiveness and positive economic impact (Norman et al., 2024; Sakel et al., 2020). This means coverage of neurology services is locally determined and inconsistent across different regions of the UK, and there are major disparities in provision compared to other European nations (Norman et al., 2023; Sivan et al., 2022). In the wake of cross parliamentary work in the UK, policy changes to address inequitable access and integration of clinical services for long term neurological conditions are being instituted. The National Institute of Care Excellence (NICE) is developing a quality standard for rehabilitation of chronic neurological disorders (NICE, 2023), while disorder specific work on brain injury has included the development of a formal strategy by the UK government which addresses inequities in care (Menon & Bryant, 2019). These developments are synchronous with the National Institute of Health Research (NIHR) prioritising research into long term health conditions, and the effective delivery of services across health and social care (NIHR, 2021).

The effective functioning of multi-disciplinary teams within individual areas of specialisation has been comparatively well researched (Onyett, 2008). However, a specific difficulty in clinical care for neurological conditions is ineffective communication between medical teams implicated by complexity (Marin et al., 2016). The transition and management of care across organisational and geographical boundaries is an area of particular concern (Connolly et al., 2014). Ultimately the inadequate co-ordination of services and poor multidisciplinary decision making can contribute to reduced patient life expectancy (Rooney

et al., 2015). For these reasons a lack of integration between clinical services has long been identified as a pronounced need (Ng & Khan, 2009).

Forms of integration in healthcare

Two definitions of integration in the English language are of particular relevance to healthcare. These describe the bringing together of separate systems in the external world, and the manner in which different aspects of one's internal psychological world are combined to form a complex whole. The Oxford English Dictionary describes the overarching phenomenon of integration as "The making up or composition of a whole by adding together or combining the separate parts or elements; combination into an integral whole: a making whole or entire" (Oxford English, 2025a). The process of combining or bringing together separate subsystems to form a complex whole is of paramount importance to the healthcare systems of developed economies, which are being driven away from discrete models of acute care, towards better co-ordinated and continuous care.

In relation to the psychology of individuals, integration is defined as "The combining of diverse parts into a complex whole; a complex state the parts of which are distinguishable; the harmonious combination of the different elements in a personality." (Oxford English, 2025b). This psychological definition has relevance to systems theory and psychoanalysis, which are discussed in greater detail later in the chapter. Setting out a definition which can encompass psychological aspects of integration highlights at an early stage the importance of individual subjectivity in how integration is understood. The basis of this thesis is that the structural integration of technical systems implicates the human ability or lack thereof to integrate aspects of self into the complex whole of the NHS and its repeated organisational changes. The whole as it relates to healthcare systems is therefore framed in terms of both its complex array of systems, but also how this is experienced subjectively by the people who access and deliver care.

A huge and imprecise range of definitions exist for the concept of integration within healthcare settings (Armitage et al., 2009). A distinction is made for the purpose of this thesis between integration and integrated care (Shaw et al., 2011). Integration is defined as the processes, methods, and tools required to bring together different aspects of health and social care systems (Lloyd & Wait, 2005), while integrated care separately requires human experience to be the central organising principle of clinical service delivery (Leutz, 1999). While these experiences are typically thought of as relating to patients, those of professionals are also relevant to understanding the impact and effectiveness of re-organising healthcare systems.

An important historical aspect of structural integration within UK healthcare has been the practice of organisational merger. This emerged from central government policy reforms in the 1990s. A notable legislative framework was the NHS and Community Care Act, which introduced an internal market, and paved the way for the introduction of new public management principles based on private sector practices (Lane, 2002; Thornicroft, 1994). These steps created distinct purchasers and providers orientated to free market logics of competition, and the subsequent formation of NHS trusts, who were incentivised to attain the autonomy of foundation trust status. A wave of organisational consolidation was synonymous with this period in NHS history, driven by efficiency savings, financial pressures, and the rationalisation of acute care (Spencelayh & Dixon, 2014).

Organisational merger of NHS trusts has historically been evaluated on the basis of quantifiable outcomes and parameters (Fulop et al., 2002). This includes the assessment of structural factors like bed numbers or staffing levels, clinical outcomes associated with remission and mortality, and performance against access to recommended clinical treatments. Measures of process such as appointments, admissions, and waiting times are also routinely evaluated (Spencelayh & Dixon, 2014). Despite the continued high incidence of organisational merger in the NHS, research repeatedly demonstrates no consistent evidence

for the quality of hospital care being improved (Beveridge et al., 2025). Furthermore, a recent evidence synthesis suggests an unintended consequence of hospital merger may be an adverse impact on professionals experience, thought to adversely impact patient satisfaction with clinical care (Mariani et al., 2022).

The previous NHS Long Term Plan set out sustainability and transformation plans which further accelerated merger and consolidation of smaller NHS trusts, seeking to improve the efficiency and co-ordination of care across larger geographical areas (NHSE, 2019). In this way the dynamics of marketisation appear to have survived a system wide pivot from competition to collaboration on the integration of healthcare systems. A comprehensive meta-review by Wei et al. (2022) found facilitators of interprofessional collaboration to include organisational structure, understanding of primary task, the allocation of power, and professional role clarity. While role ambiguity, ineffective power distribution, and dysfunctional hierarchical structures formed barriers to collaboration. However, the systemic and psychodynamic basis of these theories of human action are noticeably absent. This includes from the body of literature reviewed, and in the reviewer's synthesis and discussion of findings.

The literature pertaining to merger and integration could be meaningfully enhanced through reference to applied theoretical models consistent with human behaviour being driven by unconscious motivations, beyond rational awareness or control. Systems psychodynamic approaches have a rich history within observational organisational research, and offer a framing of merger and integration as disrupting the emotional equilibrium of human systems, implicating various professional and organisational boundaries (De Gooijer, 2018; Hujala & Oksman, 2018).

Organisational Research and Ethnography

The whole system changes required to integrate NHS care is a generational shift, occurring quickly and at scale. The research addressing reorganisation in healthcare has historically focussed on structural factors, with emotional dynamics within and between subsystems relatively overlooked (Alderwick et al., 2021). The result is that healthcare professionals are inadvertently conceived as rational actors within technical systems (Hujala & Oksman, 2018). This conceptualisation is indicative of the prevailing positivist paradigm within health research of evidence-based medicine (Krantz, 2018).

The biomedical model of healthcare has been successful on the basis of scientific and reductionist principles, focused on evidencing and treating biological and physical causes of illness. However, the benefits of this technical approach have tended to obscure the relational aspects of individual care (Camargo-Borges & Moscheta, 2016). Although recognition of the social and psychological determinants of health has grown over time (Engel, 1977), technological advances continue to drive the dominance of the biomedical model. This remains the case in complex long term conditions, despite the intersection of highly specialised treatments often producing contradictory and impenetrable clinical recommendations (Greenhalgh et al., 2014).

Institutional research into healthcare systems which seeks to highlight human factors is a developing literature base (Hughes et al., 2020). Ethnographic research is well suited to the study of change processes within large healthcare institutions, and offers a way of integrating various ways of thinking about complex systems. This can include systems theory, creative approaches to knowledge production, and reflective learning models (Closser et al., 2022). The aim of ethnographic research can be described as generating knowledge pertaining to the behaviours, social interactions, and belief systems of a specific cultural context. Ethnography is rooted in the field of anthropology, and constitutes both a process

and product of organisational research (Closser et al., 2022). The process of ethnography relies on in-depth qualitative research methods, including immersive participant observation, various types of interviews, and reflexive approaches to researcher subjectivity (Black et al., 2021).

In terms of employee numbers, the NHS is one of the world's largest and relationally complex organisations (Bailey, 2020). Qualitative approaches to healthcare research can offer contextualised insights into complex local systems, challenges, and organisational cultures (Savage, 2000). The immersion of ethnography is also suited to understanding the structural elements of care, such as evidencing service gaps and cultural barriers to access (Black et al., 2021). While participative approaches can also offer ways of co-producing services with diverse local populations, as the practice of ethnography in groups can produce greater equity in the production of knowledge, and addresses some critiques of anthropological enquiry rooted in colonial attitudes to western knowledge and power (Strudwick, 2021).

Systems Psychodynamic Thinking

A key aim of institutional research and professional consultation from a systems psychodynamic perspective has been to understand collective behaviours within institutions by integrating psychodynamic and systemic theories (Neumann & Hirschhorn, 1999). Although the product of interdisciplinary thought across psychoanalysis, group relations and open systems theorists, the approach arguably emerged within organisational theory in the seminal work titled 'Systems of Organization' (Miller & Rice, 1967), and in the UK came to be synonymous with the Tavistock Institute in London (Fraher, 2004).

Psychoanalysis

A rich tapestry of psychoanalytic concepts has been derived from the body of knowledge and practice synonymous with psychoanalysis. A brief overview of their inception

is presented here, alongside their application to the unconscious dynamics of human institutions. Sigmund Freud was one of the 20th century's most iconic, consequential, and controversial figures, and credited with the inception of psychoanalysis (Wollheim, 1981). This is both a clinical practice grounded in observation, and a broader philosophical attempt to articulate a metaphysical theory of the human mind (Bell, 2018). Psychoanalytic theory is based on a conceptualisation of human anxiety, and the ways in which threatening aspects of experience are defended against. The clinical application of psychoanalysis still exists as a modality of treatment today, and is arguably the foundation of modern talking therapies (Yakeley, 2018). The increasing complexity of presentation in secondary mental health services has been associated with increasing interest in a psychoanalytic understanding of human distress (Stern et al., 2015). Freud himself turned his topographical model of the unconscious mind outwards towards the end of his life, and started to consider the unconscious relational dynamics between people, for example in Group Psychology and the Analysis of the Ego, Freud (1921) described emotional suffering as emerging from human fragility in the face of nature's overwhelming power, and the simultaneous inadequacy of social groups to provide ameliorative and protective relationships (Freud, 1930).

Freud's foundational ideas about the individuals internal world as emerging in relationship to an external object, is a position consistent with subsequent Kleinian and post-Kleinian theories (Diamond, 2020). Melanie Klein proposed from her clinical work, and close infant observation that intolerable internal states threaten to overwhelm individuals from birth. Klein characterised these distressing somatic states as the foundation of a persecutory and defensive mode of functioning, which she called the paranoid-schizoid position (Klein, 1946). Torres and Mendes (2024) posit that such extreme mental states are incapable of being linguistically expressed, but signify a period of profound vulnerability, and dependency on others for survival. Rather than emerging from a rational sense of self in the

world, these distressing internal states evoke a nameless embodied dread. Klein theorised these feeling states are liable to be defended against by a process of splitting and projection, which eject distressing states outside the infant (Klein, 1946). In the context of an attuned relationship, these forms of prototypical communication can be received by another, and using their capacity to think symbolically, can be made sense of and responded to. Depending on the context and emotional capacity of the other, they will either be in a position to meet the emotional need, or pursue a strategy which in some way avoids the underlying distress (Hinshelwood & Fortuna, 2017). Such a model can be found in psychoanalytic ways of responding to mental health problems, but has also been applied as a model of containment in institutional life (Armstrong, 2018a).

The Tavistock Model

Against the historical backdrop of World War II, Wilfred Bion pioneered the psychoanalytic understanding of groups in the UK. He sought to understand human dynamics as they emerged in a poorly structured and facilitated psychiatric setting of military hospitals caring for traumatised veterans (Lawlor & Sher, 2021). His work extended psychodynamic theories of intrapsychic defence, giving rise to a framework of covert group dynamics (Armstrong, 2018a). These are said to be enacted beyond the level of individual consciousness, by powerful feelings, beliefs and regressive anxieties, which are in turn evoked by the individual and collective dimensions of group membership (Armstrong, 2021). These theoretical tenets contributed to the founding of the group relations movement, an experiential approach to learning how individuals and groups relate to authority, role and systems. This model influenced by systemic theory assumes that non-hierarchical groups will reproduce local patterns of unconscious relating, while also replicating aspects of the overarching societal context. Such groups enact this below the level of conscious awareness,

or individual agency of group members, but can collectively identify patterns that emerge within the group (Khaleelee & Stapley, 2018).

The integration of systemic and psychodynamic theories is somewhat contradictory. To assert that unconscious mental states exist and influence individual human behaviour, but that the behaviour of individuals and groups is also defined by the structures of human organisation and society encapsulates a dialectic tension. One which the Tavistock Model oscillates between, rather than seeks to resolve. Elliot Jaques (1953) proposed his idea of a social defence system using the theoretical framework of psychoanalysis as applied to the individual. For Jacques, the cumulative effects of grouping individuals who hold unconscious phantasies, was at base due to the shared nature of the human unconscious, rather than specific to the organisational task. Jacques later moved away from this early conceptualisation, subsequently emphasising how structural aspects of organisations shape their internal culture (Hinshelwood, 2010). Menzies-Lyth (1960) diverged from Jacques, articulating that unconscious phantasies in organisational groups are shared on account of their common working task (Hinshelwood, 2010). Her idea that healthcare systems organise unconsciously around the task of clinical care has endured, and has been cited in response to systemic failings in NHS acute hospital care. Evans (2014) states defensive practices which split off unconscious anxieties inherent in the task of patient care can represent a profound risk to patients, professionals, and the wider public.

The subjective use of self was pioneered by Esther Bick as a pedagogical method in the clinical training of child psychotherapists at the Tavistock Clinic in London (Rustin, 2003; Rustin, 2009). The method tasks training analysts to observe an infant and their primary care giver, at regular intervals over the first two years of life. Observers write detailed process notes of their experience, practicing the clinical technique of freely hovering attention. The careful use of personal subjectivity allows lived experience to be captured in a

way which acknowledges the unconscious dynamics of object-subject relationships within a naturalistic environment. These observational accounts are presented verbatim within facilitated seminar groups, allowing space for the wider reflections of a group whose task is to both understand the dynamics observed, and facilitate introspection on the part of the observer. The approach cultivates an ability to retain, feel and think about the experience of the other, doing so tentatively and in dialogue with colleagues (Hinshelwood, 2018).

Observing Organisations

The practice of psychodynamic observation has subsequently been applied to healthcare organisations, emerging as an educational approach for trainee psychiatrists intended to foster understanding of the institutions in which the trainee's worked. It was situated in the historic transition of care from Victorian institutions to the community, a process felt be evoking considerable tensions in psychiatric teams. The approach is also recounted as synonymous with ethnographic research, with a number of papers emerging from early iterations of the method (Hinshelwood, 2018; Hinshelwood & Skogstad, 2002; Long, 2018a).

Reliant on the use of self as an instrument of knowing, the knowledge derived from psychodynamic observation in organisations is co-constructed. This means research participants and researcher shape the meaning and understanding that can emerge at the level of unconscious communication. This includes the phenomenon of subjective identification, whereby content is emphasised or given valence based on the prior experiences of the individual or context. Psychodynamic observation also extends this process to reflective small groups, which emphasised shared and discursive meanings, rather than singular imposition of meaning by the researcher (Hinshelwood & Skogstad, 2002). The writing of detailed process notes from observation seeks to capture experience as perceived, in parallel

with the parameters of infant observation. The relaying of observation accounts to a reflective group both reveals anxieties of the observer, and reconstructs in part the unconscious emotional dynamics of an organisation. When given space to re-emerge in open and unstructured reflective groups, these dynamics can be thought about and processed a stage removed from their enactment within institutions (Rustin, 2003; Sapochnik, 2021).

Systems Theory

Attempts to understand complexity from a systems perspective have historically been located in observation of the natural world, deriving knowledge through action and reflection (Onyett, 2008). Open systems theory is one such approach, emerging from the study of biology, ecology and physics, and forms one basis of the Tavistock model previously outlined. It conceptualises biological systems as an array of inter-related but distinct subsystems, interdependent and reliant on their wider environment for the energy or materials required to survive. Survival depends on this continuous interaction and exchange of inputs and outputs, both between subsystems and with the wider shared environment. The demarcation and management of permeable boundaries within and between systems is fundamental to facilitating these transactional processes (Von Bertalanffy, 1950). In this conceptualisation boundaries serve the function of protecting what is contained within, but flexibly allow for adaptation and change. An allied but under-represented idea of nonlinear dynamics contrastingly purports that systems change may emerge in a spontaneous and irrational way, as a result of the capacity to self-organise. In the face of large and complex flows of information, human systems can appear chaotic and disintegrated. In this conceptualization, novel and advantageous patterns do not emerge from structural design and management by powerful leaders, but by the capacity of individual agents to learn from their experience at the boundary of chaos (Stacey, 2018). This perspective raises the possible benefits of organisational structures being organised around insight and knowledge which

arises in a spontaneous and bottom up fashion, rather than imposed from above. Furthermore the need for a reflective function within organisations that can identify emergent forms of practice and knowledge that can benefit the system as a whole.

In order to prioritise learning from experience the applied models of psychoanalytic thought previously outlined offer a means of suspending existing knowledge and its imposition over how the experience of another is understood (Casement, 2013). This is particularly true of psychoanalytic observation as pedagogy within child development and organisational life (Hinshelwood & Skogstad, 2002; Rustin, 2009). The emphasis of localised actions in complex systems on the edge of chaos implicates a pragmatic philosophy. This is a metaphysical position concerned with the observation of everyday experience, in order to understand the social world, and its signification in language. The philosophy of Charles Peirce (1985) draws from this tradition, and will be returned to in subsequent chapters as a way of conceiving the unconscious on a social and associative basis (Long & Harney, 2018).

Chapter Summary

This chapter has set out both historical and contemporary factors framing the drive towards the integration of clinical services in the NHS. Neurology was highlighted as a medical discipline which serves a large proportion of the UK population, and is characterised by a high prevalence of complex long term conditions. It was argued that insights into the organisational dynamics occurring at a conscious and unconscious level within and between professionals appears to have been largely overlooked in mainstream research, particularly how NHS merger and integration have been conceptualised and evaluated. A systems psychodynamic approach has been outlined, representing one way of diversifying the quantification of quality typical of healthcare design, implementation, and evaluation.

Locally situated knowledge of human relationships are aspects of organisational culture that are inherently difficult to quantify and report statistically.

Further research in this area is required to support local efforts to integrate services, by generating rich insights into the emotional and unconscious dynamics of organisational culture. Findings could also contribute relevant insights to wider UK health systems, which are increasingly reorganised around the principal of subsidiarity. The use of an in-depth qualitative approach would complement quantitative research used to evaluate organisational merger and integration in the NHS, and national efforts to increase technical and structural integration could benefit from understanding local human factors. The utility of psychodynamic observation as a form of reflexive ethnographic research has been identified, and is considered relevant to the profession of clinical psychology which works at the level of teams and systems within the NHS (HCPC, 2023).

To meaningfully support the integration of clinical services for long-term neurological conditions, it is necessary to assess existing empirical evidence which relates to the impact of organisational merger and integration on NHS professionals. The following chapter sets out a systematic review and meta-ethnographic synthesis of qualitative research into the impact of merger and integration on professionals within NHS hospital services. The synthesis of identified evidence will inform this thesis' primary research project.

Chapter two: Systematic Review

Chapter Summary

This chapter systematically identifies and synthesises the extant qualitative literature relating to how professionals involved with the organisational merger of acute NHS hospital trusts describe their experience. The results of a systematic literature search and a meta-ethnographic synthesis of identified concepts is presented. Details are provided on the conduct of the systematic review, approach to meta-synthesis, and the identified concepts from primary research which were synthesised. The chapter concludes by considering the strengths and limitations of the review, and how the review has informed the primary research presented over subsequent chapters.

Overview

Health and social care in the United Kingdom have recently undergone a significant reconfiguration through the creation of Integrated Care Systems (ICSs). This is a structural change which is part of wider attempts to address the competitive fragmentation, and inefficiencies of healthcare in developed economies (Charles, 2022b). The success of health systems throughout the 20th century is considered to be failing in meeting the needs of now ageing populations with increasingly complex, and multifactorial long-term health conditions (Bridges et al., 2020). The UKs establishment of ICSs, pivots from principles of free-market competition, towards multiple levels of collaboration within and between organisations. This represents a profound change to the NHS and its wider systems. The same is true of the recent decision to abolish NHS England, and integrate its functions with the department of health and social care (Wise, 2025). Both structural changes have strong parallels with the phenomenon of organisational merger of separate NHS trusts, a form of organisational change which requires the renegotiation of goals, boundaries, and professional roles. Change

in health systems has historically been conceptualised on a structural, technical, and quantitative basis (Mariani et al., 2022), meaning thick descriptions of the social and relational implications of merger and integration are poorly understood in the literature. While qualitative research in the area of NHS organisational merger predominantly addresses settings outside acute hospital trusts (Damiani et al., 2021).

This review aims to systematically identify relevant qualitative research, and through a process of meta-ethnographic synthesis, understand how professionals experience the organisational merger of NHS hospital trusts in the UK.

Evidence Synthesis Method

Meta-ethnography is a robust method of evidence synthesis, adapted from ethnography of educational settings in North American (Campbell et al., 2012). A systematic iteration of the original method is considered gold standard in qualitative evidence synthesis in UK health and social care research (France, Cunningham, et al., 2019). Meta-ethnography was selected for its capacity to synthesise either similar, contradictory, or dispersed concepts from the literature, and the scope to deepen understanding in an emerging area of research (France, Cunningham, et al., 2019; France, Uny, et al., 2019). As an interpretative method, relationships between conceptually rich qualitative studies can be explored in depth (Dixon-Woods et al., 2007; France, Cunningham, et al., 2019), which will facilitate new theoretical insights relevant to merger and integration of acute NHS hospital trusts. This includes the impact on staff, and future directions for applied research (Atkins et al., 2008; Britten et al., 2002)

Phase one: getting started

Preliminary searches showed research and evaluation of organisational merger within healthcare has been dominated by quantitative approaches, related to patient care and financial efficiencies. Evidence synthesis addressing organisational merger has been undertaken in a UK NHS context, but with a focus on quantitative research in primary care NHS trusts (Ayalon et al., 2007; Damiani et al., 2021). Qualitative research of UK hospital mergers is present from the early 2000s (Shaw, 2002), before a hiatus and resurgence in the years following the global financial crash (Fulop et al., 2012). The prevalence of organisational merger in the NHS was discussed in the previous chapter in relation to UK health reforms, which privileged competition in the tendering and procurement of services. This includes introducing the quasi-market in the early 2000s (Goddard & Ferguson, 1997), and the Lansley reforms under the UK coalition government in 2012 (Spencelayh & Dixon, 2014). A systematic synthesis of qualitative evidence from merging NHS hospital trusts was absent within the literature, meaning a conceptually rich understanding of how professionals experience merger in these contexts was identified as a gap.

The proposed method of meta-ethnography involves the translation and synthesis of primary research. It was decided that research findings derived from outside the UKs distinct socio-political context could be misrepresented by an interpretative method of meta-synthesis (France, Cunningham, et al., 2019; Sattar et al., 2021). A decision was therefore made to focus on research conducted within the NHS. A focus on the merger and integration of acute hospital trusts was chosen to address an existing focus within systematic reviews on primary care and community healthcare. This iterative reading of the literature led to the scope of the review being narrowed, to address the experience of organisational merger within UK hospital trusts, from the perspective of professionals. This was identified as an emerging area of qualitative research, that had not been subject to peer reviewed systematic review, or

ethnographic meta-synthesis. Pragmatically, a focus on acute hospital settings also provided a realistic scope within the limited resources of time and personnel available (Toye et al., 2014).

Phase two: deciding relevance and inclusion

To generate novel understandings from an under-researched area, a systematic search methodology was used to establish the available evidence (Finfgeld-Connett, 2014). Search terms were collated via preliminary searches, and included relevant free text keywords, and indexing terms, summarised in table 1. The search strategy was developed in consultation with an academic librarian, and research supervisors. Four databases were searched: CINHAL Ultimate, APA PsychINFO, SCORPUS and Web of Science, three times between August 2024 and December 2024. No limits or restrictions were applied to avoid systematic bias, and each search parameter was applied to all text. Database searching was supplemented by forward and backward citation searching.

Table 1: Search terms used

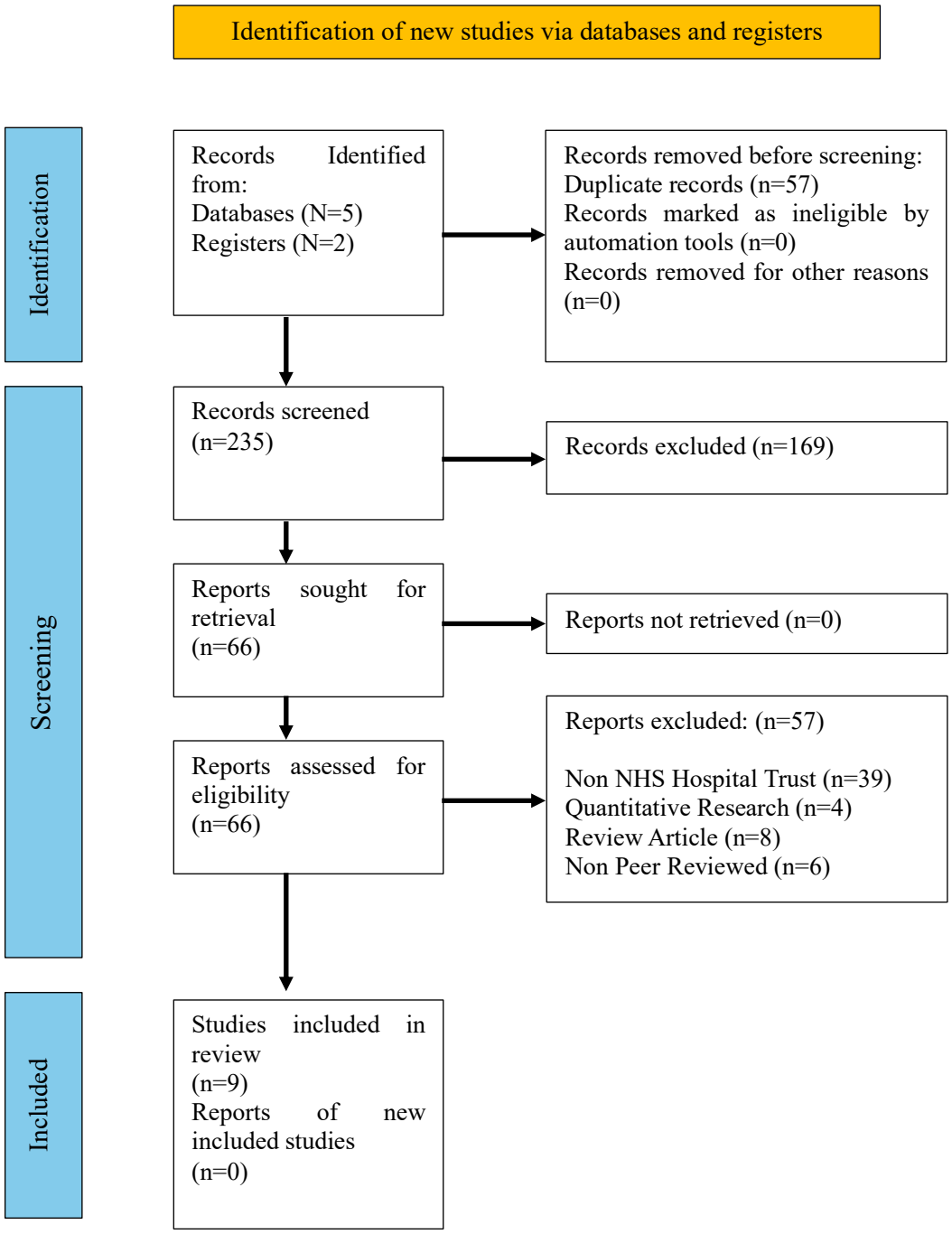
Search terms used within EBSCOhost	
Hospital Setting	hospital or hospital* or hospitals, public or hospitals, rural or hospitals, teaching or hospitals, university
Organisational Merger	health facility merger or hospital merger* or mergers and acquisitions
Qualitative Approaches	qualitative* or mixed method* or health services research

Inclusion criteria were developed with reference to the SPIDER framework (Cooke et al., 2012). Primary research articles were included if findings addressed the experience of professionals working in hospitals prior to, during, or after a process of organisational merger. Where multiple mergers across NHS contexts were reported, if concepts explicitly linked to hospital mergers could be identified, these articles were included.

Articles were excluded if; 1) the experiences of healthcare professionals relating to organisational merger were unaddressed, 2) non NHS Hospital Trusts were the research focus 3) articles addressing multiple healthcare contexts where findings relating to hospital staff could not be clearly distinguished, 4) Quantitative research, 4) non-primary research, including grey literature.

The full search strategy is reported in Figure 1, according to Page et al. (2021). Database searches yielded 212 papers, supplemented by 23 papers from citation searching. A total of 235 articles were screened via title and abstract. The full text of 66 articles were screened, with 9 articles included for evidence synthesis on the basis of inclusion and exclusion criteria. One article was included which spanned multiple NHS settings, but where findings related to hospital trusts were extractable, according to Törrönen et al. (2018).

Figure 1: PRISMA Flow Chart



Phase three: reading and quality assessment

No clear consensus exists on how to order the analysis of papers within meta-ethnographic approaches to evidence synthesis (France, Uny, et al., 2019). A decision was made to conduct the analysis in order of publication, allowing the interpretation of concepts to follow the chronological progression of socio-cultural and political events relating to the phenomenon of organisational merger in the NHS (Sattar et al., 2021). Without access to a research team, re-ordering studies on this basis of conceptual depth and richness was not used, to avoid the introduction of systematic bias (Atkins et al., 2008; Soilemezi & Linceviciute, 2018).

The final 9 articles were assessed according to the critical appraisal skills programme (CASP) qualitative checklist (CASP, 2018). A summarised table of this process is included in appendix A. The aim was to develop a systematic understanding of study strengths and weaknesses, immerse the author in the findings, generate preliminary ideas about concepts within each study, and to understand key characteristics of included studies. The CASP framework was not used to exclude studies on the basis of methodological quality (Melia, 2010; Sattar et al., 2021). As part of this evaluation, original concepts were extracted and tabulated from each study (Britten et al., 2002).

Table 2: Overview of included studies

Study	NHS Region	Hospital Context	Participants	Study Aims	Qualitative Method
Shaw, 2002	UK	Two University Teaching Hospitals	Senior Trust Managers and Professional Staff	Learn about merger from observation, and suggest future lessons	Semi-structured interviews and documentary analysis
Shield et al, 2002	UK	General Hospital Trust	Managers; Clinicians; Other Stakeholders	Work in partnership to develop the trust's post-merger strategy	Action Research Participant Observation; Group Interviews; Individual Interviews
Fulop et al, 2002	England	2 Acute Care Trusts	Executive and Senior Managers; Clinicians and Managers; External Stakeholders	Study the processes and impact of trust mergers	In-depth Interviews; Documentary Analysis
Fulop et al, 2005	England	University Teaching and District General Hospital	Internal & External Stakeholders	Explore the relational context, drivers and objectives of mergers	Documentary Analysis; In-depth interviews
Macintosh et al, 2007	Scotland	Regional Acute Services	Senior Managers; Executive and Non-Executive Directors	To present lessons learned from in-depth study of organizational change.	Observation; Individual Interviews; Focus Groups; Questionnaires
Fulop et al, 2012	England	Three multisite hospital trusts	Internal ; Executive and Non-Executive Directors External; External Stakeholders	Analyse process and results of merger and influence of consultation.	Semi-structured interviews
Ovseiko et al, 2015	England	Single, Multi-Site, and Teaching Hospital	Clinician-Scientists; Senior Managers	Inform national policy, and post-merger integration	Semi-structured interviews; Focus Group
Rogers, 2021	UK	Hospital Trust	Ward managers, specialist and senior nurses	Investigate impact of merger on compassionate care, and the role of leadership	Semi-structured Interviews
Maile et al, 2022	England	Single, Multi-Site, and Teaching Hospital	Clinicians; Administrators; Academics; Patient Representatives	To contribute an in-depth case study and practical lessons to the existing literature.	Individual Interviews; Clinical & Corporate Focus Groups ;

Phase four: relatedness of studies

A systematic search strategy, and the detailed identification of concepts with supporting evidence gave the author confidence in trusting the findings of the included research (Yardley, 2000). Through repeated re-reading of studies during quality appraisal, identification of concepts, and tabulation of the original study justifications in the data, these concepts were organised into 11 concepts. Each study's contribution to these concepts, and the distribution of concepts across the included studies is presented in table 3.

Table 3: Contribution of Studies by Concept

Key Concept	Political Policy	Financial Power	Top Down Pressures	Inadequate Resourcing	Historical Roots	Structures of Difference	Conflicting Cultures	Professional Loss	Personal Impact	Practical Facilitators	Pragmatic Progress
(Shaw, 2002)	*	*	*		*	*	*	*	*	*	*
(Shield et al., 2002)	*	*		*	*	*	*		*	*	*
(Fulop et al., 2002)	*	*		*		*	*	*	*		
(Fulop et al., 2005)	*	*	*	*		*	*	*	*	*	*
(MacIntosh et al., 2007)	*	*		*		*	*	*			
(Fulop et al., 2012)	*	*	*			*				*	*
(Ovseiko et al., 2015)	*	*	*		*	*	*	*		*	*
(Rogers, 2021)				*			*	*	*	*	
(Maile et al., 2022)			*		*	*		*		*	

Phase five: translating the studies

The researcher adhered to the meaning of second order concepts by comparative re-reading of the content, characteristics and context of included studies as described by Sattar et al (2021). Translation was undertaken iteratively on the basis of six working categories, which related to tabulated supporting extracts from each study (Britten et al., 2002). This ensured the process of translation retained the meanings intended by the original study authors.

Phase six: synthesising translations

On the basis of evidence accrued through the process outlined above, a reciprocal translation of the extracted concepts was deemed possible. This meant the findings of included studies were sufficiently alike, and without contradictory interpretations. The 11 key concepts were synthesised into 6 final concepts as presented in table 4. These concepts could be expressed as a line of argument synthesis, which sought to explain the relationships

between extracted concepts in a way which offered a broader theoretical understanding of NHS hospital mergers.

Table 4: Key Concepts and Synthesised Concepts

Key Concepts	Final Synthesised Concepts
Political Policy Financial Power Top Down Pressures Inadequate Resourcing	Political Hierarchies
Historical Roots Structures of Difference	Histories of Difference
Conflicting Cultures Polarising Change	Assimilation
Professional Loss Personal Impact	Loss
Practical Facilitators Pragmatic Progress	Pragmatic Core

Results

Overview of Studies

Nine studies were included in this meta-ethnographic synthesis (Fulop et al., 2002; Fulop et al., 2005; Fulop et al., 2012; MacIntosh et al., 2007; Maile et al., 2022; Ovseiko et al., 2015; Rogers, 2021; Shaw, 2002; Shield et al., 2002). These articles were published over a period of 20 years, between 2002 and 2022. Five studies were published prior to 2010. Five studies were conducted in England, and one in Scotland, while three anonymised the specific NHS region. A range of acute trusts were the subject of included research, including regional acute services, alongside variously merging general, district, and university teaching hospitals. All included studies utilised in-depth interview methodologies, covering both individuals and focus groups. Research participants were drawn from across the spectrum of professionals involved in hospital merger, including trust executive and senior management teams, clinicians and clinical managers, and a wide range of professional stakeholders external to acute trusts. Administrative and soft facilities management staff were absent from the participating professional groups. Interviews were supplemented by documentary analysis in three studies from the early 2000s, and two studies used in-depth observational methods which drew on participatory and action research principles.

Political Hierarchies

The policies of successive UK governments have dictated the need for NHS hospital trusts to merge and integrate their services (Fulop et al., 2002; Fulop et al., 2005; Shield et al., 2002). This legacy of national policy initiatives has reinforced ideological positions favouring merger and integration, however these top-down levers negate the buy in of frontline staff (Fulop et al., 2005). The national policy agenda has evolved sufficiently over time so as to became contradictory, creating conditions of uncertainty, and unintended organisational silos

(Fulop et al., 2012; Ovseiko et al., 2015). This complex web of local political agendas influences the consultation and implementation of mergers, with oppositional party politics often providing the backdrop to hostile stalemates which ultimately require external arbitration (Shield et al., 2002). These decision making impasses are characterised by despondency and relational conflict, both within hospital staff groups, and among the populations they serve (Fulop et al., 2012; Shaw, 2002; Shield et al., 2002).

The political climate can also create undue pressures, overshadowing the psychological safety of environments where mergers are implemented (Fulop et al., 2012). This is characterised as a dark strand pervading organisational change, in which the scrutiny of running high profile public services is compounded (MacIntosh et al., 2007; Shaw, 2002). In this context clinical leaders are tasked with communicating a rationale for externally directed changes, which precipitate the erosion of professional autonomy (Fulop et al., 2012; Shaw, 2002). The remit of government is to shape and hold to account the system as a whole, but this necessarily underplays the diverse local, organisational, and relational contexts of merger, in favour of simplistic notions of change (Fulop et al., 2005; Fulop et al., 2012).

Inadequate Resourcing

The need for financial security is a feature of how NHS hospital trusts survive in polarised systems. The decision to merge in this existential context can be characterised by regaining control with fractured subsidiary systems, in order to compete adequately with regional tertiary providers, and manage the demands of external regulation (Fulop et al., 2012; Shaw, 2002). Underlying these factors is an unspoken assumption of learning from merger and its underpinning philosophy in the private sector (Fulop et al., 2005; Fulop et al., 2012; Shield et al., 2002). However, NHS hospital trust mergers are not backed up by additional resources, but carry an expectation that savings will be made from day one. This practice directly

contradicts private sector assumptions that merger and integration is resource intensive, and will disrupt managerial control in the short-term (MacIntosh et al., 2007; Shaw, 2002; Shield et al., 2002).

The practical disturbance of merger is therefore experienced as unanticipated, with the task of managing change underestimated (Fulop et al., 2005). The workload associated with merger exhausts senior managers, who without additional resources lose focus on the usual function of their role (Fulop et al., 2005; MacIntosh et al., 2007; Shield et al., 2002). Despite the significant efforts of senior and middle managers to cover gaps in resourcing, frontline staff still perceive their needs to be ignored (Fulop et al., 2002). This results from the preparation and implementation of merger also being perceived to overload patient facing roles (Fulop et al., 2005; Rogers, 2021). Cumulatively, the desired improvements to clinical services and broader developmental work can be delayed long after merger is planned to be completed (Fulop et al., 2002).

Structures of Difference

Merger often involves different constituent trusts which can be differentiated by their distinct heritage. These histories can be characterised by futile institutional war, often predating the professional lifespan of staff groups undergoing organisational merger (Shaw, 2002; Shield et al., 2002). These histories live on in newly merged hospital trusts through legacies of organisational performance or failure, and are outworked in the stereotypes, values, and practices of previously distinct staff groups (Shaw, 2002). Merger is a symbolic opportunity to consign organisational stereotypes to the past (Maile et al., 2022), but staff groups who identify with past successes are better able to engage with the process of merger (Ovseiko et al., 2015). An unspoken counter point to past success is the perceived management deficits of failed trusts. In such scenarios, clashes between successful and failed

constituent trusts can be a desired outcome (Fulop et al., 2005; Ovseiko et al., 2015). Cumulatively, these factors emphasise the valence of historic identities being carried into a merger process. This dynamic creates a pressure to simultaneously sustain and challenge past identities (Ovseiko et al., 2015; Shaw, 2002).

A discourse of dyadic competition can emerge on the basis of these different historical identities. An expression of this is a pre-occupation with how power is reorganised around historic personnel, and a struggle for one constituent trust to control new central hierarchies. These harmful rivalries between constituent groups can hinder collaboration at all levels of the organisation (Fulop et al., 2005; Maile et al., 2022; Shaw, 2002). These relational barriers lead to a focus on standardising structures and systems, with an invisible centralising force operating in merged organisations of increased scale. This can sever historic ties across specialties (Shaw, 2002). Where flexible and reciprocal communication between divisional and executive leadership has previously been valued, assimilation into larger organisational structures threatens these ways of working (Shield et al., 2002). The assertion of new public management hierarchies is feared within new organisational structures, citing the confusion of both ambiguous and increasingly differentiated boundaries (Fulop et al., 2005; Shaw, 2002; Shield et al., 2002). A shared history of relationship to an academic institution can ameliorate competition between legacy trusts, but introducing entrepreneurial values into subdivided public service cultures can both strengthen and complicate relationships (Ovseiko et al., 2015).

Polarising Assimilation

The task of merging one or more distinct cultures is formidable. The emotional experiences of staff become polarised, and are often distinguishable by the individual's stage of career (Ovseiko et al., 2015; Shaw, 2002). Anticipatory anxieties can be seen to surface during periods of consultation. If change is perceived to have far-reaching consequences for a

professionals role, and significant numbers of individuals holds an aversive stance to change, there may be an exodus of staff identified with a legacy trust (Fulop et al., 2005; Rogers, 2021). The anxieties merger evokes can also resolve in commitment to the newly formed organisation, with progressive stages of emotional adjustment apparent in staff who stayed (Ovseiko et al., 2015).

The initiation of merger talks is liable to create perceptions of take-over within one or more of the constituent trusts (Shield et al., 2002). The consolidation of subsequently displaced roles is contentious, with outrage arising from the reformation of executive teams being dominated by a single trust. It follows the perceived cohesion of senior management teams can be seen as a proxy for a merger's success (Fulop et al., 2005; MacIntosh et al., 2007; Shaw, 2002). A high cost is associated with merger being perceived as take-over by staff groups (Fulop et al., 2005). Attempts to avoid this attribution create ambiguous lines of authority which paralyse strategic thinking, obstruct commitment, and ultimately impede overall development of the organisation (Shaw, 2002). While conciliatory attempts by executive teams to communicate transparently about complex mergers, can also be lost on clinical teams (MacIntosh et al., 2007; Shaw, 2002).

Modification of Mourning

Merger introduces passive vulnerability into front line staff groups, who can feel overtaken by external forces (Fulop et al., 2005; Shaw, 2002). The anger and despair evoked by personal losses is costly. The individuals own distress is suppressed over time, and staff become cut off from the suffering of colleagues, culminating in adverse an effect on peoples home lives (Fulop et al., 2005; Shaw, 2002). Personal distress associated with change can be meaningful if ultimately patient care improves (Shaw, 2002), but it is possible demoralising loss of identity becomes unresolvable for some staff (Ovseiko et al., 2015)

Mourning the loss of an idealised organisational history is an organising idea where merger evokes the uncertainty of change (Shaw, 2002). However, the desirable cultural practices and traits of legacy trusts are hard to preserve, as informal relationships which underpin innovation and enterprise become subsumed by bureaucratic complexity (Maile et al., 2022). Merger processes stand to benefit from attending to the emotional needs of employees on an individual and organisational level, but the perception that introspection impedes development often constrains such approaches (Fulop et al., 2002; Fulop et al., 2005; Rogers, 2021).

Pragmatic Progress

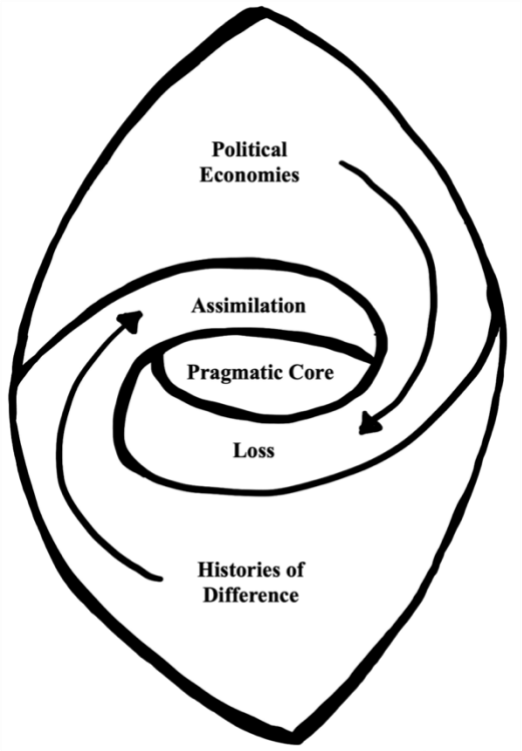
Merger is unavoidably associated with disruption, and decisions about which ways of working to preserve or violate are important (Fulop et al., 2005; Maile et al., 2022; Shield et al., 2002). High profile and representative coalitions of senior staff are need to articulate the clinical rationale for merger (Shield et al., 2002). If this rationale is communicated early and organisation wide, it can engage clinical staff and mobilise support (Maile et al., 2022). Historic differences can be overcome by finding shared ideals, that are orientated to the future rather than past (Ovseiko et al., 2015; Rogers, 2021). Groups that express hope for stability, while taking up a pragmatic position which anticipates change are well placed, and able to embrace shared opportunities and work to engage in genuinely inclusive debate (Maile et al., 2022; Rogers, 2021; Shaw, 2002). In contexts where such debate is possible, it is characterised by the painful negotiation of difference, and requires patience in the short-term (Shaw, 2002).

An acknowledgement that many cultures will exist within and between legacy organisations is a pragmatic position, allowing for devolved structures that help develop patient care (Maile et al., 2022; Shaw, 2002). Clinical leaders are tasked with straddling these organisational splits, ensuring the buy in of front line staff, and collaborating on the boundary

of corporate-clinical functions (Fulop et al., 2005; Maile et al., 2022; Shield et al., 2002). These leadership roles are regarded as visible to front line staff, who expect them to understand and ameliorate the pressure merger places on patient facing roles (Rogers, 2021). Such roles must take up conflictual functions, to absorb the macro shock of organisational change, while demonstrating open and transparent communication. Understanding this tension is required to enable good clinical care during the change processes of merger (Maile et al., 2022; Rogers, 2021). It is suggested that to avoid the alienation of staff groups, the practical and emotional dynamics of fractured and oppositional historical contexts must be understood (Maile et al., 2022; Rogers, 2021). This requires the non-linear nature of emotional reactions to be made sense of with sensitivity (Rogers, 2021).

Line of Argument Synthesis

Figure 2: A pragmatic core of professionals survive and stabilise the perception of conflictual forces within the organisational merger of NHS hospital trusts.



The line of argument is represented visually in figure 2. It asserts that a pragmatic core of professionals subject to merger display the capacity to survive powerful forces exerted by hierarchical political decision making, alongside local differences in organisational histories. The two factors which drive organisational merger are experienced as externally driven by top-down political agendas, but structured by local identities derived from history and place. The political featured in the awareness of professionals as a dark pervasive strand, that can be felt to eroded professional autonomy, and create opposing pressures on managers to implement directives that feel disconnected from front line staff groups. These broad social factors are outside individual professional agency, but translate into more immediate experiences of assimilation and loss within the practical realities of

merger. If the negative impacts of these are felt to be overwhelming, professionals resolve to leave newly formed organisations. This lack of desire or capacity to assimilate within merged systems can depend on whether new organisational structures threaten an individual's professional role.

The overarching effects of government policy and an oppositional political system were evidenced as evoking passive vulnerability in professionals. Feeling overtaken by external forces, professionals can suffer losses on both a personal and institutional level. However, in organisational contexts where introspection is discouraged, the process of mourning is curtailed. Anger is either internalised as despair, damaging personal lives, or it is projected into immediate colleagues which can sever close working relationships. The historic identities of legacy trusts are orientated to local populations and geographical place. These are carried over into new organisational systems, and polarise the process of merger. Conflict can emerge around the need for these differences to be assimilated, casting individuals and groups into either ascendant or subordinate groups. Individuals can be negatively affected by anticipatory anxieties and distrust in the face of ongoing uncertainty. This crucially detracts from delivering the primary task of patient care, and polarises the workforce. A proportion leave and seek alternative employment, while others stay and progress towards a more accepting position.

The external factors of contradictory government ideologies, and idealised historic identity, underpin more immediate professional experiences of loss and assimilation. These aspects of experience are considered within this line of argument to form a shared boundary, between a pragmatic core of professionals and the external forces which drive organisational merger. These phenomena of loss and assimilation are intermediary, linking aspects of political economies and histories of difference, to the tangibly daily reality of professionals. Merger does not simply assimilate distinct organisational structures, but threatens the loss of

valued organisational identities which have emerged from a distinct geographical place. Furthermore, assimilation has a polemical quality, appearing to amplify the ascendance or subordination of different subgroups within the new organisation.

In conclusion this line of argument highlights those professionals able to survive the conflictual pressures of merger, in turn exert a stabilising force on the new organisation. This pragmatic core are characterised by the emotional capacity to withstand, and gradually adjust to emotional losses, while also creating space for both overt conflict and the finding of shared values with colleagues who were previously competitors. This line of argument asserts a core characteristic of integration is therefore the space and capacity in which unavoidable conflicts can be held in tension, with the balancing of emotionally sensitive support, and the pragmatic ability to move forward where conflicts are only partially resolved. This holding of tension of conflictual internal, interpersonal, and organisational dynamics is conceived as the mechanism by which professionals exert stability over organisations and wider systems in which they operate.

Concluding introductory statements

The introduction of this thesis has outlined how the priorities of ICSs are in part driven by changing population level health needs. These can be partly characterised by the increasing complexity of long term conditions, requiring the collaboration of multiple clinical specialists and services. Furthermore, the nature of this organisational change can be considered as continuous with the historical phenomenon of organisational merger in the NHS, driven by the marketisation of healthcare in the UK.

This second chapter aimed to understand how professionals experience the organisational merger of NHS hospital trusts in the UK. A systematic search identified 9 relevant studies, which were synthesised using a meta-ethnographic methodology. The

review findings demonstrate professionals associated with acute NHS hospital trusts are subject to powerful socio-political interests, which create the impetus for organisational merger. This form of organisational change polarises professional experiences. For some the resolution is to seek alternative employment, while others resist injurious losses by working towards pragmatic progress. System wide transformation towards integrated care requires top-down legislation. However, on the basis of the evidence identified and synthesised, policy and legislation are subject to an intermediary process of assimilation and loss within professional groups. The UK health system is prioritising subsidiarity, the delegation of responsibility and decision making closer to local people and populations. This implicates the need for ways of generating local knowledge about the impact of significant organisational change, particularly on professionals who are tasked with the provision and administration of care.

A core component of experience for professionals who remain following transformation appears to be the capacity to progress in a way which is grounded and pragmatic, rather than idealistic or perfect. This professional agency emerges despite mandated organisational change, and clear pressures of loss and assimilation. These intermediary experiences are an expression of distal political agendas which drive merger, and historic local identities of place which appear to structure the conscious dynamics of merger which individuals can articulate. Yet, how these positive characteristics associated with professional experience are taken in and metabolised as pragmatic change, is constitutive of organisational life beyond merger.

Strengths and Limitations

This review systematically identified the experiences of professionals involved with the merger and integration of NHS hospital services. The search was conducted according to PRISMA guidelines, and a rigorous approach to qualitative evidence synthesis was used. The results indicate a novel way of understanding the experiences of healthcare professionals undergoing organisational change. The reviews inclusion criteria mean the findings and synthesis expressed is highly relevant to the NHS context. This maps on to the idiosyncratic way in which the NHS is a centralised system organised around subsidiarity. Presenting a line of argument synthesis indicates commonalities in research findings across a broad period of history. Incidentally the reviewed studies broadly track the period of history in which the merger of NHS trusts has been relevant in a marketised health system. The review findings support the use of an in-depth qualitative methodology that is able to produce locally situated knowledge about the complex human factors inherent in organisational change. This reinforces the research gap conceptualised in the previous chapter, namely that health systems are designed and evaluated as structural, rather than relational systems.

Limiting factors of this review include the exclusion of studies from outside the UK. Organisational merger is a phenomenon across the health systems of developed economies, and a synthesis of findings from a broader research base could inform approaches to integration in the UK. This decision was taken on the basis of stark distinctions in funding models (Anandaciva, 2023), and pragmatically the resources and time available within the present review were constrained. The selected studies drew their findings from a broad range of professional and stakeholder roles relevant to hospital mergers. This means experiences specific to individual groups of professionals may be obscured, and more or less relatable to the line of argument synthesis presented. Meta-ethnography is best conducted within teams of researchers. Although the present findings are strengthened by the involvement of

experienced research supervisors, it was not feasible to conduct the review and synthesis with more than one researcher. This practice can increase the potential for bias in qualitative research, and the possibility of conducting the main research project in a way which draws on diverse experiences and perspectives was highlighted as a priority.

Research Rationale and Impact

There is a need for locally situated knowledge about the unconscious aspects of organisations working to integrate clinical services, which addresses the human and emotional impact of organisational change (De Molli, 2020; Pratt & Crosina, 2016). Such a focus would help to foster understanding of human factors typically overlooked by the more readily quantifiable parameters used to evaluate healthcare integration. A specific need in neurology services includes evidence to support effective communication across organisational boundaries (Hogden et al., 2017; Howard & Potts, 2019). The use of reflective space to support interprofessional collaboration has also been identified as a related domain warranting further research (Wei et al., 2022).

The systems-psychodynamic frame has been outlined, and offers a range of reflective and experiential modes of enquiry capable of generating thick descriptions of health systems change. Empirical applications of this approach relevant to clinical psychology have focussed on understanding individual clinical settings, where the focus has been direct patient care (Blacker et al., 2017; Goodwin & Gore, 2000). The application of this methodology to an NHS organisational context of an acute NHS hospital trust is therefore considered an appropriate development.

Problem Statement

Organisational merger and integration of acute NHS hospital trusts is a long standing phenomenon, relevant to the integration of healthcare systems in the UK. The extant literature articulates that professionals implicated in system wide change are subject to powerful interests associated with local geographies and socio-political agendas, which translate to proximal experiences of assimilation and loss. Therefore, how these external factors relate to a pragmatic core of professionals who persist in their roles, while others choose to leave their organisational context is inadequately addressed. One reason is the extant literature relies on qualitative knowledge privileging individuals self-reported rational understanding, meaning the unconscious aspects of organisational culture as a whole are under-represented.

Research Aim

The present study aims to generate locally situated knowledge about the integration of clinical neurology services, using an in-depth psychoanalytic observational methodology which reflexively makes use of subjectivity.

Research Questions

On the basis of this research aim, the following research questions will be addressed:

- What can be learned about post-merger organisational culture from observing the integration of neurology services in an NHS hospital trust?
- What does a psychodynamic method of observation allow to be hypothesised about the unconscious aspects of integrating NHS hospital services?

Chapter Three: Methods

Chapter Overview

This chapter presents a detailed account of the study's rationale and conduct. A relevant philosophical framework is presented, together with an appropriate methodology. Subsequently the procedure of the study is outlined in depth, including the ethical considerations, practicalities of data collection, and justification for the method of analysis. The chapter concludes with an overview of steps planned and taken to disseminate the findings.

Ontology and Epistemology

The branch of metaphysics known as ontology is concerned with the nature of reality, and what there is to be understood about the world. Epistemology is an associated field, concerned with the theory of knowledge (Burr, 1998; Harper, 2011). The ontological assumptions one makes about a field of research, necessarily constrain subsequent epistemological statements about what, and how, it is possible to know about that topic (Willig & Rogers, 2017). The research paradigms pursued across the social sciences are constellated by various responses to the questions of ontology, epistemology and methodology (Willig & Rogers, 2017). Several dialectic ideas are apparent across various metaphysical positions, arrayed between the extremities of positivist and constructivist ontologies, naïve realist and radical relativist epistemologies, and hypothetico-deductive or hermeneutical methodologies (Guba, 1994).

Hinton (2002) outlines a catastrophic culmination of modernity as marked by colonial imperialism, slavery, and genocide. To which he states a post-modern turn to the social construction of knowledge arose as a polemic. Constructivist ontologies centre the influence of political, cultural, ethnic, and gendered histories. From an epistemological position of relativism, knowledge arises from the confluence of linguistic, cultural, historical, and

technical contexts (Harper, 2011). Guba (1994) states these factors must be actively addressed to ensure the creation of altruistic and empowering knowledge.

An epistemological position of radical relativism rejects the possibility of one objective truth, favouring a plurality of understanding(s) in a given field. The explanatory accounts which arise from such an approach are nuanced and sophisticated, but necessarily local and specific in nature (Guba, 1994). Although debated widely, some social constructivist writers conflate epistemological with ontological relativism (Harper, 2011). This form of over generalisation would mean an assumption that knowledge in the social sciences is co-constructed between people and through language, necessitates a wider assumption that no underlying reality exists. For example, if the construction of knowledge about organisational culture is based on the absence of a single shared reality, one would fundamentally be unable to demonstrate the superiority of one view relative to another (Elfenbein, 2023). This form of reasoning can inadvertently undermine the political or moral challenge of injustice (Siegel, 2013). One example is to structurally undermine the value of an individual's capacity to know based on their existing disadvantages and oppression, which already exclude them from the power to make decisions (Fricker, 2007). This resonates with the previously discussed centralisation of decision making powers in UK health systems, which have made it harder for local knowledge and understanding to shape the allocation and use of resources.

This thesis therefore adopts an ontological position of Critical Realism (CR) (Guba, 1994). This is a position allied to critiques of modernity and positivism. It was originally developed by the philosopher Roy Bhaskar (2014), and posits a intransitive reality only accessible to human perception indirectly. Human knowledge is considered transitive, apprehending imperfectly through symbolic and static language the dynamic structures and processes underlying the social world.

Philosophical Framework

A pragmatic philosophy concerned with everyday experience in a manor akin to psychoanalysis, and consistent with the ontology and epistemology of critical realism is articulated in the work of Charles Sanders Peirce. Long (2018a) summarises his ontological position as consisting of processes and relations, where nature itself is a dynamic stream of relationships, said to have semiotic meaning. In his theory of semiosis, Peirce (1985) addresses the notion of signs, as containing three, related parts. The sign-vehicle (smoke which signifies fire), the object which is signified (the fire signified by smoke), and the interpretant, whose interpretation makes the meaning of the sign manifest. Peirce's interpretant can equate to a human mind, although this is not considered necessary given the determining nature of the sign-vehicle. In relation to CR, the dynamic relationships underlying reality are said to exist whether or not they are signified and expressed by a human mind. For example, smoke signifies fire regardless of whether a person interprets this to be the case (Long & Harney, 2018). On this basis Bohm (2004) states that symbolic meaning is implicate, which is described as unbroken and interconnected to a deeper whole. Subsequently, meaning is decoupled from the act of human interpretation. What it is possible for humans to signify and represent in language, past, present, or future, therefore already exists in the human capacity to use and interpret signs (Long & Harney, 2018).

Peirce's philosophy is concerned with the pragmatic coherence between knowledge and reality, rather than the fundamental correctness or accuracy of how reality is represented (Long & Harney, 2018). Although a deviation from the beginnings of critical realism in philosophical realism, Peirce's assertion that the nature of underlying reality is independent of human interpretation is considered consistent. Realist iterations of critical realism consider knowledge trustworthy to the extent that structures underlying reality can be articulated (Guba, 1994).

The philosophical framework outline above is consistent with the concept of abductive enquiry, as distinct from inductive, or deductive scientific enquiry. Abduction is the creative process by which a hypothesis if formed, and the logic by which new ideas are introduced. Peirce's own description is as follows:

> "The surprising fact, *C*, is observed.
> But if *A* were true, then *C* would be a matter of course
> Hence, there is reason to suspect that A is true."
> (The Peirce Edition Project, 1998, p. 330)

Peirce's non-cartesian view of cognition, encompassing the range of human perceptual experiences is consistent with an embodied psychology of human experience (Cromby, 2015). This means individual subjectivity across any sense modality can be used to generate associations, as the basis of creatively hypothesising about the nature of the social world. In Priece's language, 'surprising fact, C'. The working back from these pragmatic associations from observation is consistent with a critical realist ontology which assumes an underlying, albeit complex reality which determines the nature of human experience. Abduction is an associative logic, but also the basis of a methodological approach to research. An observational qualitative methodology is considered consistent with the form of abductive enquiry described above, and

The need identified in the literature review for qualitative knowledge about the process by which pragmatic progress is achieved by NHS professionals subject to merger and integration is consistent with abductive enquiry as a methodology. This approach detailed in subsequent sections will assume the ontological position of critical realism, and aspects of Priece's pragmatic philosophy, that an underlying reality exists independent of human interpretation. To interpret and hypothesise about the underlying realities shaping organisational merger in the NHS, in-depth observational material will be interpreted via an associative group. This is in order to hypothesise the links between what Priece refers to as

‘surprising fact, C, and the underlying truth which is hypothetically a matter of course. the following sections this approach will be outlined in detail,

Methodology

Research in organisational settings has historically been positivistic, taking an epistemological position of naïve realism (Elfenbein, 2023). Verifiable knowledge has therefore been assumed to correspond to reality in an uncomplicated way, an approach synonymous with empiricism, and hypothetico-deductivist natural science (Lincoln et al., 2011). However, quantitative methodologies inadequately address the consequences of observation in human social contexts, meaning an imperative for empirical data can fuel a myopic bias against other forms knowledge (Lincoln et al., 2011).

The theory and practice of psychoanalysis has provided concepts widely accepted in the popular imagination as explanatory tools, relating to the clinical treatment of psychological distress, how social groups function, and broader cultural practices (Fotaki et al., 2012). The underpinning assumption is the dynamic unconscious, which presents significant methodological challenges to empirical research. The inaccessibility of the unconscious to quantifiable measurement renders quantitative methodologies at odds with the proposed phenomena itself (Rustin, 2016). Consequently, psychoanalysis as a positivist science is heavily critiqued for its sparsity of experimental confirmation (Grünbaum, 2018). Contrastingly, relativist attempts to frame psychoanalysis as an artistic and linguistic tool undermine the unconscious as a real and motivating force behind human behaviour, and risks undermining subjective consistencies between people (Clarke, 2017).

Various methodologies attempt to integrate psychoanalysis with systems theory, and have been used as a framework for understanding organisations (Clarke & Hoggett, 2019). Drawing together Peirce’s philosophy, and following a theoretical basis of dreaming as a social and cultural phenomenon (Lawrence, 2018), Long and Harney (2018) propose the

associative unconscious as a conceptual basis of enquiry. The associative unconscious is the unconscious on a systemic rather than individual level, comprising an infinite number of symbolic associations, past, present and future. It includes processes and symbolic relationships already articulated by humans in complex social systems, and those theoretically available, but as yet unexpressed.

Considered as a network underpinning human systems and the social nature of thought, the associative unconscious is capable of producing system-wide symbols. These symbols may be represented or observable in any constituent group of an overarching whole. However, isolated subsystems can be considered to only hold partial knowledge pertaining to the system as a whole (Lowney, 2022). The production of knowledge about organisational systems as a whole is mediated along many lines, but Long and Harney (2018) emphasise the interpersonal and relational process of symbolisation in terms of psychoanalytic defences. They cite theories of thinking (Bion, 2018) and group dynamics (Bion, 2003) to illustrate how unconscious processes of relating to oneself and others serve to constrain a systems access to symbolic meaning held in the associative unconscious.

An explorative methodology was considered appropriate to the study aims. The intention being to create reflective space which use the containing function of groups to amplify associations to observations of organisational life. This form of creative enquiry is concerned with the discovery of new possibilities, typically precluded by empirical forms of logic. It was therefore the intention to use a qualitative methodology as a form of abductive enquiry. The aim being to generate locally situated knowledge that was previously inaccessible, and consider hypotheses applicable to wider efforts towards integration in UK health systems.

Research Design

The researcher approached an acute NHS trust in England, which provides hospital and community services across a diverse geographical area. The trust was formed via an organisational merger prior to 2020, bringing together two constituent trusts which separately ran two large general hospitals. As experienced nationally, the COVID-19 pandemic caused severe disruption to the delivery and management of routine clinical care, and meant the integration of clinical services across the newly formed trust were delayed.

Neurology services from the constituent trusts had continued to operate under distinct divisional management structures, aligned with the physical sites of the historic trusts. In 2023 a comprehensive programme of work was initiated by the trusts board to integrate its clinical services across a range of medical specialities. This process of organisational transformation was initiated prior to and independent of the present study. These efforts centred on a corporate led programme of work named the Clinical Services Integration Programme (CSIP), which was considered pertinent to researching the dynamics of integration within healthcare generally, and neurology services in this single locality. In line with a previous clinical role held by the researcher within the trust, it was possible to negotiate access to this programme of work on the basis of strong professional links, and the trusts existing priority to integrate its neurology services.

The CSIP consisted of an overarching programme board, which was chaired by a member of the trust's executive officers. The programme initially focused on four medical specialties across the newly merged hospital trust, and for each speciality representatives were present from both general hospital sites. Neurology was one of the initial four specialties to be included. The programme board also consisted of various administrative and corporate teams, notably the trusts transformation team. Each speciality agreed a range of work streams and tasks at the programme board, which met quarterly. A weekly CSIP catch

up group was convened and led by the trust's transformation team. The expressed purpose and task of this meeting was to monitor progress towards actions agreed at the programme board, and to agree actions on any outstanding areas of work. Clinical managers from each medical specialty joined the call each week at assigned times. Neurology was assigned a 30 minute time slot each week, although this varied in duration and timing dependent on demands across the wider organisation. The observation was considered to start at the diarised time each week, and if delayed the experience of waiting to join the call was included within the researchers written account. Allowing for these week to week variations, four hours of meeting time were directly observed, but incorporating the time spent waiting to join meetings, this totalled 6 hours.

The researcher initially negotiated permission to approach the entire programme board and all of its work streams associated with neurology for consent to observe, however the only area of work where adequate consent could be obtained from all participants was the CSIP weekly catch-up. The significance of only being granted consent to observe a weekly catch up meeting which had a practical focus on collating progress towards previously agreed actions shaped the extent to which hypotheses arising could be considered directly relevant to other areas of the wider CSIP. However, the refusal of permission to work streams which included more clinically orientated professionals, or where the focus was less practical can in itself be considered a significant omission. Using a systemic basis of each subsystem being related to the organisation as a whole, it is reasonable to assert that the dynamics observed within the CSIP weekly catch up, would be of relevance to the wider dynamics occurring within the integration as a whole. For example the observed meeting included internal boundaries between medical specialities, and the researcher was required to negotiate these ethically within the agreed research protocol.

Local Involvement Activities

The researcher was informed by the UK standards for public involvement in research (Crowe et al., 2020), and collaborated with local NHS clinicians, organisational consultants expert in observational methodology, and engaged with local Healthwatch and Neurology Networks. A moving patient testimony within one such public forum highlighted that access to neurology services based on geographical place was inequitable, with significant disparities in the type of care patients receive based on their home address.

A structured review of the preliminary proposal was undertaken in collaboration with the local Healthwatch Service. A need to communicate a rationale for organisational observation as a means of supporting improved patient care was highlighted. The impact of discrepancies across local neurology provision was a priority for the patient population. Supporting organisational integration across a new geography aimed to address this issue of inequitable access.

The research design limited the scope of the study, focussing on the role of professionals within the CSIP, rather than also observing patient, carer, and public forums relevant to neurology. This was in keeping with the design and operation of the existing CSIP identified for observation. These factors helped inform a research focus on professional attempts to integrate clinical services for neurological conditions.

Research Procedure

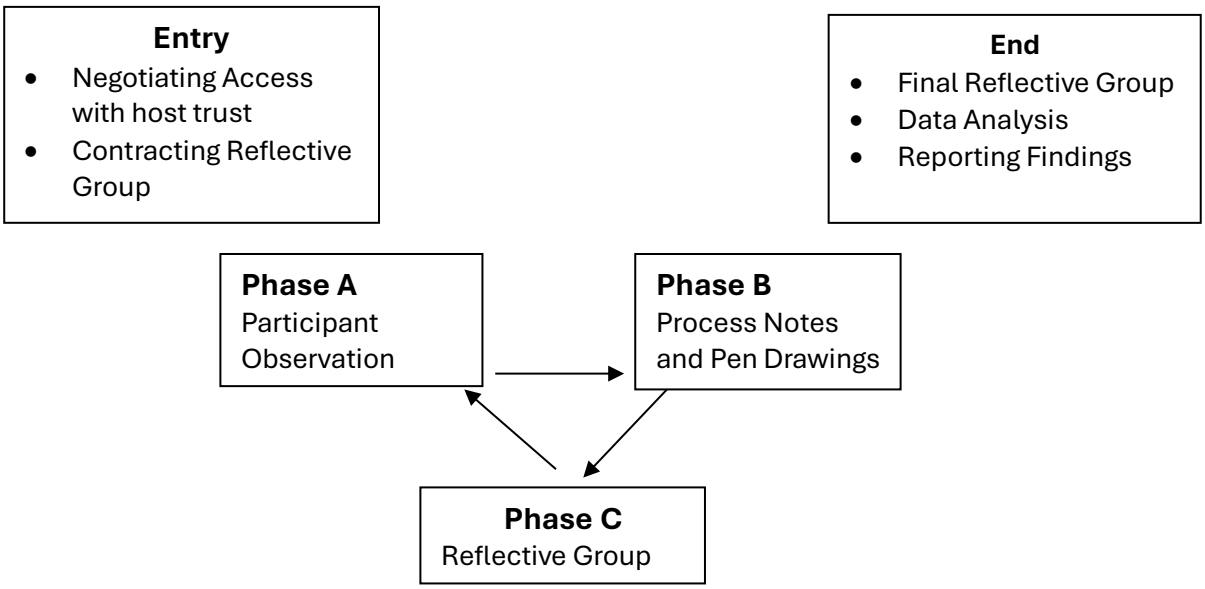
A visual overview of the research procedure is provided in figure 3. It involved data collection being divided into three related phases, which repeated cyclically during the study. The process was book-ended by a process of reflection on gaining entry to the NHS trust, and concluded by thinking about the research process and findings as a whole, marking the start and end of the data collection process. Phase A involved the researcher observing the CSIP

within the host NHS trust. In phase B the researcher produced written process notes, and pen drawings from memory of the observation. Phase C involved the verbatim reading of process notes and sharing of created images with an external reflective group. This group offered their reflections and associations to the material in an unstructured way. The process was designed to run sequentially, over a total of 6 observation sessions. The phases were recursive, meaning the content of the observational account, and associations from each observation informed the content in following repetitions of the cycle.

Phase A - Psychodynamic Observation

A total of 6 meetings were formally observed within the host trust. The researcher was able to negotiate access to the weekly catch up, within the CSIP. The researcher observed a segment of this meeting focussed on neurology services. The primary task of this meeting was to follow up on tasks and actions relating to Neurology integration, that had been agreed at the programmes overarching steering committee. The programme of work was routinely recorded digitally, with the data held within the trust. However, these digital recordings were not accessed for the purposes of the research.

Figure 3: Three phase observational approach



Phase B – Process Notes and Pen drawings

According to the methodology outlined by Hinshelwood and Skogstad (2002), the researcher wrote detailed process notes from memory, immediately following each observed meeting. Taking care to record as much detail as possible, and not to directly interpret or theorise about the observed material within the written account. Each account included the researchers' contributions to the setting if engaged directly by participants, the private feelings, thoughts, and emotional responses, and associations of the researcher, alongside a recollection of the speech, behaviours, gestures, body language, facial expressions evident in the group during the course of the observation.

In reference to the epistemological position of the present study, Peirce's non-cartesian view of cognition offers a coherent basis on which to mobilise sense modalities beyond verbal and written language. Drawing is a medium which articulates more than can be described verbally, and has been used extensively within the Tavistock tradition of organisational consultancy (Lawlor & Sher, 2021). Bollas (2017) describes the mediums capacity to express what was known, but not yet thought or articulated. His analogy of an unthought known is congruent with the associative unconscious. Nossal (2018) draws on the writings of David Armstrong (2018a), to propose drawings speak the language of the unconscious by enhancing the capacity for serious play (Winnicott, 1991). As a tool in organisational research, drawing creates space for profound work by consistently providing access to unconscious material, and can also express thoughts and feelings held more widely than just the individual drawing the image (Harding & Nossal, 2008). In this way, access to a shared representations of the associative unconscious across the organisation can be maximised by an additional means of association and creative expression.

Where spoken and written language is inherently limited and incomplete, the practice of drawing from observation offers an additional dimension to making sense of complex

social systems. Sapochnik (2021) hypothesises that aspects of meaning from an observed setting are obscured and repressed by the dynamics of the group. Drawing offers a spontaneous transitional space, in which tacit knowledge akin to the unthought known can be transferred to a visual form. The resulting images allow for the exploration in language of what was unconscious in the observed setting. In his conceptualisation, observation, and drawing captures what is repressed and projected by the group, but also identifications from within the observer (Sapochnik, 2021). The use of a reflective group to collaboratively make sense of what is drawn offers triangular space (Britton, 2004), which under the direction of a facilitator can hold in mind the need to differentiate object from observer, and address the replication of anxieties that may have been repressed in the observed setting.

An approach to creating drawings from observation is provided by Sapochnik and Izod (2021), and forms the basis of the approach used in the present research. Following each observation the researcher undertook to draw their impressions and associations. This was completed as soon after the observation concluded as was practicable. The researcher sought to draw without intention, neither aiming at, nor avoiding description. The image(s) drawn were not corrected in any way, and the researcher drew quickly, attempting to bracket memory and desire (W. R. Bion, 2013). Drawings were made using pen and ink, on paper. The resultant images were digitised by photographing each image, with these digital files presented in each reflective group meeting, for the purpose of generating additional associations to the observation within the group.

Phase C - Reflective Group

In line with Hinshelwood and Skogstad (2002), a reflective group was convened independent of the observed trust. The purpose of this group was to generate reflections and associations to the researcher's observational material. This process allowed the group to work collectively towards a shared understanding. This approach cultivates an ability to retain, feel and think about the experience of the observed organisational setting, in a way which is tentative and in dialogue with the evolving content of the observation account.

The membership of the reflective group consisted of a band 8D consultant clinical psychologist, band 8B counselling psychologist, band 8B clinical psychologist, a social worker, and the researcher who was at the time a trainee clinical psychologist. Two of the group identified as male, while the remaining three identified as female. The ethnicities represented within the group included white British, south Asian, and white African. The researcher attempted to recruit individuals with executive and consulting backgrounds, but was unsuccessful. Two of the reflective group had completed post-graduate training relevant to the methodological approach, and all members held organisational roles within the NHS which had direct clinical contact with patients, and the managerial, administrative and for one individual the executive functions within NHS trusts. All reflective group members were external to the host NHS trust. This absence of existing relational ties to the setting helped to generate free associations to the observational account. The group also offered a parallel space for introspection on the part of the researcher, supporting the researcher to develop an analytic and reflexive stance, and to respond iteratively to content brought and omitted from the observational material. The group comprised a facilitator experienced in psychodynamic observation, the researcher, and a further three individuals with a professional interest in the methodology.

The reflective group was convened prior to the first observation taking place, and the first meeting focussed on contracting and practicalities of the group. The format and boundaries of the group were agreed collaboratively on this initial call, and were as follows. The reflective group would meet for 75 minutes on each occasion and would be conducted online via MS Teams video call. Each meeting was conducted in two parts. In part one the written process notes from the previous observation were read aloud by the researcher, with the group subsequently sharing their reflections and associations to this material. The second part of the meeting entailed the researcher screen sharing pen drawings relating to the same observation, followed by the group sharing further reflections and associations to this visual content.

The reflective group met once for each meeting observed within the CISP, and it was intended that observations and reflective groups would follow sequentially. After contracting, the first reflective group meeting considered the researchers negotiation of access to the host trust, and six subsequent sessions focussed on individual observational material, before a final meeting where the group reflected on the observation as a whole, without any presentation of material.

Qualitative Methods

In view of an epistemological position of critical realism, a methodology based on abductive inquiry, and the overarching aims of the study, reflexive thematic analysis was considered the most appropriate qualitative method. A rationale is provided below, alongside consideration of alternate approaches.

Reflexive Thematic Analysis

Thematic analysis was first outlined by Braun and Clarke (2006), and was intended as a flexible qualitative method, accommodating various philosophical positions. Its proliferation across academic fields has been accompanied by a lack of rigor, especially unclear or contradictory ontological and epistemological positions (Braun & Clarke, 2021). The researcher therefore sought to ground the present analysis in a well-defined philosophical framework. The present research required an approach which could clearly articulate the place of researcher subjectivity, alongside the epistemological position positing relevance beyond the local research context. On this issue of applicability outside the immediate context, thematic analysis limits the risk of further extending the interpretation of data already generated within an interpretative frame of participant observation and free association. This approach has been applied effectively to observational systems psychodynamic research, in both clinical and organizational healthcare contexts (Blacker et al., 2017; Gray, 2021).

Thematic analysis can accommodate various epistemologies, spanning scientifically descriptive to the artfully interpretative, with many idiosyncratic attempts to integrate elements of both (Braun & Clarke, 2019). Coding reliability (Joffe, 2011), a scientifically descriptive method focused on reliability and hypothesis testing was deemed unsuitable for generating insights from associative enquiry. Similarly, framework approaches acknowledge researcher subjectivity, but use theory to guide deductive analysis rather than relying on the associations core to abductive enquiry (Brooks & King, 2017).

Reflexive thematic analysis was therefore chosen for its inductive approach, which aligned with the study's conceptual framework. It also offered the flexibility to tolerate the realist assumption of an associative unconscious, while containing a robust framework for interrogating the socially and culturally bound nature of producing qualitative knowledge. Its

core principle remains to identify patterns or themes within a dataset, having evolved from content analysis (Byrne, 2022). However, the method captures the interplay between the dataset, theoretical assumptions, and the researcher's role in knowledge production (Braun & Clarke, 2019). These aspects are consistent with a methodological approach that holds as its strength the researchers subjective mind as the instrument of knowing (Hollway, 2018).

Grounded Theory

This qualitative method is attributed to sociologists Glaser and Strauss (2017), who were concerned with the systematic collection of qualitative data, identification and integration of categories as method, and generation of an explanatory framework as theory. Grounded theory employs several key strategies including constant comparative analysis, theoretical sampling, and theoretical coding (Starks & Brown Trinidad, 2007). Realist forms of grounded theory are consistent with critical realism. However, in order to allow the production of theory derived from the data, grounded theory methods are necessarily a-theoretical (Willig & Rogers, 2017). This was considered incompatible with the present study based on the assumption of an associative unconscious, and the implications of an abductive method of enquiry.

Grounded theory approaches use iterative analysis to inform the ongoing collection of data. This is broadly present in the recursive cycle of socio-analytic methodologies. The researcher's intention however was to adopt an observing position akin to the analytic concepts of freely hovering attention, and being without memory or desire (Hinshelwood, 2018). It was deemed analysis of data arising from the observation should be undertaken once data collection was complete. The researcher had also held a clinical role within the host organisation during the research design and conduct, this was felt to compromise a

requirement of grounded theory to set aside theoretical assumptions which had necessarily been held by a practitioner psychologist in training (HCPC, 2023).

Interpretative Phenomenological Analysis (IPA)

IPA is a method of analysis widely practiced in the social sciences, and is based on the philosophical system of transcendental phenomenology. As such IPA is concerned with the consciousness descriptions an individual provides of how they experience the world (Willig & Rogers, 2017). Phenomenology is often located between realism and relativism; however the nature of external reality is of little concern to the practice of IPA. It is an underlying assumption that the researcher is unable to directly access the conscious experience of the individual, and knowledge derived from analysis is necessarily an approximation. Using what is known as the double hermeneutic, the focus of analysis is to give voice to the quality and texture of peoples experience, and subsequently interpret this through existing psychological, social, and cultural contexts (Larkin et al., 2006). In relation to the present study IPA was considered unsuitable given the researcher's own experience of an observed setting would form the basis of analysis. The limited capacity for phenomenological knowledge to be used outside its specific context was also a significant limitation. The present studies interpretative findings are necessarily tentative and hypothetical, but the intention was to inform future research, policy and practice relevant to healthcare integration.

Reflexivity

Qualitative research is intersubjective, the result of sense making at the intersection of conscious and unconscious communication between subjects (Clarke & Hoggett, 2019). Any articulation of an underlying reality is therefore bound by the social and cultural constraints of inquiry (Hall, 1999). Characterising subjectivity in the context of a dynamic unconscious,

Hollway (2018) proposes the concept of a defended subject. Drawing ideas from the psychoanalytic school of object relations, she describes the defences of repression, splitting, projection and introjection to illustrate how people are neither fully known or knowable, to themselves or others.

As knowledge derived about the social world is inseparable from the observing subject, reflexivity is paramount to good research (May & Perry, 2014). Reflexivity is an iterative process of self-examination, where the researcher seeks to uncover and articulate how personal context and bias influence the process and findings of research (Campbell et al., 2021). Amongst the varied theoretical perspectives on reflexivity, there exists a shared concern for critical thinking, and a distinction between functional and personal reflexivity (Braun & Clarke, 2023). Within the present research the use of multiple, concurrent strategies ensured the credibility and accuracy of research findings (Braun & Clarke, 2013).

The research method operationalises reflexivity within the process of abductive inquiry into the organisational life of an acute NHS hospital trust. The process of presenting observational material to an external reflective group primary makes use of the researchers' subjectivity. In view of this the researcher used a reflexive journal throughout, helping to identify unconscious resonances with the material, and to separate out responses associated with internal patterns of relating, and those of the observed setting. A self-reflexive statement is also presented below, highlighting the researchers conscious awareness of their historical context, embodied self, and personal-professional positionality (Braun & Clarke, 2023).

Self-Reflexive Statement

I am a White British, cisgender male, in my early 30s. I was born in an affluent area of the English home counties, and attended local comprehensive schools. Whether or not borne out in my genealogy, the British painter and social critic William Hogarth features

prominently in my family's oral history. This affinity articulates my own ambition and capacity to achieve, but also an esteem for creativity and feeling as a vehicle for social change. My father worked as a landscape gardener, my mother as an art psychotherapist, and my younger sister studied fine art and worked as a chocolatier. My parents owned their home outright, and I was privileged to grow up with my needs for shelter, warmth, physical safety, love and belonging, met in a good enough way. I was a quiet, and reserved child in my early years, but naturally athletic. I was recruited into the football academy system at 11, and the idealised hope of a career in football formed my identity as an adolescent. Sport provided confidence in my abilities, and a way of expressing myself. I found an environment that seemed to reward an underlying repression of feeling, demanded by familial relationships, disposition and circumstance. In retrospect football afforded me an outlet for feelings I couldn't otherwise express, and an experience of difference from my peers. Having come from an affluent, and predominantly white area, I've since lived in a range of places, alongside people of different social, economic, ethnic, and religious heritages.

My Father broke down quite suddenly in his early adolescence, understanding his emotional difficulties as an enduring mental illness. This narrative underpinned a real ambivalence about discussing feelings as a family. I internalised an avoidant relational pattern, fearing what it might mean to express strong feeling. This was the way of navigating life I settled on, until in my early twenties I struggled to grieve the loss of an identity I had built around football. I turned to NHS services as a patient, and subsequently to psychoanalytic help. I've been able to slowly integrate feeling into a conscious sense of myself and the world. At the end of 2023 my father passed away following a long battle with cancer. The gradual process of grieving his loss has coloured the entirety of the research process. In writing a eulogy for his funeral, I was reminded of an anecdote that his father, my grandfather, used to read the final chapter of a book, before deciding whether to read it in

full. I hadn't been aware this was also how he approached his work as a solicitor, flicking to the end of new papers to determine the invariably correct answer, and subsequently working out how he had arrived there in retrospect. This resonates with my own sense of intuition and the freedom I have found in associative thought. I am also struck by a parallel with the logic of abductive reasoning.

In 2014 I graduated into a period of austere economic and social policy in the UK. I worked for 9 years in a range of support roles in adult mental health services. This formed a perception that local needs, whether of patients, professionals or the public are subservient in the hierarchy of health services. In my experience meaningful change and impact occur slowly, through service and sustained commitment to people and place, but can be torn down quickly by centrally mandated change. The name Thurston, from my paternal grandfather, is synonymous with the fairgrounds and piers of England. It is a historical link to the coastal region I relocated to for training, and a relational tie to a community who are subject to structural inequalities in a way that I wasn't growing up. Investing into a geography connected with my families past and present resonates with a turn towards subsidiary of commissioning of health services. I am interested in furthering the capacity of health systems to identify the needs and challenges particular to a place.

A postgraduate psychoanalytic course, and psychodynamic work on an acute psychiatric ward introduced me to the theory and practice of consulting to health services. I had held a clinical role in neurology services during my first year of doctoral training. During this time the idea, design, and negotiation of the research took place, in the context of a dual role as clinician and researcher. As I worked clinically, I became aware the trust had been formed through a merger before the pandemic. I observed a disparity in service provision across different geographical areas of the same trust, and that the position of staff seemed

organised around these now historic boundaries. I resonate with the dynamic of hoping to bring together opposing ideas or groups in a way which improves life for myself or others.

Sources of Data

The qualitative data derived from observation, and the reflective group had three constituent parts. The first of these was the observational material, which was read aloud and shown to the reflective group. Second was the groups spoken associations and reflections to the written account, which were recorded and transcribed verbatim. The third and final component was the reflective groups reflections to pen drawings the researcher made following each observation. Drawings were presented as digital images to the group, whose responses were recorded and transcribed. These constituent parts are contained within the transcript of each reflective group meeting. It was decided to analyse these parts chronologically and sequentially, so the analysis captured the cyclical and recursive nature of the method outlined in figure 4.

Figure 4: Qualitative data sources

Scope of data collection

Reflexive thematic analysis offers flexibility relating to the amount qualitative data collected and analysed (Byrne, 2022). For student projects Braun and Clarke (2023) recommend generating between 5-20 hours of data, depending on the level of academic study. The present study utilises a multi-phased method, meaning for each organisational

meeting observed, 60-90 minutes was used to write process notes and draw from observation, and each corresponding reflective group lasted 75 minutes. The dataset as a whole therefore represents approximately 30 hours of data.

The methodology of abductive enquiry into the associative unconscious, justifies the decision to observe one setting within the host trust over 6 meetings. This small number of direct observations, in concert with a multi-phased method is consistent with what Levitt et al. (2021) describe as methodological integrity.

Transcription

Each reflective group was conducted via MS Teams and recorded. A verbatim transcription was generated automatically by MS Teams. The veracity of these initial texts was checked against the entirety of each meetings original recording by the researcher. This aided the process of familiarisation, and ensured transcription remained true to the original recordings. An orthographic approach to transcription was selected (Braun & Clarke, 2013). This approach captured spoken language and communicative features such as pauses and laughter. Punctuation was used in such a way to replicate the spoken language. All text was anonymised by assigning researcher-defined pseudonyms, and any identifiable information was redacted.

Method of analysis

The 6 stages of Reflexive Thematic Analysis were used to guide the analysis (Braun et al., 2023). Rather than a linear process, the analysis progressed through these stages in a recursive way. (Byrne, 2022).

Phase 1: Familiarisation.

The researcher immersed themselves in the dataset through repeated reading and re-reading of the transcribed data. In this phase of analysis, the researcher simultaneously played the audio and video recordings of the reflective group. The researcher began to note ideas relevant to the study aims, with the intention to explore these further. The focus at this stage was not to develop specific codes, or identify definitive patterns in the data

Phase 2: Coding

Individual codes constitute the smallest unit of analysis, and capture specific meanings within the data relevant to both study aims. A systematic approach to line by line coding was adopted, which progressed chronologically through the distinct sections of the data outlined in figure 4. An example coded transcript is provided in appendix B. The analysis moved from a focus on semantic to latent meaning, as the data was iteratively considered as a whole. In this way codes were revisited, and where necessary revised, or sections recoded as meanings across the data as a whole were identified. All codes were collated, including the relevant data segments for the subsequent phases of analysis. The development of codes evolved organically, and was conceived of as a product of the researchers understanding of the research as a whole. This combination of process and subjectivity allows for rigorous analysis, and for similarity and difference to be differentiated in the data.

Phase 3: Initial theme generation.

The collated initial codes were then developed into draft themes. The researcher focussed on creating meaningful patterns from the data, that addressed the stated research aims. Consideration was given to more than one preliminary map of themes, before proceeding with a version felt to capture in a good enough way the meaning relevant to the study's aims, and that was authentic to the data as a sequential whole.

Phase 4: Reviewing and developing themes.

Initial themes were subject to recursive review. Recognising this as an active and interpretative phase of the analysis, repeated reference was made to initial codes and textual extracts. Where appropriate phases 1 and 2 were revisited in line with the insight gained in stepping back from the detailed process of coding.

Phase 5: Refining, defining and naming themes.

Theme definitions were written to clarify the coherence of each theme individually, and in reference to the story being told about the data as a whole. This process helped determine the order in which to present themes, how to name themes in a way which conveyed their core meaning, and whether individual themes presented a coherent concept, or were more appropriately subdivided.

Phase 6: Producing the report.

The final report was complied with a view to presenting nuanced individual themes, explicating relationships between themes, and to producing a coherent story of the whole meaning generated through analysis. This process provided the opportunity to further refine themes, and to revisit earlier phases of analysis as appropriate. The write up incorporated an overview introducing the analysis, and combined data extracts with the researcher's narrative. The analysis incorporated both semantic and latent themes, deriving meaning from the specific and wider implications of data derived from interpretation

Participants

Observation Participants

Agreement to develop the research protocol and apply for ethical approval was negotiated via a member of the Trusts executive team. Once the relevant ethical and governance approvals were in place, the researcher approached the clinical services integration programme steering committee chair. The project was discussed formally at the programme board, and approval was granted to seek consent from all potential participants within the CSIP. Given the resource intensive nature of the methodology and the partial participation in the study from members of the CISP, it was not possible to observe the programme in an exhaustive way. The researcher approached each member of the programme steering committee, a weekly meeting comprising members of the trust's transformation team alongside clinical managers, and a project team seeking to repatriate a specific clinical service to the trust. The sample was considered opportunistic, on the basis of participant involvement within an existing professional forum, and on willingness to provide informed consent. The pool of potential observation participants was self-selecting on the basis of role within the CISP.

Inclusion Criteria

Healthcare professionals with an existing role within the CSIP were eligible to participate in the observation. This included those working within the host NHS trust, or within stakeholder organisations relevant to the integration of clinical neurology services.

Exclusion Criteria

The observation was limited to healthcare professionals, and therefore patients, family, carers, wider clinicians or staff within neurology, and the general public were unable to participate. The function of professional roles represented within the CISP was outside

direct clinical care, and as such staff with an exclusively patient facing role in the organisation were not part of the pool of potential participants. It was a feature of the CSIP that patients and carers were not directly involved with routine meetings.

Reflective Group

The decision regarding who was to facilitate the group was made in consultation with research supervisors at the University of Essex. Psychodynamic observation is a specific and technical methodological approach, and the group was facilitated by a professional with theoretical and applied experience of the approach. Consideration was given to including experts by experience and lay members of the public, but it was appropriate to the resources of the project to limit the group's membership. Reflective group participants were selected on the basis of existing professional networks of the researcher and group facilitator. This included professionals with a working knowledge of the methodology, or interest in developing the approach within their own practice, and whose interest in the project was in a professional rather than personal capacity.

Inclusion Criteria

Participants were required to have experience of psychodynamic observation or consultation within an organisational context, and to be available to participate in up to eight online reflective group meetings

Exclusion Criteria

Individuals who had taken part in the observation as a participant were unable to take part in the reflective group. It was also decided within the time scale and available resources of the project not to apply for ethical approval which would facilitate patients or the public from participating within the reflective group.

Ethical Considerations

The study was accepted onto a Health Research Authority pilot: streamlining research applications where NHS staff are participants. Approval for NHS governance purposes was obtained from the NHS Health Research Authority (HRA) and Health and Care Research Wales (HCRW) (Appendix C). Ethical approval for the project was granted by the University of Essex, via ERAMS. (Appendix D). The British Psychological Society code of human research ethics (Oates et al., 2021) was adhered to throughout the research process.

Informed Consent

Prospective participants were provided with a participant information sheet, specific to either the observation or reflective group. Provision will be made for follow up conversations with prospective participants to answer questions and provide clarification on any aspect of the research. All those approached will be provided with time to consider the details of the research and their role within it. Participants of the observation and reflective group were provided separate covering letters, participant information sheets, and consent forms. The researcher communicated their availability to discuss specific questions arising with each prospective participant.

Observation

Permission to seek consent from staff involved with meetings related to the trusts clinical services integration programme was negotiated initially with members of the executive team, then broadly via the programmes steering committee, and finally by seeking individual consent from professionals taking part in specific forums. The observation was started in a specific forum once all attendees had provided written consent.

Participants were provided with a cover letter (appendix E) , detailed participant information sheet (Appendix F), including a detailed overview of the research purpose, method, procedure, anonymity and confidentiality, potential risks, and right to withdraw, and a blank consent form (appendix G). Participants were asked to return a signed consent form once they had read the participant information sheet, and any questions arising had been satisfactorily addressed.

Consent for the observation was sought over a period of months, with trust staff given ample time to decide whether or not they wished to participate on the basis of information sheets provided, and to raise any questions with the researcher for discussion. Although the researcher offered to meet with staff members on a one to one basis to answer questions, or further clarify any aspect of the study, there were no requests for such a discussion made to the researcher. The decision regarding participation in the study was voluntary, and the information provided emphasised that consent regarding participation may be withdrawn at any time without penalty. Consent was also monitored on an ongoing basis throughout the study. Given the nature of the methodology, the researcher was attuned to feelings within the group and was able to reflect on the possibility of any undue impact of the observation. Through this collective and multistage process, it was not deemed necessary to discontinue the observation at any point. All observation participants returned signed and dated consent forms directly to the researcher, prior to the observation commencing. An electronic copy of the respective consent form, signed and dated by the researcher, was returned to the participant for reference. While a further copy was stored digitally on the University of Essex online servers.

Reflective Group

Prospective participants for the reflective group were provided with a cover letter introducing the research study (Appendix H), detailed participant information sheet (Appendix I), and a consent form (Appendix J). The researcher offered to meet with potential participants on a one to one basis to answer any questions arising.

All supervision group participants provided written consent prior to taking part in the research. An electronic copy of each consent form, signed and dated by the researcher was returned to participants, with a further copy stored digitally on the University of Essex online servers. The decision regarding participation in the study is entirely voluntary. The chief investigator shall emphasise to them that consent regarding study participation may be withdrawn at any time without penalty.

Right to withdraw

The two participant information sheets detailed that entry into the study was entirely voluntary. The right to withdraw at any time was explained in supporting documentation, alongside the practical steps an individual would take to do so.

Anonymity and Confidentiality

Identifiable participant information generated within observation process notes or transcription of the reflective groups was anonymised, redacted, and individuals assigned a pseudonym to protect against inadvertent identification. There were times during the data analysis when research supervisors at the University of Essex read through written process notes from observation and transcripts of supervision groups. These individuals did not have access to identifiable information.

Data Protection

The researcher and academic supervisors complied with the requirements of current data protection regulations, with regard to the collection, storage, processing, and disclosure of personal information and undertook to uphold the core principles of the legislation. Participants identifiable information, including consent forms, group recordings, and verbatim transcripts were password protected and stored on a secure University of Essex sever which was compliant with current data protection regulations. In accordance with the General Data Protection Regulations, there are instances when it could become necessary to break confidentiality. This underlying duty of care was outlined to individuals at the point of consenting to participate.

The researcher was the data custodian and maintained all records and documents regarding the conduct of the study. If the researcher were no longer able to maintain the study records, it was agreed the first academic supervisor would be nominated to take over this responsibility. Access to the information stored was limited to the researcher, research supervisors, and if requested the relevant regulatory authorities. Computer held data including consent forms, link document with participant pseudonyms, observation process notes, digital recordings of the reflective groups, and anonymised transcripts of these recordings were stored securely on the University of Essex online server.

Managing Risks

Observation Participant Welfare

The potential for psychological distress in observation participants was considered, due to anxieties provoked by the act of being observed. Anxiety typically resolves in the initial minutes of an observation; this was outlined in participant information sheets. Provision was made for participants to contact the researcher, or named supervisors to raise

questions or concerns about the conduct of the research. An overall mitigation of risk was that individuals were being observed in the existing capacity of their role as a publically funded professional working within the health service. As such significant scrutiny and evaluation is already a feature of the daily practice of those participating within the observation.

Reflective Group Participant Welfare

The potential for psychological harm arising from contributing within reflective groups was considered. Reflective group members were chosen based on familiarity with the methodology and overarching theoretical framework. Given reflective groups were recorded and subject to qualitative analysis of verbatim transcripts, participants were informed of the possibility and parameters to withdraw from study. Steps to ensure confidentiality and anonymity maintained.

Researcher Welfare

Use of self within the research process has the potential to evoke psychological distress. Adherence to the study's detailed protocol was considered a mitigating factor. Measures open to the researcher in this domain were the capacity to pause or stop the reflective group as required, and to access both informal and formal support of research supervisors, professional support structures, and supervisors as required. The opportunity for routine debriefs with the research supervisor and group facilitator were available throughout the data collection process. One function of the reflective group itself was to offer a containing and supportive space to help facilitate effective observation of the host NHS trust.

Dissemination Plan

With the consent of the host NHS trust, a digital copy of this thesis will be made available via the University of Essex Research Repository following successful completion of the Doctorate in Clinical Psychology. A report summarising the key findings and implications of the research was shared with the host trust, documented in appendix K. Further follow up meetings to disseminate the findings were also offered to the trust. It was envisaged the relationships formed would support ongoing partnership working between local stakeholders invested in developing neurology related services within, and outside the NHS. The scope of data collected is envisaged to meet the requirements for further analyses. This may be of interest to academic book publishers, either as a stand-alone book, or collaboration amongst other authors applying systems psychodynamic thinking to health systems in the UK.

The researcher intends to submit a number of manuscripts for publication within academic journals. The target journals include Journal of Health Services Research and Policy, International Journal of Organizational Analysis, Journal of Organizational Change Management, Psychoanalysis, Culture and Society, and International Journal of Organization Theory and Behaviour. The researcher plans to prepare a poster and/or presentation of findings for consideration at the following conference: International Society for the Psychoanalytic Study of Organizations Annual Conference. Local dissemination in person will focus on within stakeholder forums related to neurology, and interdisciplinary research events at the university. The development of professional networks within and outside the NHS have created opportunities to meaningfully disseminate findings across front-line clinical staff, NHS corporate structures, and wider stakeholders' networks, including the local Healthwatch service. These links will ensure that findings can be conveyed to patients and carers in the local area, for whom the integration of local clinical care is most pertinent.

Chapter four: Results

Chapter Summary

The research findings are presented in relation to the two identified research questions. A reflexive thematic analysis identified four main themes, and 11 sub-themes which are presented in figure 5. Two main themes address what could be learned from in-depth observation of a local programme to integrate neurology services, while the remaining two main themes are considered in relation to the unconscious aspects of integration that could be hypothesised from the data. The potential relevance of findings to the integration of healthcare more broadly are outlined where relevant. For reference all drawings made from observation are provided within appendix L.

Direct quotes within the chapter are indented, written in italics and concluded with a citation. This citation indicates which phase of the research methodology the quote has been taken from. Phase 1a relates to the researchers written observation account, phase 1b relates to the reflective group's discussion of this verbatim account, phase 2a relates to the presentation of drawings (these have not been analysed directly but provided within the appendices), and phase 2b relates to the reflective group's discussion of these drawings. The following notation is used; (participant pseudonym − Observation Number : Phase of methodology). For example (Sophia − Observation 6: Phase 2b), refers to a quote taken from the transcript of the sixth reflective group, which corresponds to material from the six week of observation, spoken by Sophia within the reflective groups discussion of drawings made from association. Tables 5 and 6 provide an overview of where direct quotes have been cited from within the body of qualitative data.

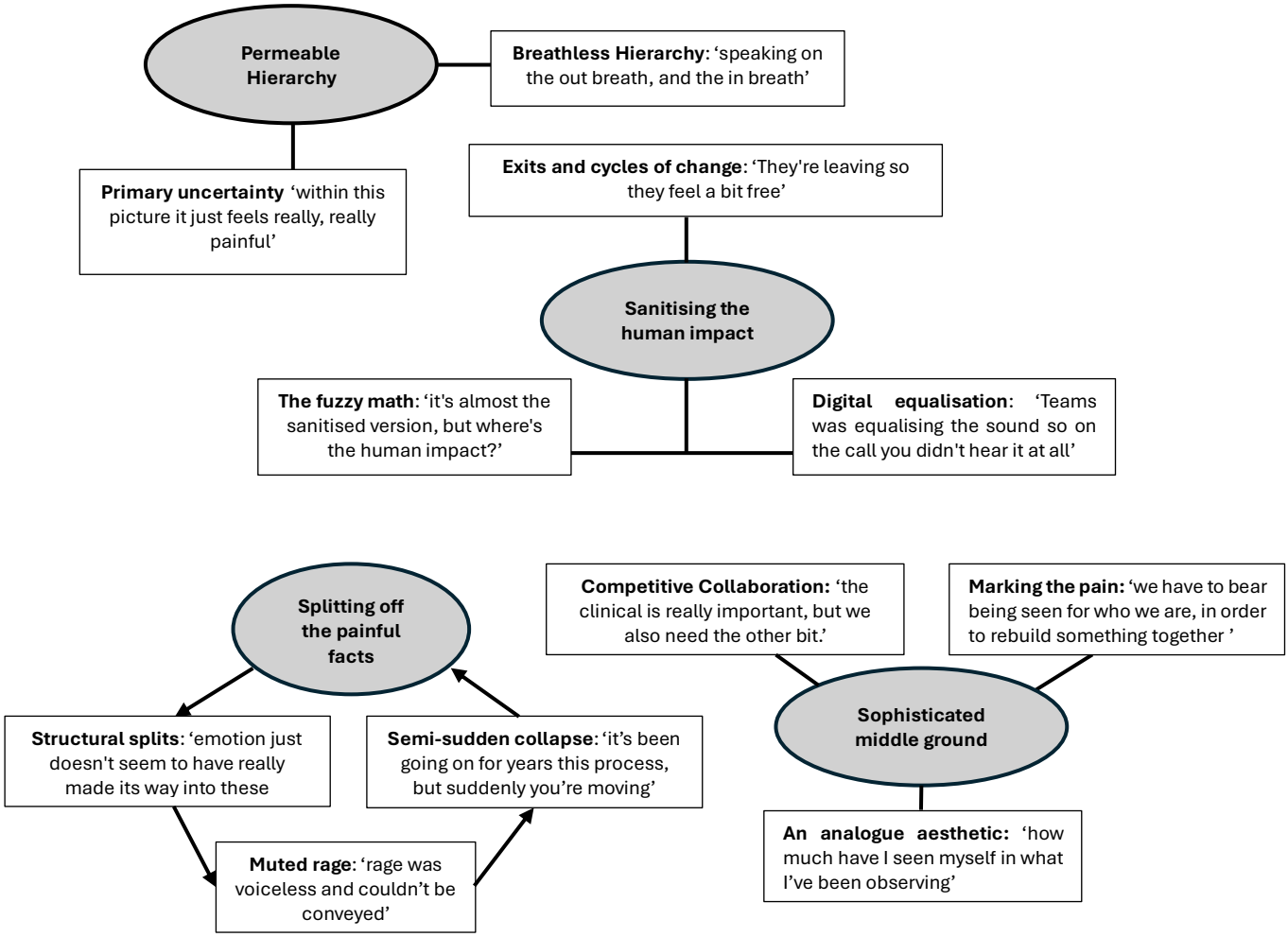
Table 5: Overview of citations from qualitative data within Part One.

	Permeable Hierarchy						**Sanitising the Human Impact**								
	Breathless hierarchy			Primary uncertainty			Exits and cycles of change			The fuzzy math			Digital equalisation		
Stage of method	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2
Entry				*											
Observation 1		*	*		*									*	
Observation 2		*							*						
Observation 3		*			*			**		*					
Observation 4			**						*		**	**			
Observation 5				*	*									*	
Observation 6		*							*			*			

Table 6: Overview of citations from qualitative data within Part Two.

	Splitting off the painful facts									**Sophisticated middle ground**								
	Structural splits			Muted rage			Semi-sudden collapse			Competitive collaboration			Marking the pain			An analogue aesthetic		
Stage of method	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2	1a	1b	2
Entry	*																	
Observation 1		*			*			*										
Observation 2			*	*	*	*						*						
Observation 3		*			**													
Observation 4		*	*															
Observation 5		**							*** ****									
Observation 6															**			**

Figure 5: Thematic Map of Main Themes and Sub-Themes



Part One: What can be learned about post-merger organisational culture from observing the integration of neurology services in an NHS hospital trust?

The reflexive thematic analysis identified two main themes relating to this first research question. These were named 'permeable hierarchy' and 'sanitising the human impact'. A characteristic of the integration programme was an observed uncertainty underlying the appearance of rigid organisational hierarchy. The analysis linked this uncertainty with the defensive management of feeling, including an overt focus on quantifiable data, cyclical patterns of change, exits from the task consistent with professional

role, and the fragmentary impact of digital technologies. A detailed account of each theme is provided below.

Main Theme: Permeable Hierarchy

Overall this main theme captured the presence of conflictual pressures within the observation, including the fast paced certainty of a top down hierarchy, and an underlying uncertainty about how to manage changes to structural and relational boundaries within the organisation. This tension between opposite and polarised aspects of organisational life left the researcher grappling with a sense of ambiguity and anxiety. Although for the researcher these feelings emerged in the context of establishing a temporary role within a changing organisation, the rationale for their relevance to the observed setting is summarised below.

The sub theme ‘breathless hierarchy’ illustrates how top down hierarchies could be perceived in an NHS organisation undergoing transformation. This related to pace and pressure towards progress, which was felt to border on panic within the integration programme. Responsibilities seemed to be passed up or down the systems hierarchy, with actions and progress subjected to multi-layered scrutiny and accountability. The impression of neat structural divides was implicit, portraying a powerful corporate structure which overarched siloed medical specialities.

The capacity for unionised conflict to delay the integration process was apparent through the intrusion of strike action onto the observed setting. This reinforced a conventional power divide. These attempts to disrupt decision making seemed to ostensibly fail. Evidence of a dialectic became apparent, underlying the perception of an immutable hierarchy. For all the certainty structured hierarchy seemed to afford, the researcher repeatedly needed to re-negotiate entry across seemingly well-defined boundaries. This connected the observation material to profound uncertainties in the system. This nuance

contrasted clear structures with a fundamentally permeable system, raising questions whether rigid hierarchy was as a façade for emotional realities underlying integration. The reflective group became interested in the relational pulls apparent in navigating the feelings evoked by change in a hierarchal, but uncertain system.

The sub theme of 'primary uncertainty' captured how in the face of overwhelming anxiety, false certainty could be sought through dyadic relationships. The enactment of arbitrary and opaque boundaries which arise in a face paced hierarchy had the effect of obscuring space for human feeling within a group focused on measuring progress towards agreed tasks and actions. These differing but related dynamics seemed to generate intolerable anxieties within the researcher, which were felt to recreate in part a dynamic present within the organisation, which was undertaking the complicated and unclear task of integrating. In considering the observation as a whole, these polarised states of certainty and uncertainty were an important characterisation of the organisations manifest culture, and foreshadowed how professionals were subsequently observed to manage the emotional responses evoked by engagement with the task of integration by inadvertently splitting off painful feeling states.

Sub-theme one: "imagine your breath rising and falling, speaking on the out breath, and the in breath": Breathless Hierarchy

This illustrates the frantic pace taken up within the observed meetings, in which logging completed tasks and the actions agreed by a hierarchical steering committee were prioritised. Project titles and terms listed in an action log were truncated into acronyms, with fine grain details covered at pace:

> *"It initially was like very breathless at points, like fast-paced … like barely pausing for breath. A lot of like acronyms that were hard to follow"*
>
> (Harry - Observation 1: phase 1a)

Reflective group members connected with a feeling of panic in response to the fast paced and fragmented nature of the observation account in its early stages:

> *"It does evoke a difficult feeling for me though, I think. There's something hard to sit with, something. Ava, you mentioned panic, didn't you? And I think that, feels familiar and resonates with me."* (Sophia - Observation 1: phase 2b)

The researcher articulated a felt pressure to produce meaningful findings, connected to an organisation in the midst of the pressure to deliver successful change. This resonated with the prospect of documents written by clinicians being negatively scrutinised in a corporate context, evoking the prospect of top-down evaluation .

> *"the text of the kind of tendering document produced was, like, really verbose … 'we have a tendency as professionals to be to be too verbose and use too many words, but they're not needed'. The association I had was this kind of, I had to write a document that was trying to sell the observation to members of this programme, and I ended up being really verbose and not kind of getting across, really in a way I was happy with. Like what, what it was about."*
>
> (Harry – Observation 2: Phase 1a)

The pace and pressure to deliver results were associated with set lines of authority and the prominence of economic principles. This was concretely apparent in the executive's decision to retender the trusts remaining inhouse soft facilities management staff:

> *"…there's an opportunity for the board to like do one thing across the trust. So, these soft facilities management people at* [redacted] *are going to go out to a kind of private provider … There's a lot about losing their status as NHS employees"*
>
> (Harry – Observation 3: Phase1a)

The rights of unionisation were seemingly held in high regard by the board, and considerable efforts were made by corporate staff to step in and fill gaps during the resultant strikes by facilities staff. This evoked positivity in the reflective group's membership, who considered the possibility of democratising decisions. However, the resultant disruption to the integration programme meant the reflective group perceived conventional top-down hierarchy to prevailed:

> *"Do they know that their absence has had more of an impact? I think there's something about that, that's kind of cut off in a way. Let's just get an external contractor in. It's just the irony of that".* (Isabella – Observation 4: Phase 2b)

One member also articulated an initial prospect for greater understanding of 'how the other half live', as having reverted to hopelessness:

> *"the hope for me then was like, see what it feels like to kind of be on the other side. It was almost like hopefully by then there will be more appreciation. But the reality is they're still going to be outsourced. And the people who are striking are nuisance. I feel a bit hopeless"* (Ava – Observation 4: Phase 2b)

Over time the reflective group became interested in the impenetrability and apparent difficulty in making sense of the content manifestly observed. There was a curiosity whether the legitimate and mundanely necessary focus on practical detail and completed actions might inadvertently obscure the mess and emotionality of the work:

> *"But I think that is an interesting observation, isn't it? Like paciness, detail. All of those things. What are they? You know, they can seem very, very reasonable on the surface. You know, time pressures. We need to have all of these kind of erm.*

> *Spreadsheets and logs and what have you, but yet, you know, what are they defending against? What is the, the, messiness? As, as Isabella says, of the work or the emotions of the work"* (Sophia – Observation 6: Phase 1b)

Sub-theme two: "the hope might be that [boundary] provides, structure, clarity, emotional safeness, connection, whatever. But yet within this picture it just feels really, really painful": Primary uncertainty

The process of obtaining ethical approval for the research, and negotiating access to the integration programme took a considerable period of time. The prospect of not being able to gather data created a pull towards making use of relational capital to negotiate access to a professional forum relevant to the integration. Receptivity to observation within the organisation contradicted the researcher stereotypes about a rigid and inaccessible top-down hierarchy. While it was possible to approach and speak directly with senior members of the trust's executive and non-executive team, whose support did help access to an existing programme of work. Contrastingly, requests to observe aspects of integration closer to direct patient care did not gain traction:

> *"I was put in touch with [redacted] who has worked closely with me through the ethics process and on negotiating access to groups. We have talked about a shared background in the third sector, and the relationship has been warm and very accommodating … I have wondered about my dual role as clinician and researcher, and whether it has suited the management of the organisation as well as me, to lean on this clinical identity."* (Negotiating Entry : Phase 1a)

The trust was a large and complex organisation, the intricacies of which were not immediately apparent to the researcher. In the face of feelings of overwhelm, it was only

possible to generate progress through dyadic relationships. This had been established on the basis of an existing, and jointly held clinical role. This created a relational pattern which required the researcher to attend to the boundaries of clinical, and research role within the organisation. It raised curiosity in the wider reflective group about permeability underlying what had initially appeared to be a rigid hierarchy. Where on one level it had only been possible to think of professionals in terms of a rigid clinical or corporate identity, over time it the more complicated reality that many individuals in the past or present held multiple identities could be appreciated. This pragmatic pull to lean on specific relationships in order to enter a complex system, and the overlapping nature of singular professional identities reverberated through the observation:

> *"He'll message me directly on the chat, so it seems to be a quite ... a normal practise to be kind of messaging as you go along, but he'll send me team's messages like he often comes in late from other calls about a different specialty or kind of related piece of work. But then like will be saying like, is anything interesting come up like? So, I find myself having to respond."* (Harry - Observation 1: Phase 1a)

Curiosity about a need to attend to the boundaries of the research role, was triangulated to indistinct time boundaries. Scheduled times for different medical specialties to join the catch up call varied considerably week to week, according to wider organisational pressures. This produced uncertainty in the researcher, and a felt imperative to re-negotiate access each week by initiating direct communication, ostensibly to avoid encroaching on the discussions of medical disciplines outside neurology. The reflective group took this up as a curiosity about whether anxieties were evoked by difficulties defining the group's membership, time boundaries, and primary purpose as part of a complex and unknown wider system:

> *"It feels difficult each week. You know, it's the bit where I'm like, when should I join? It's not like clockwork that it starts at a certain time and it it moves around, the order moves around. [It] feels really hard to stay in touch with … my messaging is often like take my anxiety. I can't take my feelings about this. I can't hold them and it like, maybe it gives it to them"* (Harry - Observation 3: Phase 1b)

The ethical decision to obtain individual consent from programme participants also highlighted uncertainties about how boundaries were negotiated within a complex system. Focusing the research on Neurology provided clarity to the research, mirroring distinct boundaries between specialities akin to the clinical practice of medicine. However, the relative safety of these defined boundaries took the form of arbitrary splits when viewed from higher levels of the organisation. This was located in perspectives on consent held by the corporate transformation team. Working across the organisation as a whole seemed to translate into greater openness to negotiate consent in a more pragmatic and fluid way:

> *"… made me think about the distinctions between medical specialties, and my own need to define the focus of the project [based on] the limits of my resources and capacity"* (Harry – Observation 5: Phase 1a)

Introducing a question of consent into the ongoing task of integration opened up the nature of merger within a large and multifactorial organisation. Informally staff group were willing to participate, but reticent to provide formal consent. The invitation to consent seemed to contrast the historical system wide directive to merge and integrate separate organisations. The researchers repeating difficulties in negotiating diffuse boundaries across the observation were condensed by the reflective group into a question about anxieties in a system engaged in changing its underlying structures:

> *"I do think boundaries are really challenging, like entry, boundary of access like how do I enter the meeting? How do I access the meeting you know really, really interested in the invitation for you to break your research boundaries in this observation, which is like oh just stay, you know presumably people know that the remit of your kind of research."* (Sophia – Observation 5: Phase 1b)

Main theme: Sanitising the human impact

The conflicts and anxiety relating to hierarchy and uncertainty which have been set out above linked to how these feelings appeared to be overtly managed within the observed setting. The dynamics of how professionals may have been impacted are set out in this second main theme of 'sanitising the human impact'.

The contradiction of uncertain permeable boundaries within a rigid hierarchy seemed to create an imperative for concrete ways in which professionals could legitimately exit the task of integration. This is captured by the sub theme 'exits and cycles of change', and included partial avoidance through temporary periods of leave, or moving to other projects within the trust. Some professionals were observed to be freed from the pressures and anxieties of change by working towards leaving their professional role within the organisation. A key characteristic of this sub theme was how the authority afforded to different professional roles was mobilised, in order to create legitimate exits or absences from the pressures of integration. A dividing line between clinical and corporate staff became apparent. Although the reflective group could conceptualise the pressures on these two groups as both being considerable, there was a tendency for their representation to become split or oppositional.

This overt pattern of exit and absence was also linked to more nuanced ways in which feeling was inadvertently managed within the observed group. A practical focus on managing data and progress towards externally agreed actions was the primary purpose of the group. However the associations and reflections to the observed material highlighted unconventional ways in which such a focus could be considered to partition off the human impact of change. The sub theme 'the fuzzy math' captures how quantification both created distance from the practical reality of structural change for both clinicians and patients, while also uncovering profound differences and inequity between geographical areas. There was also observed evidence that the financial resources to meaningfully address these gaps were unavailable.

The pragmatic leveraging of a digital meeting space illustrated how the varied realities of human feeling associated with professional's home life could be simultaneously evoked by, and digitally equalised from the work of the weekly catch up. These findings are captured in the subtheme 'digital equalisation', which illustrates a link in the findings between what is practically observable in the context of an online meeting, and the surrounding realities whether external and practical, or reactions and feelings internal to individual which the wider group are not immediately aware.

The practically orientated sub themes within 'sanitising the human impact' provide a bridge to later main themes, which capture hypotheses generated about the unconscious aspects of the integration programme. These centre on the disavowal of intolerable feelings, and how these unconscious states within the organisation may both assert influence, and be effectively worked with.

Sub-theme one: "They're leaving so they feel a bit free … they know the exit point": Exits and cycles of change.

Temporary and permanent exits from the task of integration were a way anxieties about the underlying reality of the work appeared to be regulated. This first became apparent in the researcher's preoccupation with negotiating an ending to the observation, at a point in the research when through the process of reflection and association, disavowed feelings had erupted into the observer's awareness:

> *"SOPHIA: where's your emotions at right now? I don't know. It just feels. Important to us. … HARRY: Yeah, thinking about ending, really. And that's in my mind. SOPHIA: So that's kind of interesting in a way. So, because right now we're in this space, which was sort of four weeks ago or something in terms of the observation, but you're connecting with, you know the ending and the moving forward"* (Observation 3: Phase 1b)

This pattern of exiting the intensities of the task was repeated in the corporate transformation team's ability to work towards a categorical time boundary. As a function of working into and across specialised front line services, this team were able to hold in mind a point at which their work would be handed back to clinical colleagues. This was emphasised towards the end of the observation by a communication outlining the pressure and secrecy of the transformation teams next important project to be taken forward. This exit from shared responsibility would be enacted regardless of progress towards the end points originally envisaged:

> *"there's talk of like this transformation process being handed back. Sort of before it's finished or, or like. The transformation team, feeling it's not quite, not going to be where they envisaged it, but it'll be for the frontline teams to take it forward."* (Harry – Observation 3: Phase 1b)

The concept of exits was also identified across a number of observational drawings:

"I've had this with a couple of your drawings, Harry. My association when I saw that or the way I interpreted that was it was again an exit, you know, it was a way out of something. So, I've had that few times, be it like Windows or whatever. But like an exit out of. A doorway, rather than a cupboard."

(Sophia - Observation 4: Phase 2b)

This transferring of responsibility for the task was thought about by the reflective group in the context of open ended clinical work facing front line professionals. Alongside the fact that transformation might have been a repeating experience for professionals whose employment in the trust extended beyond recent political cycles:

"I really resonate with the idea of like, there's a kind of perfect point of being integrated. But actually in 5-10 year's time you get a new government that want to do something different, and you never arrive" (Harry - Observation 2: Phase 2b)

A stark dilemma seemed to face clinical staff, who were unable to the access the same hard endings open to the transformation team. Curiosity came to centre on how the absence in reality of a true end point might influence how the integration programme functioned. The observation occurred during the 2024 Olympics, with parallels drawn to the cyclical and politicised nature of NHS transformation. This association seemed to highlight a practical, but possibly idealised focus on achieving integration. This however appeared arbitrary in the context of the unfinishable task of clinical care, and the cyclical reorganisations:

"it's sort of arbitrary, sort of man-made idea, isn't it, that every four years you've got this huge thing to build towards? It does like structure, effort and you measure effort

towards that. There is something kind of cyclical about it. It's not just always on … I'm thinking, that the [redacted] who's leaving, who's, who has seemed very engaged with this transformation process, but is it? Is it possible because there's an out"

(Harry – Observation 6: Phase 1b)

It was apparent professionals more connected to front line care resorted to the authority of their individual role. There were multiple instances of leave being booked to coincide with scrutiny at the overarching programme board. While the concrete prospect of leaving the organisation imposed a boundary which seemed to enable warm and personable engagement with the task to continue.

Sub-theme two: "Presenting things in data and bar charts, it's almost the sanitised version, but where's the human kind of impact?": The Fuzzy Math

The weekly catch-up meeting tended towards quantifying progress and identifying shortcomings. This focus on fine grain detail covered at pace was perceived by the reflective group to mute the emotional reality underlying integration. For example, the impact of under-performance at one hospital on key marginalised patient groups, and what enforced changes to the structure of the organisation would mean in practice for professionals. Money and its scarcity were also exposed as fundamentally dictating the limits of care. While this reality could be managed by individuals and teams through concrete exits and absences, a quantitative focus on the subtleties of data and targets appeared to be taken up as a structural defence against feeling. The group repeatedly considered the mitigation of risks arising in the data, quantified through metrics on key performance indicators. The spectre of breaching contractual obligations on neurology waiting times was particularly attended to, with

considerable work being undertaken outside the meeting to scrutinise waiting lists, in order for any inaccurate reporting to be amended:

> *"a lot of this meeting was about how do we mitigate the risk of breaching … doing a lot of work that isn't the work. It kind of becomes the work. But it is like running through two different waiting lists and checking that we're not double counting people and someone's spending hours doing that"* (Harry – Observation 4: Phase 1b)

These administrative efforts to mitigate risk evoked a degree of cynicism in the reflective group's associations:

> *"My mind went to the Bush era in America and this idea of the fuzzy math, because you could just present the data as you want"* (Isabella - Observation 4: Phase 2b)

The pressure to focus on presenting figures evoked scepticism about who this task served, but scrutiny of the data did evidence important gaps in neurology services. However, in the absence of additional money being available, the solution pursued was to apply for charitable funds. This attempt to pay for clinical roles with charitable funds alongside the use of humour to address difficulties with arithmetic brought up a level of criticism and judgement about the capacities of those in charge. This mirrored direct comments to the researcher in the setting, which illustrated persecutory feelings, and the need to diminish one's own capacities in order to inhabit the space:

> *"I was addressed directly by the facilitator when he had "tied myself in knots" about the funding split and proposed length of fixed term contract. "This is off the record". "Don't put this in your report Harry" … "It's this kind of soft qualitative evidence the NHS needs". I felt a need to respond verbally, "I think you're over-estimating my maths".* (Harry – Observation 3: Phase 1a)

Despite the reflective group's criticisms, understanding for the inherent difficulty and pragmatism required by the task was also evident:

> *"It's almost like people are just trying to find some way to kind of, maybe not so much subversively, but just trying to work within really limited [resources] … maybe the work is people just trying to find maybe inventive or slightly just different ways of trying to fix this problem"* (Ethan – Observation 6: Phase 2b)

The gaps identified in services were not uniform across the trust's geography. Performance data illustrated profound differences highlighted between the Neurology departments attached to the separate hospital sites. As a function of the integration programme a decision was taken to move towards a single management structure, where the strongest neurology department would take a lead across the two sites. One professional described this step as coming to represent "totemic change" for the integration of neurology services. A consequence of merging the departments in this way was to produce a mathematical average of key performance indicators. This appeared to mean legal and contractual risks identified in one department would be equalised, while the high performing numbers apparent at the other would be blunted:

> *"They talked about a movement to a single management structure across the two sites. How like having the effect of averaging? A good and a poor number. So, like the one hospital site, [redacted] … no risks around their waiting times and things. And then really long waiting times in [redacted]. If you bring them together, you get a kind of mathematically an average, but also like a kind of middling wait time number."* (Harry – Observation 4: Phase 1b)

Consideration of the two departments on the basis of risks in the data prompted the researcher to produce an image based on the concept of bearish and bullish financial markets. Associations were made in the reflective group to the process of merger and integration within the trust:

> *"Where my mind went was the sense of like integration, but the integration of the animals has been together, but they're not a whole animal, you know, so these two animals are, still their original selves, kind of stuck together almost rather than like 2 animals coming together to be a different being…we can kind of stick things together, but they're not, they're not a whole being. They're two beings stuck together. And then how does that function?"* (Sophia – Observation 4: Phase 2b)

One reflective group member took up this capacity for data to mask the underlying realities of decision making as a violent and forceful act:

> *"something quite violent but, almost in the guise of something quite neat and data … … forcing something to come together. Without necessarily thinking about what, what that would be like"* (Isabella – Observation 4: Phase 2b)

Sub-theme three: 'Teams was equalising the sound so on the call you didn't hear it at all': Digital equalisation

It was the case that the majority of meetings within the CSIP were conducted online. This created opportunities and risks, particularly regarding the emotional dynamic at play. Online meetings removed geographical barriers to the work, but automated technologies unintentionally equalised the emotional valence present within the task. This effect of digital technology being mobilised contradicted the intention of improving social connections during the COVID19 pandemic. However, the transposition of online meetings to the task of

integration seemed to have created a sense of disconnection and separateness, emphasising the consequence of merger having created a now geographically larger trust:

> *"Sometimes you can kind of come in and out of the meeting. You can choose what to share. erm. And then you're out. And like Ethan said, you don't have to connect with the care, the people, the patients."* (Ava – Observation 5: Phase 1b)

The reflective group was also curious about the digital environment's propensity towards hegemony, equalising environmental differences which greater home working was simultaneously accentuating:

> *"Something about space and shared space and you mentioned I think last week about your space and where you are doing the work. At home with two small children and you know all of the environmental noise and goings on, that's kind of just a door away. And then you mentioned the woman on the call with the dog, and she was experiencing this kind of noisy, whatever was going on for this dog. And she was sort of sharing this is my moment. And yet that moment couldn't be heard because teams drowns it out or whatever it does to stop the noise coming in. And yet so she's sort of communicating. This is my current situation. But that's not being shared. You know, that's not been experienced by all. And then the sort of feedback is, oh, well, don't worry about it because we're not experiencing it. So, we can get on with our meeting. Yet she's experiencing it. And it just made me think about this work. Taking place remotely. The group doesn't have a shared space to do the work in"*
> (Sophia – Observation 1: Phase 1b)

Part Two: What does a psychodynamic method of observation allow to be hypothesised about the unconscious aspects of integrating NHS hospital services?

The practice of exiting the task of integration, a focus on the intricacies of reporting data, and the subversive effect of technology on human feeling captured by 'sanitising the human impact', were considered intermediary and transitional phenomena. They linked apparently clear organisational hierarchy, observational material that illustrated uncertain boundaries, to the hypotheses developed below that attempted to articulate what might be occurring below the level of conscious awareness. Consequently, hypotheses about the potential for unconscious feelings to be split off within the integration programme could be identified in observational data. The main themes of 'splitting off the painful facts', and 'sophisticated middle ground' capture conflictual pressures hypothesised between the task of care in clinical neurology services, and the realities of its organisational and bureaucratic oversight. The paradoxical conflict of balancing these tasks, identified through observation and association is set out, alongside potential ways forward of holding together the painful task of care, with the impossible breadth of corporate oversight.

Finally, the analysis highlighted how the integration of emotional content within the task of integration might be achieved, captured in the main theme ' sophisticated middle ground'. Particularly how subjectivity within the limits of a robust reflective group may offer new ways of thinking about the task of integrating NHS hospital services.

Main theme: Splitting off the painful facts

Abductive enquiry allowed this hypothesis of split off feeling to be developed, to include the nature of 'muted rage', and its potential consequences for the integration routine monitoring of tasks, and how these experiences might be repressed, before re-emerging semi-suddenly into awareness.

The progression of feeling in the observed setting was identified with a cyclical pattern, captured in the main theme ‘splitting off the painful facts’. This main theme describes what could be hypothesised about the nature of structural splits between feeling and practical tasks in the observed setting, given the propensity for aversive feelings to be avoided on a practical level as set out in ‘sanitising the human impact’, this main theme develops this further, hypothesising first the conscious inaccessibility of feeling despite attempts to access it,

The reflective group experienced difficulty connecting with feeling in the researchers written observation accounts. This is explored in relation to the researcher’s internal world, and linked to the unforeseen implications of the observed setting being hosted online, and the resonances with familial losses the researcher experienced. The process of distinguishing this as an internal pattern in the researcher, and the possibility of this pattern being present in the observed setting is considered. The continued presence of this dynamic over time despite the reflective groups capacity to recapture feeling through discussions was considered to emphasise the possibility of this dynamic existing in the observed setting.

A sequential progression to identify ‘suppressed rage’ was made in the data, describing from multiple angles an experience of holding intense feeling internally without expression. The process of identifying this sub theme specifically focused on unconscious contents was marked triangulation throughout the data. Including direct observations, the synchronicity of associations made in the reflective group, and with regard for the overall chronology of content and events within the observation as it unfolded. This inexpressible feeling is finally linked through the sub theme ‘semi-sudden collapse’, to conceivable consequences for the organisation, both internally in relation to the integration of previously separate departments, and in the management of boundaries with the trust’s external stakeholders.

Sub-theme one: "the emotion just doesn't seem to have really made its way into these meetings" : Structural splits

Within the observational material, resonances to familial roles and personal experiences of loss were prominent. These had been evoked initially by the online setting of the integration programme, with working at home increasing physical proximity to these aspects of self. The emotionality and conflicts associated with these experiences had needed to be shut out during the observation in order to engage with the task, but could then be thought about in the context of a reflective group:

> *"This also implicates where I work at home, and the physical surroundings of the room I join meetings from. I had to move the desk into the bedroom after our son was born at the start of the year, and I drew the bedroom door locked shut – I would otherwise have the family walking in on calls, and a feature of working in this space is hearing all kinds of emotions going on from a different part of my life.…*
> *The picture on the wall is an initial impression by an artist, for a stained glass window my dad commissioned for his local church, on the centenary on WWI. It depicts a solider in no-man's land. My dad passed away in November last year, and there has been a lot of feeling to keep at bay while the pace of the work has continued unabated."* (Negotiating Entry: Phase 1a)

The reflective group found it hard to connect with the emotionality of written observational accounts from the integration programme. This dynamic was able to be thought about at an early stage by the reflective group, and could be held in mind as the observation progressed:

> *"Every time you talk, every time there's a presentation, I lose all feelings, and I don't know what happens to my feelings. I just feel. Yeah. I just feel really empty and blank.*

And then they seem to be recovered when the group talks." (Ava – Observation 3: Phase 1b)

A link was made between the reflective group feeling split off from their emotional world, and the evaluative connotations of needing to present positive results to a hierarchical system. What resulted was a pressure towards finding concrete answers, such an enactment in the reflective group was grasped at an early stage in the research:

"I found myself, Ava, after you'd spoken about that sadness. You know, you shared your sadness and like that had been quite prevalent throughout most of Harry's sharing of the account. And then I noticed myself wanting to, like, check it like, is that still there? ... how do we connect, you know, how do we form a group when we're working. In quite disparate ways, when we're not together. And does that rush? Does that mean that we rush towards a finding of something, a kind of, you know, like the concrete." (Sophia - Observation 1: Phase 1b)

Over time this was triangulated back to the integration programme. The task of integrating neurology services was increasingly characterised from the reflective groups perspective as focussed on reporting quantitative data, at the expense of connecting with the emotional reality of clinicians, and importantly patients:

"that's now the task, isn't it? Completing the action log. That probably feels much more definable, isn't it? If we put something in this column, if we filled in that box, you can imagine that fills. Maybe for that that gap to fill up that we've done something today we kind of ticked off the next thing. Yet it all just feels it was even more of removed from the people like the patients" (Ethan – Observation 5: Phase 1b)

It was the experience of the reflective group that access to feeling could be recovered by talking together, and building on each other's free associations collaboratively. When the dynamic of splitting off from feelings persisted in the observation material, despite growing awareness in the observer and reflective group, the significance of this pattern for the observed setting was increasingly thought about. There was a propensity to build towards a rational understanding of the programmes task, which would invariably collapse and remain elusive. This was felt to highlight how a focus on numbers and statistics inadvertently sidelined awareness of the people involved, and indeed emotionality more generally:

> *"I felt like I had far more clarity. I was like, OK, I'm kind of getting this a little bit and then I've totally lost it. I like completely. I just shifted and I was like, no, I've got no idea. Like I don't know who the membership is anymore. I don't know what the task is. And it was when you started to talk about the merger bit and I wrote here like, I can't keep my attention. And I was working really hard. Yet, I couldn't. And it just went again. And. And then I was drawn to how this meeting felt really fact heavy, which I think you know. Isabella, you mentioned specifically. And I was like, where's the emotion? Like, where are the people actually? So, I'd lost the people completely today. Like, where are the people, where's the emotion?"* (Sophia – Observation 4: Phase 1b)

The further from the integration programme that the reflective groups curiosity started to rest, this pattern was accentuated. For example, the experience of clinical professionals appeared remote, while the painful realities for neurology patients were at times completely obscured from awareness. The dynamic of inequalities underlying the work to integrate neurology services, amid pervasive limits on funding, appeared underacknowledged in the meetings that were observed week on week:

> *"coastal communities, is a big part of the process. They're trying to go through. So, there's these like historically very neglected communities, underfunded, really poor health outcomes. And there's a worry about bringing some of the services kind of back from out of area like specialist services, bringing them back. By kind of opening the floodgates to that unmet need. That funding is fixed for the kind of years to come, so Commissioners are really nervous about. It'll have consequences, you know, like, it's the right thing to do. Perhaps, but. What's that actually gonna mean organizationally, if suddenly? You need to be providing X amount more with the same amount of money."* (Harry - Observation 2: Phase 2b)

The ambiguity regarding the affective tone of patient and professional experiences was contrasted by responses evoked in the reflective group to drawings and associations from the material. An image drawn in a freely associative state evoked curiosity about whether attempts to contain overwhelming feeling were failing, with emotion permeating the narrative being written about the task. An impetus to impose boundaries around feeling was thought of as a defensive act, rather than the functions of boundaries which might enable productive work on the task:

> *"when you presented the written narrative, I was really interested in like boundaries. So I thought about boundaries in relation to time and then we referenced boundaries in relation to like the portions of the meeting that people have, and you've talked about boundaries in relation to how to join and those sorts of things. And then in this in this picture, I'm like looking at like these kind of faces have been held in like. A boundary held in something, yet That, you know the tears are kind of coming out of that … A containing of something that can't quite be contained. erm. if you think about a boundary as being a way of containing, I don't know, whatever, an emotional*

experience or a group, whatever, then the hope might be that that provides. Structure, clarity, emotional safeness, connection, whatever. But yet within this picture it just feels really, really painful" (Sophia - Observation 4: Phase 2b)

These insights led the reflective group to consider whether the clinical task of neurology was influencing how the work of integration was being taken up. The group hypothesised from their own clinical experiences and interests whether the task of neurology privileged diagnosis and quantification of illness, when faced with caring for patients with life long, degenerative conditions:

"I really connected with that, like a real sense of pain, of that, you know, the real pain of, of the work. And it made me think about how. The emotion just doesn't seem to have really made its way into these meetings. erm. And, It made me think about the task of the work, not the task of transformation, but the task of the work. And how that's managed actually more widely. You know how the pain of that is? Is coped with, is made bearable, is defended against, you know, and then how much of that actually gets into this kind of work as well." (Sophia - Observation 5: Phase 2b)

Sub-theme two: 'What felt like rage was voiceless and couldn't be conveyed' : Muted Rage

At the start of the observation reference was made to an in person engagement event involving all neurology staff. Significant efforts were made to prepare for this meeting, at which the decision to form a single management structure across the neurology departments would be communicated. The perception of positive feedback from this event was emphasised earnestly, and directly to the researcher in the aftermath:

"So they'll be like an [redacted] neurology service, whereas currently there's erm.

> *Neurology in [redacted] and Neurology in [redacted], and that's persisted as a structure from before the merger. So they're going to have an engagement event where basically all the frontline staff are invited to a presentation to explain about those steps. And another person from the transformation team was kind of called in. Felt like, a kind of weighty presentation, or that this was like an important meeting that was a bit of like. It's important this goes well. the other person was called in to talk about this slide deck and he was presenting that."* (Harry – Observation 1: Phase 1b)

As the engagement event was debriefed and picked over in subsequent weekly calls, there were indications tensions lay beneath the surface. Where it had been planned for a clinical leader to help communicate the planned restructuring to the large group they had failed to speak, forcing the transformation team to assume public ownership of the decision. There were also significant delays in responding to informal questions raised by clinical staff at the event, and this was repeatedly thought to be risking the initial positive engagement of clinical colleagues. This was subsequently linked in the observation account to an acknowledgement that neurology staff would actually need to undergo a formal consultation process by human resources:

> *"it was a recommendation from HR that the planned changes require a period of consultation … It was best in the long run in case anyone were to raise a grievance down the line."* (Harry – Observation 3: Phase 1a)

A stark association with anger and rage emerged in connection to this engagement event, initially pervading the procedural process of the reflective group. The second reflective group had needed to be postponed, meaning the material relating to the engagement event was considered after a delay. This related to extenuating circumstances of a group member,

which were subsequently shared in association to the inaccessibility of emotion in the observation account:

> *"I still can't connect with the emotion as you're talking. I just don't get it. But what I did get though, as you were talking, was an association, a really strong memory back to last Monday. This time last Monday when I was trying to negotiate these big systems. It was all automated. It was all through an instant messaging, chat thing. So I was asking this person, please can I speak with you because my connection was timing out… And this person on the other end was saying I'm really sorry I can't call, you can't call us. We've got to do it this way. And I remember at the time I was kind of simultaneously looking at my bank account, seeing these withdrawals just coming out like one after another after another, trying to speak with Sony. But it was all through this instant messenger and the feelings that I had at that time were I felt totally powerless. I felt like there was nothing that I could really do and real rage of like, you know, how dare this person, like, I'm just watching like, my money just kind of go out of my account and I can't access anybody."* (Sophia – Observation 2: Phase 1b)

The researcher's separate resonance with rage was articulated independently in their written account of the same week. Flexibility in the weekly catch-up's time boundaries meant the meeting had significantly over-run from its planned timings, encroaching on a separate clinical commitment of the researcher:

> *"I desperately tried to push down rising turmoil about the meeting rolling into another commitment. A need to split these feelings off. What felt like rage – was voiceless and couldn't be conveyed."* (Harry – Observation 2: Phase 1a)

In combination with a delay in accessing the containing function of the reflective group, the researcher had experienced a pressure to move on from feelings which had erupted into awareness:

> *"I just couldn't get away. I was just screaming inside. So that week and then this one felt like the feeling was most at the surface like a bit all over the place. So I'm, I'm maybe I'm sort of feeling glad that's done. Move on. Do something else."*
>
> (Harry – Observation 3: Phase 1b)

A link was drawn to the more overt ways in which the pain of the task seemed to be avoided, was there was an overwhelming pressure to cut off feelings of rage within the integration programme. The emergence of this intense feeling through intersecting associations of the reflective group was hypothesised to describe a muted quality to aggressive feeling the further removed one was located in the systems hierarchy:

> *"I was thinking are people flying away from the task. So there's something around, yeah. So there might be kind of the fight and the aggression, but it almost as if the aggression is like muted somehow. Whether that is by actually kind of the mic being off or people not waiting for their turn or certain members not being able to be observed because they haven't consented, there's something around opportunities to move away from the task at hand. …I found myself, as you were talking, Harry, still thinking about who are the people that this particular team is trying to serve. So I couldn't. Yeah. So I found myself in my mind, just wandering off and thinking, yeah, who are the people and the rage? Who's this on behalf of?"*
>
> (Ava – Observation 2: Phase 2b)

Sub-theme three: 'For integration of any type a wall has to come down and we have to bear being seen': Semi-sudden collapse.

The pace of change was hard to gauge for individuals involved with the integration programme. Movement to a single management structure had in the early stages of negotiating access appeared a distant hope. However, once the observation began this change had emerged quickly as a concrete next step for the trust. The observer's impression of moving quickly towards structural changes was contrasted with the expressed experience within the programme of stagnation and protracted delays:

> *"as I've been negotiating access, some of these, the idea of one service managing the whole of [redacted]. So the management, rather than it being split between two sites, that felt like a bit of a pipe dream, as I was setting the research up. But it's sort of like happening now, and I kind of shared. Kind of encouraging, what I thought was encouragingly, like a supportive thing, like it seems like progress is happening, but that doesn't... I think they feel like it's quite stagnated at times, slow going, hard work."* (Harry – Observation 1: Phase 1b)

As the observation came towards a conclusion, the observer experienced difficulties staying in contact with the content of weekly meetings. This was thought about under the imperative towards exits from the task, however a synchronous event which intruded into the process of writing up an observation served as a way to think creatively about the task of integration:

> *"my personal phone pinged was like a WhatsApp for the road. I'm on, someone's garden had like a wall running down the side which had collapsed inexplicably on to their garden. It was like real sadness around, just really decimated, like years' worth of work to like build their garden. But it was all like the different members on the*

street coming together to help and. I think maybe linked, was like I just had found that meeting hard to take in and I when I came to draw, I was like, I don't really know what I would draw about this." (Harry – Observation 5: Phase 2b)

This metaphor of sudden collapse was related to the experience of integrating neurology services within the trust. The merger had been completed legally prior to the COVID19 pandemic, which had subsequently delayed the integration of clinical services. The move towards a single management structure had a history as old as the organisation, yet appeared to be experienced as a sudden overwhelming loss of identity:

"the division between the two hospitals is being taken out. Semi, semi suddenly, like it's been ongoing for years this process, but it's like suddenly you're moving … you kind of build around that boundary, to an extent in your identity." (Harry - Observation 5: Phase 2b)

The image of collapsed boundaries drew associations from the reflective group which linked the nature of leadership, communication and hierarchy across broader transformation in the NHS:

"it feels to me like knowledge is kind of really held and known, in one place, often in that kind of more leadership place where you know lots of kind of work is happening from. A, erm, you know spreadsheets and action logs and the kind of things we've talked about in our meetings. And then, but you kind of won't go and speak to the team's kind of doing, doing the day job, and, and ask them about their knowledge of transformation. You know, what's the vision, where are we up to? And often people don't really know is my experience myself included, erm on occasion and then and

then one day it all changes like seemingly, you know, the walls fall down. The service changes and it's almost like it's come out of nowhere."

(Sophia – Observation 5: Phase 2b)

When taken together with the association of rage to significant structural changes, the image of a collapsed boundary further characterised these hypothesised aspects of the unconscious. One thought that was shared highlighted how exposing it could feel to suddenly lose a sense of containment, and how this might evoke difficult feelings for the observer and observed. Associations to a collapsed wall also illustrated emotional difficulties in bearing the painful feelings of exposure in oneself and others. This might illustrate how to professionals avoid explicit awareness of impending change:

"one thing that struck me was with this wall coming down. You could then see completely into this person's garden. And it was a very, very beautiful or is a very, very beautiful garden, I'd kind of never seen. Never seen into it before, of course, because the wall was there. But you know, just lovely. And so I kind of stopped, just appreciated it, but then thought, oh gosh, felt a bit guilty because I was like, actually, no, that's somebody's like, private space. ... there's sadness and loss and pain and everything. And now I'm appreciating this tree. I'm appreciating this flower or shrub, or whatever it is that you've drawn. And then I thought, oh, you know, is there something in that. For integration of any type a wall has to come down and we have to bear being seen."

(Sophia – Observation 5: Phase 2b)

This was thought about in relation to the functions a boundary wall may serve, delineating the limits of a space, and protecting from external intrusions. The collapse evoked

an emotive response from the local community, with a lot of energy directed towards rebuilding the wall quickly. In practical terms this hadn't happened, and there was curiosity about difficult feelings which had surfaced in the midst of practical offers of help. The emotional pain of a neighbour losing much of a garden invested in over many years appeared difficult for the wider community to tolerate:

> *"there was a lot of energy, like it literally just happened, and the messages were coming through and stuff. But the walls like not built still it's like, you know, that metal fencing up and. There's a lot of, like hope and energy around it very quickly, almost like it's hard to sit with this person's pain. They've been there for 30 years and. The pain's like, still there, so there's no wall in its place. It's just a gap."*
> (Harry – Observation 5: Phase 2b)

The pressures to reconstitute a collapsed boundary quickly, related to the task of integration for the trust. The prospect of rebuilding in a way that embraces the need for new internal structures, while bearing the loss of what old boundaries contained and defended against was hypothesised to be a difficult task:

> *"how to come together to rebuild, like how? How do you do that? … That's the trickiest, bit actually, and where like what? What does it look like? 'cause it can't look the same as it looked before. Boundary can't be in the same place because. You know, we've got a merger type situation occurring, so it needs to look different. But how do you put all these? These component parts back together again."* (Sophia – Observation 5: Phase 2b)

The observational material also raised a question whether relationships with external partners might be affected by new internal structures. The repatriation of disease modifying

treatments from a regional tertiary centre had highlighted questions about the absence of additional funding. The responsibility for significant unmet needs in local coastal communities, many of whom had been unable to access the regional centre should now fall to neurology's single management structure. The associative depiction of an impenetrable wall at the boundary with another territory evoked curiosity about the impact of local merger and integration, and whether external partners felt pulled to defend their own capacities and local populations:

> *"if overdone boundaries can be divisive and impenetrable. You know that top wall feels like it represents more of that, erm, perhaps than something nurturing and growth orientated"* (Sophia – Observation 5: Phase 2b)

Main theme: "it's not quite the idealised change … But it's not quite standing still either, it's kind of something in the middle': Sophisticated middle ground

Despite the apparent difficulties with making space for feelings identified in the written observation accounts, and the dynamics of the reflective group, an hypothesised way to progress through these challenges emerged in the data. The written observational account and associative process of the reflective group picked up tensions between the corporate and clinical functions of the organisation. The tendency was for each to denigrate the other, while the prospect of bridging the perspectives of each seemed to risk flooding any one individual. Holding space for opposite and conflictual forces within the organisation was emphasised in the reflective groups discussions, as a way of uncovering feelings that had initially split off. This culminated in an identified sub theme of 'competitive collaboration', capturing how a corporately led integration process which was associated with significant pace of change catalysed collaboration across previously separate neurology departments.

The capacity for systems to hold together these competing pressures was hypothesised to require a level of sophistication that was hard to conceive. The nature of this task was expanded by the sub theme ‘marking the pain’, which sets out how the benefit of integrating split off feelings into the programme could bring the benefit of more complete understanding of the system as a whole. This invoked metaphors related to physiological responses to threat, which can have the effect of shutting down the human capacity to think.

Finally, the sub theme ‘an analogue aesthetic’ identifies ways in which tensions between the identification of patterns in the observed setting, and with the internal world of individuals involved in trying to make sense of observations emerged in the data. The capacity to bare this tension within the findings related reciprocally to an identified need to tolerate the different tasks of separate professional groups. The prospect of realistic change, which has the capacity to straddle idealised progress and feared inactivity, was considered to be partly dependent on the capacity for vulnerability, acknowledging the duality of one’s own internal world, context, and feelings, and how these relate to external efforts towards integration in the organisation.

Sub theme one: ‘it's marrying kind of in a way the two, the clinical is really important, but we also need the other bit.’: Competitive collaboration

The observational account highlighted the role of competition within the trust’s hierarchy. The programme board could be characterised by roving scrutiny, appearing to shift between medical specialities based on performance and progress towards integration. A straightforward consequence could be that more junior professionals absented themselves from this space. However, it was also clear that alliances between professional groups could be consolidated or mobilised as a result of these pressures. In this way the need to evidence effective performance, and address clinical or corporate risks in a competitive system

catalysed collaboration. The reflective group used evidence of such instances, alongside the emergence of sporting imagery in the groups reflections to think about the benefits and complexities of holding space for these pressures to co-exist:

> *"it made me think about competition and collaboration. So this idea that one is, not quite the opposite of the other, but you know the two, if you are thinking about a collaborative endeavour, whatever that might be. It's really important to hold competition alongside, because the two are so connected, yet we often think about them as quite separate, you know? So like, we're going to collaborate, we're going to connect, integrate, merge. And almost this assumption that we can do that in a non-competitive way, or issues of rivalry and competition and those sorts of things. won't Feature. You know, we've said this is what we intend to do. And yes, how sophisticated in a way. erm. A system or group would need to be to really hold both of those at the same time. erm."* (Sophia – Observation 2: Phase 2b)

Sub theme two: 'We have to bear being seen for who we are': Marking the pain.

The possibility of integrating feeling into the trusts hierarchical system was considered as an important middle ground, and equated metaphorically to the human nervous system. The observational account illustrated a tendency for change to be represented as top down, emanating from a place of leadership. Meanwhile associations to the material had raised a question whether lower echelons of the system could experience structural changes as collapse. The prospect of integrating feeling from professionals involved in front line patient care was considered a way of assimilating important environmental information, akin to the autonomic awareness of demands being placed on the body:

> *"I'm trying to draw a really clunky parallel with like the nervous system. You know the different functions of it and almost. Some of the functions are just automatic.. ...*

You need to be able to hear when the body is telling you you're hungry or you need whatever. But like, it can't run the show." (Harry – Observation 6: Phase 2b)

The risk of disconnecting the integration of services from the impact and feeling of change in frontline services was considered to be a question of imbalance. It raised the prospect of an organisational system which is hypersensitive to threat, and unable to function effectively. The disorganising effects of emotional trauma were thought about by the reflective group, who considered if the felt sense of safety and threat in the environment could be more attuned by creating ways of taking in peripheral information from wider parts of the system. This would need to be of an order different to the routinely quantitative focus taken up by the integration programmes weekly catch-up:

"I'm thinking then what happens when you've got like a disconnect between that you know, we often talk, don't we when the like limbic system is like hyper, urm, functioning and you know the kind of cortex hasn't kind of for whatever reason, trauma or whatever done its job properly … when the system gets out of kilter, out of balance, you know, that's when you can see kind of difficulties and maybe that's what we're kind of always trying to achieve some sort of homeostasis, some sort of balance. So the whole, the whole system can function well enough."

(Sophia – Observation 6: Phase 2b)

Sub theme three: 'how much have I seen myself in what I've been observing': An analogue aesthetic.

In contrast to depicting negotiation of entry to the observation, the researcher was able to represent the self in their observational account as it concluded. This raised questions about the value and impact of using aesthetic subjectivity, in an integration programme which

appeared to place value on quantification, metrics, and evidence. This illustrated the difficulties in holding together opposite positions or pressures, a dynamic considered relevant a repeating dialectic theme, whether between clinicians and managers, or structures and feeling. The tendency within the observational material for separate aspects of integration to be brought in a fragmented way, or split off from awareness, emphasised the role of subjectivity and choice in bringing these aspects together. Holding in mind the whole system, and its wider context was made possible through freedom derived from collective reflection. This enabled the researcher to think in a creative and associative way, despite overwhelming professional pressure to produce impactful and meaningful results:

> *"I've kind of observed a part of the system and how's that kind of influenced what I've seen and? And a kind of analogue. Yeah, thinking about my research as kind of analogue, it's not. It's quite in some ways quite artistic, and how legitimate is that? How much is it gonna actually, like offer something helpful? Or maybe the blankness is like how do I actually translate this into findings … a pressure or a fantasy to, like, come up with something really impactful and meaningful."*
>
> (Harry – Observation 6: Phase 2b)

Reflecting on the observation as a whole, it was surprising to connect the reflective group's disparate associations to a rubbish bin throughout the observational account. This could be thought about as a reference to the tendency towards splits uncovered within the system, and the tendency for difficult feelings to be disavowed. The reflective group took this further by considering how its own make up, and attitude towards the task had resembled the system under observation. This included the merging of participants with professional roles across two separate NHS trusts, and a tendency to seek after an answer in response to the

observational account. These ideas were represented metaphorically by one member's association to Sherlock Holmes in response to a drawing from observation:

> *"it feels like I'm looking at kind of drawings or whatever from a different generation almost, you know, from a different time from an older time. … it felt really familiar and it kind of was really making me think about a particular kind of period of time, but I didn't kind of land it and then looked over at the drawing with the magnifying glass. And then that made me think of, and then the whole thing kind of came together, and it made me think of Sherlock Holmes"(Sophia – Observational 6: Phase 2b)*

A tendency towards solving integration, as if it were a dilemma with a perfect or idealised resolution also emerged in the observed setting by association to the Olympic cycles. The reflective group queried whether this had shaped how it had taken up the task of reflection and association to the material. The famous literary detective Sherlock was thought to represent a phantasy that knowledge about how to conduct and complete the neurology integration exists, which if only revealed would unlock all the answers. The intractable reality of human life and death is considered to be outside such a solution, and associations were made to the cyclical history of NHS change and transformation. The founding ideals of an iconic institution remained at some level in its fabric, but the pressure of time and change had repeatedly driven its reformation. The potential of unearthing buried feelings, and rich histories of institution and place was a possible but fragile contribution of associative enquiry through non-hierarchical reflective groups. In a world of data and metrics, pursuing a paradigmatically opposite frame represented an anxiety provoking risk with unknown rewards.

Chapter five: Discussion

Chapter Summary

The research findings are discussed in relation to the two stated research questions, covering both locally situated and reflexive understanding of a specific organisational culture, and generalisable hypothesises about the unconscious human dynamics of integration. The theoretical context and contribution of these findings is then linked to implications across the domains of policy, practice, and future research. The strengths and limitations of the research are considered, alongside the researchers learning and reflections on the research as partially fulfilling the requirements of a professional doctorate in Clinical Psychology. The chapter ends by drawing together final conclusions from the project as a whole.

Research Aims

To explore what could be learned about organisational culture in a recently merged NHS acute hospital trust, by observing the integration of clinical neurology services. The following research questions were stated in pursuit of this aim: 1) What can be learned about organisational culture from observing the integration of neurology services in a recently merged NHS hospital trust? and 2) What does a psychodynamic method of observation allow to be hypothesised about the unconscious aspects of integrating NHS hospital services?

Part One: What can be learned about post-merger organisational culture from observing the integration of neurology services in an NHS hospital trust?

The false certainty of organisational structure.

The analysis highlighted top down power within the observed trust, evidenced by the intrusion of centralised executive powers into the observation. This was apparent in the recent history of organisational merger itself, and the intrusion of unionised conflicts unrelated to neurology, into the content of the observed setting. These disputes had arisen from executive decision making powers within the organisation. Blau (1970) defined the vertical axis as a parameter differentiating formal authority within an organisation, while the horizontal axis is said to represent organisational scope, functional specialisation, and the division of labour. As organisations increase in size along the horizontal axis, the number of intermediary vertical levels tends to increase. In public service settings like the NHS, this is often associated with increased hierarchical complexity and top-down decision making power (Laloux, 2014). The influence of hierarchy was characterised within the observational process as fast paced, evaluative, and having a steep differentiation between those with and without power. Rigid structural power has been shown to detract from the emotive and human task of clinical care in an acute hospital, creating barriers to professionals making emotional contact with human fragility, and patient experiences of loss (Lyth, 1960). A hierarchical pattern of division and subjugation can also contribute to inadequate emotional regulation across organisational subgroups, when the organisation is considered as a whole (Bunderson et al., 2016).

Clinical-corporate subdivides

A consequence of formal hierarchy within the observational material encompassed a superficial splitting of clinical and corporate roles along the vertical axis, with power initially observed to be concentrated at the top of the hierarchy. The trusts monitoring of clinical

performance particularly illustrated an underlying evaluative culture, which seemed to permeate from the top down. This orientation to scrutiny and fast paced evaluation of performance can be understood in relation to broader socio-political values in the UK. In the context of longstanding pressures to scrutinise value and performance of publicly funded healthcare, the managerial logic of corporate governance asserts tensions between executives, managers, and the priorities of clinicians (Brignall & Modell, 2000). The research design helped to render categorical distinctions between corporate and clinical roles. Adherence to the projects ethical approvals introduced a novel perspective on the historical merger, and subsequent integration programme as it related to neurology. These research boundaries made the complexity and scope of the research project finite, in a way that was less available to the corporate transformation team. Superimposed over the integration programme, the singular research focus on neurology contradicted the multi-factorial complexity facing the transformation team, whose work was replicated across multiple divisions and medical specialties. Underwood (2024) identified that conflicting priorities between corporate and clinical roles require sophisticated leadership to navigate effectively. Steps to avoid conflict by increasing transparency over the breadth of complexity and bureaucratic scrutiny can move tensions away from the clinical-corporate interface. However, competition can shift to the interface between distinct clinical departments (Lachmann et al., 2024). This phenomenon of competition between previously distinct neurology departments emerged in the observation through the observed settings primary focus on quantifiable performance, mandated from outside the trust.

This pattern of competition was hypothesised to have a structuring effect on the integration programme, appearing to have de-emphasised the space and capacity to think and feel about the human impacts resulting from changes being implemented by the CSIP. The recommendation of Fulop et al. (2012) drawn from the systematic review findings, to invite

recognition of conflicts between departments in the short term, can be extended by the present findings to state that if unattended to, the emotional consequences of change may underpin avoidance through overemphasis on procedural and technical implementation of organisational change.

The themes identified in an observed setting which sat at the interface of clinical and corporate functions along the vertical axis, demonstrates the potential of locating reflective capacities within, and not alongside practical implementation of change. Rowe et al. (2020) found a key barrier to reflective practice in corporate NHS contexts was the pressure to use time efficiently. In-depth reflective practices of the kind present within the research method have historically contradicted the prioritisation of efficiency in highly pressured environments. However, space for collaboration and non-hierarchical decision making can have a positive impact on staff performance and well-being (Irons, 2024). The multifactorial pressures on acute hospital care were recently highlighted by Lord Darzi (2024), who saw them as driving destructive short-termism in the NHS. This resonates with the capacity to think about the emotional impact of integration that was being sidelined.

The paradoxical pressures of clinical and corporate care

The advent of free market economics in the NHS is first attributed to Thatcherite reforms in the 1980s and the advent of an internal market during the 1990s (Pollock, 2004), further solidified by the 2012 Lansley reforms (DHSC, 2012). This legislative thread through successive governments, from across the political spectrum has helped cement performance management as a tool of market logic within the oversight of the NHS (Mason & Araujo, 2021). Cooper and Lousada (2018) argue that evidencing the effective use of public funds was a way New Labour sustained funding for the post war social settlement, under pressure from neoliberal marketisation, in an increasingly globalised world economy. In the context of

austere economic policies following the global financial crisis between 2007-2009, health services pivoted first towards greater levels of competition as previously described. But in the period since increasing emphasis has been placed on collaboration within and between different aspects of health systems. Evidence has suggested collaboration predominates at the level of commissioning NHS services (Allen et al., 2017). However, the present findings illustrate how these corporate realities can become disconnected from the implementation of change within clinical services. The pressure to evidence performance is tied to financial survival, and represents an existential task which the organisation must engage with, but this can be conceptualised as contradicting the primary task of clinical care (Armstrong, 2018b). The administrative burden on healthcare systems can also be understood as functioning to avoid the distressing realities of human frailty, and the painful impotence experienced in the face of death and loss. If the survival of an organisation depends on evidencing effectiveness by quantitative measures, the normal anxieties evoked by working with painful bodily states of illness and deterioration are liable to be subjugated and avoided (Rizq, 2013).

The NHS undertakes to meet the health needs of all, but within stark limits on the funding and resources available. As a public service exclusively funded through taxation, the NHS aspires to universal coverage free at the point of access. The post-war social settlement in the United Kingdom set out to make healthcare accessible to the most disadvantages populations, in recognition of the collective human cost of World War II (Blackburn, 2018). Contrastingly, privately funded healthcare systems offer greater access, choice, and quality of care to a proportionately smaller percentage of the general population. For example in 2019, approximately 10% of the United States (US) population did not have access to health insurance (Keith, 2020). Extrapolating the position of Cooper and Lousada (2018), the US model splits off those least able to afford care, while the UK proports to make care available to all, regardless of individual capacity to pay. The UK approach abides by particularly stark

financial constraints, spending a lower percentage of gross domestic product on healthcare compared with other developed economies (Cooper, 2019). This social context frames the integration programmes focus on financial costs as reasonable and legitimate. However, health economics can be mobilised in many directions. It has been argued in light of the austere economic policies in the UK following the 2007 global economic crash, that healthcare coverage and access was especially harmed in the most disadvantaged population groups (Stuckler et al., 2017).

The sub-themes set out under “Sanitising the human impact”, suggest this wider context translated into the integration of clinical neurology services within the trust. In line with the systematic review and qualitative meta-synthesis previously set out, a focus on performance evoked painful differences in organisational histories in the observed trust. This included past regulatory and statutory investigation of one constituent trust within the merger. These structures of difference were carried forward into the new organisational context, with a disparity in performance apparent between the two main neurology departments. One consequence of forming a single management structure was to create statistically average performance data across the two sites. The potential for dyadic competition between the two departments, as described by Maile et al. (2022), was not addressed overtly in the observed meetings. However, the pressure to focus on data and quantification revealed a focus on mitigating the risk of one department breaching key performance indicators. This incidental impact of performance management systems in the NHS highlights the additional workload and competition that administrative oversight can create (Cossar & McIntosh, 2025). Furthermore, the impact of bureaucratic oversight in healthcare has been associated with failures in clinical and emotional care (Franco-Santos & Otley, 2018). There appeared limited space for reflection within the integration programme on the human impact of performance

monitoring, or on the way this task can obscure both interprofessional relationships and patient care.

Procedural defences

Concrete differences between clinical and corporate roles were identified by the observational material. Corporate transformation roles were able to work on projects in a time limited way, while more clinically orientated professionals had no obvious exit from patient care. A link between the absence of adequate professional autonomy and increasing levels of staff burnout in the NHS has recently been stated by Essex et al. (2023). Menzie-Lyth's seminal study on organisational culture in healthcare (Lyth, 1960) proposed deference of responsibility to senior colleagues in the face of existential anxieties evoked by care, also motivating many to leave their organisational and professional roles entirely. A similar tendency was observed in the present research, with those closer to patient care seeking exits from the additional demands of integration. A critique of Lyth's original work was a lack of transparency over her methods and data (Tutton & Langstaff, 2018). The present research offers systematic evidence of unconscious emotional avoidance operating at the level of structural integration.

Professionals in the observation appeared to defend against the anxieties opposite to the distinct purpose of their role, which as outlined appeared to solidify in the integration around a preference for the quantification of change. An unexpected equivalence to the concept of social defences against anxiety in clinical staff (Lyth, 1960), was that monitoring performance across the trust required corporate professionals to comprehend the systems cumulative breadth and complexity, while holding responsibility for its short-comings. The reality of corporate decision making under economic constraint represents an existential threat within marketised health systems. The time-limited corporate leadership of the

neurology integration may have served a comparable function to those in clinical management roles seeking exits from the task of re-organisation. If corporate autonomy offered protection from the emotional pain of frontline clinical care, in its place the demand to work across complex and diffuse organisational boundaries evoked feelings of overwhelm. The capacity to step away may also have positioned the transformation team as a container for the grievances of frontline professionals.

The challenge and potential of integrating the corporate and clinical functions of one organisation captures an aspect of integrated care more broadly. This can be formulated as holding in mind the complexity and breath of organisational life, alongside the depth of contact with human vulnerability. These contradictory demands on professionals are encapsulated by the needs associated with long term neurological conditions, requiring technical, co-ordinated and emotionally present support from multiple aspects of health systems. The privileging of abstract quantitative data may represent an illusory form of containment and safety (Armstrong, 2018a). However, it risks progress towards integrated care being inhibited by an unconscious retreat from its unresolvable tensions.

Organising around the surprising fact of uncertainty

The experience of negotiating and taking up a temporary research role within the CSIP evoked significant anxieties, both in the researcher, and in the observed setting. A question arose in the reflective group whether boundaries and procedural tasks were simultaneously necessary and appropriate to the setting, but also inadvertently clung to in the face of significant and consequential changes being implemented. The necessity to repeatedly re-negotiate entry to each observed session illustrated how boundaries could be experienced as unstable, fragile, and emotionally fraught. A research focus on Neurology made the level of organisational complexity more manageable. This exclusion of other specialties because of

pragmatic limits on the researcher was hypothesised to mirror divisions within the trust, based on the technical specialisation of clinicians. In this way the observations parameters captured how professional knowledge and capacity can take precedent, rather than holistic needs of individual patients or populations. Uncertainties evoked in the researcher at the boundaries between specialisms highlighted the neurology integration was affected by events and pressures across the organisation more broadly. Specifically, difficulties negotiating entry to online meetings highlighted stark structural divisions within health systems that organise around medical specialisation (Liberati et al., 2016; Pradelli et al., 2025). Although characteristic of western medicine in acute hospital settings, biomedical specialisation is arguably ill equipped to deal with the epidemiological and public health consequences of an ageing population, with increasingly complex long term conditions (Lynch et al., 2022).

Uncertainty was also evoked at the boundaries between co-existing professional roles. This pressure exerted on the researcher distorted the preliminary impression of clean differentiation, based on specialisation, role, and organisational structures. Rigidity in public institutions has been shown to characterise maladaptive relational patterns, which are barriers to moving from fragmentation to integrated and holistic care (Chan et al., 2024). The present findings contribute an understanding that the reality of boundaries are ambiguous and complex. The blurring of personal and professional roles can evoke uncertainty, for example an individual in a corporate role may also hold clinical training and expertise. This form of nuance can be quickly subsumed by categorical attributions in groups, avoiding the anxiety and ambiguity required for a balanced understanding of complexity (Bion, 1961). This tendency towards a two dimensional characterisation created the conditions for feeling splits, in line with the structural divisions more readily observable.

A distinctive relational pattern was identified in the observation, as a way of navigating uncertainty, with pervasive pressure to deliver results in terms of the research and

integration programme. Bion (1961) articulates the concept of pairing as a defensive basic assumption in groups. He described an unconscious fantasy that a complete solution to a task or dilemma will emerge from the close unity of two group members. Armstrong (2018a) describes this dynamic as concerned with the pursuit of certainty, but in reality progress towards an organisation's primary purpose is avoided as a group is unconsciously drawn into a position of passive waiting. The scale of the newly merged trusts size, and the complexities of its ongoing transformation created conditions where dyadic relationships were a way of tolerating, or negating uncertainty. The researcher pragmatically relied on such relationships to gain entry to the observation, and direct reciprocal communication was a result throughout the observation. This management of anxieties by unconsciously seeking an idealised outcome carries the risk of obscuring awareness of good enough local solutions to the dilemma of integration (Ferlie et al., 2013).

The systematic review identified that a consequence of merging NHS hospitals is to evoke anxieties about professional and institutional survival. Open systems theory in organisational contexts frames survival as depending on the permeability and management of boundaries (Katz & Kahn, 1978). This includes the exchange of information between internal structures, and at the interface with the external environment. Within this framework the dissolution of a boundary delineating separate neurology departments represents an existential threat, with merger subsequently realised in the form of integration. The analogy is comparable to a biological system no longer being able to defend its external boundary, or autonomously manage its own internal structures. The cascading results of which include serious illness, and ultimately death. In light of this, the observation of a rigid top-down hierarchy might be considered an attempt to defend against disintegration amid the profound changes to internal boundaries instituted by merger and integration. It was considered earlier that siloed working practices emerge as a function of steep organisational hierarchy. If an

organisation seeks to emphasise hierarchy as a way of managing change, its capacity to respond flexibly can be compromised (Scott & Davis, 2015). The collapse of an historically clear distinction between neurology departments seemed to ground a free floating experience of permeability and uncertainty throughout the new organisation. Anxieties previously held in equilibrium by historic organisational structures, may have precipitated the move to a single neurology management structure as representing totemic change. Integration in these circumstances was thought of as a goal that can be attained. Rather than a dynamic relational process which must continue to be reflected on and worked out over time. In such circumstances transformation can become equivalent to structural change (Godbole & Burke, 2019). Within the trust integration appeared taken up in a way which created distance from the human impact, a consequence of which can be located in the organisational literature on social defences against anxiety.

The subjective use of self in complex organisational systems

As a researcher, I held a dual role as clinician within the trust that I observed. The main themes relating to "Permeable hierarchy", and "Sanitising the human Impact" were identified from data generated through the subjective use of self, and also a form of analysis which relied upon my own interpretation of the data. This is caveated by the integral use of a reflective group, which is addressed below. Therefore the anxieties identified within the observed system must be considered in the context of my taking up a temporary role, not directly related to my routine clinical work as a psychologist. The possibility here is that my own anxieties and fear were inadvertently projected onto the group which I joined, and noted down as aspects of the groups dynamic. This is particularly relevant to the characterisation of clinical and corporate roles within the organisation. While these were interpreted as holding distinct, and contradictory tasks, in a manor continuous with my own professional experiences past and present. The fact distinctions between corporate and clinical roles emerged from this context is

itself a way of understanding the integration programme, as we might reasonably assume that professionals involved in the programme must also experience and interpret their experiences through their own developmental experiences.

Despite this, the provision of a reflective group within the process of data generation and analysis offers a layer of reflexivity which appear distinct from the CSIP processes and human dynamics that were observed. One might reasonably argue that the research took place within a very specific aspect of the integration programme, and that reflexive practices may have been well established in other areas of the programme. If this were the case, it is especially meaningful that I was not grated access to these spaces, having successfully negotiated permission to request consent from all aspects of the programme relating to neurology. Therefore the willingness of professionals in the CSIP to allow an observing researcher-clinician access only to a task and finish group focused on quantification of change may illustrate a reticence opening up emotionally vulnerable spaces to outside observation.

In summary the internal responses evoked in the task an integration programme should be considered relevant to how one individual understands the process as it unfolds, and also that interpretation of its strengths and weaknesses can be meaningfully ameliorated by the use of a reflective group external to the organisation as outlined in the research methodology.

Part two: What does a psychodynamic method of observation allow to be hypothesised about the unconscious aspects of integrating clinical neurology services?

The main theme "Splitting off the painful facts" relates to this second research question, and captured the potential for human feelings to be transmissible within groups. Wilfred Bion's psychoanalytic concept of container-contained relationships (Bion, 1959), offers a theoretical basis for understanding the destructive and ameliorative potentialities of integration that could be hypothesised from the observation. A brief overview of the concept's origin is given below, elaborating on the introductory chapter, and its relevance to the unconscious aspects of integrating clinical neurology services within the observed trust is subsequently provided.

Bion's theory of container-contained follows the foundations of Kleinian object relations, which addressed how intolerable emotional states are managed relationally in early life (Klein, 1946). Bion made links between the therapeutic process of psychoanalysis with adults, particularly individuals experiencing psychotic states of mind, and early development within dyadic infant-caregiver relationships (Hinshelwood, 2024). Applied to organisational systems, how internal psychological states of another individual or group are thought about will dictate the felt experiences of professionals within the organisation. The nature of containing structures will either help make sense of distressing internal states, or compound their fragmentary quality (Torres & Mendes, 2024). Hinshelwood (2024) describes the parameters of container-contained relationships to include the cohesion of the container, how disturbing the projected contents are, and the overall flexibility of the relational process. Depending on these factors, containment may be experienced as rigid, fragmentary, or flexible (Torres & Mendes, 2024). These first two structural qualities represent dysfunctional relational processes. Rigid containment is characterised by non-responsiveness, with the projected feeling state retaining its absence of symbolic meaning. While in the case of

fragmentation, the container is overwhelmed by the intensity of projected feeling and is no longer able to take in the experience of another. This articulates both sides of a dialectic observed at different points within the integration programme, namely the perception of a powerful and rigid hierarchy, alongside an anxiety provoking disintegration of previously held boundaries.

Flexible containment represents a more adaptive third way, describing the capacity for projected feelings to enter a permeable container, where they create an impact, but the container is sufficiently robust to retain its form. Flexible containment takes in and modifies an intolerable feelings state, before then making it available through communication in a symbolic and more manageable form (Hinshelwood, 2024). Applied to organisational life, an individual or sub-system can be said to take in the type of containment repeated over time in the wider organisation. How distressing feeling states are consistently responded to therefore constitutes a template for ongoing emotional relatedness within the organisation (Mendes & Hinshelwood, 2024). These relational templates existing at an implicit and unconscious level can be hypothesised through observation and attention to the felt experience of taking up a temporary role in organisational systems (Hinshelwood & Skogstad, 2002). The default forms of containment identified can be thought of as an aspect of organisational culture, which would otherwise evade awareness and systematic enquiry.

The relational basis of containment is compatible with biological theories of emotional co-regulation (Torres & Mendes, 2024). One example is the neurobiology of reflexive and abstract reasoning within one individual, being made available to another experiencing intense emotional states (Miller & Kulaga, 2023). On this basis a flexible container is willingly subjected to identifications with intolerable feelings states of the contained, which in their absence would not be represented in symbolic thought or language. The nature of container-contained relationships within an organisation may resonate with an

individual's early developmental experience of threat and change. This may be evoked on a somatic, rather than cognitive level, and either support or accentuate the emotional impacts of change. Similarly, this applies to the observers' developmental history and relational pattern. The absence of containing structures within organisational life risks the transmission of distressing somatic states more broadly across the organisation (Kahn, 2019). This is mirrored in the function of the observer, with the express presence of a reflective group tasked with containing the process and contents of observation.

The digital mediation of human loss

Digital technologies were implemented at pace across the NHS in response to the COVID19 pandemic. However, the benefits of digital transformation are no silver bullet, and need to be considered alongside ongoing implementation challenges and the need for investment (Peek et al., 2023). Significant efficiency savings within the integration programme seemed possible through technology, in relation to time and reduced environmental impact of meeting online. This was simultaneously true for the reflective group, for whom it would not have been feasible to convene in person. However, the potential for digital technologies to complicate organisational culture through layers of feelings evoked by working online was identified under the subtheme "digital equalisation". Sittig and Singh (2015) highlighted that the impact of health information technology within human systems has been inadequately conceptualised. Their socio-technical model allows dynamic interactions between humans and technology to be acknowledged in complex systems.

Alongside their many technical benefits, the present research found preliminary evidence that digital technologies exert a social and emotional impact in the context of healthcare transformation. The effect of the observation taking place online is considered here

as a primary way in which personal and professional identities were simultaneously evoked by the digital medium of communication, in a way which wouldn't otherwise have been the case for meetings taking place physically in person. It is considered that this intermediary space provided a space in which internal contents, and the realities of the integration could become blurred. This was particularly relevant to the associative method of enquiry undertaken, as the use of associations within the time boundary of the observation were subsequently used to generate hypotheses about unconscious aspects of the integration programme.

Organisational life has been broadly affected by the increasing prevalence of digital technologies, a trend which is only set to increase. On the basis of increasing digitisation, Krantz (2010) asserts that modern institutions more closely resemble distributed networks, rather than bounded hierarchical structures. Working online dislocated professionals in the integration programme from a shared physical environment, and this appeared to have emphasised structural splits from feeling associated with clinical care in the organisation. A defensive splitting from feeling in NHS institutions has previously been associated with the inability to take in important information from various levels of the organisation, resulting in siloed working practices and failures in strategic thinking (Fotaki & Hyde, 2015). Personal-professional boundaries were simultaneously blurred and rendered intangible by the online environment. This corroborates research by Stamenova et al. (2024), who identified virtual workspaces contribute to the erosion of psychological boundaries. In psychoanalytic terms this may serve to heighten unconscious anxieties in individuals and the system as a whole. The scope for digital working practices to emphasise anxieties about fragmentation and disintegration may in part account for the stark contrast within the observation between rigid hierarchy and profound uncertainties over role, boundary, and task. Digital technology may also have created a vehicle for observation in which personal associations about unconscious

aspects of the integration programme were both more readily accessible, and less able to be made use of owing to the collision of integration processes dictated by quantification of change, and the filtering out of external intrusions within home environments.

The silencing and projection of human rage

The communication of plans for a single management structure to Neurology staff was only described in positive terms within the observed setting, despite the need for a formal consultation process arising. In contrast, rage was hypothesised to be an unconscious response to this change being communicated. It could not be expressed either at the staff consultation event, or within the observed integration programme. The emergence of associations to rage in the reflective group was synchronous with this engagement event, and concurred across separate participants within the reflective group. The chronology and synchronicity across the integration programme and reflective group was used as the basis of triangulating these associations to rage. This transmission of feeling identified by the reflective group was via a process analogous to the broad psychotherapeutic concept of countertransference, meaning the entirety of the clinicians emotional reactions and associations to a patient can be clinically meaningful (Heimann, 1949). A caveat to the practice of using internal responses in this way, is the need to differentiate between responses arising from one's own developmental context, and those associated with another individual or setting.

Projective identification is an associated concept, describing how individuals who receive split off emotional contents can identify with these in such a way that the experience seems to originate internally (Ogden, 1979). The symbolic and synchronous identifications with rage by the reflective group were characterised by distance from both the integration programme, other reflective group members, and through spontaneous personal resonances. The presence of physical and emotional distance from the integration programme meant the

relational impact of an intolerable feeling states was indirect, and less concrete. The capacity of the reflective groups to think symbolically about organisational life is partly a function of their distance from the original affective experience (Britton, 2004). An associative space meant content associated with painful loss and rage could be thought about slowly, and tested against various perspectives within the group. This contrasted the in person engagement event, which was raised within the observed setting, at which profound management changes were communicated directly. Any emotional response from staff would have to be made immediately, and in a public forum. The unspoken projection of anger hypothesised to have arisen from the prospect of significant change was through an associative process, taken in and articulated symbolically. This in way previously inaccessible to the organisation (Hinshelwood & Skogstad, 2002; Sapochnik, 2021).

This hypothesis that rage was evoked in response to loss associated with the structural integration of neurology departments corresponded to the meta-ethnographic synthesis. It was found that hospital mergers can undermine the identity and security of professional roles, through loss and a need to assimilate new ways of working. Rage is a complex affective state, synonymous with developmental experiences where one's basic needs for care either were or might have been compromised. Whether in early life, or as an adult, such failures in care can evoke existential threat and the loss of an object that has come to be depended on. This has a affective and preverbal component, given humans are born into a state of profound physical dependency (Hinshelwood & Fortuna, 2017). Where rage or anger predominate, the capacity to appreciate good and bad as co-existing is temporarily obscured. Rage motivates action in line with survival, but can also be characterised as a secondary emotional response, attempting to cover experiences of disintegration and loss (Stubley, 2025). As previously stated fragility and loss are inherent in human mortality and ubiquitous in the context of hospital care (Lyth, 1960).

The disavowal of rage in response to historic professional boundaries disintegrating, risks undermining the emotional capacities of professionals. Individuals under significant stress are prone to experience their inner world as fractured and disintegrated. Such a state is characterised by the internal and external world being separated out into good or bad objects, with a tendency towards either denigration or idealisation (Klein, 1946). This way of relating initially emerges and is worked through in early life, but the associated defences of splitting, projection, and projective identification remain accessible throughout the lifespan. All individuals are said to have the capacity to split off painful aspects of experience, in order to survive circumstances of overwhelming threat (Hinshelwood & Fortuna, 2017). In healthcare organisations, patient experiences are primarily contained by clinical staff. However, the capacity to do so in a sustainable way relates to the organisations ability to contain the emotional responses of professionals engaged in the task of patient care (Armstrong, 2018a). An area which merits further exploration is whether professionals in such an organisational context may be less able to flexibly contain the emotional loss synonymous with degenerative neurological disorders, in an adaptive and sustainable way. This would further elaborate the meta-synthesis finding that merger and integration can adversely affect patient care (Rogers, 2021).

The capacity for organisational leadership to take in, process, and communicate back intolerable feeling states such as rage requires flexible emotional containment. An organisational structure which inadvertently splits along the seams of professional role, splitting off feelings states from quantifiable progress towards change, is unlikely to identify or generate symbolic meaning for painful feeling states. This carries the potential for the transmission of distressed feeling elsewhere within the organisation, with unforeseen impacts on clinical care, and professional experiences. Aversive feeling states may drive adverse professional experiences, but as information could also be made use of in support of effective

integration. The potential benefits of embedding bottom-up decision making, through an associative reflective function within healthcare organisations have been proposed on this basis (Lazes & Rudden, 2022), and the conceptualisation presented offers a detailed account of how reflection amongst healthcare professionals may aid collaborative practices (Wei et al., 2022).

The possibility of semi-sudden collapse associated with integration

In practical terms the COVID19 pandemic delayed the post-merger integration of clinical services within the observed trust. The two neurology departments needed to continue functioning independently to sustain patient care during and beyond the pandemic. Under these circumstances integration was not feasible, but this may have contributed to a subtle denial of its later inevitability. Bion (1961) described several basic assumptions which large groups can unconsciously adopt, inadvertently sabotaging progress towards the groups primary working task. His concept of the fight/flight basic assumption can include the projection of intolerable and split off feelings states outside the individual or group. However, groups operating in a fight/flight mentality can also avoid painful feeling states through passive escape. Steyn and Cilliers (2016) demonstrated that professionals who feel subjugated to executive decisions, which repeat historic cycles of change, defend themselves by detaching from transformation processes. This was echoed in the present findings by the question of individual consent to the research process, which evoked significant anxieties and uncertainty in the researcher. Specifically, larger forums in the integration programme did not make themselves formally accessible to the researcher. The original scale of change associated with organisational merger was likely to have foreclosed a participative and democratic decision making process within the trust (Dean et al., 2020). It is therefore considered the decision not to pursue implied consent on ethical grounds was not only justifiable, but highlighted the vulnerable position many professionals without decision

making capacity in their roles are forced to inhabit. This context of limited involvement within the decision making process to merge, may have been an important context to research data which indicated the planned removal of the boundary between clinical neurology department risked being experienced as a collapse.

Open systems theory characterises the dissolution of boundaries as threatening the survival of an organic system (Von Bertalanffy, 1950). The merger of human organisations is defined by the removal of boundaries between component subsystems, and is a necessary pre-requisite of integration. However, in a socio-political context which has applied free market principles to healthcare delivery, this dissolution can require the renegotiation of oppositional relationships (Marks & Mirvis, 2010). Within the observed trust this equated to newly interdependent subsystems, being faced with the prospect of mandated collaboration. Fulop et al. (2012) found that if performance discrepancies between merging cultures exist, conflict allows for differences to be understood and adequately addressed. It appeared in the observed setting that the reality of boundary changes was avoided, until the implementation of integration was felt as a semi-sudden collapse. In the context of defensive splits being mobilised between feeling and structures in the organisation, change seemed to equate to the collapse of an unconscious constellation holding intolerable states at bay. A tendency for split off emotional contents to suddenly return to consciousness can result from the loss of an external object, into which the bad experience was projected (Hinshelwood & Fortuna, 2017). The practical integration of two previously distinct and competing neurology departments could symbolise the return to consciousness of emotional content associated with rage and loss that had been defensively repressed.

Possibilities and pitfalls of self as the instrument of knowing

The research methodology has parallels with my own developmental history. I have in the past experienced psychological states which can be conceptualised as the transient

dissolution of boundaries between internal and external realities. While at points this has been the basis of confusion and distress, it also provides a deeper capacity to think intuitively and associatively. This personal context to the conduct and results of the research is relevant to how the findings are understood and applied. As previously discussed the process of working with the transference is fraught, and includes the risk of misattributing internal experiences to external realities, and vice versa. However, the key finding of the project, specific to the novel methodological approach, are the hypotheses relating to the nature and consequences of split of feeling states within the organisation. These have been discussed in relation to projective identification, a phenomenon in which the connection between an external reality, and the containing individual is by definition blurred. This is encapsulated by the way rage, and semi-sudden collapse entered the observational data.

There are important parallels between the themes of loss and the associated disavowal of rage, with my personal experience of close familial loss during the conduct and writing of the research. Rather than a simplistic flaw in the research, these resonances illustrate the relevance of internal and personal processes within how professionals understand the organisational changes they are required to navigate and implement. The way digital technology inadvertently functioned within the context of the integration programme, and research process served to emphasise the blurring of this personal and professional divide. Linking the meta-synthesis findings, with the identified splits between structure and feeling in the observed setting, it is apparent there is a need for robust spaces within organisational change. These should be capable of containing the negative projections typical of corporate-clinical divides, and working with emotional vulnerability in an open, non-defensive, and transparent way. The methodological approach adopted within the project offers one way of realising aspects of these high ideals. It provides a robust, practicable, and transparent process which can operate as an adjunct to existing organisational change processes. The

demographic make-up of reflective groups is an important consideration, in that the personal and professional background of those involved should be considered as constitutive of the associations that can be generated at a given point in time.

Taking up a research role as participant observer is markedly different from being invited to work in a consultative capacity. The research role I negotiated lent itself to being quiet, reserved, and taking information in. My clinical and research experiences throughout the doctorate have shown me this way of being can offer a great deal, but can also raise anxieties associated with being observed. Working with the unconscious aspects of individual and organisational life requires the holding together of conflicting positions, being at one moment open to free association, while also attuned with compassion to people's conscious experience. Holding these positions in tension internally speaks to the organisational task of integration, and the need for containment which is flexible. The profession of clinical psychology offers a medium which is compatible with the approach taken within this project, but is neither necessary nor sufficient to doing so successfully. I recognise the divergence from mainstream principles of evidence based practice adopted here, which pervade healthcare and clinical psychology more generally. However, a critical approach to evidence and the inequalities it can perpetuate remain a significant strand within contemporary thought. The approach taken by the current research is compatible with an ideographic approach to clinical practice, including work at the level of systems, for which manualised and prescriptive models of practice do not exist.

Implications for Practice

The need for sophisticated middle ground along the vertical axis

Containment offers a conceptual framework for understanding the research findings, but also an applied model of practice, through which unconscious aspects of integration could be articulated. Bion argued that container-contained relationships are the basis of human thought and creativity in social groups, which necessarily emerges from fragmentary feeling states (W. Bion, 2013; Bion, 1962). As developed in the following research implications below, this model could form a creative contribution to NHS integration and organisational change programmes.

Steep vertical hierarchies may be a necessary function for the organisational division of labour (Blau, 1970), but create both helpful and unhelpful distance from the uncertainties inherent in clinical care (Armstrong, 2018b). Armstrong (2018a) and Hinshelwood (2024) have outlined adaptive and maladaptive forms of hierarchical containment in healthcare institutions. If the containing function of the organisational hierarchy was fragmentary, the disorganising effects on front line professionals may have been stark. The identified need for a sophisticated middle ground articulates how unconscious conflicts might be worked with adaptively to both inform and understand change. The observed absence of a mechanism for identifying defensive emotional responses, may have further propagated the fragmentation of feeling within the organisation.

A need to hold in tension competition and collaboration within the integration was apparent, specifically in the quantitative differences in performance between the two neurology departments. The transition from mandatory competitive tendering to integrated care systems has been framed as replacing competition with collaboration, within and between organisations (Charles, 2022b; Charles et al., 2021). Within the observed material position appeared somewhat idealised, and would disavow the ongoing prospect of

competition within the organisation. It was also hypothesised that where competition between local departments collapsed through merger and integration, this had the potential to be displaced onto external relationships. The prospect of a new equilibrium across the wider system was identified by association to a new substantial boundary at the new extremity of the organisational territory. The systematic review highlighted that where different organisational cultures are merged, conflict and competition can be beneficial if it helps to address past failings and clarify the future direction of the organisation (Fulop et al., 2012).

The adversarial and business logic of corporate roles in the NHS has previously been conceived as incompatible with the clinical task of care (Cosford, 2021). The perception of training and skills of those in corporate roles appeared to be flattened by a rigid hierarchy, a configuration typical of large public institutions in the UK (Laloux, 2014). However, the observation found that an anxious and defensive mode of functioning prevailed, individuals were more likely to be related to in a one dimensional way. An example was professionals being identified with their immediate organisational role, when in reality a range of personal and professional roles were held simultaneously. An environment which prioritised flexible containment would help professionals relate in a way which acknowledges the complexity and tensions of holding multiple professional and personal identities.

The research method was characterised by freely associative enquiry, predicated on the containment of fragmentary contents identified from observation. Conducting a reflective process slowly, within a group of diverse perspectives, meant no single experience was privileged. Furthermore, the aspects of the observed setting hypothesised to be repressed could be partially re-enacted in a reflective and unstructured space (Sapochnik, 2021). The reintegration of fragmented feeling states outside the observed context allowed for the formulation of hypotheses about the underlying nature of anxiety in the organisation. An organisational split between structure and feelings states associated with loss was

hypothesised to risk being followed by collapse. This would equate to the sudden removal of emotional equilibrium. The availability and timing of such an associative space within broader organisational change processes is therefore considered important. In contrast to the post-merger context of the observed trust, consulting professional groups prior to and during significant organisational change could be enhanced by associative enquiry. This would allow hypotheses about the local and emotional impact of change to be held in mind, articulated as symbolic hypotheses, and addressed adequately if subsequently materialised.

The Kleinian concept of depressive position is both a developmental achievement, and an emotional state. In both instances it holds a reciprocal relationship with more schizoid mechanisms of coping (Hinshelwood & Fortuna, 2017). Consequently, the depressive position involves more complex relational anxieties, rather than basic fears orientated to immediate survival, and in this state one can tolerate the co-existence of good and bad in others (Ogden, 2018b). Any realisation that both good and bad exist together externally, must also be reconciled with one's internal reality. An inescapable task therefore becomes the acceptance of one's own destructiveness and possibility of having caused harm to others. If conflictual feelings of guilt and anxiety evoked by this realisation can be tolerated, individuals can begin to mourn the loss of safety this more simplistic world offered, and begin to attempt relational repair (Ogden, 2018a). The need to bare and contain unacknowledged somatic states related to loss and grief were identified throughout the observation, at the level of individuals, groups, and inequitable social systems. The contrast with a bureaucratic context demanding the quantification of progress is stark. If the painful limitations and emotional conflicts of human experience can be better contained and tolerated within healthcare systems, a greater capacity for teams and individuals to work towards realistic progress may emerge.

The capacity to tolerate existential anxieties evoked in healthcare systems includes centralised demands for quality and efficiency, alongside the emotional pain of direct patient care. The capacity to straddle these two competing demands would offer a space capable of integrating patient and professional realities, addressing a tendency for splits between corporate and clinical roles in the organisation. If the account of rigid psychological structures serving a defensive function is accurate, their perceived collapse could have stark consequences. However, such collapse can also represent an opportunity to address feeling states which had been defended and split off, with new ways of being emerging spontaneously. If the (re)-emergence of repressed feeling could be worked through, in containing relationships, they might be resolved in a way which supports, rather than hinders integration. The reflective groups tendency to try and resolve or solve the observation material through insight could be understood itself as a defence against the complex reality of NHS institutional life, and its underpinning task of attending to the care of those who are ill or dying. The use of individual and collective subjectivity helped redress this orientation towards the quantification of change. However, to overstate the hypothetical nature of knowledge derived from observation would obscure its role in a wider multi-disciplinary conversation, about how the NHS adapts to the changing demands of healthcare in the modern world.

The concept of work group mentality represents a rational, task-orientated state where a group is able to collaborate in a way that is unhindered by the dynamics evident in basic assumption modes of functioning (Bion, 1961). The work group mentality is promoted if unconscious anxieties can be contained in a flexible way characterised by proactively holding together contradictory tensions (Long, 2018b). On the basis of the present findings, it is argued this productive mode of functioning in organisational life would be supported by finding ways to bare intolerable feelings. The present research articulates how the individual

and subjective experience of professionals is capable of enhancing or limiting organisational change, and this reality contextualises the speculative aspect of the present methodology and findings, and relates to the significance of its real world applications. The irrational and unconscious nature of human feeling and action is ubiquitous. It can either be engaged with organisationally as a means of contributing to wider change processes, or denied, closing down creativity and the capacity for thought.

Containing organisational structures

The poor structural integration of acute hospital care can negatively affect the outcomes of people with multiple long-term conditions (Bellass et al., 2023). A related finding has been that the inability to integrate unconscious feelings, phantasy, and identifications is a largely unaddressed component of efforts to integrate care. Developing the routine capacity to gather and process information on human feeling during change processes could facilitate a fuller understanding of what integration entails for NHS organisations. A goal of integrated care is to achieve greater collaboration across various healthcare subsystems. The present research highlights how collaboration across corporate and clinical functions within one organisation requires specificity in how relational dynamics are understood.

How to privilege this alongside structural changes is an important consideration, and analogous to the multiple functions of the human nervous system. The capacity to detect and interpret stimuli, both from the bodies internal states and wider environment is essential. It allows for both internal regulation, and the coordination of one's action in the world (Mai & Paxinos, 2011). Whether worked with or not within healthcare systems, the unconscious is hypothesised to have a bearing on organisational culture and effectiveness (Petriglieri & Petriglieri, 2020).

Leadership, consultancy and practitioner psychologists

To achieve a more nuanced psychological conceptualisation of the integration programme required a containing function, with the capacity to take in unconscious aspects of feeling within the organisation. Incorporating associative enquiry into the routine practices of organisational change could contribute by transforming unconscious contents to the level of symbolic thought. An example arising from the findings was that for corporate teams communicating significant organisational change, the capacity to work with profound anxieties at an explicit level was beyond the immediate capacities of the professional roles from which it was required. Those responsible for communicating threatening change appeared to be without a clear framework with which to address the hostility of felt but unarticulated responses in frontline professionals. It is argued the integration of human feeling would complement approaches to complexity and change in healthcare which conceptualise professionals as rational actors (Khan et al., 2018).

The intersection of corporate and clinical teams along the vertical axis emerged as an opportune location for split off feelings to be absorbed and processed within NHS institutions. If the complex feelings evoked above and below this intersection remain split off, the present findings indicate the risk of semi-sudden collapse. Therefore the ameliorative function of leadership and management roles could be enhanced by professionals with the capacity to formulate across a dialectic between centralised performance monitoring, and the effects of feelings states associated with clinical care.

Practitioner psychologists are creatively positioned to work at the boundary of clinical care and corporate leadership. This professional identity and training involves the application of psychological theory at the level of individuals and groups, supervision and management of teams, and to leadership at the level of organisational systems (HCPC, 2023). All clinical professionals who transition into organisational management and leadership face significant

challenges (Cilliers & Henning, 2021), but the clinical knowledge base of a practitioner psychologist is directly transferrable to the human dynamics of organisational culture. The professional training of practitioner psychologists omits extensive experience of consultation (BPS, 2019), particularly exposure to the systems psychodynamic model. It is therefore recommended that experience of consultation and leadership is made more of a focus within the training of practitioner psychologists. This specialisation of practitioner psychologists would be in keeping to wider efforts to develop the psychological professions workforce, and efforts to expand training in psychological therapies (Anderson et al., 2021).

The present study evidences an approach capable of conceptualising the unconscious dynamics across large and complex organisations. Beyond simply a theoretical framework, the approach has been shown to work within existing professional roles, and organisational programmes. The use of routine reflective spaces within executive and management contexts of NHS trusts could support the integration of feeling into organisational change such as merger, integration, and transformation. The systems psychodynamic model represents a significant minority in the field of organisational consultancy, but the present research presents preliminary evidence it can help understand emotional complexity across clinical and bureaucratic demands placed on NHS institutions, and where these tasks intersect.

Developing an aesthetic organisational frame

The associative form of enquiry adopted by the research was inspired by the use of art as social critique. Notwithstanding the discussion of the present findings, this approach can lean towards a form of institutional diagnosis, and criticism. I have gone to great lengths to conceptualise the method as a creative way of generating hypotheses, but the suggested progression to test the ideas generated is consequential and important. This could be in the form of participative approaches to action research and consultation, or more quantitative

forms of enquiry. The ethics of observational research have been addressed by Hollway (2018), and on this basis I sought to incorporate a position of compassion for both the anxieties associated with the emotional depth of clinical care, and the burdens which come from the breadth and responsibility of administrative oversight. This represents a tension in any form of healthcare organisation, which is unresolvable at the scale of publicly funded NHS services. Indeed the capacity to bare these conflicting tasks, resisting the urge to try and seek a resolution emerges in the present findings as an important reality that can get lost in the pressures to transform and survive. Associative enquiry approaches offered a commentary on this conflict inherent in transformation, and highlighted aspects of human feeling which are painful, but worth integrating. What the approach cannot do is dictate solutions outside a dialogical conversation with the range of disciplines engaged with the delivery of care in the NHS.

Implications for Policy

UK public health data suggests that an ageing population with increasingly complex health needs is changing priorities for the NHS (McKee et al., 2021). Specifically, there is a growing need to pivot towards preventative and relational community approaches (DHSC, 2025), pivoting away from inefficient and exponential spending on acute hospital services. The organisation of health services around steep hierarchies and medical specialisation is justifiable in the context of highly technical medical treatments, but may be too readily generalised to community based care (Bloem et al., 2020). The decentralising of clinical care provides opportunities to rethink the way that health systems are designed and implemented and a local level (Cairney et al., 2024). Based on the present research finding that executive and clinical working tasks can appear to contradict one another, flattening organisational hierarchies to achieve distributed decision making, with fewer bureaucratic imperatives is

suggested as a way of supporting opportunities to integrate feelings evoked throughout organisations.

Laloux (2014) described an evolutionary framework of organisational culture. He suggested a progression from power centric, fear orientated cultures, towards self-managing systems with decentralised authority structures. According to Laloux, rigid hierarchies are characteristic of conformist and achievement orientated organisations, of which large public service institutions are typical (Essex et al., 2023). The prediction by Laloux (2014) is that external performance driven targets create a pressure to deliver success. The implication derived from the present findings is that top-down administrative pressure excluded space to think about the clinical task of care and its unconscious implications for integration in a newly formed organisation. This dynamic appears to have been compounded by a demand for integration and organisational transformation to be achieved by a specified date. Closing the gap between contradictory tasks of administrative oversight and clinical care could help address this. Evidence demonstrates non-hierarchical healthcare structures can offer improvements in patient satisfaction and professional experience, alongside significant cost savings by providing fewer hours of higher quality care (de Bruin et al., 2022). The challenges of such approaches highlight the need for sophisticated mechanisms of support, and a systemic capacity to think equitably about the needs of individuals at all levels.

The complexity of monitoring progress against performance objectives has recently been acknowledged in the decision to abolish NHS England (Wise, 2025). The removal of mid-level administrative functions within the NHS may facilitate greater autonomy at the local level, meaning space is created for the feeling and responses of individual clinicians. However, the loss of ameliorative functions within intermediary institutions could also accentuate top-down pressures on performance (Lambert, 2024). The further concentration of decision making power to central government risks stretching the NHSs vertical axis, further

dislocating the integration of feeling at the local level. In the context of a central government seeking to drive efficiency savings from above. (Bagenal, 2025), these policy decisions appear to challenge preceding attempts increase subsidiarity within healthcare systems (Charles, 2022a). The Specialised Neurology Service Specification indicates the need for equitable access to neurology services as close to home as possible (Thomas, 2023). The systematic review and present study highlight the significant impact on healthcare professionals of bringing together previously separate subsystems, and how doing so may implicate historic relationships with regional tertiary treatment centres. In order to realise the aim of integrated neurology systems, the relational impact of repeated transformation on professionals must be addressed. In relation to the observed organisation, sweeping reforms to NHS England and ICBs re-open the geographical boundary previously bridged by merger and integration. The method of associative enquiry within the present research contributes a way of generating thick descriptions of the unconscious feelings associated with place which could help bridge widening hierarchical gaps.

Further Research

Developments at the local level

The present research could be developed by including feedback loops between observation findings and the organisation. This would introduce the testing of hypotheses, which within both the clinical practice of psychoanalysis, and organisational consultancy is an imperative. The pragmatist concept of truth derived from research dictates its application must be of utility in real world contexts. Extrapolating from the present research findings, there is a need to test whether the conceptualisation of structurally split off feeling, and semi sudden collapse of this organisational defence would open up new possibilities for the professionals involved. Broadly such an approach would address whether Bion’s theoretical

paradigm of containment is of practical benefit to the process of integration within acute hospital trusts. One approach would be to conduct in-depth, semi-structured interviews, with individuals who participated within the observation. In a research context this would create a forum to test out hypotheses developed from observation, and to triangulate findings from observation (Clarke & Hoggett, 2019).

There is also a need to broaden the focus of research along the vertical and horizontal axes. Vertically this would include observing settings in which the executive team makes decisions which affect clinical care, and contrastingly the front line delivery of clinical care. This would allow further exploration of the hypothesis that the task of clinical care in neurology was having an organising effect on the bureaucratic focus on structural integration. Along the horizontal axis it would be beneficial to broaden the scope of future research, decoupling it from an exclusive focus on neurology would allow the neurology integration to be understood within its wider context, and visa-versa.

The researcher approached the host trust directly, rather than being requested in a consultative capacity. This relates to the emotional tone of consent within the observation, and the limitations for feedback loops to the organisation. While it has been possible to arrange for the research findings to be disseminated back to the host trust, the true value of doing so is when done iteratively within the research process. Action research is a participative approach which employs cycles of planning, acting, observing, and reflecting. It has been used extensively to understand and seek collaborative changes to healthcare organisations (Koch & Kralik, 2009). The approach is also synonymous with the systems psychodynamic model, partly because of its shared affinity for hypothesis testing which is allied to psychodynamic and systems thinking (Rustin & Armstrong, 2019). Adopting an action research approach to furthering the present findings would provide a natural vehicle for testing the hypothesised unconscious processes.

The co-production of change

The present research method could also be extended to the practice of co-production, with the creative use of subjectivity and association not exclusive to professional training, or specialist knowledge. It would be possible for patient, carer, and public involvement to be built into all the phases of associative enquiry outlined, compatible with critical approaches to shaping the provision, delivery, and governance of clinical services (Glynos & Speed, 2012). This approach would help to address a lack of public, and patient involvement within the observed integration programme. Associative enquiry also presents opportunities for greater involvement within the integration process. A range of stakeholders could feasibly contribute to each part of an action research cycle, contributing greater patient and public involvement which was largely absent within the aspect of the integration programme observed. A facilitative role for such an approach would be well suited to practitioner psychologists, who work directly and indirectly with the diffuse set of stakeholders relevant to the integration programme, and the clinical care of neurology patients.

Quantitative approaches

The use of an associative method of observational enquiry offers the potential for creative insight which can symbolise the unthought known within organisational change (Bollas, 2017). The hypothesised avoidance of intolerable feelings through quantification of change and use of digital communication tools are insights that could be used as the basis of quantitative empirical research. This is consistent with the epistemological position of the project, which positions a systems psychodynamic perspective as one contribution within a multidisciplinary conversation about change within healthcare systems.

Computational approaches to complex systems use large data sets to work with complexity at scale. Network analysis is one such mathematical approach based on graph theory (Borgatti et al., 2009). This method is consistent with the associative unconscious as a network of symbolic meaning (Long & Harney, 2018). It offers potential to complement the present research method, as exploration on the basis of visualising big data is an emerging focus in both clinical and organisational aspects of healthcare systems (Britto et al., 2018; Toor & Chana, 2021). One such approach to visualising integration processes, including relational patterns between key actors, and the simultaneous analysis of multiple levels along the vertical axis was presented by Burns et al. (2022). Their approach could be used to identify areas in NHS trusts where associative enquiry might be usefully focussed to support the understanding of change, or effective decision making where intense scrutiny exists. In addition, this approach could be applied to large linguistic data sets, an example from the observed trust would include the routine recording and transcription of meetings within the integration programme. Analysis in this way would omit the human free associative element essential to the present research, however identifying preliminary patterns across the integration programme as a whole might inform where qualitative approaches such as the present research would best support integration processes.

Strengths and Limitations

This research evidences a novel methodological approach to associative enquiry within an acute NHS hospital trust. Working to think symbolically about unconscious contents identified ways the integration programme may have defensively organised itself against painful realities of the task. These findings highlight the relevance of psychological containment to organisational change, and how defensive mechanisms of projective identification are both used, and can be thought about to identify intolerable affective states.

A creative qualitative methodology offers an important contribution to the multi-disciplinary contributions required to successfully manage integration and change within complex healthcare systems. This is consistent with the detailed ontological and epistemological position outlined, which is capable of generating new and creative insights about NHS organisational culture where subsidiarity features within national priorities for integrated care (Charles, 2022b). The specificity of the method has generated insight into a single locality and organisational dynamic, but would also be replicable across other settings. The researcher has demonstrated how the approach can fit within existing programmes of work, with limited impact on the time, and resources of the organisation. Where the integration of clinical neurology services was focussed on structural change, the present findings suggest feeling states were defended against in an organisation facing significant change. Given the high profile evidence of recent failures in NHS patient care, ways of developing reflective capacity and coherent approaches to working with the unconscious through unstructured association and collaboration in groups could offer a valuable check and balance within wider governance structures.

Research relating to the unconscious is routinely critiqued on the basis of lacking falsifiability, and the absence of concretely measurable variables. As discussed the present findings and insights would be suited to some forms of quantitative research, however the prevailing paradigm of evidence based healthcare has historically taken issue with psychodynamic approaches (Long & Harney, 2018). The method draws considerable strengths from the use of individual subjectivity, however this emphasis on creative free association opens up the possibility of meaning being imposed over observed material, rather than emerging freely from an associative process. The use of a reflective group to generate and regulate associations offers a powerful counterpoint to a false predetermination of meaning, making use of a diversity of perspectives. Further, the associative meaning drawn

from reflection relied on synchronicity across the data set as a whole. These features are arguably absent from many other forms of qualitative research. Interpretative phenomenology analysis would offer a methodological framework consistent with interrogating the subjective position of the researcher in relation to the observed material.

A systems approach was used within the introduction to set out a theoretical framework consistent with the content and dynamics in one subgroup, illustrating in a partial way, realities present in an organisational system as a whole. On this basis I have argued that themes identified from the observation of a very specific task and finish group within the CSIP have relevance to the observed organisation as a whole, and also wider processes of integration in the NHS. However, the quantitative focus of the group observed must be acknowledged, and I have attempted to do so by framing the research questions and findings as relating to hypotheses requiring further exploration. It is very possible that other areas of the integration programme may have included structured approaches to thinking about the emotional impact of change. Had it been possible to observe those settings this may have materially changed the content of the observational data. It is important to state in this context that the methodology did not purposively select the observed setting from within the CSIP, but this was the forum made accessible to the researcher. This in itself was considered a meaningful finding in relation to the emotional dynamics of the integration, and the response of professionals to being observed.

The present research would be considerably strengthened by incorporating feedback loops into the overall design. As outlined this could include following up hypotheses derived from observation with in-depth participant interviews. This speaks to an important distinction between research and consultancy, where the latter constitutes a request from a host trusts membership. In this instance an external consultant is invited to offer insight and support towards collaborative change. Whereas the present research was initially a proposal made to

the host trust, and was not directly part of the integration programme in a capacity to contribute to planning and decision making. Action research could also offer a means of iteratively developing and testing hypotheses, an approach more closely affiliated to the clinical practice of testing hypotheses about unconscious contents. The implication for the present study is that the hypotheses and insights developed are necessarily tentative, and are likely to require further exploration and testing to verify their pragmatic usefulness within the host organisation, and broader relevance within a healthcare system undertaking integration of clinical care at scale.

There is evidence of significant inequalities in the composition of NHS senior management teams (Hussain et al., 2020), and the recruitment of the reflective group in the present research could have been more explicit in relation to evidencing its diversity. Critiques of historic priorities in equality, diversity, and inclusion can be made on the basis of solely focusing on quantifiable demographics. Progress against the NHS Workforce Race Equality Standard is an important metric, but the experience of minoritised professionals are nuanced and widely varied (Ross et al., 2020). If done well the present method of associative enquiry has the potential to contain painful emotional experiences, democratising the power and knowledge arising from professionals felt experience. The systemic use of reflective practice requires support organisationally, as the feelings evoked must be able to be contained and responded to effectively (Kurtz, 2019). Failure to do so would risk deleterious impacts on those already subject to the intersection of multiple inequalities. In light of this, future research in this mode could expand participation within the observation and reflective group to more adequately represent the local people and populations affected by organisational change.

Conclusions

This research aimed to use an observational method of subjective enquiry, exploring the process of integrating neurology services in an acute NHS hospital. The findings highlighted dialogical pressures operating horizontally between historically separate departments, and vertically between corporate and clinical professional roles. This accorded with the literature conceptualising the NHS as an intersecting spatial, and relational network. While the spatial aspects of NHS trusts such as territory and structure saturate organisational research, the present findings articulate how human feeling is both shaped by and constitutive of structural boundaries. A key finding has been to elucidate the competing tasks which emerge from publicly funded healthcare. Put simply the demands of clinical care, versus administrative oversight and bureaucratic management. Associative enquiry within systems psychodynamic frame is presented as a way of thinking about organisational life, capable of generating symbolic meaning for split off feelings.

The function of containment in human relationships and systems provided a way of conceptualising the research findings at multiple levels. This included the internal processes of the researcher, to changing ways of relating between groups within the organisation, and finally implicating long standing relationships with regional treatment centres external to the organisation. The integration of feeling into structural changes was conceived as requiring the researcher to make contact with intolerable feeling states that were personally resonant, such as rage and profound loss. Reflective non-hierarchical groups were a means of collective sense making of these unconscious aspects of organisational life. While acknowledging that in its own right this way of working is not definitive, it provides a reflexive space particularly suited to the intersection of clinical and corporate organisational roles. This function was considered as analogous to the human nervous system, which integrates various forms of

information from the external environment, and internal world, in order that decision making can accurately reflect the reality of a given situation and task.

The complexity of NHS systems was ubiquitous throughout the research process, and stepping into a new organisational context from a predominantly clinical background provided valuable personal and professional insight into the pressures operating between clinical care and administrative oversight in the NHS. The term integration is synonymous with structural changes to organisations, but a key finding of the present study was the need to integrate human feeling within the clinical and administrative task.

In combination the systematic review and primary research project found organisational transformation and integration evoke local histories associated with professional identity and place. As such the applicability of observation and associative enquiry to co-production with NHS professionals was highlighted. Suggested approaches included forums containing researchers, professionals, and by virtue of a non-hierarchical structure, the involvement of the public and patients. The use of self as an instrument of knowledge production offers much, but must be held in a curious and tentative way. Critiques of the psychoanalytic model highlight a tendency to profess absolute knowledge. While this is a stereotyped shortcoming, it is a trait to be actively guarded against. There is no value free form of research, and the associative method presented offers a practicable and robust way of embracing the way subjectivity and relationality shapes human endeavour. To sideline this receptivity to the unconscious is to embrace its governance through compulsive repetition.

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Appendices

Appendix A: Quality Appraisal of Studies included in Meta-Ethnography

		(Shaw, 2002)	(Shield et al., 2002)	(Fulop et al., 2002)	(Fulop et al., 2005)	(MacIntosh et al., 2007)	(Fulop et al., 2012)	(Ovseiko et al., 2015)	(Rogers, 2021)	(Maile et al., 2022)
1.	Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.	Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y
3.	Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.	Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
5.	Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y
6.	Has the relationship between researcher and participants been adequately considered?	N	U	N	N	N	N	U	U	Y
7.	Have ethical issues been taken into consideration?	N	N	N	U	N	Y	Y	Y	Y
8.	Was the data analysis sufficiently rigorous?	U	U	Y	Y	N	Y	Y	Y	Y
9.	Is there a clear statement of findings?	Y	Y	Y	Y	U	Y	Y	Y	Y

Note. Y=Yes, N=No, U=Unclear

Appendix B: Example Coded Transcript

Transcript

9 September 2024, 07:59am

0:10NOAH: Morning, Isabella.
0:12ISABELLA: Hi Noah, how are you?
0:13NOAH: Yeah. Good to see you.
0:15ISABELLA: Good weekend.
Yeah, I lot going on, I imagine.
0:22NOAH: Yeah, my daughter started school last week, so.
0:24ISABELLA: Oh my goodness, how did it go?
0:26NOAH: Yeah I think it went all right.
0:29ISABELLA: Oh, how exciting. How are you? Did you manage?
0:33NOAH: Yes, yeah, fine. It felt like a really long week.
0:37ISABELLA: Yeah, it it. It does. I think everything is dictated by school now. But how exciting my goodness.
0:44NOAH: Yes.
0:45ISABELLA: Morning, Ethan.
0:46NOAH: Morning.
Hi, Ava.
0:50ISABELLA: Hi.
0:51AVA: Morning. Morning.
Morning.
0:53ISABELLA: Name.
1:01NOAH: Don't think I've heard anything from Sophia.
1:07ISABELLA: Sorry. Apologies again Noah, for having to leave at 10, But just today, thank you.
1:10NOAH: No worries.
1:20SOPHIA: Good morning.
1:21NOAH: Hi, Sophia.
1:22SOPHIA: Hi. Morning. Oh, we're back. We haven't met for a couple of weeks and we're here as a full group, which is really nice. I think it's the first time we've all been together.
So perhaps before we kick off, Noah, do you want to just update us in terms of where you are with your observations and anybody got any questions or anything before we make a start?
No. Perfect.
Noah then if you want to.
Give us a bit of context.
2:02NOAH: I've probably got one left to do.
So I thought today I would go the last time we met, I tried to do 2 in one and then it sort of it was just a tiny bit of time at the end really.
So I thought I'd go back to the week. I tried to squeeze in.
And then it would be.
If I do one more observation then that will be like one for the remaining meetings we have.
And yeah, so sorry. Go on.
2:31SOPHIA: I think, yeah, no, I think that's very sensible. And I was having similar thoughts actually in Ethan, just to fill you in whilst you're away there was one group that I had to cancel at the last minute. So it meant that when we met the second time the following time, sorry, Noah then had two observations that we thought we might try and split the time and and, go through all that material. But it was a little bit challenging in one session. So if we've got enough

Commented [HH1]: Code - negotiating flexible time boundary of the reflexive group

Commented [HH2]: Code - group membership complete for the first time of the reflective group

Commented [HH3]: Code - frame of the reflective group affected by changes in scheduling

groups, Noah.
To bring one per group.
I think that makes sense.
3:05NOAH: And it it sort of, well, we'll maybe think of this nearer the time, but it seems to have dovetailed with.
They're really pairing back the meeting I am observing, so kind of move to fortnightly, much quicker. Not quite sure what that's about, but it seems to have been a nice light window to observe where it's a bit longer the meeting.
3:26SOPHIA: Mm hmm.
3:28NOAH: Umm.
3:29SOPHIA: OK. So therefore today you'll be bringing observation number, which number will that be then?
3:39NOAH: I can't remember if I've changed this number, might be 4.
3:42SOPHIA: Yeah, I think our group meetings four.
3:46NOAH: OK.
3:46SOPHIA: And and then the observation itself is that the 4th observation as well? Or is it the third?
3:54NOAH: Feel like the 4th? I might just double check that.
3:55SOPHIA: OK.
4:05NOAH: Yeah, I don't know if it's like, just super brief recap is like. The the, two hospitals, they're they've really moved forward with changing to like a single management structure. So there's a shadow one starting and that, it's like the Ipswich management team is taking it over, because it's the sort of, quote unquote better service.
And they're doing that across the trust.
Each hospital will run its own like Acute, and A&E service, and then the Ologies will be kind of one will go to one hospital, one will go to the other. So they're sort of dividing them up. urm.
And just a sense that.
There's there's talk of like this transformation process being handed back.
Sort of before it's finished or or like.
The transformation team, feeling it's not quite not going to be where they envisaged it, but it'll be for the frontline teams to like take it forward.
((Pause))
5:20SOPHIA: Right. Thank you. Well, shall we move into however you want to present the material whether you want to start with your kind of written presentation then show anything that you've drawn or the other way it's up to you. However you'd prefer, Noah.
5:32NOAH: You know, that's it.
What's it like now?
So this was on like the back or the middle of August or the 15th?
5:40SOPHIA: Mm hmm.
5:43NOAH: I'm just wondering it might feel like I'm slightly less in that place, kind of reading back, but there's like at home a joint credit card had arrived in the post and just before the call was due to start, I

Commented [HH4]: Code - boundaries between the separate observations collapsing as the amount of material to bring increases

Commented [HH5]: Code - confusion about which observation is being considered on the call

Commented [HH6]: Code - trust wide redrawing of structural boundaries across medical specialties

Commented [HH7]: Code - process of change being handed back to clinical teams before it's finished.

Commented [HH8R7]: Code - the privilege of a hard time boundary to organisational role within change.

was downstairs and these like cards had got just lost in the mess my daughter had picked them up and something that I could like a shared account, but it's in my daughter, my daughter's name, my wife's name. So it's like I can't really see the account. erm.
And that was just before the call the the call start time was delayed again, so it felt felt familiar anxiety about how to join the call.
Not wanting to encroach on conversation, including other specialties.
Ended up messaging on the group chat, implying like a request to be called in by the facilitator.
erm, So there was, then messages in the chat coming through like.
Two call facilitators from the transformation team were completing.
Catering training.
Has explained to me once I joined the call like directly, so I was addressed that there was strike action was planned over the next two weeks at [redacted]. Soft facilities management. So that's like cooks cleaners, porters and their contracts going to an external provider.
erm.
And so just I just had a memory of like posters being physically up around the hospital about that team being sold out. erm.
Reference to, like legal strike action in emails from the CEO, this kind of reference towards the rights of, like unionisation, kind of noticed that over the last.
That's right, strikes have been ongoing for a year or so, haven't they, maybe longer.
And I had an association about a listen to an interview between Trump and Musk as like reference from Trump to Musk being like the best at firing people who strike. urm,
It's a bit. It was like a contradiction with who Trump is trying to target.
And as part of his sort of wider campaign was an idea that he'd.
He sort of messed up a bit 'cause. He's like trying to reach unionised workers, but what he actually thinks is that's that. People who strike, really.
There was quite a jokey atmosphere in on the chat. The MS Teams chat before the start of the call. It was like a meme sent with a young boy dressed as a cowboy. He was like dancing. And then he kind of finished with, like, an elaborate flourish with his hands.
And there's comments being made kind of referencing.
Discussions on the call, so like a different specialty before I joined.
It was kind of like quite warm sarcasm, like people taking the piss out of each other, but it didn't seem like malicious or.
So the head of Transformation was away on a visit today and he, like

Commented [HH9]: Code - association to the practicalities of shared bank accounts in a chaotic environment

Commented [HH10]: Code - familiar anxieties about encroaching on conversation involving other specialties

Commented [HH11]: Code - observer initiating communication to enter the group call

Commented [HH12]: Code - the fall out from a decision to retender soft facilities management to an external provider

Commented [HH13]: Code - observer addressed directly within the call

Commented [HH14]: Code - conflict between NHS staff groups and the organisation

Commented [HH15]: Code - association to the contradictions apparent in american politics between business and unionisation

Commented [HH16]: Code - jokey atmosphere in the MS Teams chat before the observed neurology section

Commented [HH17]: Code - permeable boundary between content of discussions with other medical specialties

he described it as like going to a gene therapy catapult event. erm. So this is now like into the discussion, but so the single site management structure was raised for discussion. The facilitator referenced an e-mail from HR, but neither of the clinical managers, 1 from either hospital on the call.

Had had been copied into that, one joked they felt left out.

And the content was like it was a recommendation from HR that the planned changes require a period of consultation.

Sort of. There was a sort of quote. It was best in the long run in case anyone were to raise a grievance down the line.

So the e-mail was forwarded on in the meeting.

But then a comment was made by the facilitator, who'd sent that e-mail. It was to be like, read outside the session. So I kind of looked up at that point.

It appeared.

((pause))

Cant read my writing, it was like someone had started to read the e-mail, but then was not. Yeah, I suppose it maybe felt like told off a bit or like pulled back on to the task. Erm.

So the yeah, the e-mail was sent, it was started to be read and then, he was trying to, like, continue the conversation.

Today they discussed, like planned joint funding, for a clinical nurse specialist within multiple sclerosis. The Ms Trust had been planning to fund.

Like 80% of the role, with the trust paying for the remaining 20%. But now they are pushing, the MS Trust, pushing for like 5050 split with [redacted] and there was like an annoyance that the original external offer which had been signed off internally by the DMT.

Seems to have been recanted.

And I had a curiosity about. Like the university locally, whether they were accessing similar funding streams.

But perhaps moving quicker, so like conversations about, yeah. So in my first year, I've been aware of this trust trying to fund a member of staff, and it's just been very slow to get off the ground in the NHS.

And I wondered whether someone else had moved quicker. Erm.

Yeah. And for a memory from a previous call came to mind that [redacted] the trust had suggested the idea of 5050, to try and make it happen quicker.

Yeah. In order to try and bring the time scales forward.

So it was like an annoyance that it would move to 5050, but from my memory at that been suggested in the 1st place by the trust.

I was addressed directly again by the facilitator. Err. When he like, he

Commented [HH18]: Code - Clinical managers excluded from HR communications about the creation of a single site management structure

Commented [HH19]: Code - the organisation protecting itself from grievances that could be raised by staff down the line

Commented [HH20]: Code - the assertion of hierarchy within the weekly catch up

Commented [HH21]: Code - lack of task clarity on the weekly catch up, process v's outcome

Commented [HH22]: Code - annoyance with an external charitable funder recanting an initial offer for a CNS role within Neurology

Commented [HH23]: Code - curiosity about competition between local services and institutions

Commented [HH24]: Code - annoyance being projected into external organisations

said, he was like tying himself in knots about the funding split and the proposed length of the fixed term contract. He was kind of almost embarrassed, like he couldn't work out the numbers trying to, like, stumble over himself.

And then like, this is off the record. Don't put this in your report, Noah.

This is the kind of soft qualitative evidence the NHS needs quite sort of like sarcastic.

I think maybe felt embarrassed.

So I felt a need to respond verbally, like I think you're overestimating my maths. But like I needed to offer something, that there was kind of free wheeling worry about, just like losing his place.

So the atmosphere became quite giggly, with lots of jokes being made. Erm.

Facilitator talked about their own like CPD, and a need to be more assertive.

I've written frustrated with life at the moment. I think they must have made a kind of off hand comment about that.

So this, this, that kind of talking about his need to be more assertive, it had come after an interaction with the two, like female clinical managers who somewhat forcefully directively.

Were given a time critical action that needed completing urgently before people went on leave.

And they were including in their discussion, like the availability of a colleague whose wife was due to give birth, and they're talking about him as being so helpful. But his wife is fuming. He's still at work, because things are on the knife edge at the moment.

So this like directive action giving it was closed by a joke about Chelsea Football Club.

Oh no, sorry. Close by joke about CFC not and then to the acronym CFC is used, but then, there's a joke made that it's not Chelsea Football Club, although it wasn't a bad example as they spend lots of money needlessly.

So I've I've noticed myself feeling really quite giggy and like grinning, you know, like, I felt like I couldn't keep a lid on it. I couldn't like a Cheshire cat trying desperately to stifle this, like making it harder not to smile.

Around that time, I felt like one of the clinical managers seemed to like change tone or mood.

Wondered if she was, like, frustrated with the jovial, silly tone on the call. So it like it was almost like it's switched or flipped, and then suddenly was trying to. She felt much more serious.

Commented [HH25]: Code - embarrassment evoked by the presence of the observer and imagined implications of an evaluative report, defended against with sarcasm

Commented [HH26]: Code - observed responding to direct communication of anxieties

Commented [HH27]: Code - frustration with a continuing need to be more assertive

Commented [HH28]: Code - pressures to deliver outcomes encroaching on peoples planned annual leave

Commented [HH29]: Code - tensions between being available and helpful in a professional capacity, and this causing conflict in people home lives

Commented [HH30]: Code - association to the NHS broadly spending lots of money needlessly

Commented [HH31]: Code - desperate to stifle giddy feelings and grinning like a Cheshire Cat

I suppose that kind of added to my sense of like. Stop smiling.
But the age of everyone on the call seems comparable, all white.
On my screen I appeared at the top row next to the facilitator, two clinical managers. Below. It was like the men at the top, women at the bottom.
And there was this thing about the kind of the head of transformation is a different generation. It was like the the parent was away kind of thing. It felt a bit like that.
I noticed early in the call one of the ladies was hiding her face from the screen, which was kind of.
She's like my she was kind of hunched over, maybe like under the weight of her work was my association. This was someone I hadn't seen on the call before.
I think from the [redacted] Hospital.
In relation, so back on the funding of the CNS role, clinical nurse specialist, this lady made a comment. There's a big difference between the trusts committing to 20% and 50%.
She then paused and finished her thought or statement by saying 30%. You know, she's sort of naming these two numbers.
And then, like, slowly worked out. But it was like quite a simple calculation.
And this was like around the same time as the facilitator kind of making jokes about their own maths and kind of losing the thread so there's something about sort of figures being.
People stumbling over them, finding it hard to use them. Erm.
And. Yeah. And then I've got just a thought here. Like the to the new person on the call, I followed up with them about consent afterwards 'cause. Because it was my kind of recollection I hadn't got that in place.
So after the meeting.
They responded by apologising for the chaotic meeting.
But it turned out they'd already sent me the form, so I sort of asked again for the form, but they'd already sent it signed, so I'd put that in place, but. erm
Just sort of like bit sloppy kind of a bit. Not kind of operating super smoothly.
Those are actually like my written thoughts from the meeting.
17:35SOPHIA: OK. So would we like to spend a few minutes? Reflection upon Noah's written notes and then go to the picture. Or would people like the picture now and see it as a whole? We've got plenty of time today, so I guess we can do it. However, however we prefer. Does anyone have a preference?

Commented [HH32]: Code - the tone flipping from jovial to much more serious

Commented [HH33]: Code - lack of diversity in age and ethnicity present on the call

Commented [HH34]: Code - Digital format subtly reinforcing a stereotyped gendered hierarchy

Commented [HH35]: Code - generational difference to the senior leader, meaning it felt like the parent was away

Commented [HH36]: Code - association to a member of the call being hunched over under the weight of their workload

Commented [HH37]: Code - impression of significant workload associated with the neurology department due to take over the single management structure

Commented [HH38]: Code - difficulty with maths being handled by making jokes

Commented [HH39]: Code - figures being stumbled over and not able to be used fluently on the spot

Commented [HH40]: Code - difficulty holding in mind who had given consent to participate in the observation, requesting consent when already in place

Commented [HH41]: Code - chaotic and sloppy tone to how tasks are being undertaken

No. Well, shall we start by reflection upon what Noah's brought already? And then we'll look at the picture and see how that correlates with with what we've already got. So any thoughts and reflections upon the account of this meeting?
Isabella.
18:29ISABELLA: Sorry, I thought. First of all, I think I was making more of an effort today to keep my writing and my thoughts a bit more, more organised.
And then I've tried to kind of draw out some themes.
But ((stuttering inaudible)) I'm looking back on my notes, I've I've got lots of.
Comments like erm there's a sense of being out of control.
Lots of comments about erm, that make me think of who has the control here, who's who's in charge, who has the power.
And it was. It was really interesting, kind of in in your erm reflections, Noah, the the talk about the transformation, it made me think a bit about erm, is this just something about the NHS, there's all these big ideas and then?
The transformation process isn't really what was envisioned. It's now back to the frontline work because, I think to move it forward, you said and it made me think of is this just a theme with the NHS? It's almost like is there not enough front, for the frontline staff to do and the vision doesn't always live up to to to reality.
I could. I could feel a sense of.
Almost frustration in in terms of when you were describing some of the meeting, it was almost like it was nice that it was kind of humorous and the jovial and a kind of casual. But then I felt like there was almost something not necessarily sinister, but something that felt. erm.
Almost a bit careless seeing what was going on, in terms of people who are meant to be in charge and in control.
And and your references to.
try and put Masks, are people who are really in control and powerful, and then the idea of other professionals having to go on strike. Lots of comments about being sold out. urm.
So again, my my thoughts were around, you know, who's who's got the power here? Is it the CEO's? Is it the unions? Who's who's really in control?
And then there was a comment about erm, an e-mail being shared that wasn't meant to be shared in that space. Then some other mention about people not having their figures and almost making them up or losing the thread of the math, and they made me think of

Commented [HH42]: Code - time and effort being given to organise thoughts in order to present them to the group

Commented [HH43]: Code - lack of clarity about who has the power and is in charge

Commented [HH44]: Code - NHS transformation not as envisaged

Commented [HH45]: Code - frustration that the people in charge seem careless

Commented [HH46]: Code - Hierarchical power struggles

again, is this just isn't the NHS, is it just messy and we can't keep seem to manage in a way the the thread and the organisation of it is that.
Is that the government? And it felt like the people who should be in control of all these things aren't really. And there was a sense of mischief that wasn't malicious you said, but there was almost. I made comments about. erm.
Competence, are people here who are managing these things to be trusted, as it do they know what they're doing kind of thing and that made me angry. And I wasn't sure if I was then reflecting on some things, maybe at work or.
Or personal life about not feeling in control, somebody else, always dictating or deciding, but then they don't seem to know what they're doing. So that's kind of where I went with that.
If that makes any sense, but yeah lots of, yeah, lots of thoughts around.
Who is in power here? They they know what they're doing? What's, who's managing? Who's in control?
22:00SOPHIA: I had a kind of sense of. erm, Kind of real fragmentation. I felt really fragmented throughout. A lot of that account and I was trying desperately to sort of catch up and I was thinking it almost felt like the break was longer than the break has actually been. And I was trying to sort of recall our last group meeting and then the last group meeting that you shared. erm.
And I got to think about membership and I was thinking about how we're meeting today as. erm.
A group ourselves for the first time.
As a large group and then I was trying to remember I thought has everybody done an introduction? Actually, I think Ethan and Isabella have met, but have they met? I knows are you know, so I was so I became quite preoccupied with like the group and the membership and the task. And I think then I was thinking about your group and their membership and their task and how in some way I felt like the meeting that you described was quite focused upon sort of small, small detail in a way of like.
Money. And who's going there? You know, a sense of a vision didn't seem kind of that apparent. And then I was thinking about how you opened the meeting a bit of context by saying, actually, since we last met quite a lot has happened, decisions have been made, things have taken place. And again, it did make did make me think about some of the past content around.
How to sort of engage the, the frontline workers and how that's done

Commented [HH47]: Code - anger at people who don't seem to know what they're doing dictating, leaving others feeling out of control

Commented [HH48]: Code - the perception of breaks between sessions associated with fragmented experience

Commented [HH49]: Code - preoccupation with the group membership and task

Commented [HH50]: Code - a focus on detail rather than over-arching vision apparent in the observation

and how much sort of to Isabella's point about power and authority might they have as a group compared to the sort of leadership group and how that seems to sort of ping pong around in a way, it's almost like, oh, well, the transformation's kind of done and it's not exactly where we thought it would be, but it's somewhere and now we'll kind of hand over a bit more to the frontline staff and and reflecting a bit on on again what Isabella said about.

Transformation concepts in general, I think that I got a real kind of strong sense of our organisation actually, and we're going through or we're at the end of, on paper a kind of five year intervention, transformation project and how how these things end actually like. How do you end, like the sense of transformation is done, but often something might be done perhaps on paper, maybe that's the solution or where things things have come to but?

I guess. What I'm sort of picking up on those oscillating between those two things, that sense of an ended completed transformation and a meeting that still seems to be grappling with. Quite a lot in quite fragmented way. And again, I came back to membership, which I know I've thought about before. erm.

And our membership as well.

25:12ETHAN: And before you'd said about the erm transformation lead, not being here this week, that was kind of when you said that, that kind of captured the sense I got, sounded almost like for the group it was a bit of a week off. erm.

And suppose I thought about it. Actually wondered what time they do have and there I can almost imagine their outlook calendars. Just full of all these meetings and it was almost like this was a bit of a breather to be like, bit giggly and a bit like unfocused.

Yeah. Yeah, that sense. Like whoever's normally kind of keeping things on track and a bit more focused.

And the slightly more, less charitable part of me was like wondering about, like, how competent are these people? Like, definitely, they're kind of more scathing. Part of me. I was like, yeah, like, say, like some very basic maths there. Like, we're just not grasping it.

Which yeah, was a bit frustrating. Probably a bit like Isabella's second bit. Like, come on. And the thing that really lingered with me, though, and I just couldn't.

Was when you pointed out the thing about like Trump and Musk and just that, like, yeah, really brutal. Like idea of, like, who's good at firing people.

And I related that to like much if these some of that's been outsourced, probably highly likely, isn't that people lose their jobs in

Commented [HH51]: Code - leadership and authority seems to ping pong around between different groups in the organisation

Commented [HH52]: Code - oscillating between an end to transformation on paper, and the unsolved grapple with fragmentation

Commented [HH53]: Code - a week off with the senior colleague being unable to attend

Commented [HH54]: Code - imagining full outlook calendars, and taking space for an unfocussed breather

Commented [HH55]: Code - scathing evaluation of peoples competency evoked in the reflective group

amongst that, or they'll lose pay or something like really important to their basic fundamental needs. And then this kind of giggly quite light hearted, some memes and stuff flying around and just felt like such a contrast to know there's probably this other story about. highly likely isn't it? People losing their jobs or not paying out to afford things or pay their rent or what have you?

Yeah. Yeah, that's kind of the main image. It didn't matter how much you're talking about things, it just got really pulled back to that and actually wondering about what's going on for all these other people anyway. Were they called like soft, soft services or something?

27:19NOAH: Yeah, just a link to Sophia's point there. So the the like [redacted], half of the trusts, people who do that job are already like a private provider, but the.

27:20ETHAN: And.

27:31NOAH: It's just come up for that has come up for retender. So there's an opportunity for the board to like do one thing across the trust. So these soft facilities management people at [redacted] are going to.

Go out to a kind of private provider. Thinking about membership. There's a lot about losing their status as NHS employees and all the kind of TUPE stuff. would would apply so they they shouldn't initially lose. It does remind me of some of my previous experiences years back of being TUPE'D into a different organisation and how kind of unsettling that was.

And just this strike, strike action has had a much bigger influence on the kind of, for want of a better word, corporate services, so like they've been training to do.

That these two guys have been doing like catering, training and portraying stuff and almost like it's more disruptive than doctor strikes for them.

In their roles.

28:39AVA: Makes me think, I don't know if this is the saying how the other half lives, how the other side lives kind of almost, yeah.

I was really.

Struck by the sense of exclusion so.

Every time you talk, every time there's a presentation, I lose all feelings and I don't know what happens to my feelings. I just feel.

Yeah. I just feel really empty and blank. And then they they seem to be recovered when the group talks.

And I wonder if this is.

I don't know that what happens to the feeling when the work is kind of focused on kind of tasks and getting along and kind of process

Commented [HH56]: Code - really brutal decision to outsource jobs contrasted by light hearted giggling and meme's

Commented [HH57]: Code - wondering what's going on for all these other people.

Commented [HH58]: Code - personal resonance to the unsettling nature of TUPE processes

Commented [HH59]: Code - corporate roles more disrupted by soft facilities management strikes than doctor strikes

Commented [HH60]: Code - sense of exclusion from how the other half lives

Commented [HH61]: Code - losing all feelings when the observation is presented, but recovering them when the group talks

and moving things along.
And it made me think about erm, the jokes and.
Kind of always at the moment of humour, as a way of kind of almost.
Getting rid, or at least an attempt to try and get some feeling kind of moving in the in the team or in the members. ermmm.
I think someone used the word sinister. I think when that was kind of mentioned, I thought yes, cause, because the thought that came to my mind as again mergers and acquisitions but mainly kind of exclusion and what happens to people who gets.
Yeah. Who gets kind of placed aside or who gets.
Scapegoated and who get yeah, because whilst the matter's really easy, but I also wonder under pressure what happens to people.
There's almost a point of denigrating and I'm noted, Noah, you said.
You made not a joke about yourself, but you said, oh, I you know you're underestimating me. So there's something around. The only way to be here is to be.
I don't know to not to not know something around knowing and not knowing, and with the absence of the lead of the meeting.
What happens to its members, or what happens to people?
That's pretty much it. I'm just grateful that I've got my feelings back.
((laughter))
30:48SOPHIA: Oh, you're saying that's how it made me think about?
Because I was curious about your place, Noah, in the group again.
And how what you represent. And this time again, I think you're there in a sort of reassurance type capacity. You know, there's, you know, seeking, seeking a sort of reassurance from you for something. And it made me wonder about what you just said there, Ava, about how actually these, you know, these decisions, these decisions are.
Are big decisions are big decisions and important decisions, and to your point, Ethan, how is this group managing that, whether it's?
Kind of cut off from its emotional state or this kind of almost quite incongruent emotion comes in whether it's the giddiness and the giggly and all of those things and and whether that is the defence against, you know, what the task really is. And then.
Your presence is a way of just trying to seek some reassurance. You know, I don't think it's on a conscious level, sort of below the surface, but to seek that reassurance of, yeah.
Are we doing OK? Because I think it's the. Is it the head of transformation? Again, I get membership with this group really, really muddled. But is it the head of transformation that often messages you separately, Noah? Was that the person who wasn't there at this meeting?

Commented [HH62]: Code - what happens to feeling when the work is focused on tasks and moving things along, humour is an attempt to get rid of feeling find of moving in the team or in the members

Commented [HH63]: Sinister exclusion of people under the pressures of merger

Commented [HH64]: Observer Denigrating self because the only way to be here is not to know

Commented [HH65]: Code - I'm just grateful I've got my feelings back

Commented [HH66]: Code - the observer being recruited to provide reassurance in the face of overwhelming decisions that are being taken

Commented [HH67]: Code - whether the group defends itself from the reality of the task being really big important decisions

Commented [HH68]: Code - the observers presence a way of seeking reassurance the group is doing ok

32:11NOAH: Yeah, that's who I sort of set the project up with.
32:15SOPHIA: Yeah.
32:16NOAH: It's interesting (inaudible) he doesn't. I don't think he technically leads the meeting each week, he's normally there, but it is the the person who facilitated that week would normally be facilitating but. But yeah, that presence wasn't.
Wasn't there in the in the?
32:31SOPHIA: Oh, that's interesting, 'cause. I wonder if I, in my mind, that person, when you've used the phrase head of transformation and talked about how that person messages you and you were the person that you set things up with, I think I'd wrongly obviously made an assumption that that person was also perhaps the chair of that meeting. erm.
So that's interesting in a way. You know that so.
Whoever's taking up that role of the chair don't think well.
maybe others have the knowledge, but I don't think I do so again, there's something around role and membership in this group.
That's interesting.
33:12NOAH: I think it broadly less formal. I've talked about the programme steering committee. You think that is like, very formal kind of structure and.
This is much more informal catch up each week. Erm.
33:27AVA: Oh, so you think Noah 'cause you're not invited to that one, are you?
33:32NOAH: Yeah, I have joined the other one like, yeah, yeah, but not with the. I've got nowhere with getting the whole 30 odd people to give consent, so.
33:32AVA: Oh, you have like a.
33:43ISABELLA: I was just wondering if.
33:43SOPHIA: So this is the kind of task. Oh, sorry, Isabella. You go first.
33:46ISABELLA: It was just a thought just now. I'm just wondering how is if if there is any sense of anxiety, maybe about you being there, something about. Oh, don't put this in your report. I was just curious about that, that, that sense that's. And as a psychologist to be almost kind of, are there things you shouldn't be witnessing or how is it about the scrutiny? Where will this end up in terms of a report. I was just wondering when you were describing that when there is any anxiety about what your role is there. Sorry Sophia that was just just a thought.
34:19SOPHIA: No, no, go for it.
34:19NOAH: I I just had a thought about that and then pushed it

Commented [HH69]: Code - unclear roles and membership of the weekly catch-up meeting

and finish group which reports into a larger kind of steering group.
And you've probably said all of those words before, but for some reason they hadn't landed.
And and it took kind of, you know, moving through the work.
For me to connect with that and again, I wonder what commentary that is on, on the experience of of this group doing a, the task, whatever the task you know, is the task clear and how does it relate?
And then now of course I don't want to preempt something, but now it seems like there has been lots of decisions made and the group are in a different place now to the wider group, the organisations in a different place actually to where it was before.
37:49NOAH: Does make me think I've got access to those?
Things in a kind of different roles. The the breadth of what's going on in formal conversations. But what I've got consent to, like, observe, right up, reflect on here is is like.
I'm wondering about my difficulty in like differentiating those things or sort of assuming you know the stuff that I'm just sort of holding in mind obviously don't.
38:21SOPHIA: Yeah. And that's curious in a way, because I, I was thinking about how right from the beginning there was a sense of the difficulty of consent.
And and and how you manage that and how maybe we manage that.
And so it is like we've got this like.
Like appropriately so. But we've got this kind of small snapshot, you know, so this kind of wider.
Endeavour, vision, whatever it is, we might not know. So we're trying to kind of build something based on on this, again, small snapshot and it does make me think about transformation actually and think about that sense of.
How how do you communicate as an organisation when taking on something?
So wide, so vast. erm.
And communications often quite complicated. I think, in these endeavours not, not just because of issues around sort of confidentiality and things like that, but just in terms of large numbers, large organisations and reaching people. erm.
And maybe that comes back to some of the thoughts around exclusion and inclusion and.
Who's in the know the other half, one half and the other half?
39:58NOAH: Think of like the kind of, you know, the figures not really being fully on top of them in that meeting, meeting spent a lot of time looking at neurology, thinking about neurology.

Commented [HH74]: Code - it takes moving through the work to connect with the membership and task of the group

Commented [HH75]: Code - difficulty in consent reflecting the distinction between a small snap shot and wider vision of the organisation

Commented [HH76]: Code - complexity of large groups creating inclusions and exclusions

But that they're sort of more central team, they're thinking about that across different specialties, so it's like.
You gotta, like, think about which specialty and which set of numbers, and there's all that complexity like multiplied out. Whereas I'm sort of zoomed in on one area.
And.
40:31SOPHIA: I'm just looking down at my notes actually, just as we're talking about these bits and I'd written down here, one of my reflections and just written the messiness of collaboration. And you know, maybe that is partly what we're kind of exploring now, you know?
It's it's such a messy endeavour and I think often it's tried.
(Pause)
The complexity of it, as you've just said it, I wonder whether sometimes that isn't really.
Given. The sort of. The weighting it should be given in a way. I think it's often kind of simplified. It's like, oh, we need to collaborate. Collaborate is often thought about as a wholly positive sort of endeavour. And the pain of collaboration and the inclusion exclusion, as we've talked about with the mergers and the acquisitions, it's.
And what Ethan was saying about, you know, those who don't make it, you know, it's.
It is an incredibly painful process. Yeah, I don't know whether.
That is attended to and whether some of what we see is a way of managing that.
Before we move on to the drawings, I've just been curious. I don't know why, but it's just come into my head a couple of times as we've been talking, but.
How are you feeling, Noah? Like, where's your emotions at right now? I don't know. It just feels.
Important to us.
42:23NOAH: Yeah, like right now, I suppose cause 'cause. Actually my observations are further on than this one I talked about today.
42:28SOPHIA: Mm hmm.
42:31NOAH: Relief that it's like.
42:32SOPHIA: Mm hmm.
42:34NOAH: Ending. Not that it's ending, but like I've I've got them. I suppose got my researcher hat on, like got more or less the material I need.
42:41SOPHIA: Mm hmm.
42:45NOAH: Yeah, thinking about ending, really. And that's in my mind.

Commented [HH77]: Code - zooming in on a specialist area manages complexity being multiplied out across the organisation

Commented [HH78]: Code - messy complexity of transformation not given the weighting it should be

Commented [HH79]: Code - whether the painful inclusion and exclusion of collaboration can be attended to, or whether it has to be managed by splitting off feelings

42:49SOPHIA: So that's kind of interesting in a way. So because right now we're in this space, which was sort of four weeks ago or something in terms of the observation, but you're connecting with, you know the ending and the moving forward. And again it's just it's where we locate isn't it that?

43:07NOAH: And and this this week and the previous week was the one where I had, like, just a completely separate clinical meeting like right after the observation was due and I just couldn't get away. I was just screaming inside. So at that week and then this one felt like the feeling was most at the surface like a bit all over the place.

So I'm I'm maybe I'm sort of feeling.

Glad that's done. Move on. Do something else.

43:35SOPHIA: Hmm.

43:37NOAH: There's and. That's the sort of transformation sort of team isnt it, it's removed.

43:42SOPHIA: Mm hmm.

43:43NOAH: That's a bit critical, but like they get to move on and do the next thing.

43:50SOPHIA: But there's something interesting in that which is that you know, the that unbearable feeling, this other pain, the messiness, the scream, you know, that just has, like, just have to move on from that, you know, need relief from it. Like, where does that relief come from? Erm.

44:05NOAH: Yeah. And in the small way each the start of each meeting.

I've never like just signed on at a time where it's like neurology starts at this time. I've never just like, joined the call at that time. I have to like.

Negotiate it. Check. I'm not going to stumble into something else. Like.

Yeah. It's hard to sit with.

44:29SOPHIA: Yep.

Any final associations or reflections before we move to Noah's drawing.

No, all good. OK, Noah over to you.

44:59NOAH: And if I just leave up there or maybe say something like that.

45:07SOPHIA: I think you can just leave it up there, given that we've heard your written account already.

((Extended Pause))

If anyone wants to share any thoughts or associations, please do.

I'm having a feeling of this is familiar. Did we? Was it Isabella and I

Commented [HH80]: Code - managing difficult feelings evoked by focussing on ending and moving on from the work

Commented [HH81]: Code - glad to be moving on from feeling all over the place

Commented [HH82]: Code - where does the relief from pain come from if it can't be moved on from

who saw this very briefly at the end of? Yeah.
46:09NOAH: I did. We did sort of very briefly.
46:26ISABELLA: But why? I was curious about the dog. Noah. Oh is. I don't know if we talked about that last last time.
46:35NOAH: like it, so it must have been. It's a bit hazy in my memory but. So it's like my dad's, it used to sit on his like man, window sill to like, around that time, I think I'd been back to my parents. It's now, like, on the desk here.
Just thinking about the sort of.
Just. Yeah, it's a nice thing to have. It's also, like, super sad. A lot of, like, really intense feelings stirred up around that time. Think about that thing of, just in a bit of a rush to get away from feelings. I think I. Yeah. I think I drew it because it was just very, like present on the desk. It's sort of blended in now, but just had brought it back.
Let me think of like this is so much. You just have to, like, lie down and sleep like.
There was a dog in another drawing, wasn't there. It was like one of the erm.
Managers had like a dog, barking away in the background.
47:33SOPHIA: Mm hmm.
47:35NOAH: But the facilitator was like.
Don't worry, we can't hear it. So just carry on.
Hmm.
((Extended Silence))
48:47SOPHIA: When you first put the picture at Noah, before I realised that it was familiar, again, the first thing that struck me. Was the sense of something quite fragmented, which is what struck me with the account of the meeting as well. The verbal account of the meeting, which is almost looks like it's lots of individual drawings erm, rather than like a drawing erm, that,
That has a kind of narrative together as a whole. And so that was one of the first things that erm, struck me.
And then I thought, oh, some of that's familiar. Like the kind of money at the top that bit was familiar. And so the American flag and what have you. But then I was looking at other aspects, thinking, oh, no, no, no, we can't familiar because I don't feel like I've seen this before. Like, I hadn't held in mind the dog, actually. And and, you know, Isabella picked up on that as well, didn't she? Even then, as you sort of gave an account of the dog and where the dog had come from, it connected me with that feeling of loss. And, you know, you'd spoken previously about. Kind of the significance of. of loss in your experiences recently you know relation to your dad. So yeah. So now

Commented [HH83]: Code - sadness physically present on the observers desk, with the association to shutting down as a defence against strong feeling

Commented [HH84]: Code - the observation as fragmented, rather than a narrative of the whole

I almost hadn't noticed the dog the first time that you presented it.
And now I'm kind of just really like, really focused on on that and.
I'm feeling quite sad, actually, lost and.
(Pause)
And a sense of like. how to move on and moving on and?
Again with this piece of work in mind with all transformation change there is loss and then there is this new reality and.
Lots of clinicians do stay and experience multiple transformations, or organisational change experiences over the course of their career.
51:02 NOAH: Yeah, from your account, it's like, oh, we've kinda done this before. It feels familiar, but not like. And like, money's still there at the top, kind of dictating everything and.
But it's kind of new and we, like, can't hold on to what we lost last time, let alone this time.
51:21 SOPHIA: Yeah. And the other thing that's just come to my mind is.I talked about collaboration a little bit today and I think I remember last time talking about competition and when I saw the flag and the whistle and what have you. I remember having an association to kind of sports day and our conversation went to that sort of drive or move in many schools to make Sports Day a less competitive endeavour. So it is this kind of more collaborative kind of fun, you know. erm experience, yet?
Can you take competition out of collaboration? You know, can you completely separate these things?
And is this always quite a competitive experience.
52:24 AVA: I was trying to think about if this was an image in a gallery, what would I call it? Still not sure, but maybe something around something to capture that the lost or lost.
And frequencies I don't know. I guess all these items I was thinking there kind of household items, they're quite.
52:40 SOPHIA: Mm hmm.
52:46 AVA: Separate, but together.
I'm also noticing the absence of colour as well. The black and white. I know your drawings have been black and white mostly now.
But that's different to the first images that you did. erm.
And I was also thinking about the bin and the.
I don't know if that is a bin. I hope that's a bin.
The idea that things are forgotten or kind of.
Things that have had a presence but have been overlooked.
Something about the dog, even though it's massive, but it's been overlooked or not seen.
Yeah. No, you said maybe this is metaphorical of what the experience

Commented [HH85]: Code - feelings of loss only attended to and taken in after repeated reflection

Commented [HH86]: Code - how to move on from loss following multiple changes and transformations over a clinical career

Commented [HH87]: Code - cyclical pattern of money dictating change, and difficulty holding onto repeated losses

Commented [HH88]: Code - the initial use of colour in drawings contrasted with subsequent use of black and white

Commented [HH89]: Code - massive things that have had a presence are overlooked, forgotten or binned

has been.Do you know this is unrelated to my association with this photo, but I'm remembering.What you had said earlier at the start, Noah around kind of the personal and the professional and all of these different bits, but the, at each drawing there's been an attempt or a pull into kind of bringing your home life into the work. So I think there's something around, I don't know, that feels quite significant. So the dog. erm. The normal everyday household items, I don't know. There's something that's quite full and complex and we can't tease it out like the work and the professional. erm.
Despite you trying to be cut off and separate it kind of always brings you back.
Maybe I'm speaking about myself here, but yeah.

54:47SOPHIA: We have talked about people's contexts, haven't we that we I think one of the observation sessions we did talk about the fact that this transformation project had I think started around the time of COVID and the changes to online working. And I was just thinking about the other reference to the dog, Noah, where somebody was really grappling with you know working from home being at home. The dog was barking very loudly it was. Interrupting upon that person's ability to engage or connect with the meeting. But actually there was a sense of like, Oh no, that's OK because we can't hear. We can't hear that background noise. So so the the meeting is fine because that's that's been dealt with by teams. You know, teams are so good now it kind of.

55:26AVA: Hmm.

55:36SOPHIA: Manages to to sort of factor out the background noise, yet actually that person on the screen in the moment is trying to manage paying attention to a meeting and that kind of dog's needs whatever's going on with the dog and.
Being kind of, have feelings in relation to that and thoughts in relation to that. And and I wonder if in some ways that kind of. Personal professional I guess is is there with the task, but whether it's. It's absolutely there when you're working in that home environment and. That sort of dual dual focus.

56:15NOAH: And on the calls, it's very much like our backgrounds today. There's like a mix. So there's people with corporate image, people where its blurred. I've tended to leave mine like this. erm. Yeah, the idea that you can.
Like a background up and like visually, you're just there present, but you're kind of.
Yeah, the personal.
Yeah, I think I have just felt surrounded by it in my space.

Commented [HH90]: Code - despite trying to be cut off and separate the everyday household items and roles always come into the work

Commented [HH91]: Code - the personal and professional intrusively present when working online at home

56:44SOPHIA: Mm hmm.
56:48NOAH: And where do you like?
I suppose difficult to draw the line 'cause if you draw it.
In a very corporate way, you're kind of denying possibly that influence or some of that stuff going on in your life, but then?
If you go too like.
There needs to be some sort of boundary 'cause, otherwise you're not in a kind of working role, are you? But.
57:09SOPHIA: Mm hmm.
57:11NOAH: Hmm hmm.
57:17SOPHIA: And perhaps what these signify, they're all kind of ways in which people are attempting to manage this sort of relatively new reality that we sort of find ourselves within. erm.
And it might clumsy and messy and all, but, but I guess the point in a way is that I'm not sure we.
Is it, Has it been worked through and again it makes me think about some of the content that we've discussed around the sort of working through of something. Erm.
(pause)
There's an issue, and then there's a solution, but that bit in the middle.

Commented [HH92]: Code - there needs to be some kind of boundary, otherwise you're not in a working role

58:01NOAH: This just great brief thought about Ava's point about like sort of the time I drew the picture that had colour. Those resources were just available, whereas possibly not super deliberately. But like I've I've just had pen to hand, so I've drawn in black and white. So something about your resources shape the the form, but like maybe the feeling as well you know like erm.
58:02SOPHIA: Hmm mm
58:28NOAH: And I was thinking about teams as well. The fact that you're it's got certain parameters. So it's sort of.
Perhaps lead you down certain types of interaction? Erm.
58:46SOPHIA: Oh thanks Isabella Bye bye. I should have checked that. Actually at the beginning of the meeting. Does anybody else need to leave before quarter past?
(Pause)
59:00NOAH: The erm.
The bin is like it's it's. It's like charity pot. So there's CFC is erm, I forget it. Exactly. It's like charitable foundation. Something. So the MS nurse. It's like, partly the charity funding. And then they're partly going to fund it through this charitable.
And it's like very badly drawn, but it's like kind of begging hands. It's like drawn on the thing. So it's like you need to, like, beg this money

for this like clinical post, you know, like.
Presumably it's pretty needed erm.
Sort of contrasted with the the the like money bags. The top was in. I was thinking about Chelsea and the sort of money sloshing around.
59:44SOPHIA: Mm hmm.
59:53NOAH: Critique of Chelsea is they're just.
They're buying like, three times as many players as they need, and they've just got all these assets, but they don't really know what to do with them.Sort of embarrassment of riches.
1:00:27ETHAN: I found a lot of urm.
That's the images on this like bottom half of the picture plan to associate them all with something that's like quite warm, quite comforting and quite cut off from like, all the discussion around money and power and the politics, thinking that the flags like the dog and I wasn't, I guess, like the flag. And there were. So knowing you're a little bit Noah and just thinking about football and like maybe they're kind of more enjoyable aspect of that and this, not sure what it was, but it's sort of split a bit like a like a pipe like the sort of pipe you sort of smoking. But I began to like have this always like quite.Like fantastical, but like, just very homey. Cut off, like this place of a dog. maybe this sort of fire. But just in how contrasting that was to like the top half of this picture. So like I find myself just not wanting to look at it like just feels like you said this like, oh, this looks like a snake. I think he said earlier, it's like representing this kind of breathlessness of someone just talking like endlessly and money and all that drive and just how.
Distinct these things were maybe this sort of bottom half being quite restful is almost like.
Quite cut off from all that and we stopped in out said earlier that idea of the dog just being maybe just so tired. erm.
Or just like you know, dogs done with its day. So just, has a nap, you know.
Maybe not so troubled by all these very like human creations around money and resources and demand.
1:02:06 NOAH: I was definitely drawing like soft facilities management at the bottom right. So it's like the.
The the transformation guys were having to train in catering.
It's meant to be a ladle, you know, like a big like school. School dinners like ladle, kind of. erm
1:02:19 ETHAN: OK.
1:02:24 NOAH: Yeah, that I hadn't thought to. That top is really all that kind of corporate definitely drew the the light up and down was

Commented [HH93]: Code - begging money for a needed clinical role, compared to money sloshing around in professional football.

Commented [HH94]: Code - a split between warm comfort, with money power and politics

Commented [HH95]: Code - creature comforts cut off from breathless human demand

just the thought around the.
Pace and just very packed speech. But yeah, ended up drawing A was maybe like it meant to be like a bull whip. There was some like cowboy references and.
Yeah, that kind of free floating. Like are we doing it right? Is it? Is everything on point? And yet, yeah, just contrasted with quite kind of homely. (inaudible) almost my first day back at the hospital would have been about five months ago was like this team, that's, was on strike more recently going round the hospital with like placards and whistles and.
Demonstrating basically so.
((Pause))
1:03:28AVA: Something quite depressive in like in like a balanced doesn't I? I guess I didn't really see the split between.
The corporate and the other side, I feel quite kind of wholesome.
And maybe there's some hope in the transformation team kind of.
Training for the other types of roles. I guess from my experience or in different kind of organizations, usually like catering quite lower banding roles.
And they're already outsourced. So actually there's they don't might not get the benefits of NHS in the same way. So I don't know, there's something quite.
But yeah, potentially, hopeful.
About getting the experience of.
Yeah, getting the experience of what? It's what, what it's like. And the things that are involved in doing the role.
And I quite like a good a good erm strike as well. So I don't know. It feels like a sense of justice. I don't know. I feel I've. I've, I feel hopeful.
((Pause))
1:04:51NOAH: When Sophia brought up the sports day thing, it's I think it just came back to mind. But there was a reflection.
Like a random drawing weeks previously was like a, it was like the the pivot of a seesaw. And then I had drawn like two shadows almost coming off that. But then I remember seeing, like, the Olympics. And it was like the Paris mascot. You know, the kind of like it's describe it. It's kind of like a, 2 triangles or something, bit of a non non shape. But. Yeah. The last time we spoke briefly about this picture, it was like the idea of an Olympic cycle and the kind of hope.
That made me think of. The hope that we're like building towards something and I think we were thinking a bit before about a bit of a like. Maybe impossible task or bit idealised task that we're gonna arrive at transformed service. Then there's this idea of, like, maybe

Commented [HH96]: Code - contrast between a bull whip and homely rest

Commented [HH97]: Code - a hopeful and wholesome position of balance and perspective taking

feel more depressed about, like, we're just going to start again in like another five, 4-5 years another transformation maybe like swing back to a Tory government, you know, like a sort of.
You never, never finish it. It's just sort of peaks again.
1:06:14 SOPHIA: I kinda wonder if within that and and Ava bringing up this kind of depressive place, you know, where where the kind of good and bad can be held and whether there is.
You know, there is a sense of of, of movement or progress or whatever the right language is, but a sense of of of change.
But it's not quite the change. The idealised change, the kind of, you know, fancy words on the paper and the gloss and all of that kind of stuff. But it's not quite standing still either, and and, you know, achieving nothing over this kind of five year period or whatever it might be. But it's kind of something in the middle and.
As Ethan was talking and I also hadn't really connected with that sense of the split of the picture. erm.
But that made a lot of sense. And then I was thinking of the split of the charity box and the kind of money bags and the sort of excessive sort of money and wealth and what have you and.
Again, it may. I don't know. It made me think about like, where is that middle middle ground? You know, where are the middle grounds of the splits?
And I wonder if we see some evidence of that being grappled with in this group. Actually, you know, so, it reminds me of that sense of, like, how do we progress without engaging the frontline workers? Like, that feels important. It is an endeavour that's, one that we want to be as inclusive as we can. Yet that feels really, a really difficult task. And then kind of what Ava's talking about with the sort of training and so maybe there is a sense of.
Attempting to.
Sort of.
Do and grapple with that.
But is it really known you know? Is it kind?
The conscious endeavour I don't get the sense of that a lot with this group, but then again, is that just how transformations?
Take place.
Or evolve.
((Silence))
1:09:11 NOAH: I've kinda wond.. yeah. Wondering about like our membership in this group. It's kind of two sets of people that I know from different settings sort of coming together with.
Like a role in Lincolnshire years ago and then a role in Essex and a bit

Commented [HH98]: Code - a depressive place in the middle, where good and bad can be held together and realistic change made

Commented [HH99]: Code - not often getting a sense that the group is consciously grappling with the middle ground between splits

like the two hospitals, they really have been very separate.
Different counties geographically like. erm.
And then how we kind of?
Yeah. No, no. Grand reflection on it. But like how we come together, there's all kind of like.
different histories we have, with how we've worked together for longer or shorter period of time.

1:10:03 SOPHIA: And that links me back to some of my early thoughts in this group because, you know, we've come together to achieve a task and you know, Noah, you kind of brought that. And then I was thinking about how this morning I was thinking how gosh, does everybody, has everybody met, you know, I know we've all met separately, but have we all met in this group? And again, so it's not just those basic things of, you know, are we familiar with each other enough to do the task? You know, how how? erm.
Have we all met? The group membership does look different each week or could look different each week due to people's availability etcetera so. Yeah, those those sorts of issues that are really important when you think about working together for the purpose of.
Of whatever that goal might be. erm.
And how that's quite difficult actually because.
How do you do that in a timely way? How do you do that over a setting of teams? Erm.

1:11:28 AVA: I do wonder if there's something around role being quite important and I for me I've been less preoccupied with that because I guess maybe I've passed that on to you.
Sophia 'cause, I know you will do that. I don't know. There's something around. So right now I'm thinking, oh, no. Should I have been thought more thoughtful of the membership of this group or? Do I just turn up and I just turn up.

1:11:51 SOPHIA: Absolutely.

1:11:53 AVA: So I'm just thinking about roles that we take up formal roles or informal roles that we assign ourselves, or we get assigned to doing.
That would normally be my role of thinking is everyone, but now I'm just just arriving and talking and yeah.

1:12:10 SOPHIA: Absolutely. And it's now making me think about how erm, obviously I'm here facilitating this space. So therefore taking up that role. Erm.

1:12:17 AVA: OK.

1:12:22 SOPHIA: Thinking about your group Noah and and I realise now I'm sitting here thinking I still don't know who the chair of the

Commented [HH100]: Code - there all kind of different histories with how we've worked together for longer or shorter periods of time.

Commented [HH101]: Code - difficulty of creating a coherent and consistent membership in a timely way in an online setting

Commented [HH102]: Code - The task of thinking about the membership of the group falling to the role of the facilitator in the group.

meeting is actually, you know, because I'd wrongly assumed it was. It was somebody else. erm, But again, maybe I'd been thinking more about those things because of of my role in this group.

1:12:45 NOAH: Yeah, I don't think I know formally, you know, like, I think it is the.

I also so I imagine the people that facilitate it each week erm, is kind of between 2, I imagine them being line managed by the head of transformation. erm.

It is like having your boss in a meeting, but your your you're you're running it and they're kind of informally.

1:13:10 AVA: Hmm.

1:13:13 NOAH: He's being deferred to, or kind of like talked to in a knowing way kind of like.

They're having to take up a kind of.

In that moment, A roll above their boss or like kind of for the for the duration of the call, it's like.

erm I dont know like it's kind of, a kind of scrutiny.

1:13:44 SOPHIA: There is an interesting issue of authority. I think of power and authority with this project and the group.

I was going to say it's hard to know it where, where it's located, but actually in reality maybe it's dynamic, you know, maybe it does actually move around. Yeah, because we talked about different groups and the power located in different groups such as, you know, workers who are striking and, you know, heads of and facilitators of and, you know, members, it's it's sort of like what you know.

Power moves, doesn't it, it can. It can be dynamic.

But ultimately, there's this kind of pot of money or various pots of money that gets deferred back to as being.

Being the overall source of.

1:14:40 AVA: Yeah.

1:14:41 SOPHIA: And power.

1:14:43 NOAH: This soft facilities are like the lowest band that that seems to have had a huge effect on the function of these like quite senior transformation roles.

1:14:54 SOPHIA: Mm hmm.

1:14:55 AVA: Hmm.

1:14:57 SOPHIA: But you made a comment that actually the soft facilities when they're not functioning as as they should be, causes more disruption than, say, the medics, the doctors not being, which is ahh, yeah, kind of interesting reality. I'm conscious we're coming to the end of our meeting. We've just got a sort of minute or so remaining. So let's just check in. We've got our next group booked

Commented [HH103]: Code - the attention to aspects of the observation emerging from the formal or informal role taken up / assigned within the reflective group

Commented [HH104]: Code - issues of power and authority being negotiated within the weekly catch-up

Commented [HH105]: Code - dynamic movement of power between groups in the organisation, but ultimately deferring back to money

for next Monday. At the same time, is that OK with everybody?
1:15:27 AVA: That's our final group. Yeah, Noah.
or have we got another?
1:15:31 NOAH: I've got that as six of eight.
1:15:34 AVA: Oh, OK.
1:15:35 NOAH: We've actually got a few.
1:15:38 AVA: OK, I'll to add them in then, OK.
1:15:40 ETHAN: Think I said to you, Noah. So I've got a family thing next Monday, so that one. But I'm about for the others as well
1:15:44 NOAH: Yeah, of course.
1:15:50 SOPHIA: Right. And maybe next week when we meet Noah, there's just one that I was struggling with an eight, the 830 start. So maybe if we just have a few minutes when we meet next time.
1:15:58 NOAH: Yeah, right.
1:16:03 SOPHIA: OK. Well, thank you.
1:16:04 NOAH: Thanks.
1:16:06 AVA: Thanks.
1:16:07 SOPHIA: Thanks everybody for attending and we'll see everybody next week. But Ethan will see you the following week.
1:16:13 ETHAN: Perfect. See you later. Bye bye.
1:16:14 AVA: Ok bye.
stopped transcription

Commented [HH106]: Code - negotiating on-going membership of the reflective group

Appendix C: HRA Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Harry Hogarth
Trainee Clinical Psychologist
[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

04 March 2024

Dear Mr Hogarth

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The Organisational Dynamics of Integrating Neurology Services in an NHS Hospital Trust: A Systems Psychodynamic Perspective.**
IRAS project ID:	**331266**
Protocol number:	**V1.0**
REC reference:	**23/HRA/3633**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

Appendix D: UoE Ethical Approval

University of Essex

15/04/2024

Mr Harry Hogarth

Health and Social Care

[redacted]

Dear Harry,

Ethics Committee Decision

Application: ETH2324-1121

I am pleased to inform you that the research proposal entitled "The Organisational Dynamics of Integrating Neurology Services in an NHS Hospital Trust: A Systems Psychodynamic Perspective" has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

[redacted]

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Appendix E: Observation Participant Letter of Invitation

University of Essex

18th September 2023
Recipient:
Title:
Organisation:

Dear (Recipient)

I would like to invite you to take part in research I am conducting as part of my training to become a Clinical Psychologist. The project proposes to explore the emotional dynamics between healthcare professionals, collaborating on the integration of clinical services.

Clinical practice placements with Adults and Older Adults during my first year of training identified the integration of clinical neurology services as both an identifiable gap in the research literature, and an organisational priority within [redacted]. This is a patient pathway involving multiple medical specialities across various secondary inpatient and community services, third sector organisations, and social care.

I am proposing to use an established method of observing organisations, based on the work of Prof Robert Hinshelwood. I am inviting you to participate in this observation, as part of your existing role within the clinical services integration programme at [redacted]. I would be present within existing group forums, but would not be taking any notes in real time, or digitally recording for the purpose of the research. I have enclosed detailed information on the study, and what would be your role as an observation participant.

Please see the attached Participant Information Sheet, and associated consent form.

I would happily respond to any questions arising via email, or can alternatively arrange a call at your convenience to discuss further.

Yours Sincerely,

Harry Hogarth
Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology
School of Health and Social Care
University of Essex

[redacted]

Appendix F: Observation Participant Information Sheet

Observation Participant Information Sheet
(Version 1.0 16.09.2023)

Project Title: The dynamics of integrated care for neurological conditions

I would like to invite you to take part in a research project I am conducting as part of my training to become a clinical psychologist. Before you decide to take part, it is important for you to understand why the research is taking place and what it will involve. Please take some time to carefully read the following information. If you have any questions about the study, please contact me via email, or the address provided. Please do take some time to decide whether you wish to participate.

Who is conducting this study?
The Chief Investigator is Harry Hogarth, Trainee Clinical Psychologist, University of Essex. This research is being conducted in partial fulfilment of the requirements for the degree of Professional Doctorate in Clinical Psychology. The research is sponsored by the University of Essex and overseen by a qualified academic supervisor.

Co-researchers:
[redacted]

What is the purpose of this study?
The first purpose of the study is to generate locally situated knowledge about the emotional dynamics of attempts to integrate clinical neurology services within an acute NHS hospital trust.
The second purpose of the study is to characterise ways in which the researcher's subjectivity shapes the organisational knowledge derived from observation.

Why an observational methodology?
An observational methodology has been chosen to explore the felt and lived experience of professionals engaged with task of integration. Existing evidence in the area of integration and reorganisation in healthcare has tended to focus on objective and quantifiable outcomes. This has typically been at the expense of exploring the human dynamics of collaboration. A better understanding is needed of these dynamics to support the effective delivery of multi-faceted services for patients with complex conditions.

Who has approved the research?
The research has been approved by the Health Research Authority [approval pending] and the University of Essex, Research Governance and Ethics Committee [approval pending].

Do I have to take part?
No. Participation is voluntary, and you should only take part if you wish to do so. If you decide to take part, you are able to withdraw at a later date without giving a reason. Choosing not to take part will not disadvantage you in any way.

What will happen to me if I take part?
If you are interested in taking part, you are invited to contact me by email, to request any further information about the study. If you would like to arrange a meeting to discuss the study in more depth we will arrange a mutually convenient time to speak via telephone or video call.

Once you have had time to think about the study, I will ask if you have decided whether or not you would like to take part. If you would like to take part, I will ask you to sign and date a consent form.

If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the observations at any time, meaning information relating to your presence in the group would be omitted from every aspect of the study.

If, throughout the duration of the study, you have any questions you are welcome to contact me by phone or at the address provided.

During the observation I will be present within the group but will not be taking any notes in real time. The group will also not be recorded digitally for the purpose of the research. Following the observation, I will go away and type onto a computer anything I can recall from the session to form detailed process notes of the observed material.

The content of the observation notes will subsequently be discussed during a supervision group. This group will consist of professionals experienced in observational methods. During the supervision sessions any reference to individuals will be made via a pseudonym (fictitious name) to ensure anonymity. The supervision group will be able to see the chief investigators written account of the observation, but will not retain this beyond the group and will not have access to any personally identifiable information.

How do I find out when and where the observations will take place?
The observation will be documented within each meetings agenda, detailing where the observation will take place and on what day, date and time. These posters will be regularly updated so that the correct date and time is displayed.

How long will the observations last?
I will observe the group on six separate occasions. Each observation session will last for the duration of the meeting.

Will my contribution be anonymous and confidential?
Yes. Any reference to your data generated within observation notes, will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be stored on a secure password protected University of Essex sever which is compliant with current data protection regulations (Data Protection Act, 2018; General Data Protection Regulations, 2018). Your data will be stored securely for a period of five years, in the event that questions are raised about the research findings that require consultation with the raw data collected from the study.

There may be times during the data analysis when my research supervisors at the University read through my written accounts of the observation material. They won't have access to your identifiable information. To reduce any risk of you being identified from indirectly identifiable information, the researcher will redact any information they, the research team, or you may feel would lead to identification. The research team is aware that even if data is technically anonymous, there is a chance some parts of the information may be rendered identifiable in combination with other contextual pieces of information within this project.

In the interests of transparent and open research practices, some research publications request that researchers share their raw research data when publishing their findings. This is so that other researchers can make judgements about the quality of the research. If the research is published in a scientific journal, your data may be used to summarise the findings of the research, however your data will be fully anonymised at all times.

Your information and the chief investigators observation notes will be kept in a locked place when not being studied. Once the research is over your transcript and accompanying information will be securely kept at the University of Essex for a period of five years, after which time it will be destroyed.

It is important to note that in accordance with the General Data Protection Regulations, there may be instances when it becomes necessary to break confidentiality. For example, if I were to observe anything that causes me concern regarding patient care then I have a duty to report this to a line manager. In the unlikely event of this occurring I would always seek to discuss my concerns with you in the first instance.

What are the benefits of taking part?
The findings of the study can be used support effective integration of clinical services for long term neurological conditions in the region.
In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to support the organisational task of integration, which is occurring throughout health services nationally, with the intention of supporting improved patient care. Findings from this project will support a fuller programme of research, conceptualising the emotional dynamics of integration across complex and multi-factorial systems.

What are the potential risks of taking part?
The main aim of this study is to observe the routine functioning of a professional group seeking to collaborate on the integration of clinical services, therefore by taking part you are not be asked to do anything different or in addition to that which you would normally do. In that sense, there are very few risks associated with taking part.

It is recognised, however, that the idea of being observed can be anxiety provoking for individuals. This is a natural feeling, which often lessens after the first few minutes. If however you do feel uncomfortable, and decide that you no longer want to take part in the observation, you are free to withdraw from the observation area at any point.

I will be available for the duration of my training (up to September 2025) should you need to contact me about your participation. [redacted] (Research Supervisor) will also be available should you need to discuss any aspect of the research, especially anything that you were unhappy with.

What happens if something goes wrong?

It is unlikely participation in this research project would cause you any harm. If you have a concern or a complaint about any aspect of its conduct, you should ask to speak to the chief investigator who will do their best to answer your questions. Contact details are given at the end of this information sheet. You may also contact the Chief Investigators Academic Supervisor, [redacted]

If you remain unhappy and wish to complain formally, you can make a formal complaint through the University of Essex complaints procedure.

What happens if I change my mind and don't want to participate?

If, following the observation sessions you decide you would like your contribution to be withdrawn, you are free to request this at any point up until data analysis and publication, without having to give a reason.

To do so please contact the Chief Investigator, Harry Hogarth, at [redacted]

If you choose to withdraw from the study, we may keep the data generated from your participation that we have already obtained, in accordance with our Research Participant Privacy Notice (see below). To safeguard your rights, we will delete all personal details.

What will happen with the results of the study?
The results will form my thesis that will be submitted as part of my professional doctorate in clinical psychology. Following this it is hoped that the study will be published in a journal and be presented at a conference.

I would like to take part. What do I do now?
You will be informed of the group sessions due to be observed in the agenda circulated to all members in advance of each meeting.

Further information and contact details
If you have any further questions about this study or would like to discuss anything in more detail,
Please contact [redacted] during office hours.
Thank you,
Harry Hogarth (Trainee Clinical Psychologist)

If you wish to speak to the academic supervisor of the project [redacted] please use the following email during office hours [redacted]

Appendix G: Observation Participant Consent Form

IRAS Project ID: 331266
The Organisational Dynamics of Integrating NHS Clinical Services
Observation Participant – Consent Form

University of Essex

Consent Form – Observation (Version 1.0 16.09.2023)

Project Title: The Organisational Dynamics of Integrating NHS Clinical Services.

[redacted]

Participant Name: ……

	Please initial box
1. I confirm that I have read the participant information sheet for the above study, had the opportunity to consider the information, ask questions and have received a satisfactory answer to any questions.	
2. I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty.	
3. I have been informed that all information collected about me will be kept anonymous and confidential.	
4. I am aware I can ask questions about the study at any point, and can withdraw my consent up until the completion of data analysis and publication of findings	
5. I have been provided with a copy of this consent form and the Participant Information Sheet.	
6. Data protection: I agree to the researcher writing observation notes and I have been informed that these will be anonymous and kept confidential.	
7. I understand that the observation notes collected during the study will be looked at by academic supervisors at the University of Essex and a supervision group as outlined in the participant information sheet. I give permission for these individuals to have access to the observation notes.	
8. I understand that if the researcher was to observe any unsafe practice it may be necessary for confidentiality to be broken.	

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Appendix H: Reflective Group Participant Letter of Invitation

University of Essex

18th September 2023
Recipient:
Title:
Organisation:

Dear (Recipient)

I would like to invite you to take part in research I am conducting as part of my training to become a clinical psychologist. The project proposes to explore the emotional dynamics between healthcare professionals collaborating on the integration of clinical services.

Clinical practice placements with Adults and Older Adults during my first year of training identified the integration of clinical neurology services as both an identifiable gap in the research literature, and an organisational priority for the host trust. This is a patient pathway involving multiple medical specialities across various secondary inpatient and community services, third sector organisations, and social care.

I am proposing to use the psycho-dynamic method of observing organisations, based on the work of Prof Robert Hinshelwood. As someone familiar with psychodynamic models of organisational research and consultation, I would like to invite you participate within the studies work discussion group. The purpose of which will be to reflect on process notes, written from my observation of a professional forum seeking to promote the integration of clinical neurology services within an NHS trust.

Overall supervision for the project is provided by Prof. Andrew Bateman, while the work discussion group will be facilitated separately by an expert organisational consultant. The group would meet on 8 separate occasions, with sessions lasting approximately 1 hour. The group will be convened during the first half of 2024, and we would meet on a mutually convenient day and time, to be confirmed. Sessions would take place remotely via MS Teams. Please see the attached Participant Information Sheet for detailed information.

I would happily arrange a call to discuss any questions arising.

Yours Sincerely,

Harry Hogarth
Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology
School of Health and Social Care
University of Essex
[redacted]

Appendix I: Reflective Group Participant Information Sheet

Reflective Group Participant Information Sheet
(Version 1.0 16.09.2023)

Project Title: The Organisational Dynamics of Integrating NHS Clinical Services.

I would like to invite you to take part in a research project I am conducting as part of my training to become a clinical psychologist. Before you decide to take part, it is important for you to understand why the research is taking place and what it will involve. Please take some time to carefully read the following information. If you have any questions about the study, please contact me via email, or the address provided. Please do take some time to decide whether you wish to participate.

Who is conducting this study?
The Chief Investigator is Harry Hogarth, Trainee Clinical Psychologist, at the University of Essex. This research is being conducted in partial fulfilment of the requirements for the degree of Professional Doctorate in Clinical Psychology. The research is sponsored by the University of Essex and overseen by a qualified academic supervisor.

Co-researchers:
[redacted]

What is the purpose of this study?
The first purpose of the study is to generate locally situated knowledge about the emotional dynamics of attempts to integrate clinical neurology services within an acute NHS hospital trust.
The second purpose of the study is to characterise ways in which the researcher's subjectivity shapes the organisational knowledge derived from observation.

Why an observational methodology?
An observational methodology has been chosen to explore the felt and lived experience of professionals engaged with task of integration. Existing evidence in the area of integration and reorganisation in healthcare has tended to focus on objective and quantifiable outcomes. This has typically been at the expense of exploring the human dynamics of collaboration. A better understanding is needed of these dynamics to support the effective delivery of multi-faceted services for patients with complex health conditions.

Why a supervision group?
This study aims to use psychodynamic observation of an organisational setting. Inherent within this approach is the use of a supervision group. The purpose of this group is to reflect upon process notes generated from observation and aims to make sense of the material with reference to the observed organisation and the intersubjective use of self, from within a psychoanalytic frame.

The supervision group will take place during the week following each observation session. This pattern will be followed until the end of the observation/supervision period.

Who has approved the research?
The research has been developed in consultation with the project's academic supervisors, and formally approved by the Health Research Authority [approval pending] and the University of Essex, Research Governance and Ethics Committee [approval pending].

How long will the supervision group sessions last?
The supervision group will meet via video call on eight separate occasions. Each supervision group session will last approximately one hour.

Do I have to take part?
No. Participation is voluntary, and you should only take part if you wish to do so. If you decide to take part, you are able to withdraw at a later date without giving a reason. Choosing not to take part will not disadvantage you in any way.

What will happen to me if I take part?
If you are interested in taking part in the study, you are invited to contact the chief investigator and/or my secondary academic supervisor [redacted] by email at the address provided. A meeting will be arranged whereby your role in the supervision group will be discussed in more detail. This will also provide you with the opportunity to ask any questions you may have.

If you would like to take part, you will be asked to sign and date a consent form. If, after you have signed the consent form, you decide that you no longer want to take part in the study you are free to opt-out of the supervision group at any time.

If, throughout the duration of the study, you have any questions you are welcome to contact me or my supervisor by phone, email or at the address provided.

With your consent, supervision group sessions be digitally recorded and transcribed verbatim. Once transcribed and data analysis complete, recordings will be destroyed.

Will my contribution be anonymous and confidential?
Yes. Your data generated within the supervision group sessions, will be treated in accordance with the Data Protection Act 2018, and General Data Protection Regulations 2018. Information provided by you will be assigned a pseudonym (fictitious name) to protect your identity. Your actual details will be stored on a secure University of Essex sever which is compliant with the aforementioned data protection regulations. Your data will be stored securely for a period of five years, in the event that questions are raised about the research findings that require consultation with the raw data collected from the study.

To reduce any risk of you being identified from indirectly identifiable information, the researcher will redact any information they, the research team, or you may feel would lead to identification. The research team is aware that even if data is technically anonymous, there is a chance some parts of the information may be rendered identifiable in combination with other contextual pieces of information within this project.

If the research is published in a scientific journal, your data may be used to summarise the findings of the research, including the use of direct quotes, however your data will be fully anonymised at all times. In the interests of transparency and open research practice, some publishers of academic research request that raw research data is shared when submitting articles for publication. This is so that other researchers can make judgements about the quality of the research.

It is important to note that in accordance with the General Data Protection Regulations, there may be instances when it becomes necessary to break confidentiality. For example, if I were to observe anything that causes me concern regarding patient care then I have a duty to report this to a line manager. In the unlikely event of this occurring I would always seek to discuss my concerns with you in the first instance.

What are the benefits of taking part?
The findings of the study can be used support effective integration of clinical services for long term neurological conditions in the region.
In addition, by taking part in the project, you will be contributing to an area of study where ongoing research is required to support the organisational task of integration, which is occurring throughout health services nationally, with the intention of supporting improved patient care. Findings from this project will support a fuller programme of research, conceptualising the emotional dynamics of integration across complex and multi-factorial systems.

What are the potential risks of taking part?

Being part of a psychodynamic supervision group can be an emotionally demanding experience, and a particular characteristic will be a focus on long term neurological conditions, albeit not on direct patient care. As an individual experienced in the practice of psychodynamic observation, participation in this group is unlikely to present any challenge that is outside the realms of commonplace clinical supervision.

The chief investigator will be available for the duration of their training (up to September 2025) should you need to make contact about your participation. [redacted] (Research Supervisor) will also be available should you need to discuss any aspect of the research, especially anything that you were unhappy with.

What happens if something goes wrong?
It is unlikely participation in this research project would cause you any harm. If you have a concern or a complaint about any aspect of its conduct, you should ask to speak to the chief investigator who will do their best to answer your questions. You are also invited to contact the Chief Investigators Academic Supervisor, [redacted]. Contact details are given at the end of this information sheet.

If you remain unhappy and wish to complain formally, you can make a formal complaint through the University of Essex complaints procedure.

What happens if I change my mind and don't want to participate?

If, following the supervision period you decide you would like your contribution to be withdrawn, you are free to request this up until data analysis and publication, without having to give a reason.

To do so please contact the Chief Investigator, Harry Hogarth, at [redacted]

If you choose to withdraw from the study, we may keep the data generated from your participation that we have already obtained, in accordance with our Research Participant Privacy Notice (see below). To safeguard your rights, we will delete all personal details.

What will happen with the results of the study?
The results will inform the Chief Investigators Doctoral Thesis, submitted in partial fulfilment of the requirements of the Professional Doctorate in Clinical Psychology at the University of

Essex. Following this it is hoped that the study will be published in a journal and be presented at a conference.

I would like to take part. What do I do now?
Please contact the Chief Investigator via email to request a consent form, upon completion your participation in the study will be confirmed.

You will be informed of the practical arrangements for the supervision group sessions once a mutually convenient arrangement has been made.

Further information and contact details
If you have any further questions about this study or would like to discuss anything in more detail,
Please contact [redacted] during office hours.
Thank you,
Harry Hogarth (Trainee Clinical Psychologist)

Appendix J: Reflective Group Participant Consent Form

IRAS Project ID: 331266
The Organisational Dynamics of Integrating NHS Clinical Services
Observation – Supervision Group

University of Essex

Supervision Group – Observation (Version 1.0 16.09.2023)

Project Title: The Organisational Dynamics of Integrating NHS Clinical Services

[redacted]

Participant Name: ……

	Please initial box
1. I confirm that I have read the relevant participant information sheet for the above study, had the opportunity to consider the information, ask any questions.	
2. I have not been made to take part in this study and I understand that I am free to withdraw at any time, for any reason, without any penalty.	
3. I have been informed that all information collected about me will be kept anonymous and confidential.	
4. I am aware I can ask questions about the study at any point, and can withdraw my consent to participate at any time, for any reason, without any penalty.	
5. I have been provided with a copy of this consent form and the Participant Information Sheet.	
6. I consent to the supervision group being digitally recorded and transcribed verbatim, and agree to the possible use of verbatim quotes in the write-up of the research.	
7. I understand that transcripts of supervision groups will be looked at by academic supervisors at the University of Essex. I give permission for these individuals to have access to the transcripts.	
8. I understand that if the researcher was to observe any unsafe practice it may be necessary for confidentiality to be broken.	

Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

Appendix K: Research Report to Host NHS Trust

Organisational Dynamics of Service Integration in the NHS: A Systems Psychodynamic Perspective

Insights from the Clinical Services Integration Programme

Author: H. Hogarth, DClinPsy Candidate
University of Essex | Submission Date: July 2025

Executive Summary

The integration of clinical neurology services within a recently merged NHS trust is subjected to indepth observational research, representing a microcosm of the broader movement towards structural integration of NHS services. This project used a systems psychodynamic framework to understand the unconscious and structural dynamics affecting NHS professionals during a post-merger integration process. The insights generated are considered an essential voice within multi-disciplinary efforts to shape integration across broader NHS systems, not only structurally but emotionally and relationally—ensuring staff and system resilience.

Research Method

The study employed a systems psychodynamic approach, designed to explore unconscious emotional dynamics within an organisation undergoing structural change. This approach acknowledges that human behaviour in institutions can be motivated by internal drives, beyond conscious awareness. This is particularly true of public institutions, under dual pressures to deliver high quality clinical care. These pressures come from the primary task of clinical care, along with the expectations and associated oversight of centralised government.

Rationale for Method

This methodology was selected for its strength in:

Revealing hidden emotional processes that influence staff behaviour during merger.

Producing locally situated, emotionally nuanced knowledge that complements quantitative service evaluations.

Offering leadership and integration teams a deeper understanding of the emotional life of their organisations.

The research followed a three-phase qualitative design based on psychodynamic observation.

Phase A – Organisational Observation

Six in-depth participant observations were conducted, within the trusts Clinical Services Integration Programme.

Phase B - Process Notes

The researcher created detailed process notes after each meeting, capturing their subjective experience of events without interpreting the content. This method preserved the raw experiential data, forming the foundation for later reflection and analysis.

Visual Representations (Pen Drawings)

After each observation, the researcher also created freehand pen drawings to depict emotional impressions and symbolic content.

These images served as associative tools for collective meaning-making.

Phase C – Reflective Groups

The researcher convened facilitated reflective groups with NHS professionals.

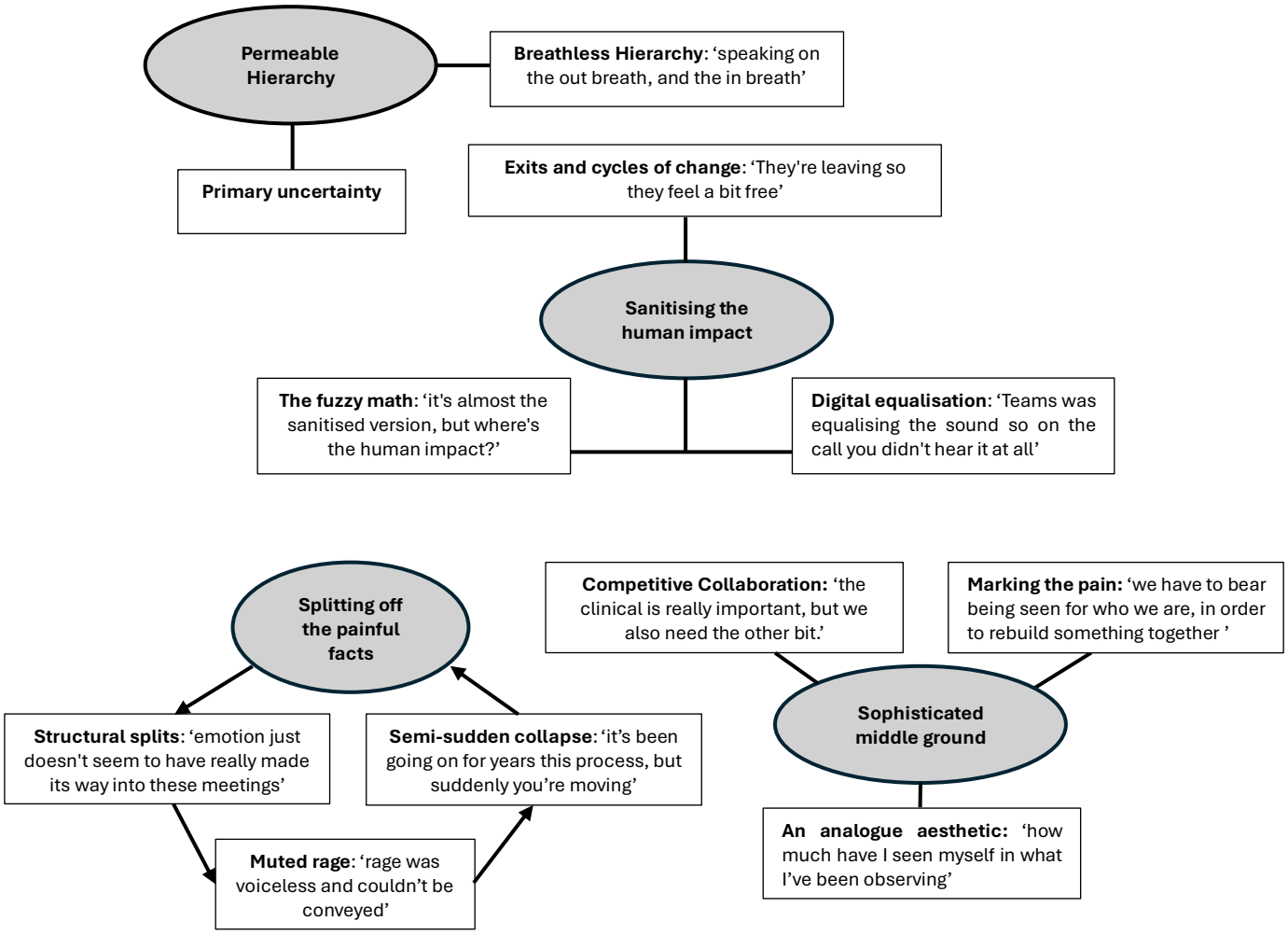
These discussions were guided by the researcher's notes and visual artefacts to stimulate shared reflection on integration dynamics.

Data Analysis & Results

The data generated was analysed using Reflexive Thematic Analysis, focusing on both overt and unconscious dynamics observed within the integration programme.

Themes developed from association to the observed material allowed creative hypotheses to emerge about underlying pressures exerted within the integration

Key Findings



Permeable Hierarchy

Profound uncertainty emerged through the process of negotiating entry to the integration programme. This was most tangible at the boundaries between highly specialised medical disciplines.

In contrast to observable top down executive powers, these vertical splits between services were in reality unclear, and a contrast between the breadth of the corporate task, and the specialisation of clinical services was identified.

Anxiety evoked in the researcher sat below the surface, and was initially hard to communicate or reflect on.

The pace of change was breathless, with the task of quantifying progress evoking a felt sense of panic. This pace seemed at the expense of time and space to consider the emotional aspects of change.

The contrast between certainty of hierarchical control and anxiety at uncertain boundaries might serve partially to defend against painful uncertainty. This uncertainty seemed to create a pull towards passive certainty, seen in a hope that paired relationships between two individuals might have the capacity to resolve complex problems.

Sanitising the Human Impact

Professionals made use of the authority in their distinct roles to escape the pressures of change. Those orientated closely to front line services could be observed to find exits from the evaluative oversight of the programme, while corporate teams could invoke strict time boundaries to their involvement with the task.

Clinical and corporate tasks were characterised by paradoxical pressures. The open-ended nature of clinical care, contrasted the breadth of responsibility for measurable outcomes facing corporate professionals.

An emphasis on metrics and KPIs inadvertently obscured the human impact of change. The task of clinical care in Neurology was hypothesised to be emotive, characterised by baring with the pain of chronic conditions. This wasn't represented in data-centric narratives which prioritised the achievement of discrete goals.

Digital technologies amplified how split off painful emotional content could appear within the programme. The digital work environment placed professionals in greater proximity to personal identities and associated emotional contents, while paradoxically obscuring these aspects from the wider work group. In this manor digital ways of working emphasised the distributed and networked aspects of the organisation, above a centralised hierarchy and identity

Structural Splits, Muted Rage, and Sophisticated Middle Ground

Painful emotional experiences, such as grief, anger, and loss, seemed subject to structural splits between the clinical and corporate functions of the organisation.

The politicised and bureaucratic framework in which the trust must operate was identified as reinforcing

An emphasis on structural integration precluded space to take in and make sense of the emotional experience of professionals.

Professionals rage in response to loss was hypothesised by associative enquiry. This emotion was further associated with the semi-sudden collapse of structural and emotional boundaries. This suggested the inevitability of post-merger restructuring had been avoided, before suddenly re-emerging into awareness.

Competition was considered inseparable from collaboration, in contrast to integration being synonymous with increasing professional co-operation.

A psychologically informed approach to integrating clinical services emerged as requiring the capacity to mark and metabolise painful emotions such as loss, rage, and anxious uncertainty. Such an approach needed to consider how tensions between idealistic change and operational stasis are navigated.

The research method offers an analogue but under-utilised perspective to a multi-disciplinary and multi-modal conversation on NHS integration in the 21st century. As a process in-depth psychodynamic observation offers a vehicle for containing split off emotional contents, in order to make use them as information in system wide change. containing others

Implications for NHS Leadership and Practice

A. Containment as a Leadership Task
Leaders must recognise their role as emotional containers—not just operational managers.
Providing unstructured reflective spaces can help to identify and manage unconscious anxieties within organisations. Hypothesised to improve the coherence of change processes, by ensuring they response to the reality of their emotional impact on professional groups.
The practice of associative enquiry undertaken with the project is considered of relevance to the identification of organisational threats, which may be underpinned an unconscious equilibrium which is defending against painful emotional realities. Framing the approach as routine contribution rather than solution would offer an appropriate and valuable addition to managing complexity within public institutions.

B. Integration Metrics Must Acknowledge Emotional Realities
Integration outcomes should include qualitative feedback on team cohesion, morale, and staff psychological safety—not just throughput and efficiency.

C. Merger is More Than Structure—it's Emotional Reform
The project literature identified professional identities rooted in previous organisational "histories" can shape how merger is experienced. In the local context this was grounded in differing performance between neurology departments, for which the integration appeared to have contrasting implications

D. Systems Psychodynamics Offers a Lens for NHS Change
This methodology allows for the "unseen" dynamics of change to be identified and processed—informing local change practices, alongside a wider role within recurrent system change, for example the upcoming merger and integration of ICBs.

Recommendation	Strategy
Establish reflective groups	Consultant led sessions for corporate and clinical teams

Recommendation	Strategy
Develop "containment literacy" in leaders	Training for senior staff in emotional containment and organisational dynamics
Implement qualitative metrics	Add narrative-based evaluation of staff experience during organisational transformation.
Guard against emotional collapse	Monitor signs of split-off distress (e.g., staff exits, silencing, disengagement)
Maintain pragmatic continuity	Support mid-level staff leading change and continued operational delivery

Conclusions

This research used an observational, reflective approach to study how neurology services are being integrated within the trust. The study found tensions both between departments (horizontally) and between clinical and management roles (vertically). These findings reflect existing literature that describes the NHS as a complex relational network that is widely distributed, but centrally governed.

A key insight was a hypothesised conflict between the demands of clinical care and bureaucratic oversight. The research used a systems psychodynamic lens to explore how emotional responses—often unspoken—affect how staff navigate organisational change. Feelings like frustration, loss, or anger were found to influence behaviours and group dynamics, especially in the context of boundaries between professional roles and departments shifting.

The study highlighted the importance of "containment"—the ability of people and groups to overtly manage difficult emotions—in supporting staff through change. This was drawn from the researcher's own emotional experience within the observation, identifying shifting relationships within the hospital, and possible changes to longstanding links with external treatment centres arising from redrawing of geographical boundaries.

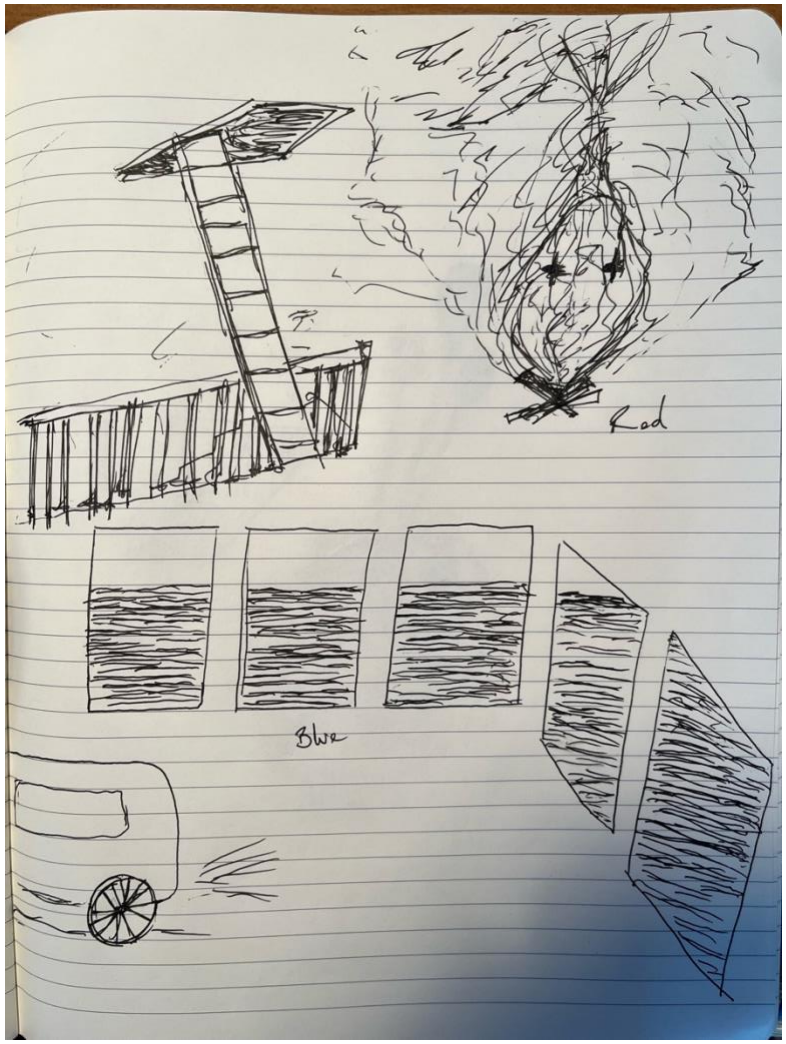
Reflective, non-hierarchical groups are a way of helping staff make sense of change and uncertainty. These forums can offer a space for shared understanding across clinical and corporate roles. The approach is analogous to the human nervous system, which coordinates input from various sources to guide effective decision-making. In this way the provision of reflective spaces enhancing organisational capacity to integrate human feeling into structural change processes.

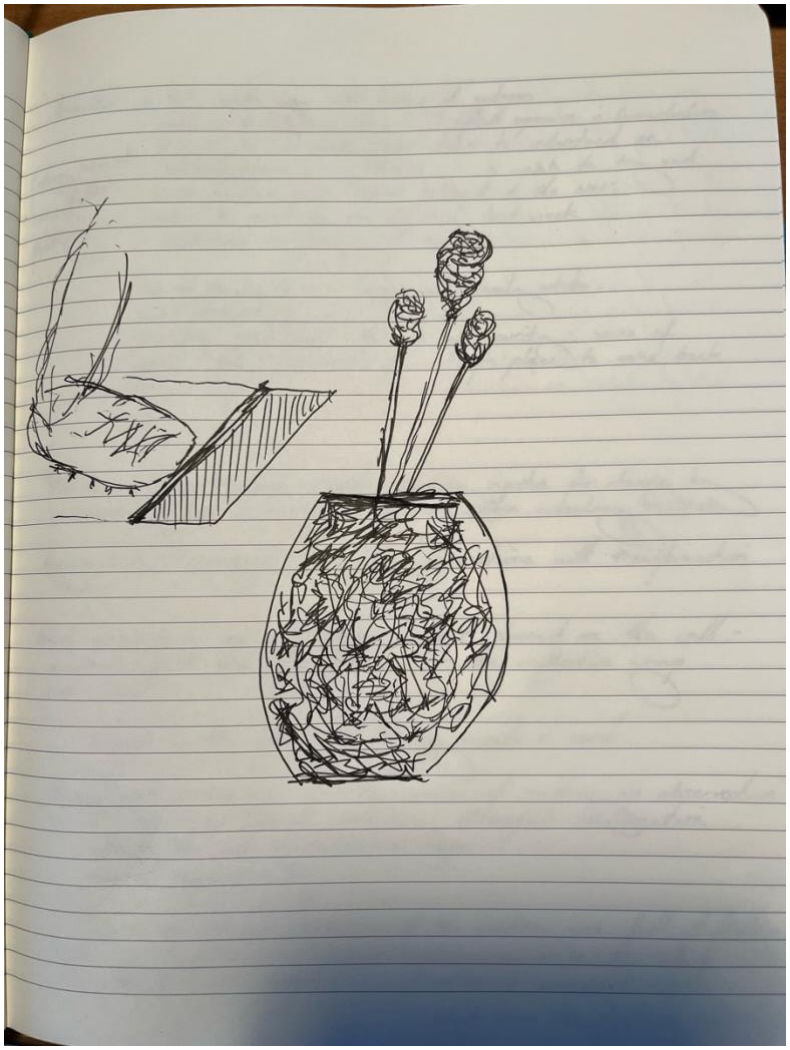
Organisational change brings to the surface deep-rooted professional identities and histories. Observational and reflective methods could better support collaboration and co-production between NHS staff, researchers, and patients. However, the reflective use of self in research must be done with care, avoiding assumptions of certainty. Instead, the approach adopted by the present research encourages openness and curiosity to how unconscious processes may shape individual and collective behaviours. Ignoring these dynamics risks reinforcing their repetition, rather than amelioration and change.

Appendix L: Observation Drawings

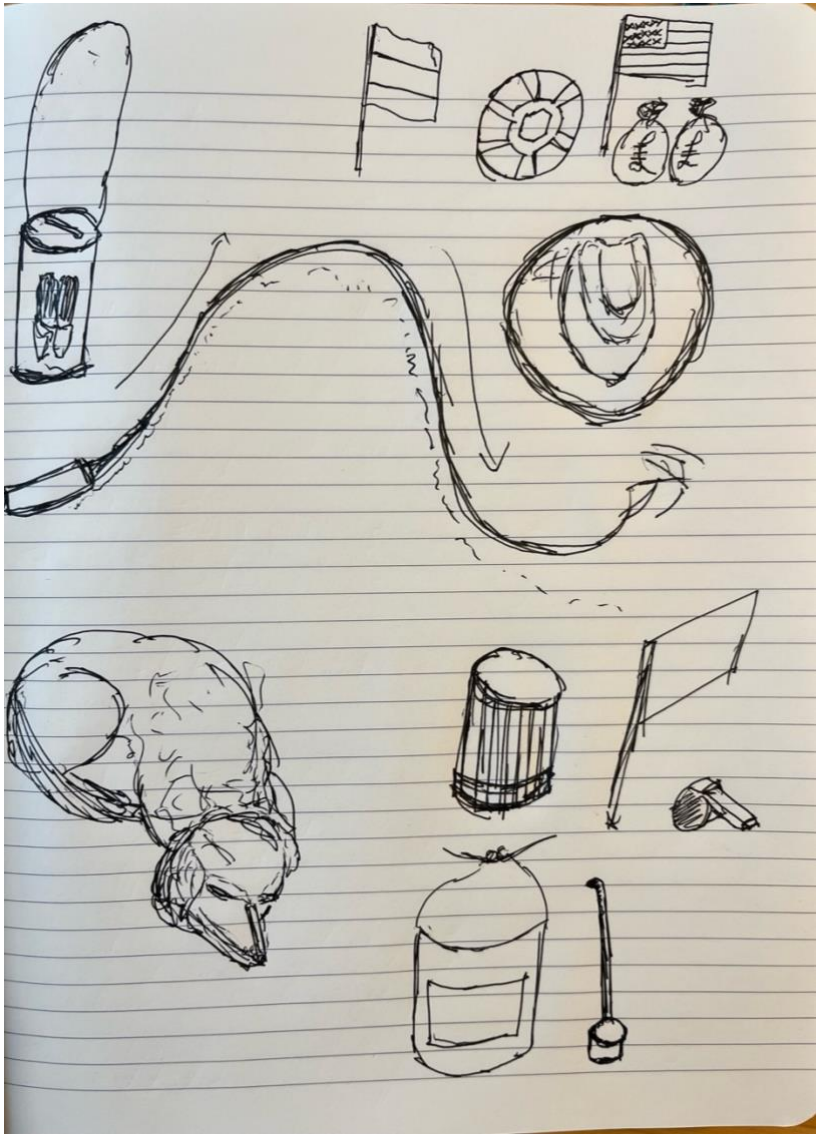
Observation 1

Observation 2

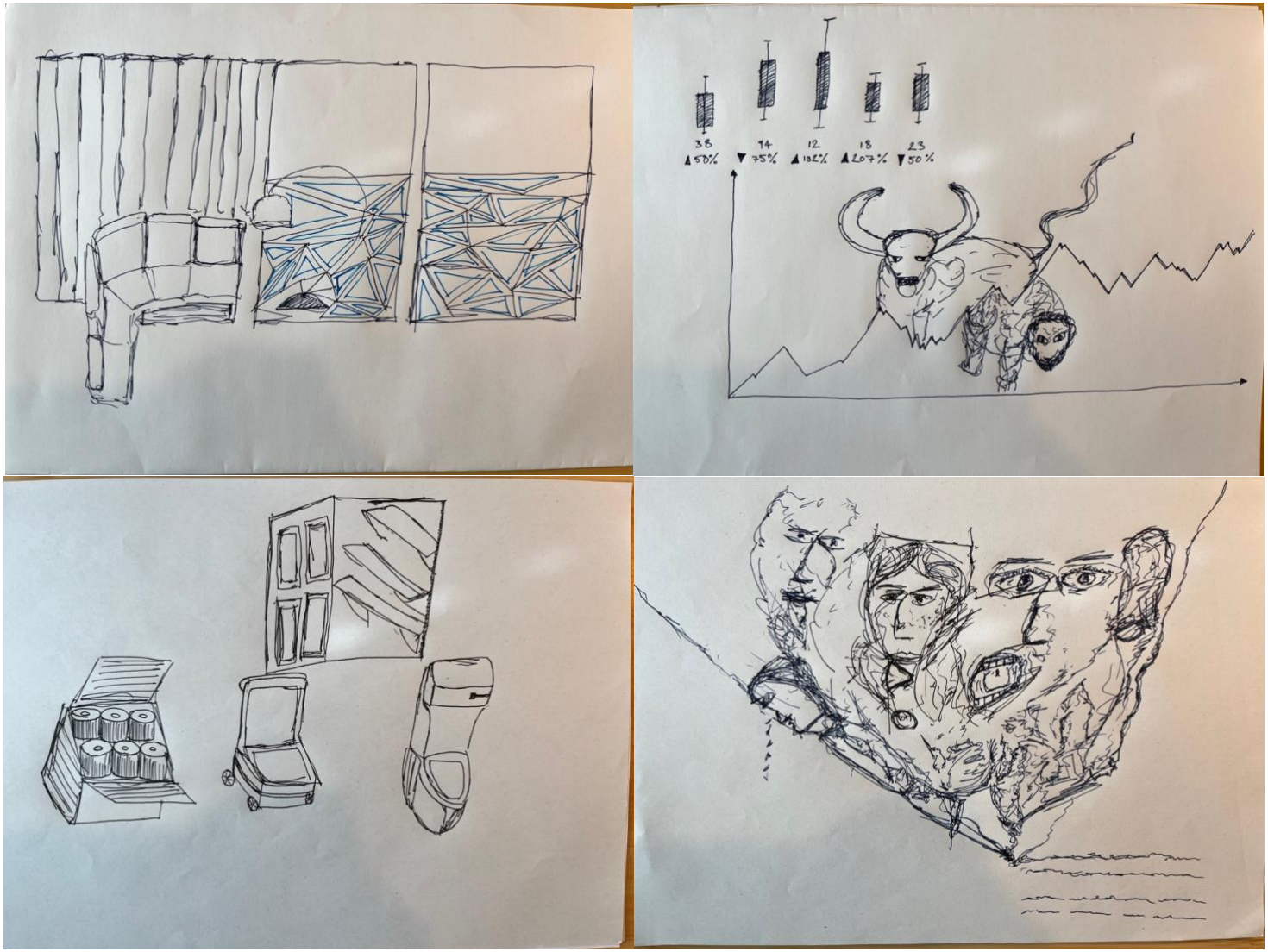




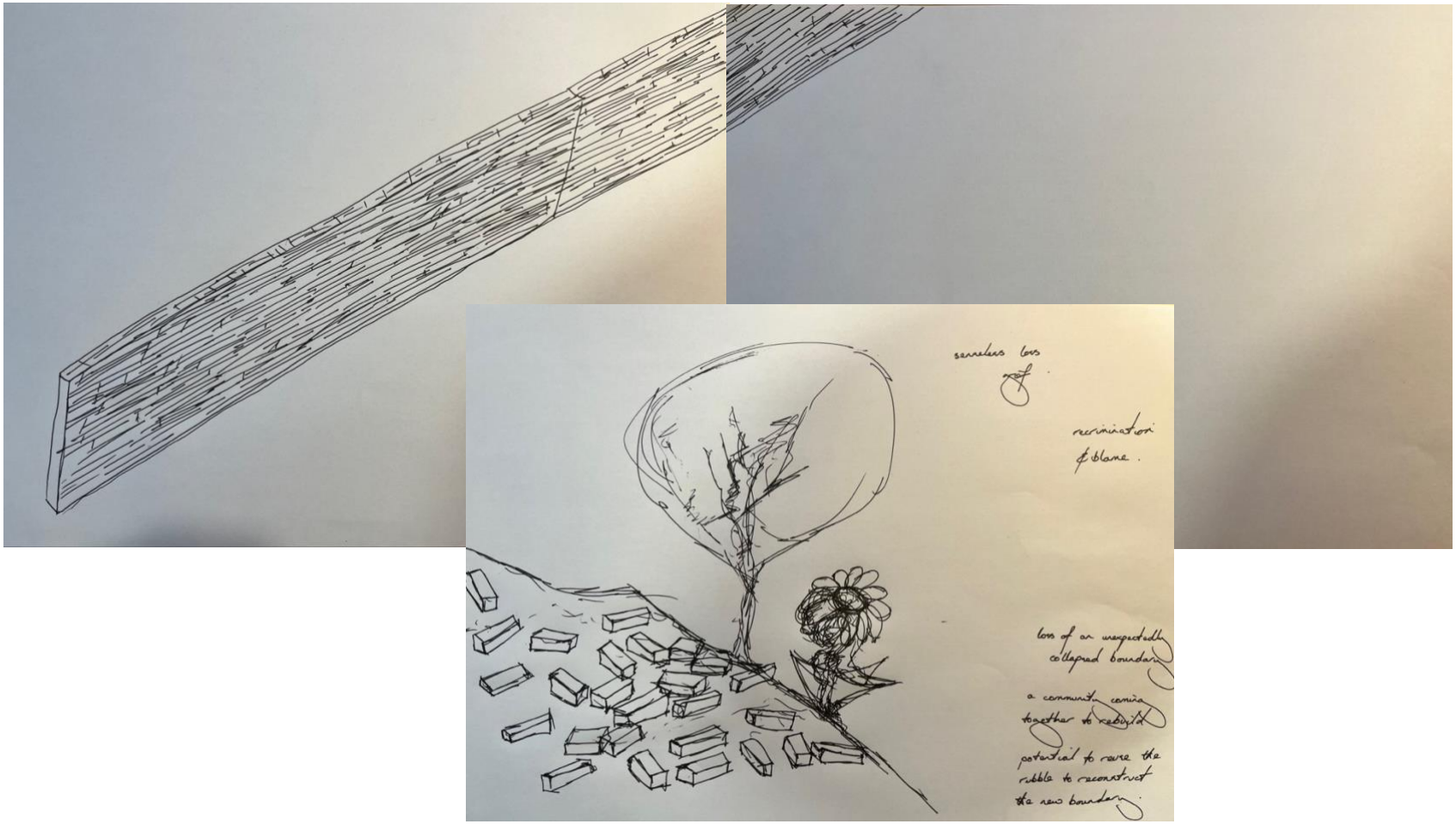
Observation 3



Observation 4



Observation 5



Observation 6