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Going through changes: a single point of access for health and social care

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GOING THROUGH CHANGES: A SINGLE POINT OF ACCESS FOR HEALTH AND SOCIAL CARE

By

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October 2013

***A thesis submitted in partial fulfilment of the University's requirements
for the Degree of Doctor of Philosophy***

ABSTRACT

Background: Integrated working between health and social care services within England has been encouraged by Government policy in the last decade, and has been argued to provide a seamless, joined up experience for service users (Department of Health 2011). One way of integrating care is through the use of a single point of access to health and social care services. A single point of access to services has been trialled in mental health and learning disability services to improve access, and following on from policy (e.g. Department of Health 2007) and support from literature (Rogers, Entwistle & Pencheon 1998; Lovell & Richards 2000; Raine, Carter, Sensky & Black 2005) a single point of access to health and social care for older adults has been implemented in parts of the UK. This thesis examines the implementation of one such single point of access.

Objectives: The aim of the study was to examine the single point of access and whether it had any impact upon integrated working within a county in England, UK.

Methods: An ethnographic approach was taken, using a combination of methods including interviews, focus groups and observations. This was complemented by a grounded theory approach to analysis.

Findings: The single point of access had an adverse effect upon integration. The poor management of change and lack of communication led to issues within the single point of access such as failure of IT systems and duplication. Staff became frustrated and disengaged from the process, and consequently reported feeling disempowered, retreating back to their professional 'tribes'.

Conclusion: Firm conclusions about the efficacy of a single point of access with regard to its effect upon integrated working could not be reached. However, the findings suggest that clear communication, continued change management and recognition of professional culture are decisive factors when attempting to integrate health and social care. Further research into the impact of a single point of access upon integration as well as outcomes for service users is recommended.

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Finally, I would like to thank the staff working within community health and social care in Countyshire, who have made this thesis possible. As an ex health professional with first-hand experience of working within the public sector, I hope the information contained within will help them in their endeavours to provide health and social care support to those who need it more than ever in these challenging times. Thank you to you all for your continued participation in this research – although it's a terrible cliché, I could not have done it without you.

Rationale

The population of older adults is increasing within the UK. Older adults are the most numerous consumers of services and account for the largest percentage of health and social care spending (Department of Health 2011). As a result it has been argued that the strain on health and social care will escalate in coming years, particularly with growing budget cuts (Department of Health 2011) and to date little progress has been made within England to provide integrated health and social care services for older adults (Evans & Forbes 2009). Integrated care does not necessarily need to be provided through organisational integration; rather integrated care can be provided at a clinical and/or service level (Ham and Curry 2010). One way of providing integration is through coordination of services (Leutz 1999). Within the county under study, integration was provided through a single point of access to health and social care services with the aim of coordinating health and social care provision within the county.

Although there have been studies into the single point of access within mental health and learning disabilities services (Lovell and Richards 2000; Raine et al. 2005; Watson, McDonnell and Bhaumik 2005), further research is required to fully assess the benefits of a single point of access for older adult services. Therefore, it is prudent to evaluate the single point of access to health and social care for older adults, as an initiative that aims to reduce duplication and allow health and social care services to operate in a more efficient and effective way (e.g. Raine et al. 2005). With further pressures mounting upon health and social care (Department of Health 2012), how services operate, and how change is managed within health and social care will both become increasingly critical if these changes are to be successful.

Aim of the research

The overall aim of the research study was to discover whether a single point of access had any impact upon integrated working within Countyshire. In addition, I wanted to explore staff views on integrated working and whether they felt that working within the single point of access team contributed to integrated working across the county as a whole. Furthermore I wanted to investigate whether the single point of access led to an improved service for service users.

Aim

To explore the implementation of a single point of access within Countyshire with regard to integrated working, waiting times and outcomes for patients.

Objectives

1. To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful
2. To identify whether the single point of access had an effect on integrated working within Countyshire
3. To identify whether the single point of access met its objective of improving integrated working
4. To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working
5. To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

Research question

'Does a single point of access to health and social care have any effect upon integrated working?'

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CHAPTER ONE - INTEGRATION

Introduction

The topic of integrated working between health and social care has been a key feature in policy and strategy documents since 1997 (e.g. Department of Health 1997; Department of Health 2001; Department of Health 2006a; Department of Health 2008a; Department of Health 2011; Department of Health 2013a), and much has been written with regard to the benefits of integrated working:

'...integrated services are much more likely to improve people's health and wellbeing in ways which treat them with dignity and respect, and it makes financial sense to get rid of duplication and waste' (Local Government Association 2013: 1)

Although the quote above from the Local Government Association suggests that integration can improve health and social care, relatively little progress towards the integration of health and social care services has been made in England (Evans & Forbes 2009). It has been suggested that much of the literature extols the virtues of integrated working without clear evidence to support its use:

'much of the current literature is very descriptive and sometimes very 'faith-based', emphasising the perceived virtues of partnership working without necessarily citing any evidence for the claims made' (Glasby, Dickinson & Miller 2011: 2)

Throughout the course of this chapter I will examine integrated working within and between health and social care in England. This will illustrate the current view of, and the history surrounding integration between health and social care, to set the context for the rest of the thesis. This first chapter will include definitions of integration, proposed levels of integration, the impact of and issues related to integration, the historical separation between health and social care and key examples of integrated working within England.

The historical background of health and social care provision within England will first be investigated, to give a contextual view of integrated working between the two and the subsequent implications for the current study. A review of health and social care since the turn of the nineteenth century and the background of integration

between health and social care in England will be followed by an overview of recent developments within health and social care policy making and strategy development.

In order to establish whether a single point of access has any impact upon integrated working as set out in the aims of this thesis, what is meant by integration and integrated working will next be discussed. This chapter will examine the various definitions of 'integration' of health and social care within the relevant literature. Levels of integrated working within and between organisations will then be considered, and the levels of integration proposed by Ham and Curry (2011), Leutz (1999) and Fulop, Mowlam and Edwards (2005) will be discussed.

The impact of, and the issues identified with regard to integrated working within the recent research literature will also be examined within this chapter, as well as outcomes for service users and examples of integrated working in practice. Despite being promoted in high level strategy documents (e.g. Department of Health 2013a; King's Fund 2014), it remains unclear in the research evidence as to what extent integrated working is beneficial for service users or staff working within integrated services (Dickinson, Glasby, Miller & McCarthy 2009; Glasby, Miller & Posaner 2013; Ham, Heenan, Longley & Steel 2013). The suggestion will be made that although integrated working has featured heavily within policy and strategy documents, as well as research papers for some time, little progress has been made and there is conflicting evidence about how well integration works, both as an attempt to economise (Leutz 1999; Shaw & Levenson 2011) and in terms of outcomes for service users (Da Silva 2012) despite 'success' stories presented in policy and within the literature.

Health and social care in England

Health and social care has traditionally been provided separately within England. The Poor Law in 1601 stated that local authorities were to provide care to the elderly and infirm (Thane 2009). The initiation of workhouses, which were provided by the local authority in each region for those who were capable of work but otherwise destitute, and care for those who were elderly or infirm, was the stepping stone towards the means tested social care system that is in force in England today (Thane 2009). Those wishing to enter the workhouse were required to give information on admission that would determine their status within the workhouse,

such as whether they were able to work or merely required care (Higginbotham 2012). Due to the poor standard of care given to the infirm within workhouses, legislation was passed in 1885 stating that health care was to be provided to inmates of workhouses in a separate but nearby location.

In 1948 health care became freely available to all on a national basis (Thane 2009). The legacy of these historical arrangements for offering treatment and care remain today in the form of a National Health Service (NHS) which is free at the point of use, and personal Social Services, which are accessed via both a means test and eligibility criteria through the Local Authority (Department of Health 2003). Therefore, differences in the provision of health and social care have existed since separate provision of these services on a national basis in England began. The divide between health and social care in England is still evident today, both in practice and in policy making. Integrated working within and between these services continues to be the exception rather than the rule (Ham, Dixon & Brooke 2012). The NHS and Local Authorities serve the same population, but have separate funding streams, separate commissioning arrangements, separate policy making and separate employment terms and conditions for their staff, all of which have been identified as barriers to integrated working (c.f. Stirling, Malcolm & Corbett-Nolan 2013; Khaldi 2013; Roland, Lewis, Steventon, Abel, Adams, Bardsley, Brereton, Chitnis, Conklin, Staetsky, Tunkel, Newbould & Ernst & Young LLP 2013; Weeks 2007).

However, despite historical separation, governmental policy and strategy increasingly suggests that health and social care organisations, and professionals within them should work together to provide integrated care. The integration of health and social care is by no means a new concept. As far back as 1973 the NHS Reorganisation Act stated that health and social care should work with one another in collaboration to provide care through Joint Consultative Committees (Department of Health 1973). Early attempts to plan care through collaboration were inadequate and calls for further reform were made (Glasby et al. 2011).

In 1989 the Conservative government's White paper, 'Working for Patients' (Department of Health 1989) was published. 'Working for Patients' had two main objectives, firstly to give better choice to patients about the services available and secondly, to give rewards to NHS staff who ensured this better choice was achieved. This choice was to be achieved through an internal market with a purchaser/provider split and a focus on competition. In order to become a provider, individual

organisations, for example Ambulance Services, had to become an NHS Trust. General Practitioners (GPs) were able to secure the 'best' provider for care within their community although it was unclear as to whether this 'best' provider should provide the best care or the best value for money. The NHS and Social Services continued to operate as two separate entities, each providing health or social care independently. Each locality was able to purchase care as they saw fit for their population, creating the potential for inequality and inefficiency in provision (Rivett 2012).

However, with the election of New Labour in 1997, integration once more became the focus of governmental policy regarding health and social care in England. The 1997 White paper from New Labour, 'The New NHS' stated that services would be constructed around the service user who could expect a fast and dependable service. The internal markets introduced by the earlier Working for Patients White paper were deconstructed and more money was made available for the NHS (Rivett 2012). 'The New NHS' claimed that integrated, inter-agency working would reduce hospital admissions, enable smoother discharges from hospital and lead to an increase in community based working (Dickson et al. 2009). Within the White paper, New Labour made claims about partnership working which were not grounded in research based evidence, which may not have been available at the time; rather they appear to have been grounded upon aspirations for health and social care and to date the evidence for integration is mixed (Dickinson et al. 2009). Despite this, with the introduction of 'The New NHS' White paper, Social Services and the NHS were expected to work together in a more coordinated and integrated way than they had previously.

Integration continued as a theme for the Labour government and their plans for health care provision within England. In 1999 the Health Act was released, containing guidance that pooled budgets could be utilised in order to break down barriers between health and social care provision within England, allowing the easier transfer of funds between health and social care bodies. Coordination of services was also encouraged within the paper.

Integration was also at the centre of the White paper, 'Our Health, Our Care, Our Say' published by the Labour government in 2006. This paper stated that health and social care services should focus on patient centred, integrated health and

social care with greater emphasis on the individual and their needs rather than teams of professionals and a rigid system of working (Koubel & Bungay 2009).

Further guidance released in 2008, the Adult Social Care Workforce Strategy: Interim Statement contained guidance stating that integrated working should be a key driver for change in health and social care. This strategy was aimed at Local Authorities and social care providers. Integrated working between health and social care organisations was to be achieved by effective leadership, investment in shared goals, cross agency ownership of these goals and effective resourcing (Department of Health 2008a). The justification given for the focus on integrated working by the Adult Social Care Workforce Strategy was that, 'adopting integrated working practices... offer(s) the potential for better service outcomes' (2008a: 4) however why this should be the case was not explored within the paper.

Despite being advocated in governmental policy documents since 1997, relatively little progress has been made in England with regard to the provision of integrated health and social care (Evans & Forbes 2009). Other territories within the United Kingdom such as Northern Ireland, Wales and Scotland have made further progress towards the provision of integrated care. Within Northern Ireland, inter-agency working has been in place for 30 years. Integrated working within this setting has been demonstrated to break down, 'professional straitjackets' (Heenan & Birrell 2006: 63) between professionals and has reportedly lead to less duplication and more holistic packages of care being delivered to service users. Additionally, in Scotland, both primary and secondary health services are provided through allied local health boards (Evans & Forbes 2009) supported by a clear direction in policy making since 2004 (Ham et al. 2013). Moreover, since 2009 Wales have been following the same collaborative health partnerships model as Scotland, with positive outcomes for joined up working between health services in the country (Ham et al. 2013). It is unclear as to why so little progress has been made towards integrated working within England. It has been suggested that lack of clarity within policy directives from the English government and subsequent changes of direction with regards to priorities may be at the heart of the issues (Evans & Forbes 2009; Glasby et al. 2013) and may account for the delay in progress.

Recent developments

In 2012, the coalition Government outlined plans for the provision of health and social care within England for the duration of their office, which once more featured the integration of health and social care at the heart of the policy directives. Health care was to move to GP based commissioning in Clinical Commissioning Groups, with the goal of enabling front line staff (predominantly GPs) to have more control over how and where budgets were spent and with patients at the centre of care (Department of Health 2012), echoing earlier policy as discussed above. NHS Primary Care Trusts (PCTs) would cease to exist in the same form once GP Commissioning Groups had been established. Additionally, public health responsibilities would be transferred to Local Authorities rather than local PCTs. Competition was to be encouraged, as well as an increasing role for private companies in the provision of health and social care. As demonstrated earlier in the chapter, the idea of competition was not new. The 1989 White paper posed by the Conservative government also encouraged competition between providers to provide the best value care. Additionally, the 2012 Health and Social Care Act refers to patients at the centre of the NHS, as did the 1997 New NHS paper, thus the idea of patients at the centre of care is not a novel concept and has been proposed within policy for many years. Social care has also been subject to change with the implementation of the Care Bill (Department of Health 2013a) and integration features at the centre of more recent strategy documents (e.g. Department of Health 2013b).

Further policy was issued by the Department of Health in 2013 with regard to the provision of health and social care in England, stating that clearer information should be available for service users to enable informed decision making about care received (Department of Health 2013c). Additionally, coordination of services features as a key component of policy surrounding the provision of health and social care (Department of Health 2013d; Department of Health 2013e).

Furthermore, 'Making the NHS more efficient and less bureaucratic' requires that by 2015, all hospital records should be electronic, and more service users should be able to request GP appointments, order prescriptions and communicate with their GP surgery electronically (Department of Health 2013f). Local services are also being encouraged to add to the body of evidence based research regarding

'what works' in a local context in order to inform the broader national picture (Department of Health 2013g). Additionally, measures were to be introduced to collect service user's experiences of integrated care (Department of Health 2013h). Of significance for the research contained within this thesis, guidance issued in May 2013, 'Making sure health and social care services work together' states that health and social care providers should work together in a coordinated way, removing barriers to integration, provide better information for service users and their carers and support service users to make decisions about their own health care.

Of the most recent developments, perhaps of most consequence for the research contained within this thesis is within the Care Bill (Department of Health 2013a). Within this Bill it is stated that a Local Authority must ensure the integration of care and support provision where the individual Local Authority sees any benefit for the individual population within the area. Integration is therefore at the discretion of local services rather than a nation-wide requirement. This lack of uniformity adds the potential for variation in the provision of integration. As local arrangements may vary there is a risk that service users may fall into an implementation gap (Glasby et al. 2011) where they do not meet local eligibility criteria despite having health and social care needs.

Implementation gap

Within the health and social care sector, national policy is interpreted and delivered in a local context as called for in the Care Bill (Department of Health 2013a). However, with variation in provision and confusion over responsibilities, there is a risk that service users who do not fit into traditional categories may fall into a 'no man's land', where neither health nor social care believe they should be responsible for providing services to the individual in question:

'All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens, people, often the most vulnerable in our society... and those who care for them find themselves in the no man's land between health and social services. This is not what people want or need. It places the needs of the organisation above

the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money—it is unacceptable' (Department of Health 2000: 3).

Furthermore, there is a risk of inequalities as policy is interpreted into practice (Hunter & Kiloran 2004) with variation in local provision, resulting in service users experiencing differing levels of care as a result of differing interpretations of integrated services across the country.

A recent report commissioned by the King's Fund (2014) outlines the issues surrounding the integration of health and social care, and makes the case that the main difficulty is that of alignment between health and social care within England. This alignment is on three levels – how needs are assessed, the lack of alignment between funding streams and the differences in how health and social care are commissioned, which leads to difficulties when coordinating health and social care. It has been argued that these fundamental issues often lead to service user's needs not being met by local provision, or confusion regarding which funding stream should be utilised to pay for different aspects of care and can result in a complete lack of funding being provided or inappropriate care being delivered (King's Fund 2014).

Shaw, Rosen & Rumbold (2011) state that:

'...the organisational separation of health and adult social care services (with the exception of Northern Ireland) has been a further cause of service fragmentation for many users... (resulting in) a lack of service coordination for individual patients... which often results in patients experiencing discontinuity of care when they are transferred from home to hospital, or vice versa' (p. 4).

Although the integration of services aims to avoid duplication, delays and use of additional resource, the historical separateness of these systems could lead to gaps in provisions for some service users, with negative outcomes (Shaw et al. 2011). For example, Oliver, Foot and Humphries (2014) suggest that fragmentation in the care of older adults¹ can lead to delays in service provision for potentially vulnerable and frail service users. As health and social care has traditionally been provided separately, there are distinct differences such as terms of reference, interpretation of

¹ Older adults in Countyshire are defined as those over age 75 (Countyshire PCT 2012) but as over 65 by the Centre for Workforce Intelligence (CfWI) (2012).

policy and employment terms and conditions (Stirling et al. 2013; Khaldi 2013; Roland et al. 2013; Weeks 2007). When these two services are required to work together as per recent developments in health and social care policy, each individual service's high level policy making and commissioning may be incompatible. This may introduce complexity when planning service provision (Glasby et al. 2011) and result in a gap in provision.

However, within the literature integrated working is promoted as a method to overcome gaps in patient care (e.g. Veronika Thiel, Sonola, Goodwin & Kodner 2013; Frontier Economics Ltd. 2013) with the argument that with better coordination of care, the risk of a gap is reduced. Nonetheless, as argued by Oliver et al., the traditional separateness of health and social care may mean that individual services are unclear about their responsibilities when it comes to integration. Oliver et al. argue that rather than focussing on individual diseases, the full range of an individual's needs should be addressed in order to overcome the implementation gap. Furthermore, it has been suggested in the Joint Committee on the Draft Care and Support Bill that clarity over which service is responsible for which areas of care will be required to deliver successful integrated care (Great Britain Parliament 2013). Confusion over responsibilities may be exacerbated by the number of definitions of integration within the literature - and the role of each organisation may be dependent upon the definition.

What does 'integration' mean?

'Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about' (Shaw et al. 2011: 3)

'Integration' is a term frequently used to describe a broad range of health and social care delivery arrangements, and may mean different things to different individuals (Graham 2013). For example, in a paper produced for the English Integrated Care Network, Thistlewaite (2008) defines integrated health and social care as 'a single system of needs assessment, service commissioning and/or service provision' whereas Roland et al. (2013) state that there is, 'no single definition of integrated

care' (p. 1). However, NHS England (2013) outlines integration as, 'person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family' (NHS England 2013).

Within a paper produced for Monitor, the sector regulator (Monitor 2014), integrated care is defined as an approach that, '...seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well coordinated around their needs - it is by definition both 'patient-centred' and 'population-oriented' (Frontier Economics Ltd 2012: 15) whereas Shaw et al. (2011) argue that 'integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about' (p. 3). Shaw et al. (2011) also draw a distinction between internal (within the NHS) integration and external (NHS with Social Services) integration. Furthermore, Shaw and Levenson (2011) state that, 'integration can take a number of forms – ranging from a loose collaboration between different providers, through to full mergers' (p. 4). Integration may also take the form of partnerships between health and social care providers (Dickinson et al. 2009) and may be defined differently by these providers dependent upon the local context (Dickinson, Glasby, Nicholds, Jeffares, Robinson, & Sullivan 2012).

Thus, within the literature, 'integration' has been used to refer a number of arrangements, including partnership working, joint working or integrated working, to name but a few variations (e.g. Dickinson et al. 2009; Glasby et al. 2013; Department of Health 2013a respectively). There is no one definition regarding integration and integrated care within the relevant literature (Roland et al. 2013), which may lead to confusion for service users, professionals working in the sector and policy makers (Barr 2002; Cancer Campaigning Group 2012).

A lack of definition has been suggested to lead to confusion for service users – after consultation with service users, the Cancer Campaigning Group (2012) advises that a working definition of integrated care for service users would be useful. However, a paper produced by National Voices (2012) states that a definition is not important:

'...people want coordination. Not necessarily (organisational) integration. People want care. Where it comes from is secondary...They expect professionals to work

together as a 'team around the patient', and they want services to work together likewise: that is, to come together at the point they are needed, and to meet people's needs in the round' (p. 1).

It would seem that although service users are confused by the myriad descriptions of integrated care provision, ultimately it is the care received that is of key importance, not how it is organised or defined.

Although I have demonstrated that within the literature, definitions of integration vary, within this thesis Barr's (2002) definitions will be utilised in order to draw distinction. Barr (2002) defines integrated working as an attempt to bring services together to work in a coordinated way, whereas interprofessional working is an attempt to encourage collaboration between professionals (Barr 2002). I have chosen these definitions as they are flexible and encompass a range of provision under a broad umbrella of 'integration' and 'interprofessional'. Furthermore, Barr's definitions capture the elements of the single point of access within Countyshire, where 'integration' was through local arrangements and a pooled budget for the service, and 'interprofessional' working was encouraged through the creation of a single point of access team. These different levels of integrated/interprofessional working are not unique to Countyshire – different levels of integrated and interprofessional working are common across England and the rest of the UK (e.g. Curry & Ham 2010). There are a number of approaches when defining the levels of integration which will next be considered.

Levels of integration

As the definition of integrated working varies within the literature, the complexity of and potential for integrated care provision also varies, which may lead to a lack of uniformity in provision across England (e.g. NHS England 2013). As such, a number of levels and dimensions of integration have been proposed within the literature.

The World Health Organisation (2008) recognises the different models that exist and describes a range of vertical and/or horizontal integration happening across organisational boundaries. Integration may occur at different levels within and across organisations – there is no 'one way' of integrating services, argue Curry and Ham (2010). Wistow (2011) argues that health and social care organisations are

complex, many levelled organisations, and as such any attempt to integrate these systems must also be multi-levelled. Wistow states that integration can be vertical (combining primary, community and hospital services) or horizontal (involving multi-disciplinary teamwork). Additionally, Curry and Ham propose that integration can also be either 'real' or 'virtual'. 'Real' integration is defined as creating a new single organisation to provide all services. 'Virtual' integration is a network of organisations working together, joined contractually.

Additionally, Ham and Curry (2011) argue that integration between health and social care can take place at three levels, macro, meso and micro as outlined in Table 1 below.

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Table 1. The levels of integration (based on Ham & Curry 2011: 3)

Ham and Curry argue that each level of integration can operate either in isolation or by building on the previous level. These levels allow identification of who is involved within the integration, and whether integration is through policy, financial arrangements and high level management or whether integration is provided at a lower, front line staff level. This identification is suggested to allow the establishment of where within the organisational structure changes will occur and which staff within the organisation, if any, will be affected (Ham & Curry 2011).

Leutz (1999) proposes an alternative three different ways of working or levels of integration:

Table 2. Levels of integration as proposed by Leutz (1999)

Leutz's three levels of integration can be compared with Ham and Curry's macro, meso and micro levels of integration as the three levels described by each model are similar, however Leutz gives more detail regarding each level, whereas Ham and Curry's model is broader and less specific, and as such may also be useful when considering integration. However, both models identify three similar levels of integration at a full service, specific needs or individual level.

Despite both Leutz and Ham and Curry identifying three levels of integration, Fulop et al. (2005) state that to consider levels of integration is to only consider the governance and organisational (and thus structural) aspects of integration and that rather, the process and cultural changes that occur when services are integrated should also be considered which is echoed in change management literature (Kotter 1997; Hayes 2007). Based on evidence from a portfolio of research, Fulop et al. argue that integration occurs through 5 dimensions: organisational, functional, at a service level, at a clinical level and can be either normative or systematic. The organisational dimension refers to whether integration is through mergers and/or structural change or virtual through contracts. The functional dimension defines how non-clinical support and back-office functions are integrated. The service level dimension refers to how clinical services are integrated between organisations. The

clinical dimension considers how care is integrated - intra (between professions) and inter (within same profession) professionally - and whether there are shared guidelines or pathways. Finally, a normative dimension of integration refers to shared values in co-ordinating work and collaboration in the delivery of care, and a systematic dimension of integration covers the coherence of rules and policies at various levels in the organisations.

Fulop et al. argue that these factors are crucial in the success of any venture into integration and cite various studies into the delivery of integrated care as evidence for these factors (Goodwin, Peck, Freeman & Posaner 2004; Shortell 1996; Shortell 2000; Warner & Gould 2003). These studies were international, not just based in the UK, and one (Goodwin, Peck, Freeman & Posaner 2004) is based on lessons from health and social care but also considers other sectors such as the biotechnology industry, the defence industry, and the industry related to crime, disorder and drugs. A summary of these studies is provided in Table 3 below.

Authors	Summary	Critique
Goodwin, Peck, Freeman and Posaner (2004)	Aims to investigate the creation of networks, both within the health care industry and from other sectors i.e. biotechnology, defence, crime, disorder and drugs and suggest lessons learned for the creation of networks in health and social care. States that there is no one best model for networking.	Does not pose an actual model for networking between health and social care, rather each sector described as utilising a different style of networking. Questionable how transferable lessons from different sectors are due to the different structures in place
Shortell (1996)	Aims to advise and support integrated as well as more cost effective care	Based on evidence from America therefore transferability questionable, additionally, the evidence for cost effectiveness of integration has been argued to be weak (Leutz 1999; Ramsey & Fulop 2008)

Shortell (2000)	Aims to provide advice to support integrated care	Based on evidence from America therefore transferability questionable
Warner and Gould (2003)	A study of five integrated networks in development between health and social care in Wales, using levels to define the policy, finance, management and clinical level of integration within each network	Limited to one area under control of Welsh Assembly Government therefore transferability questionable as provision now varies compared to England with separate policy making

Table 3. Summary of studies used to support the dimensions of integration

As such, Fulop et al.'s dimensions of integration are not solely based on evidence from existing studies into health and social care. However, the suggestion of considering cultural and process issues as Fulop et al. suggest are supported by other research (e.g. Kotter 1997; Hayes 2007; King's Fund 2012; Goodwin, Smith, Davies, Perry, Rosen, Dixon, Dixon and Ham 2011).

As well as levels and dimensions of integration, Peck (2002) and Glasby (2005) highlight the depth and breadth of partnerships as of importance when considering the nature and type of integration. According to both Glasby and Peck, depth ranges from 'sharing information' to 'formal merger' and breadth ranges from 'health and social care' through to 'health, local authority and wider community', reflecting the levels proposed by Leutz, and Ham and Curry with further increments which may help to understand and define arrangements for integration in more detail.

Overall, as with the definition of integration, within this section I have demonstrated that there is no one way to define the levels of integration within and between health and social care organisations. The above evidence from Fulop et al., Wistow, Leutz, Glasby, Peck and Ham and Curry suggests that there are myriad possibilities for integrated working within and between health and social care. Furthermore, I have demonstrated that the evidence points to a number of complexities that must be considered when integrating these two historically separate services such as separate funding, commissioning and policy making.

Within England integration can take a different form dependent upon the local context (e.g. Department of Health 2013a). Ham and Walsh (2013) suggest that no one level of integration and integrated working is superior to others in terms of outcomes for both organisations and service users, rather it is how the integration of the traditionally separate organisations and their respective cultures and processes are managed that is key, which will be one of the main focal points within this thesis in terms of integration within Countyshire through a single point of access. However, a number of benefits and disadvantages to integrated working have been identified within the literature, which will now be considered.

Integrated working – impact and issues

Thus far I have demonstrated within this chapter that integration is not a new concept and has existed in policy and strategy documents for at least thirty years. The definition of integration and the levels at which integration take place has been demonstrated to vary dependent upon the context and type of integration. It has been suggested that local issues may also contribute to complexity (Glasby et al. 2011). The impact of an 'implementation gap' for service users has also been discussed with reference to how integrated care is planned and implemented. I will demonstrate throughout the remainder of this chapter that although integration is still an aspiration for health and social care in England according to high level strategy documents, the evidence for integration is mixed. The benefits and challenges, outcomes for service users and some examples of integrated working will be examined in turn.

Impact

Goodwin et al. define integrated care as, 'an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well coordinated around their needs' (2011: 3), that has the potential to deliver a reduction in hospital admissions and stays, increase staff and patient satisfaction, improve quality of care and result in a significant cost reduction for those commissioning health and social care. Additionally, Tucker and Burgis (2012)

highlight integration in Norfolk as a successful enterprise that was supported by positive feedback from staff working in the area and a 31% reduction in hospital admissions. Miller and Cameron (2011) have identified other benefits of integrated working as the following;

- increasing the ability of health and social care services to manage risk and avoid harm to service users in the community;
- reduce duplication and increase coordination;
- improve standards, practice and recording and
- improved communication

Jointly commissioned health and social care services may be one way of working more efficiently and reducing the financial strain on both services, as the service users using health and social care services can often be one and the same (Hudson 2011). Indeed, savings of around £300,000 to £400,000 have been identified from partnership working (NHS Confederation 2012).

Additional benefits to integrated working are highlighted by Glasby et al. (2011) as helping to deliver packages of care to individuals, share information and enable continuity of care, as well as make the best use of resources. Glasby et al. (2011) also draw attention to the ability of integrated working to deliver packages of care to those with complex needs who do not fit into the prescribed categories in the existing welfare system and thus at risk of falling into the 'gap' as discussed above. Furthermore, Ham and Walsh (2013) state that:

'the evidence of the benefits, in particular to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be coordinated around the needs of people and populations' (p. 1).

Issues

Despite integrated care having support within the literature as identified above, Glasby et al. state that:

'much of the current literature is very descriptive and sometimes very 'faith-based', emphasising the perceived virtues of partnership working without necessarily citing any evidence for the claims '(2011: 2)

As an example, Begley makes the statement that, 'patient or client care given by any one professional on their own can never be as good as care given by a full team' (2008: 276) but does not base this statement on any evidence, thus demonstrating a gap between aspirations for integration as opposed to actual evidence supporting integration within the research literature.

Further challenges to the efficacy of integrated working come from Brown, Tucker & Domokos (2003) who compared two community care teams, one integrated and one non-integrated, and found no significant difference in the numbers of service users remaining independent in the community as a result of intervention from integrated community care teams. Brown et al.'s participants did have some unexplained disparities between levels of professional input and quality of life scores which were not explained in the findings, however, despite service users receiving input from non-integrated professionals having better quality of life and lower depression, more of the service users in this group passed away during the study. In comparison, service users receiving integrated care reported higher levels of depression and lower quality of life, resulting in more admissions to residential homes (Brown et al. 2003). These findings do not support the benefits of integrated working identified above by Miller and Cameron (2011), however Brown et al. do state that a higher proportion of service users allocated to the integrated group were identified as high intensity, requiring more intervention and subsequent admission to residential homes. This may explain why there was no difference overall in service users who remained independent in the community within this study and no benefits were found for integrated working. Brown et al. also claim some benefits from integration within their findings, including the assertion that community care provided through integrated teams may lead to quicker assessment, as communication between teams, and understanding of one another's roles may be increased when working together in an integrated team. However, Brown et al. also state that an integrated 'one stop' community team led to an increase in self-referrals which, although positive for service users when accessing services, may be construed as a drawback for community services already under pressure.

As highlighted above, Goodwin et al. (2011) argue that integrated working is a more cost efficient way of providing health and social care, supported by a statement from the NHS Confederation (2012). However, the financial benefit of integrating services has been contested by other researchers within the literature. For example, Leutz (1999) states that integration often requires expenditure before it becomes cost efficient. Additionally, Glasby et al. (2013) state that, 'there remains insufficient evidence to know what impact joint working might have on future spending' (p. 28). Shaw and Levenson (2011) state that, 'two years of initial development, followed by a minimum of one year of live working, and almost certainly longer, is required to show the initial effects of major changes to service organisation and provision, particularly financial savings' (p. 4). Therefore, integration may not result in a quick win solution for saving money as promoted by Goodwin et al. and the NHS Confederation.

Additionally, a number of barriers to integrated working have been identified within the literature, including professional and cultural barriers (e.g. Atkins 1998; Hollingsworth 2013; Stirling et al. 2013; BPIB 2013; Ham et al. 2013; Langford, Baeck & Hampson 2013). Tudor Jones (2013) identifies that a barrier to integration can occur when particular professions such as GPs, who have previously been identified as averse to integrated working (Glendinning 2003), are not fully engaged with integration. Professional and cultural barriers to integration will be discussed in more detail within subsequent chapters; however it is important to note at this stage that professional barriers have been highlighted within previous research as having the potential to adversely affect integration.

Furthermore, research into partnerships in health and social care tends to focus upon the process of partnerships rather than the outcomes for service users (Dowling, Powell, & Glendinning 2004). It remains unclear as to whether integration has a real impact on clinical outcomes for service users and some research (e.g. Roland et al. 2013) reveals that service users do not believe that integration of services provides any improvement in their care.

Perkins, Smith, Hunter, Bambra and Joyce (2010) argue that there is little evidence to suggest that partnership working between health and social care reduces inequalities or leads to better outcomes for service users. Additionally, Dickinson et al. (2009) suggest that service user outcomes have not been investigated in sufficient depth; therefore it is not possible to measure the efficacy of

integrated working for service users. Dickinson et al. suggest that although an integrated approach may mask any complexity within the health and social care services for service users, the complexity still exists within the organisations. This complexity can lead to issues when integrating services, such as information technology systems, referral management and professional cultures (Dickinson et al. 2009). As highlighted above, it has been suggested that service users are ambivalent about how services are organised, as long as they feel that they are getting the care that they need at the time that it is required (Brown et al. 2003; National Voices 2012; Local Government Association 2013).

Nonetheless, Dickinson et al. state that in their research, service users valued being able to have some control and say in the services which were provided to them, which is another identified benefit of integrated working (Miller & Cameron 2011). However, Dickinson et al. state that the service users in their study were of a younger age and that the wish for more involvement in services may not be transferable to other populations of service users such as older adults. Despite Dickinson et al.'s statement that younger adults are more receptive to integrated working, Goodwin et al. (2011) set out the case for the integration of services for older adults. Integration, according to Goodwin et al. is an approach that is suited to older adults who may have complex needs and require coordinated packages of health and social care. Moreover, a study carried out by Help the Aged in 2001 found that older adults wished to assist with and inform the development of services, and to have more involvement in designing, planning and measuring services (HOPE Group 2000; Ellis 2001). The messages regarding integration and service users within the literature are mixed.

The overall message from the evidence base suggests that there is no clear support for integrated working between health and social care services, and yet, there are some identified benefits such as a reduction in hospital admissions and stays, reducing financial strain on services and the ability to deliver coordinated packages of care, reducing duplication. However, there is unclear evidence as to whether integrated care really makes any difference to how service users feel about or experience their care, with some suggesting integrated working improves service user satisfaction (Goodwin et al. 2011) and others suggesting it makes no difference to service users as long as they receive the care they need, when they need it (Brown et al. 2003). The ability of integration to enhance cost effectiveness has also

been disputed. Despite this mixed evidence and lack of clarity, integrated working is still on the agenda for health and social care in the future (Ramsey & Fulop 2008; Department of Health 2012; Department of Health 2013a).

Although integrated care is heavily featured within policy and strategy documents as well as research outputs, I have demonstrated within this section of the chapter that the evidence is mixed, both in terms of financial savings, time savings for professionals and outcomes for service users. Ham et al. (2013) concur, stating that there is a, 'lack of well-designed studies and evaluations of the impact of integrated care' (p. 78) as does evidence from Cameron, Lart, Bostock and Coomber (2012) who state that frequently, small scale studies are utilised in order to promote integrated working which are poorly reported and with no evaluation of cost effectiveness, which is also argued by Burgess (2012). It is difficult to draw conclusions or make generalisations to other areas where integrated care is developing. As such it is prudent to carry out further research with regard to integrated working within England to establish what benefits, if any, that integrated working has, both in terms of cost (financial and in terms of time) and outcomes for service users (Ham & Walsh 2013) as well as impact upon professionals working within this sector.

Chapter summary

Within this chapter, the definition of integration within the current research has been examined, and it has been argued that the definition varies dependent upon the level of integration and local context. Levels of integration have also been discussed. I concluded that like the definition of integration, the levels of integration can vary dependent upon the type of integration in question. Furthermore, it has also been argued that rather than just examining levels, dimensions of integration should also be considered in order to take professional and organisational culture into account.

The history of health and social care provision within England has also been considered, as well as recent policy developments. The potential for gaps in provision was also discussed. Despite integration being promoted as a holistic way of working for both professionals and service users, there are still gaps in provision resulting in service users not receiving the care they require, and confusion over responsibilities between health and social care providers:

'...the literature (and indeed much recent policy) around effective partnership working tends to assume that partnership is automatically a 'good thing' and that it somehow improves outcomes for service users and carers... In practice, this remains a relatively untested assumption' (Glasby 2012: 7)

Integration is still at the heart of governmental policy for health and social care despite the mixture of evidence for this way of working. I have demonstrated within this chapter that little progress towards the integration of health and social care has been made within the last 30 years despite integration between health and social care featuring in governmental policy documents since 1997. This lack of progress has been argued to be due to a variety of issues, not least the lack of clarity within policy directives from the English government and subsequent changes of direction with regards to priorities (Evans & Forbes 2009). I have demonstrated within this chapter that the evidence to support integrated working is mixed. I have presented conflicting evidence about how well integration works, both as an attempt to reduce cost (Leutz 1999; Shaw & Levenson 2011), in improving outcomes for service users (Da Silva 2012) and whether service users believe it has any impact on their care (Dowling et al. 2004; Roland et al. 2013).

As well as presenting the evidence for and against integration of health and social care, I have demonstrated that there is no one definition of integration. As such, how the success of integration can be defined and measured is questionable. The definition of success itself is open to interpretation dependent upon the local context. Where does this leave integration in terms of its efficacy? The literature points to a number of potential benefits to integrated working, such as reduced hospital admission, improved coordination and improved communication between professionals (Goodwin et al. 2011). However, a number of potential barriers have been identified, not least professional and cultural barriers between professions and organisations respectively (Atkins 1998; Hollingsworth 2013; Stirling et al. 2013; BPIB 2013; Ham et al. 2013; Langford et al. 2013). Chapter two will move the discussion onwards, and examine the development of professional identity within health and social care and barriers to integrated and interprofessional working. As integrated working often relies on the creation of new teams, team development and issues within teams will also be considered. I will argue that the development of

professional identity relies on the creation of barriers between 'us' and 'other', which is not conducive to team working or integration.

CHAPTER TWO – PROFESSIONAL IDENTITY AND TEAM WORK

Introduction

In order to make the change to integrated working, individual professional cultures, beliefs and socialisation processes are set to be challenged as professionals are asked to work together in new ways. Understanding how professional identities are constructed may help to understand the potential consequences that this might have for the integration of health and social care. In this chapter I will demonstrate that the formation of professional identity actively encourages the formation of an 'us' and 'other' which Mandy, Milton and Mandy (2004) have previously compared with Tajfel's (1974; Tajfel & Turner 1986) social identity approach. Within this chapter I will outline this comparison, and I will argue that the formation of 'us' and 'other' is not conducive to team formation and team working. I will suggest that the formation of 'us' and 'other' could have a negative impact upon the integration of health and social care. Theories of identity formation including Giddens' (1984) structuration theory and Berger and Luckmann's (1991) theory of socialisation will be discussed, as well as interprofessional rivalry and the effects of this rivalry in the workplace.

In order to achieve integrated working, particularly in the context of a single point of access, health and social care professionals are often required to work together in a team (e.g. Brown et al. 2003). Team working in the literature is therefore considered within this chapter, including Tuckman's (1965; Tuckman & Jensen 1977) model of team development, Gersick's (1988) time and transition model and McGrath's (1991) Time, Interaction and Performance (TIP) model. I will argue that no one theory of team formation is adequate to fully explain how teams form and operate, however each theory highlights similar areas of consideration with regard to the formation of effective teams. Finally, as individuals who are frequently under pressure, it has been argued that health and social care teams are more at risk of a phenomenon known as 'groupthink' (Snell 2010). The phenomena of group think will be discussed with reference to the relevant literature.

I will suggest that there are a number of barriers to team working within health and social care that begin to form during early training, and are actively encouraged through the assimilation of professional roles and the development of 'us' and 'other'. It has been previously suggested (e.g. Glasby et al. 2011) that these barriers can have an adverse impact on attempts to build integrated teams of health and social care professionals. I will go on to argue in subsequent chapters that effective change

management will be required in order to facilitate effective integrated working in teams within and between health and social care.

A consideration of the social influence upon identity formation

When considering how individuals work together within and between inter-professional teams, their individual cultural and social backgrounds must also be considered (Giddens 1984; Berger and Luckmann 1991; Crotty 1998). Each individual member of a team has their own cultural and social history, influencing their interactions:

'Without culture we could not function. Culture has to do with functioning. As a direct consequence of the way in which we humans have evolved, we depend on culture to direct our behaviour and organise our experience' (Crotty 1998: 53).

Berger and Luckmann (1991) suggest that individuals are born into 'structures' defined as cultures or societies that shape and mould their world view, depending on the culture and practices of that structure. An individual then becomes acquainted with the world through a process of secondary socialisation, experiencing and learning about other structures by participating within them and taking on roles. Berger and Luckmann go on to suggest that, 'structures are embodied in individual experience by means of roles' (1991: 91) and, 'all (social) conduct involves roles' (1991: 92). Within the context of the current study, the structures present were the PCT and Social Services, both of which had their own rules and roles within them. Furthermore, the professional role within which an individual was employed also had its own specific rules and regulations. These professional roles can be also be defined as structures. According to Berger and Luckmann, individuals become part of a defined structure through their education within specific roles, which define rules and guidelines for how an individual should behave within that role.

Berger and Luckmann's ideas about learning a specific role, or a profession led me to structure and agency theory, proposed by Giddens (1984). Within structure and agency theory, human 'agents' are influenced by the societal 'structure' within which they operate. Giddens explains, 'each person is positioned in a 'multiple' way within social relations conferred by specific social identities' (1984: xxv). According

to Giddens, individual agents operate within many different structures, such as a profession, a position within a family, and a gender, all of which are governed by a separate set of rules and expectations. Structures, according to Giddens, are 'dual' – that is to say, structures influence individuals and their social conduct, but individual's behaviour within the structure maintains and continues that structure (Sewell 1992).

Giddens argues that structures cannot exist without agents acting within them, and can be both enabling and disabling in terms of an individual's comprehension of their social world. Structures can constrain the world view of individual agents, and influence their behaviour. This notion is particularly relevant with reference to professions in health and social care. The structures of a profession are maintained and continued by agents who operate within them, continuing the existence of the profession by obeying the traditions and rules within it. Each profession has its own traditions, rules and language which an individual must learn in order to operate within it. I argue that a profession can therefore be seen as a structure.

Different societal structures have different rules, which shape the agent's behaviour within that structure. Berger and Luckmann (1991) argue that social identity forms through a process of primary socialisation, which takes place in the society into which one is born. An individual then enters into a process of secondary socialisation through interaction with different social structures. Secondary socialisation is:

'the acquisition of role-specific knowledge, the roles being directly or indirectly rooted in the division of labour... secondary socialisation requires the acquisition of role-specific vocabularies, which means... the internalisation of semantic fields structuring routine interpretations and conduct' (Berger and Luckmann 1991: 158).

Although Berger and Luckmann do not specify that secondary socialisation specifically takes place within a professional context, I argue that the principles can be applied to the process of the development of a professional identity through Berger and Luckmann's emphasis on the division of labour and role-specific vocabulary. However, an emphasis on socialisation as central to the development of identity does not allow for any biological influence upon personality or identity development, which critics such as Bordieu (1977) believe to be of importance when

considering the formation of identity. However, the extent to which biology plays its part in the formation of identity is contested by Ridley (2003) who argues that human genomes do not consist of enough genomes to account for all human variations; rather socialisation plays its part in identity development.

The formation of professional identity in health and social care and socialisation

Each health and social care profession can be argued to have an individual culture, set of beliefs and socialisation process (Hall 2005). Medicine was first recognised as a professional role in the early nineteenth century and other roles in the health and social care arena have developed since then (Witz 1992). Some health professions, such as nursing, have been in existence for over a century and have developed a deep rooted culture over a long period of time. It has previously been argued that professional culture within health and social care is based upon the development of in groups and out groups as part of the socialisation process (Du Toit 1995; Lingard, Reznick, DeVito & Espin 2002). This section of the chapter will consider the development of professional identity in health and social care through socialisation and the development of 'us' and 'other'.

With similarity to the social formation of identity as proposed by Berger and Luckmann, and Giddens, Du Toit (1995) argues that the development of professional identity consists of a process of socialisation with professional peers. Standards are internalised on both a formal educational level and an informal level. Becoming a professional, according to Du Toit, is an acculturation process through which the values, norms and symbols of the profession are internalised – thus the culture of a specific profession is learned. Socialisation is embedded further through the influence of role models who exemplify the standards and skills that are valued within the profession. Of equal importance are those who do not demonstrate the qualities associated with the particular profession and therefore demonstrate how not to behave. Du Toit asserts that acculturation begins early in professional training.

However, not all health and social care professions have existed for the same amount of time, nor have the same professional standards or specific role. For example, occupational therapy has previously been described as having no defined role, that is to say the range of specialities that occupational therapists can cover is

wide ranging (Edwards & Dinette 2010). Occupational therapists can be found in diverse areas, from washing and dressing assessments, to wheelchair assessments, to workplace based assessments. On this basis, Edwards and Dinette argue that occupational therapists have difficulty defining their role and explaining what they 'do', as well as having a lack of professional status and poor recognition within the healthcare arena.

Additionally, social worker students have also been found to have difficulties in defining a professional identity (Adams, Hean, Sturgis & Macleod Clark 2006). According to Adams et al., first year physiotherapy students had the highest levels of professional identity compared to other student groups although the reasons for this are not clearly identified within the study. Social worker students were found to have the lowest levels of professional identity in Adams et al.'s study. It has previously been suggested that social workers have had an identity crisis. In 2004, a Community Care paper stated that the government wished for social work to have closer links with education and health care. This raised the concern that the boundaries between the health and social care professions were becoming blurred. It was suggested that asking these professionals to work together in integrated, multi-disciplinary teams may lead to further blurring of roles and responsibilities between health and social care professionals, and consequently less defined job roles (Community Care 2004).

Health and social care professionals have previously been described as reluctant to work in integrated teams (e.g. Glendinning 2003) which could potentially be attributed to the perceived threat of the blurring of roles and responsibilities. Indeed, Hall (2005) argues that health care professionals strive for boundaries in their professional lives, as creating boundaries allows for favourable 'in' group comparisons and protection from negative repercussions, as well as enhancing the authority of the individual profession. Carpenter (1995) states that the development of in groups and out groups can lead to interprofessional rivalry and create barriers to effective integrated working. Interprofessional rivalry within and between health and social care professionals will next be considered.

Interprofessional rivalry

Mandy et al. (2004) state that interprofessional rivalry and 'tribalism' can have a negative impact upon service delivery within health and social care systems. Interprofessional rivalry, argues Carpenter (1995) is a direct result of the specific ways in which health and social care professionals experience socialisation. As well as having a negative impact upon service delivery, interprofessional rivalry has also been identified as a cause of poor communication and low work satisfaction amongst health and social care professionals (Ryan & McKenna 1994). Poor communication has also been linked to a lack of trust between health and social care staff (Vivian, Marais, McLaughlin, Falkenstein & Argent 2009) and as a barrier to integration (Ingram & Desombre 1999; Molyneux 2001).

Mandy et al. (2004) have compared interprofessional rivalry to Tajfel and Turner's (1986) social identity theory. In turn, Tajfel and Turner were influenced by the work that Berger and Luckmann had carried out with regard to the social formation of identity (Hogg 2006). Social identity theory operates on the basis that individuals will identify more closely with other individuals whom they believe to belong to the same social or 'in' group as themselves, and view other social groups as 'other' or an 'out' group. These beliefs about 'in' groups and 'out' groups are based on negative stereotypes which reinforce the positive aspects of those within one's own 'in' group and emphasise the negative traits of 'out' groups (Reeves, Lewin, Espin & Zwarenstein 2010).

Hogg (2006) argues that social identity theory should be considered as a sociological approach rather than just as a theory of inter group conflict. Groups compete with one another in order to be viewed positively, which combines a number of factors, states Hogg. For example, it has been argued that categorising other individuals into groups forms an essential stage in making sense of the world around us in a social context (Hayes 2000). This categorisation has been argued to enable the depersonalisation of these individuals into stereotypes and facilitates a positive identification with one's 'in' group (Hogg 2006).

The social identity approach also encompasses the formation of negative attitudes towards those classed as an 'out' group. Identifying with an 'in' group

consists of making prejudiced judgements against 'out' groups in order to preserve the positive self-image of the in group (Tajfel 1978). Prejudice arises as a result of the formation of in groups and out groups, categorising others into these groups, then making evaluations about these groups on the basis that they are factual and unchanging (Tajfel 1978). Tajfel refers to this process as assimilation. Tajfel (1969) argues that in order to make sense of the social world in a way that preserves the positive image of the in group, consistent in group and out group evaluations are made (Tajfel 1969). Conflict can arise as a result of being asked to leave the 'in' group and work as part of a new 'super group' – it has previously been argued that individuals prefer to stay within their original 'in' group to preserve positive self-esteem and identity (Hogg 2006).

As demonstrated above, it has been argued that health and social care professionals are educated in such a way that emphasises the 'us' and 'other' between professions in parallel to Tajfel and Turner's theory (e.g. Du Toit 1995). Comparisons can be drawn with the socialisation of health and social care professionals and the development of barriers between identified 'in' group and 'out' group members at an early stage in education (e.g. Du Toit 1995; Adams et al. 2006). Within health and social care, the differences between professions - their values, skills and treatment specialities - define each profession and the differences between professions (e.g. Beattie 1995; Du Toit 1995; Atkins 1998).

Tajfel and Turner's social identity approach has been widely used within the literature to describe the tensions between individual health and social care professions when asked to work together in an integrated team (e.g. Carpenter & Hewstone 1996; Hind, Norman, Cooper, Gill, Hilton, Judd & Jones 2003; Pollard, Miers, Gilchrist & Sayers 2006). Furthermore, Mandy et al. (2004) found that amongst physiotherapy and podiatry students, negative stereotypes of the other profession had already been formed prior to any education, and were reinforced as a result of being educated in silos or 'in' groups. There is therefore a strong evidence base that highlights the development of 'in' groups and 'out' groups or 'us' and 'other' during the education of health and social care professionals .

Us and other

Hall (2005) suggests that individual health and social care professions have evolved over time in their own silos due to the difficulty they have experienced in defining their own individual professional identities. As a result of this struggle to have a definitive identity, Hall argues that each separate profession develops common experiences, values, language and problem solving tactics which help to solidify an individual profession's identity. Both the educational and socialisation experience that student practitioners experience during their training help to shape and mould the individual's world view to enable them to perform their individual professional role on graduation (Hall 2005). The different values instilled by each profession during their learning and socialisation process reinforces the difference between the health and social care professions, and therefore the viewing of different professionals as outsiders, and 'other' (Hall 2005). This development of the 'other' may create the feelings of 'us and them' that arise when health and social care staff are asked to work together, and create a professional barrier to integrated working.

Lingard et al. (2002) argue that construction of the 'other' on the team – those that are a different profession to oneself is key to the development of professional identity. The perception and categorisation of the 'other' allows the new professional to assimilate themselves and their role in a context that would otherwise be confusing and chaotic. Within the study conducted by Lingard et al., nurses and surgeons were found to make negative assumptions about the 'other' professions, making more positive assertions about their own profession. Lingard et al.'s findings also link with Tajfel's (1974) suggestion that, 'intergroup differentiation... provide(s) order, meaning and social identity' which leads to the, 'enhancement of, whatever differences do exist' (p. 75).

Barbaro-Brown (2010) states that once impressions of 'other' professions are created, they are hard to change and will inevitably become a barrier to integrated multi-disciplinary team working. This may certainly be true for those health and social care professionals who have already qualified and developed negative feelings of the 'other' as a result of their socialisation, and will need to be given careful attention if integrated working is required. If integrated working is to be successful, professional barriers between 'us' and 'other' will need to be broken down (Barbaro-Brown 2010).

However, the development of 'us' and 'other' may vary dependent upon the team in which the new professional is socialised. Baxter and Brumfitt (2008) found

variation in whether professionals defined themselves individually as a member of a profession or as a member of a multi-disciplinary stroke care team. How an individual defined themselves was dependent upon how much time was spent as part of the multi-disciplinary team. Those who spent more time in the team described themselves as a member of the team rather than as an individual profession (Baxter & Brumfitt 2008).

Despite defining themselves as members of a multi-disciplinary team, participants in Baxter and Brumfitt's study stated that they believed there to be a danger in not maintaining one's own professional identity when working in a multi-disciplinary team. This 'danger' was linked by participants to risks in a changing landscape of health and social care and risk of litigation which links with Hall's (2005) assertions. According to Hall (2005) one's profession provides protection from potential repercussions of malpractice or accusations of poor performance. Additionally, Braithwaite (2011) argues that professionals group together within professional 'in' groups in order to psychologically protect themselves. This is echoed within other literature (e.g. Menzies 1960; Atkins 1998; Hall 2005). It could be argued therefore that professional barriers create a feeling of safety within a complex and stressful environment (Baxter and Brumfitt 2008) and as such are a necessary part of socialisation.

Traditionally, students within each professional group were educated separately from one another in university education (Beattie 1995). According to Abbott (1988) this separateness has contributed to competitiveness between the health and social care professions and causes conflict when attempting to integrate different professions into multi-disciplinary or integrated teams. Although Abbott's reference is from 1988, students of each discipline are still educated in groups within their professional silos for the majority of their education (Maben, Griffiths & Robinson 2007).

However, separate education is now complemented in present day education with the introduction of interprofessional education (IPE), available at 74 of the universities within England by 2011 (Barr, Helme and D'Avray 2011). IPE has been argued to encourage collaborative learning within and between health and social care professions, and has been suggested to increase knowledge about other professions and their roles, improve working culture and lead to an increase in patient satisfaction (Reeves, Zwarenstein, Goldman, Barr, Freeth, Hammick, &

Koppel 2008). IPE can also enable students to develop the skills required for effective interpersonal communication (Barwell, Arnold & Berry 2013). Furthermore, Priest and Roberts (2006) argue that interprofessional training should be offered to health and social care professionals both pre and post registration in order to fully prepare staff for working within integrated teams.

Despite IPE becoming increasingly available for the next generation of health and social care professionals, the majority of those practicing in health and social care currently did not have any experience of learning or working in an interprofessional environment during their education. These individuals were educated within their own professional silos (Maben et al. 2007) in a way that has been described as 'tribalistic' within the literature. This may contribute to the development of 'us' and 'other' and ultimately act as a barrier to integrated working (Becher 1989; Beattie 1995; Atkins 1998; Carlisle, Cooper & Watkins 2004; Blackmore, Chambers, Huxley & Thackwray 2010).

Tribalism within health and social care

As a result of the professional barriers created through early education and socialisation in the workplace, health and social care professionals have previously been described as behaving in a tribalistic way (c.f. Beattie 1995). The use of the term, 'tribe', to explain belonging to a particular professional group is not new – many researchers have previously categorised health professions in this way (e.g. Becher 1989; Beattie 1995; Atkins 1998; Carlisle, Cooper & Watkins 2004; Blackmore, Chambers, Huxley & Thackwray 2010). All human beings are driven to belong to some form of tribe, argues Atkins (1998). Becher (1989) and Atkins (1998) suggest that as professions contain individual cultures of their own it could be argued that individual health and social care professions are like tribes – Beattie describes:

'the interplay between the affective life and sense of identity of the student and the moral ordering of the school; the central place of ritual and ceremony; the processes of doctrinal conversion and the transmission of structurally approved imagery and language; the power of hidden or tacit and informal messages alongside the formal educational activities of the school' (1995: 14).

The education of professions in their respective cultures has been cited as the cause of tribalistic barriers between the different professions - Beattie (1995) states the term 'tribalism' is apt for describing the boundaries between health care professionals, boundaries that begin when professionals learn their trade in separate professional groups as described above. However, not all academics are against the education of professions in tribes. Robyn (2000) actively encourages the creation of a tribal environment in education, with the argument that educating students in 'tribes' is preferable, as tribes provide a welcoming, cohesive connection that unites students around rituals, providing individuals with a place to belong to and something to work for.

However, it has been argued that the acculturation process within health and social care professions is so strong that when asked to work in new ways, whether as part of a multi-disciplinary team or what Atkins describes as a, 'sensible innovation' (1998: 303), it is only natural that individuals who have been educated in a tribalistic way will feel grief and loss. Despite Atkins' argument, Baxter and Brumfitt (2008) do not agree, stating that time spent in a multi-disciplinary team helps to re-define one's professional status without any reference to loss. Nonetheless, Baxter and Brumfitt do concede that health and social care professionals naturally create barriers between professions for protection and safety.

I have demonstrated that throughout the literature, it has been argued that the formation of professional identity encourages the creation of barriers between 'us' and 'other'. Preferable treatment is given to insiders, with prejudice about outsiders. In order to work together in new and innovative ways to support integrated working, health and social care professionals are increasingly being asked to work together in integrated teams (e.g. Department of Health 2012; Department of Health 2013a; Department of Health 2013b), away from the traditional 'in' group which will require the formation of new teams.

Working in a team

The call for integration between health and social care often requires individual professionals to work together in new and innovative ways, including working within new multi-disciplinary teams that had not existed prior to the implementation of new policies and procedures (Baxter & Brumfitt 2008). I have been building the argument

within this chapter so far that health and social care professionals are educated in what could be described as a tribalistic way, with emphasis on one particular 'in' group profession and the rules and traditions of this profession. This form of education emphasises professional boundaries and actively encourages the formation of 'us' and 'other' within the workplace. In order to provide integrated care, individuals are often required to leave their individual professional team, thus going from 'us' to 'them' to form a new integrated team.

Within the literature surrounding the integration of health and social care, it has been argued previously that there are many barriers to successful team working. Northouse and Northouse (1998) state that interprofessional team working can often be complicated by conflict, confusion over job roles and issues with autonomy, thus creating professional barriers to team work. Glasby et al. define professional barriers to team working as, 'differences in ideologies, values and professional interests' (2011: 6). Furthermore, Ham and Curry suggest that the, 'evidence indicates that organisational integration will not deliver benefits if clinicians do not change the way they work' (2011: 2). This view is echoed by Hudson who states, 'focus upon *interorganisational* working has not been matched by equal attention to *interprofessional* relationships' (2002:7, his emphasis).

Pasini (2011) argues that health and social care professionals tend to focus on their own individual professional team's best interests rather than those of the integrated team. Additionally, it has been suggested that some health professions are more predisposed to creating professional barriers than others. For example, it has been argued that GPs are less open to partnership working than other professions due to their perceived power within existing community care organisations (Glendinning 2003). Glendinning states that professionals, fearing a loss of professional autonomy, have in the past rejected change to partnership working.

Additionally, as discussed above, health and social care workers are traditionally educated and socialised in silos, therefore there may be little incentive for them to join teams that may be viewed as out groups if they believe there to be no shared goal or a unified 'us' striving for the same goal. Dickinson et al. (2009) report that staff working within an integrated setting are often unable to articulate any shared goals. A united philosophy of goals and a shared vision of outcomes is one of the main requirements for the successful integration of health and social care

according to research conducted by Fulop and Mowlem (2005) but it has been suggested that shared goals are often missing from integrated care settings (Widmark, Sandahl, Piuva, Bergman 2011). Systematic reviews of research into integrated health and social care also state that there is a lack of shared vision and shared goals in the majority of the studies included (Braithwaite 2011; Maslin-Prothero & Bennion 2010) providing little incentive for professionals to leave their preferred professional 'in' group and join a new integrated team.

Team development

There is evidence from previous studies of team work that team formation requires a staged process of becoming orientated as a team (e.g. Tuckman 1965; Gersick 1988; McGrath 1991). Tuckman's (1965; Tuckman & Jensen 1977) theory, Gersick's (1988) time and transition model and McGrath's (1991) TIP model are all theories of team development which occur in stages. These will now be examined to set the context for team formation.

Tuckman argues that the developmental sequence in small groups goes through four stages; forming, storming, norming and performing. As with all staged theories however it is questionable as to whether each and every individual group cycles through a staged process in precisely the same way. Tuckman notes that at the time of developing his theory of group development, there was a lack of literature pertaining to the development of small groups and that his theory may not be generalisable to other small groups. In addition, the majority of the case studies that Tuckman developed his theory from consisted of patients undergoing therapy in a group situation. Whether studying therapeutic interventions as a team task can lead to generalisations about team formation and behaviour is uncertain as work related tasks are qualitatively different to therapeutic interventions.

Gersick proposes a time and transition model of group development, being critical of Tuckman's theory of group development. Gersick argues that not all groups move through a hierarchical staged development, and that lifecycle phases are a more appropriate explanation of group development. Gersick acknowledges that not all teams will interact in the same way within each phase. Some teams begin harmoniously, however some begin with friction which is not accommodated within Tuckman's staged model of group development. In addition, Gersick takes other

factors into consideration with the development of groups, such as external factors including the employing organisation and resources available which is pertinent when considering how health and social care teams work together in the current context. The employing organisation and resources available are particularly prudent in light of the recent focus on integration and budget cuts for health and social care. Gersick also studied groups in a variety of different settings and could be viewed as more generalisable to a variety of settings and work tasks.

McGrath's TIP theory shares some elements in common with Gersick's time and transition model. External factors affecting teams, such as their social context, are also considered in the TIP model, factors which are not given consideration by Tuckman in his theory. Groups within the TIP model can exist over a long range of time, with a past, present and future (McGrath 1991). McGrath's TIP model can also accommodate variable membership and a variety of tasks rather than the specific goal as postulated in Tuckman and Gersick's models. Although all three models consist of a staged theory to team formation, the TIP theory by McGrath allows for factors such as variable membership that are particularly pertinent in terms of multi-disciplinary health and social care teams, members of whom will work different hours, different shift patterns and carry out varying tasks. Table 4 outlines the three theories in more detail.

Theorist name	Stage names and processes in stage
Tuckman Forming Storming Norming Performing Stages of group development	Groups orientate themselves through testing both interpersonal and professional, task related boundaries and develop relationships with team leaders and other team members (Forming). A period of conflict and resistance to group influence and task requirements (Storming) which leads to a development of in-group feeling, interpersonal sharing and team cohesiveness (Norming) and a resolution of structural issues. Roles become flexible and functional (Performing).
Gersick Time and Transition model Phases of group development	Formulation of team's approach towards their task and development of a framework within which work is completed. Further exploration and discussion of the task at hand. Development of a plan (Phase 1). A period of change based on the group's experience where the approach can be altered or developed (Midpoint). A period of working based on the plans and directions developed at the midpoint. Completion sees positive and negative consequences of past decisions coming to the fore (Phase 2).
McGrath TIP model Consists of a number of modes that define group development	Inception and acceptance of a project - goal choice (Mode I: Inception). Resolution of technical issues - means choice (Mode II: Technical Problem Solving). Resolution of conflict of political issues - policy choice (Mode III: Conflict Resolution) and execution of the performance requirements of the project - goal attainment (Mode IV: Execution)

Table 4. Theories of team formation

Each team development theory described above has the following elements in common:

- Team orientation
- Focus on task requirements and role performing
- Review and monitoring of task performance
- Achievement of a goal (whether singular or multiple)
- Task completion and feedback

Following a systematic review of the literature, the factors highlighted above have also been identified by Salas, Sims and Burke (2005) as key to successful team formation.

This section of the chapter has outlined three theories of team development, and I have demonstrated that in health and social care settings team development

may be complex. I have argued that within health and social care settings there are pre-existing barriers to integrated working. The creation of a professional identity has been demonstrated to encourage the formation of barriers between 'us' and 'other' in order to differentiate and create a defined professional identity. These professional barriers may prevent or complicate team working between and within health and social care. Furthermore, it has been suggested (Hudson 2002; Glendinning 2003; Dickinson et al. 2009; Glasby et al. 2011) that there are additional factors to consider with regard to team formation in health and social care settings such as professional autonomy and a lack of shared goal which add further complexity to team formation.

Groupthink

As demonstrated above, placing individuals into a team scenario may not necessarily guarantee effective team work without considering other factors such as professional identity. In the literature, a phenomenon known as 'groupthink' has been argued to have an adverse effect on team working and outcomes from team work, and there is some evidence to suggest that it can be present in health and social care settings. The most famous example of the phenomenon known as groupthink is the 'Bay of Pigs fiasco' as described by Pennington, Gillen and Hall (2003). In 1961, in an attempt to overthrow Fidel Castro's government, a series of bad decisions made by the then American President Kennedy and a small group of his advisors resulted in the failure of the coup, and the capture of US troops. Janis (1972) argues that the bad decisions made by President Kennedy and his advisors were as a result of a phenomenon called 'groupthink'. Janis refers to groupthink as group decisions made based on a desire for unanimity within the group rather than assessing which actions will achieve the best outcome.

The conditions that may result in groupthink have been identified as; high team cohesiveness, insulation of the group, a lack of methodical procedures for search and appraisal, directive leadership, high stress and low hope for finding a better solution than the one favoured by the group leader (Janis and Mann (1977)). Other characteristics of groupthink identified by Janis and Mann are the belief in correctness of one's own 'in' group and negative stereotypes of an 'out' group. In the context of health and social care professions, where the creation of a professional identity has been suggested to require the formation of barriers between an 'in' group

and 'out' group (e.g. Carpenter 1995; Lingard et al. 2002; Hall 2005), comparisons can be drawn with groupthink, particularly with regard to the creation of an 'in' group and 'out' group.

Groupthink may be exacerbated in situations where groups are subject to a high level of stress, such as those who work in a healthcare setting where lack of resources and high turnover of staff are present (Snell 2010). In order to overcome groupthink in health and social care settings, Heinemann, Farrell, and Schmitt (1994) state that health and social care teams require strong leadership, high group cohesiveness, an open and democratic style of team communication and minimisation of time pressure. Additionally, Buljac-Samardžić, van Woerkom, and Paauwe (2012) suggest that stable teams with effective management are more likely to make effective team decisions. Furthermore, Coopman (2001) suggests that health and social care workers should receive training in decision making in order to overcome groupthink within the setting.

There are ever increasing demands for health and social care workers to work in integrated teams (e.g. Department of Health 2011; Department of Health 2012, Department of Health 2013a; Department of Health 2013b), however a number of barriers to effective team working within and between health and social care have been identified (Northouse and Northouse 1998; Glendinning 2003; Glasby et al. 2011). Additionally, there may not always be opportunity for stable groups to develop due to the nature of health and social care provision, which may potentially create further barriers to team development (Tuckman 1965; Gersick 1991). Therefore, the steps identified in the literature to avoid groupthink may not always be possible within the setting of health and social care.

I have argued that health and social care professionals are often under pressure and as such may be vulnerable to groupthink when working in team situations. Strategies for overcoming groupthink in this setting have also been considered. I have demonstrated that placing individuals from multi-disciplinary backgrounds into a 'team' will not automatically create an integrated team. There are many nuances at play including professional culture and socialisation, 'in' group and 'out' group differences and the potential for groupthink.

Chapter summary

The formation of professional identity has been suggested to centre upon the creation of barriers between 'us' and 'them'. The creation of these barriers have been argued to arise as a result of education and early socialisation experiences (e.g. Giddens 1984; Berger & Luckmann 1991; Du Toit 1995; Lingard et al. 2002), as a result of making sense of one's role in a chaotic environment (Lingard et al. 2002), for protection, and for fear over professional identity (Baxter & Brumfitt 2008; Braithwaite 2011). The socialisation process that leads to the creation of barriers between 'us' and 'them' has led to health and social care workers being described as behaving in a tribalistic fashion (e.g. Beattie 1995) which emphasises professional differences and acts as a further barrier to integration. Comparison has been drawn with the social identity approach as defined by Tajfel (1974) with the suggestion that creation of an 'in' group and 'out' group enables the building of positive self-esteem within the 'in' group, and negative or prejudiced assumptions being made of the 'out' group, creating further barriers.

With increasing demand to work together in new and innovative ways (e.g. Department of Health 2013a) existing professional barriers will have to be broken down to create new teams (Barbaro- Brown 2010). Three theories of team formation have been considered within this chapter, and the following aspects of team formation identified as necessary for successful team development; team orientation, focus on task requirements and role performing, review and monitoring of task performance and task completion, achievement of goals and feedback (e.g. Salas et al. 2005). However, there is no settled consensus as to whether teams require on-going membership (Tuckman 1965; Gersick 1991) or whether membership can be variable (McGrath 1991). Within health and social care, it has been argued that in order to operate as an effective team, and avoid negative decision making processes such as groupthink, stable teams with effective leadership and a democratic style of communication are required, as well as high group cohesiveness (Heinemann et al. 1994; Buljac-Samardžić et al. 2012). Training in decision making has also been identified as a key consideration (Coopman 2001).

The evidence suggests that simply placing individuals into a team setting does not automatically create a team, particularly within health and social care where strong professional cultures and identities have been reinforced both through

education and professional socialisation (e.g. Du Toit 1995; Hall 2005) with an emphasis on creating an 'in' group and 'out' group (Tajfel & Turner 1986) or an 'us and them'. Although newly educated health and social care professionals experience interprofessional learning and will potentially be socialised in multi-disciplinary settings which may impact upon how they define themselves (Baxter & Brumfitt 2008), the majority of those practising as health and social care professionals currently have not experienced interprofessional education (Maben et al. 2007). As such, asking these individuals to work together will require change to the status quo. Chapter three will consider change on a number of levels – theoretically, organisationally, for staff working within health and social care, and the difference between public sector and private sector change. Leadership and disempowerment will also be discussed. I will suggest that communication and continued project management are vital for successful change with the health and social care sector.

CHAPTER THREE – CHANGE AND CHANGE MANAGEMENT

Introduction

It has been suggested that health and social care provision in England has been undergoing an almost constant period of structural change for many years (Toth 2010). Bamford and Daniel (2005) argue that this constant change has resulted in many staff suffering from change fatigue symptoms, such as a loss of motivation and feeling disempowered. As a result of governmental policy, political and financial external pressures and demands from an ever growing population, health and social care professionals are increasingly being asked to work together (Department of Health 2011). To work together will require a change for both the organisations and the staff within them (Ham et al. 2013). Accordingly, one of the key objectives of the current study is, 'To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful'.

This chapter will consider organisational change within the public sector and the effects of change upon staff working within this sector in line with this objective. To set the context, the concept of power as described by Giddens (1984) will first be discussed. The discussion will then move on to Gersick's (1991) Punctuated Equilibrium Paradigm and Weick and Quinn's (1999) interpretation of the Gradualist Paradigm of change. I will discuss whether change within the public sector can be defined as either a short sharp shift or a gradual change, and suggest that change within the public sector can be defined as both gradual and sudden, depending upon where the change comes from. The different types of change that occur within organisations, and the differences between change within the public and private sector will also be discussed. It has previously been suggested that change within the public sector is more complex than private sector change (Worrall, Cooper & Campbell-Jamison 2000). I will argue that not all organisations are the same, or react to change in the same way. Issues that have been identified in the management of change within the public sector, such as professional barriers, will then be explored with reference to Luo's (2006) phases of resistance to change.

Strategies for managing organisational change, specifically Kotter (1996) and Managing Successful Programmes (2011) will then be considered. I will suggest that a 'one size fits all' approach is not always appropriate, particularly in the context of health and social care. I will also discuss the role of leadership in successful change,

and the effects of poor leadership upon the change to integration and employee disempowerment. The concept of disempowerment will be considered in detail. I will highlight work by Skelcher (1993) who examined disempowerment in the development of public services with reference to service user experience. I will argue that Skelcher's findings can also be applied to staff if change is not implemented with care. Interpretations of employee empowerment within the available literature will also be examined. Evidence for both structural and psychological forms of empowerment will be presented and discussed. I will suggest that change within the public sector, and particularly health and social care is complex with many identified issues, particularly in terms of the long-standing organisational and professional cultures which have previously been identified as adverse to change (Menzies 1960; Atkins 1998; Lennox-Chhugani 2012). Based upon the available evidence I will suggest that any attempt to make changes to health and social care services must be sensitive to organisational and professional cultures and make accommodations accordingly.

Theories of change

Ferlie, Fitzgerald, Wood and Hawkins argue that 'professionals have the power to block change in this (health and social care) sector, so they must be engaged in a change process for it to succeed' (2005: 118). I will argue within this section of the chapter that based upon this argument, comparisons can be drawn with structure and agency theory as discussed in chapter two. Giddens (1984) proposes that power is not a separate item that individuals either have or do not have. Rather, power is related to resources. Giddens states that those who have the most useful resources, where they are depended upon by the structure and the agents within it, have the most power to effect change. Giddens' theory suggests therefore that change will be affected by those with power. Agents with power also have the ability to create and maintain systematic order or inequality. According to Giddens, power can come in two forms – allocative resources which refers to material objects, and authoritative resources that refer to command over others.

However, Giddens also states that, 'all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors' (1992: 16). Society does not command that individual agents behave like

automata - individual agents have the ability to influence any initiatives, which is also argued by Ferlie et al. (2005). This notion of power is particularly pertinent in terms of the current investigation and how change is managed within health and social care. Change within health and social care has traditionally been implemented in a top down manner, often through policy and strategy from government which is interpreted into practice by high level management (Dickinson & Mannion 2012). The government and high level management could be argued to be powerful in terms of resources, both material and command over others. It has been suggested that this type of top down change may have adverse effects on staff working on the front line; however, it has also been argued that change can only be successful with the buy in of these staff (Dickinson and Mannion 2012). This supports Giddens' argument regarding the influence that 'subordinate' (1992: 16) agents can have upon the activities of their superiors. It could be argued that professionals also have power in terms of their authority and influence over others, particularly with regard to change.

As structure and agency theory by Giddens underpins this thesis, the notion of power and its effects on change will be of key consideration as the thesis unfolds. However, it is prudent to consider criticism of structure and agency theory by other researchers. Jones, Bradbury and Le Boutillier (2011) argue that Giddens' theory is restricted to first world, western society or a society that holds material objects in high regard. In terms of the current study, the fieldwork phase has been conducted within a first world western society but how transferable structure and agency theory would be to other societies who do not place importance on material objects may be questionable. Despite this, the concept of allocative resources could be applied to most settings, including those settings where those with money or resources hold power, both in terms of material objects and command over others within a structure.

The structures that exist within the current study are on many levels. There are overriding structures in place, the PCT and Social Services, which are long existing, material structures. These long standing structures were created and are maintained by individuals carrying out roles within them. Within these long standing structures of the PCT and Social Services are individual health and social care professions, which depend upon the individuals within them upholding and continuing the rules and traditions of the professional structure. Each individual, in line with Giddens' structure and agency theory, has their own social and cultural background that they bring to a profession, and in turn to the overriding material

structure of either the PCT or Social Services. The change to a single point of access was implemented in a top down manner by high level management staff within both Social Services and the PCT after being approved by the Commissioners within the county (Single Point of Access Business Case 2008) which ties in with Giddens' assertions about change being implemented by those with material power and/or command over others within the structure. However, individuals working within the structure have the ability to influence change within a structure (Giddens 1984).

Worlsey (1970) argues that conflict arises where groups compete for access to a limited number of resources, and act in their own best interest, but asserts that conflict over resources is a normal part of society. The struggle between change implemented in a top down manner, and the professional's desire to maintain the status quo could be argued to mirror this argument, where conflict arises when groups compete for resources. This may help to understand conflict between groups in health and social care, both from a management and professional level but also between professional groups.

Within the theoretical framework of Giddens' structure and agency theory but with reference to conflict between groups, theories of change will now be considered. The punctuated equilibrium paradigm (Gersick 1991) will be compared and contrasted with the gradualist paradigm of change (as described by Weick & Quinn 1999 and Hayes 2007) in the context of the current study, to establish the theoretical undercurrent of organisational change.

Punctuated equilibrium paradigm

In change literature, change is either defined as a constant, gradual process or as a result of a sharp, sudden shock to a system which forces a response (Hayes 2007). One such researcher who argues for change as a result of a sudden 'jolt' is Gersick (1991). Gersick proposes the punctuated equilibrium paradigm and cites evidence from a range of other research (Levinson 1978; Gersick 1988; Tushman & Romanelli 1985; Kuhn 1970; Gould 1980; Prigogine & Stengers 1984) in support. Gersick proposes that change does not occur as a gradual process; rather, long periods of stability (equilibrium) are interrupted by small bursts (punctuation) of change.

According to Gersick, organisations consist of deep structures that represent the basic activity patterns which preserve the organisation's stability. The deep structure of an organisation is represented by organisational culture, strategy, structure, power distribution and control systems (Romanelli & Tushman 1994). In Gersick's punctuated equilibrium paradigm, organisations evolve through a cycle of periods of equilibrium, where the deep structures permit only limited small changes, and periods of revolution where deep structures are fundamentally altered.

During equilibrium periods, the rules underpinning the deep structure of the organisation determine how the organisation functions on a day to day basis. Change actors can make changes that affect the performance of the organisation, but they cannot alter the deep structure of the organisation. However, during revolutionary periods, change to the deep structure may come about as a result of political, environmental or social change (Gersick 1991).

An example used by Gersick to support this theory is when policy making interrupts a period of stability, causing organisational change to accommodate the new policy requirements. However, Givel (2010) argues that punctuated equilibrium theory, which is a term borrowed from biological sciences, is not appropriate with regard to politically driven change. This is due to the differing timescales, what counts as a disturbance to equilibrium, patterns of change and levels of analysis for change. Change within nature is over thousands of years, with evolution of species. Givel argues that change in the public sector can be quick and sharp as a result of governmental policy, and suggests that punctuated equilibrium theory does not adequately describe the complexity of politically driven change.

Application of Punctuated Equilibrium to the public sector

Comparisons between Gersick's punctuated equilibrium paradigm and Giddens' (1984) structure and agency theory can be drawn in terms of the long standing cultures or deep structures, and roles of actors or agents. However, Toth (2010) argues that change within the public sector, driven from a political, social and economic level, has been a constant over the last 20 years. Therefore, the idea that change to deep structures of an organisation is punctuated by periods of stability may not be consistent with the current level of change within health and social care

services in England. As such, it is prudent to consider another model of change, the gradualist paradigm as described by Weick and Quinn (1999) and Hayes (2007).

Gradualist paradigm of change

The gradualist paradigm of change is heavily influenced by evolution theory proposed by Darwin (2008). According to the gradualist paradigm of change, change can occur through a process of continuous adjustment, and is evolutionary and cumulative (Hayes 2007). In opposition to Gersick's theory of punctuated equilibrium, the gradualist paradigm states that change can take the form of small, incremental changes that can gradually create a momentous change to deep structures and organisational strategies (Weick & Quinn 1999). Additionally, the gradualist paradigm relies on a different, looser relationship with external agencies or dependents (Hayes 2007) which is a direct difference to the punctuated equilibrium theory, where the relationship with dependents is key and can affect whether change occurs at all (Gersick 1991).

Weick and Quinn define change as continuous, having no beginning or end point; rather it can be recurrent, repeated learning activities that result in gradual yet significant shifts. Politically driven changes to health and social care could potentially be viewed as continuous in that change can occur with the election of a new government or in response to new policy or strategy. I argue that some distinction needs to be drawn between political, top down driven change, and changes within an organisation that are a result of workforce innovation and in response to demand from service users. Different levels of the organisation are involved within the change process dependent upon how the change originates, and different staff will be involved. In some respect, it could be argued that both punctuated equilibrium theory and the gradualist paradigm are relevant in terms of change within the public sector. Political, top down change could be seen as punctuated, whereas changes in day to day practice by employees, for example through the use of reflective practice, could be seen as gradual change driven by response to service user requirement.

Change vs. changing

Could these two theories work together to describe politically driven change, or must change be defined as either or? As discussed, neither theory can adequately describe change within the health and social care sector, but may provide part of the explanation. Certainly, Weick and Quinn state that neither definition provides an adequate explanation of organisational change and state that, 'change never starts because it never stops... reconciliation of these disparate themes is a source of on-going tension' (1999: 381). Additionally, Hayes (2007) argues that change does not take place at a constant level – it can happen quickly, in short bursts, or slowly over a longer period of time with varying implications. One argument is for the alteration of terms, so rather than refer to 'change' research refers to, 'changing' in recognition of the never ending cycle of change (Weick & Quinn 1999). Alternatively, I prefer Hayes' definition of change, whereby change can either be incremental, where change occurs through, 'continuous tinkering, adaptation and modification' (Hayes 2007: 12), or be transformational which may, 'undermine core competencies, and question the very purpose of the enterprise' (Hayes 2007: 13). Hayes goes on to argue that most change occurring in organisations is incremental but that more than one change at a time can be taking place within the same organisation. This is consistent with my argument regarding the level of change occurring in the public sector currently. As such, Hayes' definitions of change will be adopted and utilised throughout the remainder of the thesis.

Organisational change

In terms of Hayes' definitions of organisational change, change driven by policy could potentially be defined as transformational, followed by incremental as the change is adapted into practice. The need for change within organisations can either be driven by external forces such as the market place or government, technology, economic changes or internal forces such as redesign of jobs, and changes in the organisational work force (Murthy 2007). I have considered the theoretical context of change above. As the majority of change within organisations relies upon members of staff to implement and effect change, it is prudent to consider how organisational change takes place, and who within the organisation is affected. This section of the

chapter will focus upon organisational change and factors that have been highlighted as key when implementing organisational change within the relevant literature.

Lorenzi and Riley (2000) identify 4 different types of organisational change with the potential for overlap between each type. Each type of change affects different individuals within an organisation. Operational change acts upon the day to day activities of the organisation. The single point of access within Countyshire could be identified as an operational change to the day to day management of referrals, and thus the activities of both the PCT and Social Services. Strategic changes affect the high level business direction. Cultural changes affect the core philosophies of the organisation. Political changes refer to changes in staffing due to political reasons and usually affect those at a high level within an organisation.

Lorenzi and Riley argue that in order to cope with organisational change, it is important to know at which level the change will occur, and whom within the organisation the change will affect most. Potentially, this information allows the development and implementation of change management strategies, and gives the opportunity to have processes in place to confront any difficulty that occurs as a result of the change. With important reference to the study contained within this thesis, Lorenzi and Riley argue that operational change will have the largest impact upon staff working on the front line. As these individuals are responsible for the day to day activities of the organisation, I argue that it is prudent to manage these types of changes with great care, particularly as it has been argued that front line staff within health and social care have the power to block or sabotage change (e.g. Ferlie et al. 2005, Lennox-Chhugani 2012; Dickinson & Miller 2012).

Nadler and Tushman (1995) identify the following 4 definitions of organisational change:

1. *Tuning* – where there is no immediate requirement to change but there is a requirement to seek better ways of achieving or defending the strategic vision;
2. *Adaptation* – doing more or doing things better in response to external demand for change. This kind of change does not refer to doing things differently or doing different things;
3. *Re-orientation* – initiated in anticipation of future opportunities or problems to ensure that an organisation will be effective in the future;

4. *Re-creation* – transforming the organisation through fast and simultaneous change of all its basic elements.

To some extent, it could be argued that Nadler and Tushman's definitions of change could be applied to the public services within England. As discussed at the opening of this chapter, it has been suggested that the health and social care services are facing increased financial pressure to provide efficient and effective health and social care within England due to an increasing population and a reduction in budgets (Department of Health 2011). Nadler and Tushman's, 'tuning' and, 'adaptation' definitions cover the requirement to provide more efficient health and social care to 'defend the strategic vision' of the organisations and to provide care in an integrated (and therefore different) way.

Additionally, Hayes (2007) draws a distinction between anticipating organisational change, (being proactive), and responding to change (being reactive). Hayes argues that organisations which anticipate change are better situated to cope with the impact that organisational change will have. Reactive organisations are faced with less time for planning, a lack of sufficient time to involve many people which will affect how much buy in can be secured, little time to experiment with different strategies for coping with change, and little opportunity to influence shifts in markets and technologies. Pollitt (2008) also highlights the importance of timing when it comes to successful change within the public services, and the temporal nature of change, including learning from what has failed in the past.

The majority of change literature, including that discussed above, tends to focus on evidence from the private sector and as such does not take into account the complexity of the public sector (Worrall et al. 2000, Kelly, Pearce, Butters, Stevens & Layzell 2004; Enthoven 2000; Garside 1999). It is questionable whether health and social care organisations, and the public service sector itself, are capable of fast and simultaneous change of all their basic elements as health and social care services are complex and consist of a myriad of elements and longstanding cultures. Some elements within health and social care services may be easy to change, but professional culture and barriers to integration could potentially delay or halt change (Ferlie et al. 2005; Lennox-Chhugani 2012; Dickinson & Mannion 2012). As such, change in the public sector may need to be considered separately to change in the private sector.

The differences between public and private sector change

There is some evidence to suggest that change affects private and public sector organisations in different ways (Worrall et al. 2000). Lennox-Chhugani (2012) states that professional identity is particularly strong within the health care sector.

Furthermore, Dickinson and Mannion (2012: 2) argue that:

'the ways in which (health and social care) professionals respond to policies and reforms can have a profound influence over the degree to which these are implemented and whether or not these will prove to be successful in practice'

Plamping (1998) states that the intrinsic value that professionals attach to their work within the NHS means that rather than trying to implement top down change to the organisational structure, attention should be paid to the values held amongst staff and the impact that change may have upon these values. Hyde, Granter, McCann and Hassard state that, 'NHS organisations are not operated along simple hierarchical lines amenable to simplified restructuring' (2012: 16) therefore the way in which change is implemented in these organisations requires careful attention.

Worrall et al. (2000) debate whether using generalised models of change that are usually applied within the private sector are appropriate when it comes to the public sector. Change within health and social care is usually brought about as a result of a change in government or government priorities through policy and strategy in a top down approach. This is concurrent with Giddens' (1984) assertion that change is initiated and led by agents who have material power within a structure. However, as discussed above, agents operating within the structure at lower levels do have the power to sabotage any change initiative (Ferlie et al. 2005). As such, Hogwood and Gunn (1984) suggest 10 pre-conditions for implementing policy – and some interesting comparisons can be drawn with change management strategies. These 10 pre-conditions are as follows:

1. The circumstances external to the agency do not impose crippling conditions;
2. Adequate time and sufficient resources are available;
3. The required combination of resources is available;

4. The policy is based on a valid theory of cause and effect;
5. The relationship between cause and effect is direct;
6. Dependency relationships are minimal – in other words, policy makers are not reliant on groups or organisations that are themselves interdependent;
7. There is an understanding of, and agreement on, the objectives;
8. Tasks are fully specified in correct sequence;
9. Communication and coordination are perfect;
10. Those in authority can demand and obtain perfect compliance.

Just what Hogwood and Gunn mean when they use words such as 'adequate', 'correct', and 'perfect' is not clear – this makes the assumption that there is a 'right way' of implementing change that can be applied to all organisations, without any consideration for individual circumstances surrounding individual organisations. Applying a, 'one size fits all' approach has been critiqued in change management theory (Lycett, Rassau & Danson 2004) and the same can be argued here in terms of policy implementation. Glasby (2011) agrees, stating that policy is rarely as clear and instructive as Hogwood and Gunn's assertions would suggest. Additionally, a number of studies examining change within the public sector have been conducted, some of which will now be considered.

Worrall et al. (2000) argue that change management is experienced differently within the public services, with public service managers subject to more adverse and negative effects than managers within the private sector. However, almost double the number of managers in the private sector responded to the survey sent out by Worrall et al. compared to the number of managers in the public sector, and it is unclear from the research paper where the managers worked, and whether a representative sample of public sector managers were reached. Furthermore, the public sector has undergone a number of changes since 1998 when Worrall et al.'s study was conducted, therefore it might be prudent to repeat Worrall et al.'s survey with current managers within the public and private sectors to compare results.

Bamford and Daniel (2005) report upon a change programme relating to the Public Health Laboratory Service (PHLS) where staff reported that change had been implemented at great speed, with a lack of resources, a lack of information, remote and inaccessible project management and inadequate involvement and consultation. Although the end goal was perceived to have been met, Bamford and Daniel suggest

that that the process could have been improved and lessons learned with regard to involving staff and stakeholders and managing the change project. Allowing remote management of a project and not actively involving front line staff when implementing change led to confusion over ownership and responsibility of the project (Bamford & Daniel 2005).

Based upon a literature review conducted into processes and outcomes of cultural change in health care and non-health care settings, Scott, Mannion, Davies and Marshall (2003) identify a number of barriers to change in health care settings. These are inadequate or inappropriate leadership, constraints imposed by external stakeholders and professional allegiances, perceived lack of ownership and subcultural diversity within health care organisations and systems. Additionally, a report from the King's Fund (2012) highlights leadership as a key factor for change within integrated care, drawing focus on engagement with staff and service users, through the use of surveys and continued communication. According to the report, organisations who engage health and social care staff within change experience less resistance to change from employees, manage their finances more effectively and deliver better patient outcomes. These findings are supported by a study conducted by Ovretveit, Hansson and Brommels (2010).

Ovretveit et al. conducted a study of a change project in Sweden, following a local authority during the change to integrated health and social care. Ovretveit et al. state that in early stages of the project, clinical staff were not involved. The change to an integrated health and social care system was designed and implemented without the input of those upon whom the changes would have the biggest impact. Changes in personnel, national laws preventing information sharing, information technology and limited financial resources were all identified as issues that affected the implementation of successful change, both at a macro (organisational) and micro (front line, service) level.

With similarity to Ovretveit et al.'s findings, Lenham (2009) gives a number of examples of change projects within a social care context and cites leadership and purpose, stakeholder involvement and employee involvement as key themes within successful change. Lenham states that rather than viewing resistance from individuals as detrimental when implementing change, negative input from unenthusiastic stakeholders can actually be used to benefit the change programme.

For this reason, engaging with all stakeholders and communicating with them fully is highlighted as key in making successful changes within social care by Lenham.

The issues with initiating change in health and social care may arise as a result of how change is driven. Change within the health and social care sector is mostly driven by policy and high level strategies, and is affected by issues involving cultural clashes between professions and organisations (Ferlie et al. 2005). Additionally, change in the public sector is often managed reactively in response to policy and hurriedly, without adequate leadership or project staff and a lack of funds (Goodwin et al. 2011; King's Fund 2012). According to Hogwood and Gunn, this type of change is doomed to fail. All of the studies cited above suggest that the way that change is managed within the public sector must change if new initiatives are to be successful.

According to Ham et al. (2013) the integration of health and social care services has often been concerned with structural changes or the macro level of integration where new services are formed or integration is across the full range of services. However, Ham et al. state that structural change should not be the main focus of change initiatives within health and social care particularly:

'it is hard to argue persuasively that restructuring health and social care should be a high priority. Far more important is to address the myriad barriers (financial, cultural, and so on) that in most parts of England make integrated care the exception rather than the rule' (p. 81)

Furthermore, although the majority of literature points to some form of structural integration, Goodwin et al. (2011) state that there is no need for 'real' structural integration in order to provide integrated health and social care. Rather, Goodwin et al. suggest that care is coordinated around the needs of individual service users, and services should be integrated in a way that supports this coordination, rather than fully integrated in a structural way.

The evidence from the literature surrounding change in health and social care therefore points towards a focus on the operational aspects of change rather than the structural aspects. However, it has been suggested that changes to the ways in which professionals work together in the health and social care sector is often fraught with difficulty due to the intensely hierarchical nature of these organisations

and the complexity of the professional cultures within (Kelly et al. 2004; Enthoven 2000; Garside 1999). Also, the organisational culture of both health and social care services have previously been highlighted as a barrier to change (Garside 1999) due to the level of complexity and presence of hierarchies within the organisational structures.

However, Peck and Crawford (2004) claim that organisational culture is also an issue within change in the private sector, but acknowledge that professional culture within health and social care can impede change, stating that, 'structural change may have served to strengthen attachment to existing professional culture' (p. 14). This is supported by findings from other researchers such as Lennox-Chhugani (2012) who states that, '...professional identities at the individual level are strong in the health system' (p. 81). Therefore, the effects of professional culture upon change in the context of health and social care will next be considered.

The effects of professional culture

As discussed in the previous chapter, it has been suggested that health and social care professionals develop in groups and out groups as a result of their training and socialisation processes. This has been identified as a barrier to integrated working (e.g. Lingard et al. 2002, Hall 2005, Barbaro-Brown 2010). In order for these groups to work together effectively in an integrated way, Ham et al. state that this barrier between 'us' and 'them' must be overcome. However, it has been suggested that health professionals in particular are more change averse even in the face of 'sensible innovations' (Atkins 1998: 303). Furthermore, it has been argued previously that attempts to integrate health and social care leads to, 'even clearer professional boundaries... protecting difference' (Peck & Crawford 2004: 13). In order to effect successful change, Peck and Crawford suggest that managers should shift the focus away from professional boundaries, from 'us and them' onto 'we' (p. 19).

I argued in chapter two that as a result of the way that professionals are socialised and educated, an 'us and them' develops between professionals (e.g. Du Toit 1995; Mandy et al. 2004). Peck, Towell and Gulliver (2001) argue that relationships within and between groups of professionals is dependent upon the individuals within the groups, and that some individuals are more open to integrated working than others. Peck et al. attribute this to individual experiences, and similar

findings have been reported by Baxter and Brumfitt (2008) who found that individual's definitions of themselves and their role depended upon how much time was spent in integrated teams. However, Atkins (1998) argues that when asked to work with other professionals in new ways, health and social care professionals will experience grief and loss.

Atkins' argument about grief and loss when asked to work in new ways links with the stages of grief model proposed by Kubler-Ross (1969), which was developed by Luo (2006) to demonstrate resistance to change by professionals. Luo states that resistance to change progresses through 8 phases, demonstrated by Table 5 below:

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Table 5. Phases of resistance to change (adapted from Luo 2006)

As evidence for the phases of resistance to change, Luo cites a study by Morrissey (2004) who followed a group of physicians during a change to their services within the USA. Believing the change to be against the best interest of their patients, physicians rejected the change (**denial**), and were in favour of stability and continuity of care for their patients, as has been found in other studies of a similar nature (e.g. McNulty & Ferlie 2002). It has previously been suggested that the core underlying function of health and social care professionals is to provide care to service users

(e.g. Menzies 1960). Where it is unclear that changes will benefit those within their care, health and social care professionals have been shown to reject change in favour of maintaining the status quo (McNulty & Ferlie 2002) in line with the obligations of their profession.

Similarly, Gersick states that change will be resisted if it is perceived as preventing an organisation from delivering a service to its dependents. For example, the dependents upon health and social care could be argued to be service users. Menzies (1960) argues that health care professionals, in particular nursing staff, actively avoid change to prevent being unable to provide health care for this reason. Staff will only consider change once crisis point has been reached, as change invokes uncertainty and fear of the unknown. These fears may well be valid, as Gersick argues that in order for change to occur:

'deep structures must first be dismantled, leaving the system temporarily disorganised, in order for any fundamental change to be accomplished. Next, a subset of the system's old pieces, along with some new pieces, can be put back together into a new configuration, which operates according to a new set of rules' (1991: 19)

The dismantling of structures and disorganisation, and thus changing the way that an organisation operates may lead to resistance to change in health and social care professionals (Dickinson and Mannion 2012).

As well as issues with professional culture acting as a barrier to change, Hayes (2007) states that the culture of an organisation is an important factor in how responsive to change they can be. Some organisations are more adept at interpreting and implementing change than others. Change in the public sector is often reactive as a result of policy, which Nadler and Tushman (1995) argue can be more intense than proactive change and can be constrained by time pressures and resource shortages. Coupled with professionals operating within the organisations who are change averse and lacking in resources (Marks & Hunter 2007), change within the health and social care services is complex, reactive and often met with resistance (e.g. McNulty & Ferlie 2002; Morrissey 2004).

Change management strategies

I have demonstrated that within the literature, professional culture has been identified as a barrier to change within the public services (e.g. Menzies 1960; Atkins 1998; Ham et al. 2013) as has the organisational structure of health and social care (Worrall et al. 2000). As discussed above, Giddens (1984) argues that change within social structures is implemented or influenced by those who have power within the social structure. Equally, agents, or front line staff operating within the social structure at a lower level also have the ability to influence change by resisting or sabotaging change within their social structure (Ferlie et al. 2005). Change management strategies have been developed to implement change in order to overcome such issues, which will now be considered.

Managing Successful Programmes is the mandated process for implementing change within the public services (Office of Government Commerce 2011) which was based in part upon work carried out by Kotter (1996; Kotter & Cohen 2002). Kotter proposes that there are 8 phases through which an organisation has to progress if change is to be achieved, arguing that these phases take into account how individuals within an organisation see, feel, and then change, through the process of change implementation. Kotter states that each phase should be progressed through as skipping steps will lead to unsatisfactory results and a faulty change process. The stages are outlined in Table 6 below:

Stage	Description
Establish a sense of urgency	People need to be inspired in order to move and make changes. Kotter states that 75% of leadership within an organisation needs to be willing to make change and be unsatisfied with the business in its current form in order for change to be successful.
Create a guiding team of change champions	A beginning group for change needs to have at least 3 to 5 people in situ with the right skill mix and emotional commitment to the change project. The team's sense of urgency, sense of what is happening and

	what is required for success is crucial to the success of the project.
Develop a vision of change	Vision is critical in ensuring that stakeholders, service users and employees understand the vision and strategy of the change project. Understanding and interest in the project is vital.
Share the vision, clear communication is essential	Communication regarding the change should be with as many people as possible, and messages regarding change should be communicated through every possible channel.
Empower	A can do attitude should be spread through the workforce. Progress and achievements should be recognised throughout the business and constructive feedback given.
Secure short term wins	By securing short term wins, confidence is built in the new venture. Short term goals should be focused upon and completed before new goals are set.
Consolidate change	Organisations should keep going and use the power of momentum to drive change through. On-going commitment to the change project can be gained by consolidating improvements that the change project has achieved.
Anchor change	This prevents 'old habits' coming back. The change needs to become the way that things are done within an organisation. Demonstrating how the change project has led to improvement can be used to institutionalise change, and inspire new leaders to take the change project forward.

Table 6. Stages in Kotter's theory of change management

Kotter argues that effective communication and engagement ensures that employees feel involved with change, and all stakeholders must be willing to participate. Furthermore, linking back to the importance of timing (e.g. Pollitt 2008), Kotter warns that the longer it takes to implement change, the less likely that the change will be successful.

Within the literature, other researchers are critical of Kotter's approach to change as it does not allow for variation in organisations and has been referred to as a 'one size fits all' approach (Lycett et al. 2004: 289). Pellegrinelli, Partington, Hemingway, Mohdzain and Shah (2007) argue that change will be experienced differently and may not progress in the same phased way dependent upon different people and the organisations they work within. However, Kotter's 8 stage model does allow for individuality, by placing emphasis upon individual reactions to change, but does not specifically emphasise tailoring change management to an individual organisation which has become common practice (Pellegrinelli et al. 2007). Nonetheless, Kotter's 8 phase model was used in the development of the Managing Successful Programmes (2011) model. As the mandated change management model within the public service sector, the model would have been implicated in the implementation of the single point of access in Countyshire.

Managing Successful Programmes

Developed by the Office of Government Commerce in order to manage ambitious change within public services, Managing Successful Programmes has 9 key governance themes to be considered when initiating a change programme such as integration of services within an organisation (2011), which are as follows:

1. Programme organisation
2. Vision
3. Leadership and stakeholder engagement
4. Benefits management
5. Blueprint design and delivery
6. Planning and control
7. The business case
8. Risk and issue management

9. Quality and assurance management

These strategies are based on evidence from business and management literature as well as Kotter's 8 phase change management model. Although the steps in change management as described above are part of the recommended Managing Successful Programmes methodology, not all researchers agree that a prescribed approach to change is most effective (Lycett et al. 2004). Each social structure, and the organisations within this social structure, have their own rules and guidelines for behaviour (Giddens 1984; Berger & Luckmann 1991). As such, what is appropriate within one social structure may not be within another. As not all organisations are the same, or consist of the same problems, a fixed, 'one size fits all' approach to change may not always be appropriate. Rather, Lycett et al. (2004) argue that the prescribed methods of change should be tailored to the individual organisation and project to achieve change.

So far I have demonstrated that change within the public sector has been a constant over the last 20 years (Toth 2010) and that front line staff are often most affected by change (Lorenzi & Riley 1999). Despite the development of change management methodologies as discussed above, it has been argued that health and social care professionals are naturally adverse to change (e.g. Menzies 1960; Atkins 1998) and have the power to block change if they do not believe that the change will have a positive impact upon service users within their care (Ferlie et al. 2005). I have discussed the change management strategy, Managing Successful Programmes (2011), which highlights the importance of leadership when it comes to successful change within organisations. This is particularly important to note in the context of health and social care, as effective leadership has been argued to be a key component of successful organisational change within this setting (e.g. Ham et al. 2013; Skills for Care 2013). The next section of the chapter will consider leadership in more detail.

Leadership

When considering leadership within health and social care, it is prudent to also consider managerialism, as this is oft discussed within the literature in this area (c.f. Hyde et al. 2012). A 'managerialism' ideology coincided with the Thatcher

government as an attempt to save money and increase output in the public services (Pollitt 1994). Public services had been under an increasing financial and productive pressure since the 1960's in the UK which Pollitt attributes to 3 population factors, an increase in the elderly population, the high proportion of young people, and an increase in single parent families. All 3 groups are large consumers of health and social care in the UK and placed an increasing strain on a financially challenged public service system (Pollitt 1994). It was argued by the government that better management would allow, 'political control (to) be strengthened, budgets trimmed, professional autonomy reduced, public service unions weakened and a quasi-competitive framework erected to flush out the 'natural' inefficiencies of bureaucracy' (as described by Pollitt 1994: 49). Managerialism was defined by the government as, 'a set of beliefs and practices (that) will prove an effective solvent for . . . economic and social ills' and was associated with, 'clear-sighted leadership... (that) can achieve fundamental changes' (as described by Pollitt 1994: 1).

However, there is some debate within the literature as to whether managerialism is key or whether leadership is the core component of successful change management, and particularly within the context of health and social care, managers have previously been blamed for many of the issues arising within the health service during the 1980s such as a poor use of resources (Hyde et al. 2012). Furthermore, Kotter (1990) argues that being viewed as a successful manager does not guarantee success if the individual in question is a poor leader. There is a distinction between what is defined as management and what is defined as leadership however, they are, 'complementary systems of action' (Kotter 1990: 103). Kotter argues that managers tend to be more involved in dealing with complexity whereas leaders are the key actors in change. The differing responsibilities of managers and leaders are outlined in Table 7 below.

Table 7. The differences between managers and leaders (based on Kotter 1990)

Kotter (1990) argues that managers have a higher level, strategic input within an organisation, whereas leaders have a degree of power in determining whether teams are successful. Leaders can influence their team members through their expertise, abilities and attitudes, a view which is supported by West, Borrill, Dawson, Brodbeck, Shapiro and Haward (2003). However, Peck and Dickinson (2008) suggest that little research has been conducted into leadership and management style within integrated teams, and that poor management and communication within the health and social care setting is one of the main reasons for partnership working failures.

Furthermore, O'Brien (2002) argues that 'top down' implementations of change through managerialism are rarely successful as this approach does not include front line staff and their thoughts and feelings in the process. People, and whether these people want to participate in change, are the most important factor in successful change (O'Brien 2002). Focus groups, evaluation interviews and suggestions were all trialled by O'Brien. These methods were found to improve staff's attitude towards change, but staff taking part in this process reported that they did not believe their opinion would influence change. As such, these staff felt disempowered. Disempowerment, and its influence and effect on change will next be examined in the context of organisational change.

Disempowerment as a result of organisational change

One of the key studies with regard to organisational change management that influenced the development of the current study was that conducted by Skelcher (1993). Skelcher identifies the following actions as disempowering, for service users, during service development:

- Being told, rather than asked;
- Being treated less favourably than others in a similar situation;
- Not being given any choice;
- Being promised that something they have requested or struggled for will happen, and then at the last minute being told (or discovering at second hand) that it will not; and
- Being kept waiting and/or knowing that decisions affecting them are being made, but without being told what is happening.

Skelcher argues that if any of these occur, then service users will feel disempowered during service development. Communication is at the centre of many of Skelcher's components of disempowerment, which also links with Kotter's theory of change management and making employees feel involved with change and empowered as a result. Furthermore, Peck and Crawford (2004) argue that, 'clear, consistent and frequent communication about change' (p. 18) is a key factor in successful change within the workplace. According to Kotter (1990), communication is more frequently associated with leaders, thus supporting the role of leadership in successful change within an organisation. Although Skelcher's model was developed with service users in mind, I will argue that it can also be applied to staff within the workplace which will be discussed within subsequent chapters.

Literature pertaining to empowerment within the workplace has developed into two separate perspectives which have been studied separately within the literature (Greasley, Bryman, Dainty, Price, Naismith, & Soetanto 2008). Psychological empowerment is argued by Lee and Koh (2001) to consist of the following 4 dimensions; meaningfulness – the value of the job task in relation to individual's ideals, competence – individual's belief of their ability to perform the task effectively,

self-determination (or choice) – autonomy in beginning and performing the task and impact – perception of the degree of influence the individual has on outcomes.

Lee and Koh argue that if any of the 4 dimensions of psychological empowerment are missing or if there is a low score for any one of the dimensions, the level of empowerment will be decreased for that person. According to Lee and Koh, each of the 4 dimensions should be given attention if an individual is to feel empowered within the workplace. However, Pastor (1996) suggests alternative aspects that must be considered in terms of employee empowerment. The first is personal empowerment which individuals are responsible for themselves, through their own actions and inactions. The second element of empowerment is related to the way in which individuals work with others to feel empowered in their lives. This can be related back to structure and agency theory – personal empowerment is something agents are responsible for themselves whereas working with others can be related to how individuals interact within a structure. Pastor goes on to argue that managers often misconstrue how to make their employees feel empowered. Managers may believe that they are empowering staff when in fact staff feel disempowered by their manager's actions (Pastor 1996).

Structural empowerment refers to organisational policies, procedures and structures within the workplace which enable employees to make decisions and have influence over their work (Greasley et al. 2008). Greasley et al. argue that employees cannot be described as empowered unless they feel as though they are – therefore empowerment, and the perceived level of power, is down to the individual's own perception. As such, feeling empowered may be something that managers are more concerned with than employees themselves. Employees may desire other descriptions of power such as autonomy and personal responsibility for their work (Greasley et al. 2008).

Disempowerment through management and/or leadership style is important in terms of change management. Managing Successful Programmes (2011) and Kotter (1990) both emphasise the role of leadership and empowering staff if change management is to be successful. However, as highlighted above, employee empowerment is something of a complex phenomenon. Combined with the strong socialisation and education process that health and social care professionals experience, change within the public sector may not be a straightforward accomplishment (Hyde et al. 2012; Dickinson & Mannion 2012).

Chapter summary

Within this chapter I aimed to set the context for the objective, 'To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful'. I have suggested that health and social care provision in England has been undergoing change on a constant basis in order to meet political and financial demands to work together in a more coherent and integrated way to meet the needs of an increasing population (e.g. Department of Health 2006; Department of Health 2011). In order to work together, change is required. Within this chapter I have considered change within the public sector and the effects of change on staff working within this sector in line with the objective above.

Giddens' (1984) interpretation of change was discussed and the concept of power when it comes to initiating change, with the suggestion that change is often introduced by those with power within a structure. I considered the different types of power and concluded that both high level and front line staff have the ability to affect change. The discussion then moved on to consider theories of change and change management, specifically Gersick's (1991) Punctuated Equilibrium Paradigm and Weick and Quinn's (1999) interpretation of the Gradualist Paradigm of change. I discussed whether change within the public sector can be defined as either a short sharp shift or a gradual change, and made the suggestion that change within the public sector can be defined as both gradual and sudden, depending upon where the change comes from, in line with Hayes' (2007) definitions of change.

It has previously been argued that change within the public sector is more complex than private sector change (Worrall et al. 2000). Accordingly, I have examined the differences between change within the public and private sector. I have demonstrated that not all organisations react to change in the same way, with particular reference to the difference between the public and private sector when it comes to change. As a result, I have suggested that a staged change management strategy which follows steps in a process with no flexibility may not always be appropriate. Key issues that have been identified in the management of change within the health and social care arena such as professional barriers, communication and leadership have also been discussed.

I identified that culture has previously been an issue within the health and social care sector when it comes to change, both in terms of organisational culture and professional culture. Terms such as 'grief' and 'loss' have previously been used to describe health and social care professionals' reaction to change, and I discussed work by Luo (2006) regarding resistance to change. Strategies for managing organisational change, specifically Kotter (1996) and Managing Successful Programmes (2011) have been considered and I suggested that a 'one size fits all' approach is not always appropriate.

Leadership has been highlighted by both Kotter and Managing Successful Programmes as key to successful change. I have examined leadership and managerialism within health and social care. Poor leadership has previously been linked with employee disempowerment. I highlighted work by Skelcher (1993) particularly in this context. As the thesis develops I will argue that Skelcher's ideas about service user disempowerment can also be applied to employees. Findings from the literature were also discussed, including work by Pastor (1996), Lee and Koh (2001) and Greasley et al. (2008). I have argued that empowerment can be on two levels, both structural and psychological.

The single point of access in Countyshire was implemented as a result of governmental policy including the End of Life Strategy (2008), the Stroke Strategy (2007), A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People (2006), the National Service Framework for Long Term Conditions (2005), and the Use of Resources in Adult Social Care (2009). I have considered organisational change and the top down nature of change within health and social care, and I have suggested that change within health and social care is complex. Professional identity has been identified as a barrier to change in health and social care (e.g. Peck & Crawford 2004; Dickinson & Mannion 2012; Lennox-Chhugani 2012) and as such will need to be handled with care, with consideration of professional barriers, power, leadership and communication.

The next chapter will focus upon the single point of access as a service, and the single point of access within Countyshire in more detail. The policy behind the single point of access will be examined, and some context to the current study will be given including an in-depth profile of Countyshire and the provision of health and social care within the county.

CHAPTER FOUR – COUNTYSHIRE IN CONTEXT

Introduction

It has been suggested that the pressure is mounting upon health and social care to meet ever increasing demands for access to services due to an ageing population (Ham & Walsh 2013). This potential increase in pressure was recognised by Commissioners in Countyshire:

'A combination of loss of physical mobility for one in four of the over 75's, and the fact that some of the rural areas and villages fall in the worst 10% nationally for barriers to housing and services, indicates that for people living in this area, accessibility to services will be particularly important' (Making Countyshire Healthier – Strategic Framework for Countyshire Primary Care Trust 2008-2013, 2009: 16)

The integration of health and social care within Countyshire was at the fore of the local agenda at the time of my employment as a way of meeting the increasing demands. The Commissioners in Countyshire chose to implement a single point of access as a pathway to integration of services, in response to high level strategy documents (End of Life Strategy 2008b; Stroke Strategy 2007; A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People 2006; National Service Framework for Long Term Conditions 2005; Use of Resources in Adult Social Care 2009). I was keen to re-visit the area when I began scoping for an area to study at the beginning of my doctoral studies to explore whether integration had impacted upon the delivery of health and social care in the county. The development of the single point of access was in process whilst I was working as an occupational therapy assistant within the county. As a staff member I had been interested in the impact that the service would have on my day to day job, and as a student I was interested in whether a single point of access would support integrated working in the area.

This chapter will outline the background to the single point of access within Countyshire including why I initially became interested in studying the service. I will then discuss the single point of access as described within the literature. I will consider the roots of the single point of access in specialised services such as mental health and learning disability services, and demonstrate that a single point of

access to health and social care services is not a new phenomenon. I will describe evidence which suggests that different groups of professionals have differing views of a single point of access which may affect their buy-in to the service. This could have important consequences for the roll out of the service both in Countyshire and nationally.

There are a number of single points of access to health and social care services within England. I will consider a selection of these and compare and contrast these other services to the single point of access within Countyshire. Some of the identified benefits to the single point of access will also be discussed. One of the first documents I encountered during the early days of my fieldwork was the Joint Commissioning Strategy for Countyshire. This strategy outlined high level strategy documents, whose implementation in a local context resulted in the development of the single point of access. The policies and strategy documents that underpin and support the development of the single point of access will next be examined in the context of the joint commissioning strategy that was published by Countyshire PCT and Countyshire County Council.

Finally, I will outline the context of the study contained within this thesis, beginning with a consideration of Countyshire and the single point of access in Countyshire. This consideration will include the ageing population of Countyshire, prevalent pathologies and community health and social care services available in the county. Countyshire has a large number of residents aged 75 or over (Countyshire PCT 2012), and as such access to health and social care services may become increasingly important within the next decade.

Studying the single point of access

I worked as an occupational therapy assistant in Countyshire for 14 months between January 2008 and March 2009. During that time, community health care in Countyshire was provided by the local PCT, and Social Services were a separate entity with which I rarely came into contact. My interest in studying this locality, and the integration of health and social care, was driven by frustrations that I had experienced as a health care worker and the lack of integrated care provided to service users. As a member of staff, I felt that the system was overly bureaucratic, and the issues such as duplication were compounded by occupational therapy also

being provided by Social Services in Countyshire. For me personally, these differences were an 'us and them' whilst I was working as a PCT occupational therapy assistant and I was keen for us to work in a more integrated way.

One particular occasion really emphasised the 'us and them' differences between health and Social Services occupational therapy and subsequently health and social care as a whole for me. As an assistant practitioner in the community, I held my own caseload of patients, and received a referral for an elderly service user. I arranged to visit the service user at her home to carry out an initial assessment of her occupational therapy needs. On arriving at the service user's home, I noticed that there was equipment in situ that had been supplied by our local equipment service. When I queried the origins of the equipment with the service user, she stated that another occupational therapist had already visited her but she was unsure as to which organisation this individual had come from. As the service user still had some outstanding issues that I could address from a health care perspective, it was not a wasted morning for either of us, and I continued to carry out my assessment. On my return to the office, I used the local health and social care equipment supplier's website to find out who had visited the service user previously. This supplier's website was the only place that held records of all equipment issued and the individual who issued the equipment. I discovered that a Social Services occupational therapy assistant had visited the service user only one week previously. I telephoned the Social Services occupational therapy assistant and asked if it would be possible to have a copy of her assessment of the service user, to ensure I did not make any further duplication. This request was denied. The Social Services occupational therapy assistant cited data protection in refusing to share information with me. I was astounded that members of health and social care could not share information. From my point of view, I believed that it would have been easy to verify my identity, and I had been fully CRB checked before taking up the post. I did not understand why we could not share information when we both wanted to act in the service user's best interest.

I continued to visit the service user as per the treatment plan we had written together, and learned she had received further separate visits from the Social Services occupational therapy assistant too. Eventually, I gained access to the Social Services assessment form when my manager liaised with the Social Services occupational therapy manager, but it seemed a lengthy, bureaucratic process. There

were other instances of this lack of information sharing but this service user stood out for me in cementing an interest in integrated care, as even she was surprised that we did not talk to one another as health and social care professionals. This experience inspired the current research study.

The concept of a single point of access in Countyshire was introduced during my employment as a way of providing joined up community care within the county:

"The purpose of the single point of access is to provide improved access to appropriate community services. In conjunction with integrated working, the single point of access will help deliver services for identified needs in a coordinated, timely and effective way" (Single Point of Access Business Case, p. 5)

According to the business case, the single point of access was to become the main driver of integration between Countyshire PCT and Countyshire's Social Services. This was later confirmed to me during interviews, both with the single point of access team manager and the individual who had acted as project manager for the Social Services 'half' of the single point of access. The single point of access acted as a triage service for community health and social care services within Countyshire, staffed by a professional assessment team and call handlers who would collect information about service users who were referred or called in, and either treat or pass the referral on to the relevant community team. The professional assessment team initially consisted of a community nurse, an occupational therapist from both Social Services and the PCT, 2 social workers and were later joined by a physiotherapist.

Very little work had been carried out about or into the effect of a single point of access to services upon integrated working for older adults, particularly whether a single point of access increases or improves integration between services. Thus the rationale for my study was formed. The first step of my study was to carry out a literature review of the single point of access and its use within health and social care to establish the national and international context of a single point of access to health and social care services.

The single point of access - in the literature

Although the single point of access within Countyshire was not exclusively for older adults, the service was designed with consideration for the needs of older adults (Single Point of Access Business Case). The business case highlighted that the population of older adults was growing rapidly within Countyshire. The single point of access was proposed as a way of helping existing health and social care services to operate in a "streamlined" and "efficient" way (p. 20). With reference to programme theory (as described by Millar, Powell & Dixon 2012) which is concerned with how policy is implemented into practice, national policy and strategy documents outlined the requirement for more integrated services. According to these documents, integration would provide joined up care in response to the growing pressures upon health and social care services (e.g. Department of Health 2012). The integration of services has previously been argued to reduce hospital admissions, facilitate more efficient discharges from hospital and increase community based working (Dickson et al. 2009). On this basis, a programme of joint commissioning with the outcome of a single point of access to services was proposed within Countyshire as a way of providing an integrated service in line with the requirements set out in high level policy and strategy documents.

Within the literature, the single point of access has predominately been studied within mental health or learning disability services, services for which it was initially introduced. As a result, little is known regarding the effect of a single point of access upon services for adults across the health and social care sector. The single point of access originated in mental health care. In the 1975 governmental policy document, 'Better Services for the Mentally Ill', the recommendation was made that mental health should become more integrated. One method of integrating was to introduce a single point of access and this is now a quality indicator for these services (Gask, Rogers, Roland & Morris 2001). The single point of access has been used in mental health services with varying reported degrees of success (Lovell and Richards 2000; Raine et al. 2005). The single point of access in mental health provides passage to a multi layered care system (Arthur 2005). Trained mental health professionals make a decision based on a triage assessment, which takes

place during the initial contact with the single point of access, and the service user enters the system at the appropriate level (Arthur 2005).

The success of a single point of access in mental health care settings is debated, with support from those such as Lovell and Richards (2000) who state that a single point of access offers equity, accessibility and choice compared to the traditional referral system through GPs. However, GPs have expressed concern that a single point of access could potentially result in the loss of their decision making skills with regard to making referrals to services (Raine et al. 2005). Conversely, mental health care professionals have argued that the single point of access allows expert assessment of complex problems which is in the best interest of the service user (Raine et al. 2005). Brown et al. (2003) argue that assessment via a single point of access allows a range of professionals to have input into the service user's needs and enables a joint decision to be made, if necessary, on the treatment plan. Brown et al. argue that this joint decision could potentially lead to a reduction in delay of treatment or inappropriate referrals. With an ever increasing population of older adults, reductions in delay, duplication and inappropriate referrals could assist with the management of lengthy waiting lists (Brown et al. 2003).

Evidence to support the use of a single point of access is suggested by Watson et al. (2005). This study followed the introduction of a single point of access in a community setting, specifically dealing with service users with learning disabilities. It was found that in this particular setting, with this particular client group, waiting times for services were reduced, there was a reduction in inappropriate referrals and community teams felt that the single point of access had a positive effect on integrated team working. However, how transferable this study is to other community settings is debatable, as those with learning disabilities have increased physical and specific mental health needs, and the community teams involved will vary (Watson et al. 2005). However, older adults within Countyshire have been identified as having increased physical and mental health needs (Countyshire PCT 2012) therefore based on Watson et al.'s findings it could be argued that a single point of access could potentially be beneficial for older adults.

Further supporting evidence for the use of a single point of access for older adult services is suggested by Brown et al. (2003). Brown et al. report on a single point of access with similarities to that in Countyshire, within a rural community in England. The results from Brown et al.'s study suggest that a single point of access

within community teams leads to an increase of self-referrals and a quicker assessment, as well as improved communication between community teams and increased knowledge of team member's roles. Brown et al. also argue that a single point of access for older adult services enables service users to have increased choice over the services they receive, a governmental priority (e.g. Department of Health 2006a). Furthermore, a review by Rogers, Entwistle and Pencheon (1998) recommended graduated access to NHS services, with a single point of access acting as a triage.

However, Rosen, Florin, Clarke, and Fulop (2001) state that improving access to services, for example through a single point of access, does not necessarily improve health or social care within a community; therefore the services on offer need to be tailored to the targeted population. Within Countyshire, the single point of access consisted of social workers, occupational therapists from health and social care, community nurses and physiotherapists, as well as end of life care professionals. These services were chosen by the Commissioners as the most appropriate for the community that the single point of access served based upon national policy and strategy requirements. This decision did not include services such as the Falls team, who aimed to prevent falls and admission to hospital, and the stroke service which was provided by a charity working in partnership with the NHS in Countyshire.

Based upon the available literature, it could be suggested that the single point of access has both positive and negative aspects. A single point of access to services can improve access to services, but will not necessarily decrease the complexity of services, rather it provides a frontage for service users who are navigating their way through health and social care services. The organisational complexity behind the single point of access may still exist (Dickinson et al. 2009). Some concerns have been raised about the evaluation of success rates of the single point of access, and equity of access (Rosen et al. 2001), as well as the potential loss of skills for some community staff, for example GPs (Raine et al. 2005).

Despite these potential drawbacks, previous research has indicated a decrease in waiting times as well as improved communication between professional staff and multi-skilled triaging of referrals (Brown et al 2003; Watson et al 2005). With this in mind, a single point of access for the care of older adults was recommended by government policy (e.g. Department of Health 2001) as well as international

studies into service provision for older adults (Leichsenring 2004). A single point of access has been argued to improve access to services for service users. The service also has the potential to reduce duplication and repeated assessments through formal and informal communication between health and social care staff (Thistlethwaite 2011). The single point of access for services for adults in Countyshire will be examined in detail within this thesis, however the concept of a single point of access is not a novel concept unique to Countyshire. Other single points of access to services within the UK will be considered below.

A single point of access for older adults elsewhere in England

This section of the chapter will outline features of other single points of access to health and/or social care services elsewhere within England. It is worth noting that only a small number of single points of access accept referrals for adults in general. There are however a number of services that specialise in mental health or learning disabilities, reflecting the research literature cited above.

Single points of access across England

Perhaps the most well-known service that could be termed a 'single point of access' to NHS services is the 111 number. The 111 number provides a single point of entry into non-emergency NHS services via a call centre staffed by nursing staff (Centre for Workforce Intelligence (CfWI) 2012). The 111 number superseded the NHS Direct service in 2013 (Nursing Standard 2013). NHS Direct was launched in 1998 and was established in order to provide advice and signposting to further services across the NHS (Shaw 2012) and was staffed by nurses (Department of Health 1997). Both of these services provide advice on non-emergency care and are therefore comparable to the single point of access in Countyshire in terms of NHS provision, but do not refer on to community services.

The CfWI is an organisation responsible for the planning of future workforce requirements for health and social care within England (CfWI 2014). In 2012, the CfWI carried out a study into current models of care within England entitled, 'Examining workforce and implementation challenges' (CfWI 2012), which included an examination of single points of access to health and social care services. According the 2012 report, there are a number of single points of access to health

and social care services across England but the Newcastle single point of access is given as a specific example. In Newcastle, the single point of access to health and social care services for adults reportedly saved £27,000 across all teams in terms of resources in one month (CfWI 2012). Additionally, there is a single point of access within Cornwall and Scilly Isles PCT (now a clinical commissioning group), which triages GP requests for emergency beds within the local hospital. During the first year of operation, admissions to emergency beds reportedly dropped by 7.8% which is attributed to the triage service provided by the single point of access (CfWI 2012).

Within Birmingham Community Healthcare NHS Trust there is a single point of access to both urgent and non-urgent services. The single point of access team consists of senior nurses, care staff (although no definition is given of the term care staff), social workers, mental health nurses, physiotherapists and occupational therapists. Anyone over 18 can be referred through the single point of access provided that they are at high risk of avoidable admission, have complex long-term conditions or require palliative/end of life care at home or require nursing/therapy at home (Birmingham Community Healthcare NHS Trust 2014). This differs to Countyshire in that anyone can contact and be referred on through the single point of access in the county.

Other single points of access within England with some similarity to Countyshire exist in Leicestershire and Gloucestershire. Leicestershire Partnership NHS Trust's single point of access service for adults allows access into community nursing, intermediate care, therapy services and community hospitals (Leicestershire Partnership NHS Trust 2014). However, unlike the single point of access in Countyshire, the Leicester single point of access does not coordinate access into social care. Gloucestershire Primary Care Trust (now a clinical commissioning group) had a single point of clinical access which was available to health and social care professionals to make referrals for urgent community services, assessment and treatment with the aim of reducing hospital admissions (Gloucestershire Primary Care Trust n.d.). However, the Gloucestershire single point of clinical access did not accept referrals directly from the public as the single point of access in Countyshire did.

Additionally, there are single points of access within England which are tailored to adults with mental health needs, such as in Lancashire (Lancashire Care NHS Foundation Trust 2014) or learning disabilities, such as in Birmingham

(Birmingham Community Healthcare NHS Trust 2014). Single points of access to services therefore come in a variety of forms for the adult population, but only a small number such as those in Newcastle and Countyshire cater for all adults and across both health and social care. A single point of access to services has been recommended, both within the research literature (e.g. Leichsenring 2004) and within policy and strategy (e.g. National Service Framework for Long Term Conditions 2005). The single point of access within Countyshire was developed in response to a number of policy and strategy documents, which will next be considered in the context of the Countyshire joint commissioning strategy.

A joint commissioning strategy

One of the first documents that I collected for analysis when in Countyshire was a document entitled 'Joint Commissioning Strategy - Older People Services 2010-2013'. The document was labelled as a draft for consultation at the time that I accessed it, and sets out a vision for joint commissioning within Countyshire over a 3 year period with regard to the needs of older people living within the county. I accessed the strategy via the Social Services website where it was freely available to the public. The document was published by both Social Services and the PCT as a joint initiative, with joint authorship and appeared to be presented as a joint position from the 2 organisations. The document summarised how integrated working between Social Services and the PCT would be managed locally within what was termed, "an increasingly stringent financial position" (p. 3). In order to achieve the, "transformation of services" (p. 3), the following service priorities were highlighted within the strategy:

- Agencies will work together to make available better integrated health and social care services for older people;
- Community based services will be available that will enable older people to lead full, active and healthy lives for as long as possible and to live independently in their own homes for as long as possible;
- Services will be rated as high quality, innovative and meet identified needs;
- The health and social care system will be more efficient and effective than ever before. There will be increasing emphasis on patients and service users

being supported to manage their own care and in ensuring they have access to the right level of care in the right setting when required; and

- The focus will be on enabling older people in Countyshire to make a positive contribution to their own quality of life and to their community.

These local service priorities were quoted with the Joint Commissioning Strategy as being linked to the below strategy documents:

- End of Life Strategy (2008b)
- Stroke Strategy (2007)
- A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People (2006a)
- National Service Framework for Long Term Conditions (2005)
- Use of Resources in Adult Social Care (2009)

I have extracted key points from the national strategy documents that may have influenced local decision making below. These key points are based upon my interpretation of both the local and national strategies. With reference to programme theory as described by Millar et al. (2012), during interviews with high level management staff within Countyshire, I was informed that the single point of access in Countyshire was designed with the aim of meeting the objectives outlined in the national policy documents. This included improving integrated working within and between health and social care providers in the county. According to management staff, the single point of access was Countyshire's answer to the integration agenda that filtered through from high level policy and strategy documents with the aim of providing an integrated access point to health and social care.

The Joint Commissioning strategy document stated that, "health and social care services in Countyshire will be integrated and more efficient and effective than ever before" (p. 8). The focus on efficiency and effectiveness may offer some insight as to why the single point of access was chosen as a method of providing integrated care. The cost of a single point of access was presented within the strategy as significantly cheaper (£462, 532 per annum) as opposed to the integrated community care team, the Rapid Response unit (£2, 090, 443 per annum) and the emphasis upon, "increasingly working jointly to... achieve increased efficiencies and improved outcomes" (p. 5) may support this supposition.

The cost per organisation is also outlined within the strategy, with the Local Authority spending approximately double upon the single point of access than the PCT. However, the message portrayed throughout the Joint Commissioning Strategy is that the approach to commissioning services was joint between the Local Authority and PCT. Indeed, the strategy highlights that that, "we (the PCT and Local Authority) will be investigating the impact on all parts of the health and social care system and ensuring a joint approach to delivery" (p. 3) when delivering health and social care. This statement was made within the introduction to the document and was repeated throughout, with the use of 'we' being, "used throughout (the) strategy to reflect the joint intentions of both organisations" (p. 3).

The presence of joint commissioning intentions is reflected within the Use of Resources in Adult Social Care policy document, which states that an 'excellent' local authority should:

'be working in partnership with the PCT to share investments that improve outcomes for their customers and... (agree) to share the benefits and risks in such a way that encourages joint working... good information and advice, practical support, appropriate housing options, re-ablement and joint working between health and social care (to) assist people in living fulfilled and independent lives' (2009: 6).

Furthermore, within the Use of Resources in Adult Social Care document, it is stated that:

'...people with complex health and social care needs, largely associated with long-term conditions, benefit greatly from joint health and social care assessment, care management and flexible support interventions. As well as improving the outcomes for individuals, the evidence strongly suggests that joint approaches reduce demand on both health and social care systems' (2009: 29).

However, although these statements are made within the document, it has been argued previously that there is relatively little evidence to support the use of integrated care in terms of outcomes for service users (Dickinson et al. 2009; Glasby et al. 2011). However, as suggested by previous research (e.g. Brown et al. 2003; Watson et al. 2005), a single point of access has been suggested to improve

integrated working, reduce duplication and lead to quicker assessments for service users. This may account for why the single point of access was the route chosen within Countyshire through which an integrated approach to health and social care would be delivered.

The single point of access in Countyshire also introduced a new service to service users which had not been present prior to the implementation of the service. Service users were able to self-refer to services; something that had not been possible before. Brown et al. identify self-referral to services as a benefit of a single point of access. The option of, 'self-referral to services for service users and carers' is cited in the National Stroke Strategy (2007: 45) as a way of, 'enabling and supporting people in navigating through the system... systems that do not take this into account are likely to increase inequalities of access and outcomes' (2007: 45). Within Countyshire, service users had previously expressed a wish for a single point of contact for health and social care through the Partnerships for Older People Projects (POPP) (POPP Partners and Project Spurs 2012). The response to this demand in Countyshire, according to discussions that I had with management staff, was to offer one telephone number to access all of health and social care through the single point of access. Anyone, from health care staff, to social care staff, to GPs, carers and service users themselves could contact the call centre to access services or signposting to third party independent providers. This was a change from the system in existence prior to the inception of a single point of access in Countyshire, which will be outlined later in the chapter.

In order to support this new way of working, the infrastructure and information technology within Countyshire had to change. The single point of access business case refers to additional equipment purchases and infrastructure, including the processes and charges for PCT staff, if access to the Social Services service user database was required. Interestingly, the Countyshire Joint Commissioning document referred to, 'plans to improve the information technology infrastructure', stating:

'the council has commissioned a new social care database and customer records management system, which will provide better connectivity between different parts of the care management service and smooth interface with local NHS systems. The PCTs locally have commissioned a community services system' (p. 8).

Below the paragraph containing this statement is an italicised point stating, 'Drafting note – Paragraph needed on how they (the information technology systems) will interface'. Although the Joint Commissioning Strategy outlines intentions of integrating information systems, it would appear from analysis of the above statement that the practicality of integrating the systems had not been fully explored in detail before releasing the document.

The Next Steps in Implementing the National Service Framework for Older People contains information stating that improved information technology will, 'support efficient and secure sharing of information across health and social care communities' (2006: 14). Additionally, the Use of Resources in Adult Social Care (2009) contains guidance which states that information technology and the development of paperless offices will be required to move forwards with integration between health and social care. However, it has been previously identified that information and communication systems can often be poor within and between health and social care (Care Quality Commission 2009), which, it could be argued, is reflected in the lack of information about how information technology will operate within Countyshire.

I have demonstrated within this section of the chapter that the Joint Commissioning Strategy - Older People Services 2010-2013 outlined a vision for health and social care provision within Countyshire. Within the national policy, integrated commissioning was supported, as was self-referral to services, both of which are reflected within the local joint commissioning strategy. However there appeared to be some gaps in how this provision would be arranged, particularly around the information technology systems and how these would support health and social care services within the county, despite the importance placed upon IT within the national strategy documents. In order to aid understanding of the impact of the commissioning strategy upon health and social care within Countyshire, the population and services available within the county will next be considered.

A profile of Countyshire

Countyshire is located in the south west of England and is characterised by its mixture of rural locations with urban areas. It is known for its seaside resorts and has

attracted holiday makers from across the UK since the Victorian age (Countyshire PCT 2012).

Population

According to data supplied by Countyshire PCT (2012), the population in Countyshire has grown at twice the national average rate over the last 10 years with a greater proportion of the local population being over age 50, and fewer young adults and children than the national average. As a result, the number of those requiring intensive community care had risen in the last 10 years with a resultant demand upon health and social care services in the county (Countyshire PCT 2012). Furthermore, it was estimated that the population of those over 75 years of age would increase by 72% over the next 20 years. This potentially presented further challenges for health and social care services in the area with regard to providing efficient and effective care to the local population (Countyshire PCT 2012). Countyshire is currently home to a population of 199,000 residents and has a mixture of some of the most affluent and deprived areas in the UK (Countyshire PCT 2012). The area is popular as one of the cheaper seaside retirement locations and has areas of deprivation and large council estates, which has previously been associated with ill health (NHS Countyshire 2012).

Prevalent pathologies

It is estimated that the population of over 75s in Countyshire had increased by 13% since 1996 (Countyshire PCT 2012). Old age brings a number of complications and health conditions such as arthritis, cancer, and heart and lung disease, typical of most areas within the UK (Department of Health 2001). There were 38 nursing homes within Countyshire, the majority of which were located within the seaside towns within the county; however compared to the number of nursing homes in other counties this is below average (HousingCare 2012). This suggests that the majority of the elderly living in Countyshire remain in their own homes, presenting further challenges to community health and social care services in the area in supporting and facilitating this independent living. The services available at the time of writing in the county will next be outlined in order to set the scene for the remainder of the

thesis, in order to give the reader sufficient information to understand the local health and social care provision.

Community services available within Countyshire

Community services within the area, both pre and post the single point of access:

- 25 GP practices
- Community Nursing
- Occupational Therapy
- Physiotherapy
- Social Work
- Podiatry
- Community Learning Disability team

In addition to these community services, seven community wards were developed in Countyshire in response to governmental strategy (Department of Health 2008b) which stated that more people should receive end of life care in their own home. Additionally, the change to community wards was included in the Department of Health's (2010) plans for GP Commissioning which gave GP Commissioning Consortia control over where budget was spent locally. PCT providers were expected to divest themselves of community services and contract out to external companies. In Countyshire, PCT community care moved to a social enterprise organisation, and staff were re-organised into community wards. Community wards within Countyshire provided intensive, integrated community care to those with critical or urgent needs in their own homes, in order to prevent admission to hospital, or to facilitate discharge from hospital (Countyshire PCT 2012). 7 community wards were set up in Countyshire, with each ward consisting of a community matron, 2 occupational therapists, 2 physiotherapists, 3 nurses, 3 assistant practitioners/support workers, a team coordinator and an administrator. Those admitted to community wards required specialist, urgent care, and were cared for in their own homes by a multi-disciplinary team of nurses, physiotherapists and occupational therapists. These community wards were in the process of being set up at the time of my fieldwork and it was uncertain, from the point of view of the staff,

how they would interact with the single point of access at that time. The single point of access project was a separate project from the community wards and the interdependencies between these projects did not appear to have been considered. The background to the commissioning and implementation of the single point of access will next be outlined.

Implementing a single point of access in Countyshire

The single point of access within Countyshire came about as a result of Department of Health funding to develop innovative services for older people (aged 50 years plus) in Countyshire (POPP Partners and Project Spurs 2012) and as a response to governmental policy and strategy documents, as outlined above. The POPP ran between May 2007 and March 2009 when it was replaced by the single point of access (Single Point of Access Business Case). The POPP began a variety of initiatives in Countyshire which aimed to improve services for older people within the county such as running day groups, befriending services and other projects such as repair of pavements to reduce the number of falls. Members of the POPP included Age Concern, Crossroads (who provided care and respite for carers in Countyshire), a local Racial Equality Council, and a pavement repair service (POPP Partners and Project Spurs 2012).

Another main focus of the POPP was the integration of health care and Social Services to provide a joined up service for older people within Countyshire. Whilst the POPP project was in operation, service users were surveyed and the majority stated that they would like to have a single point of contact for health and social care within Countyshire, as the majority of service users felt confused by the number of services available and the number of routes into health and social care (Single Point of Access Business Case).

Social Services were already operating a single point of contact call centre, Care Connect, which service users could access to initiate a social care assessment, obtain information on care available or receive signposting to other services. As a result of service user feedback, and the requirement from the Commissioners within Countyshire to provide an integrated service, work began on scoping out a single point of access for both health and social care within Countyshire, using the existing call centre that was operating for Social Services (Single Point of Access Business

Case). A pilot study of the single point of access was carried out with community nurses in the south of Countyshire in March 2009. When interviewed, the individual who had acted as project manager for this pilot stated that it was successful. Staff from both the PCT and Social Services were recruited into post. The single point of access went live for the south of the county in June 2009. The north of the county has continued to use the traditional GP referral route, demonstrated in Figure 1, below.

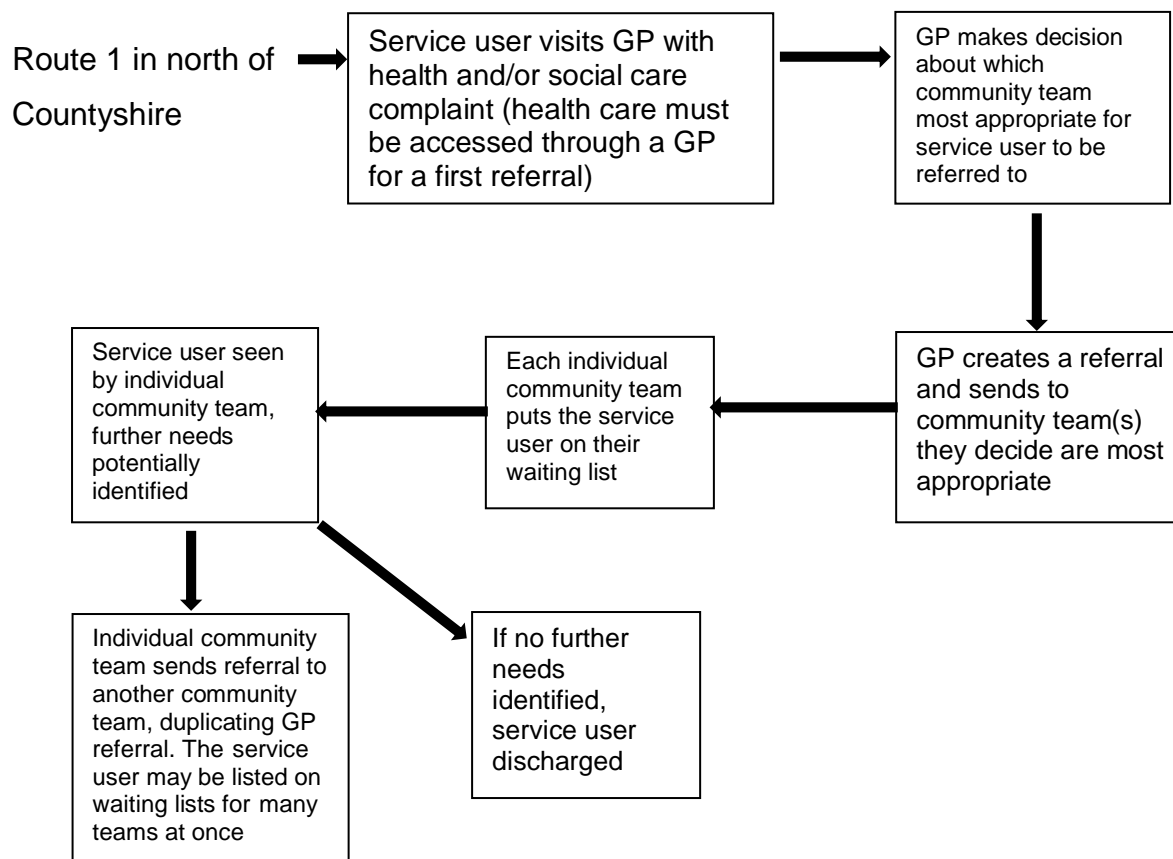


Figure 1. Access to community services in the north of the county

In the south of the county however, community services were to be accessed in a different way. Community services were still accessed via the GP, but could also be accessed via Care Connect, the Social Services call centre (Care Connect was later outsourced to a private company, which will be discussed in more detail later in the thesis). The process is highlighted in Figure 2, below.

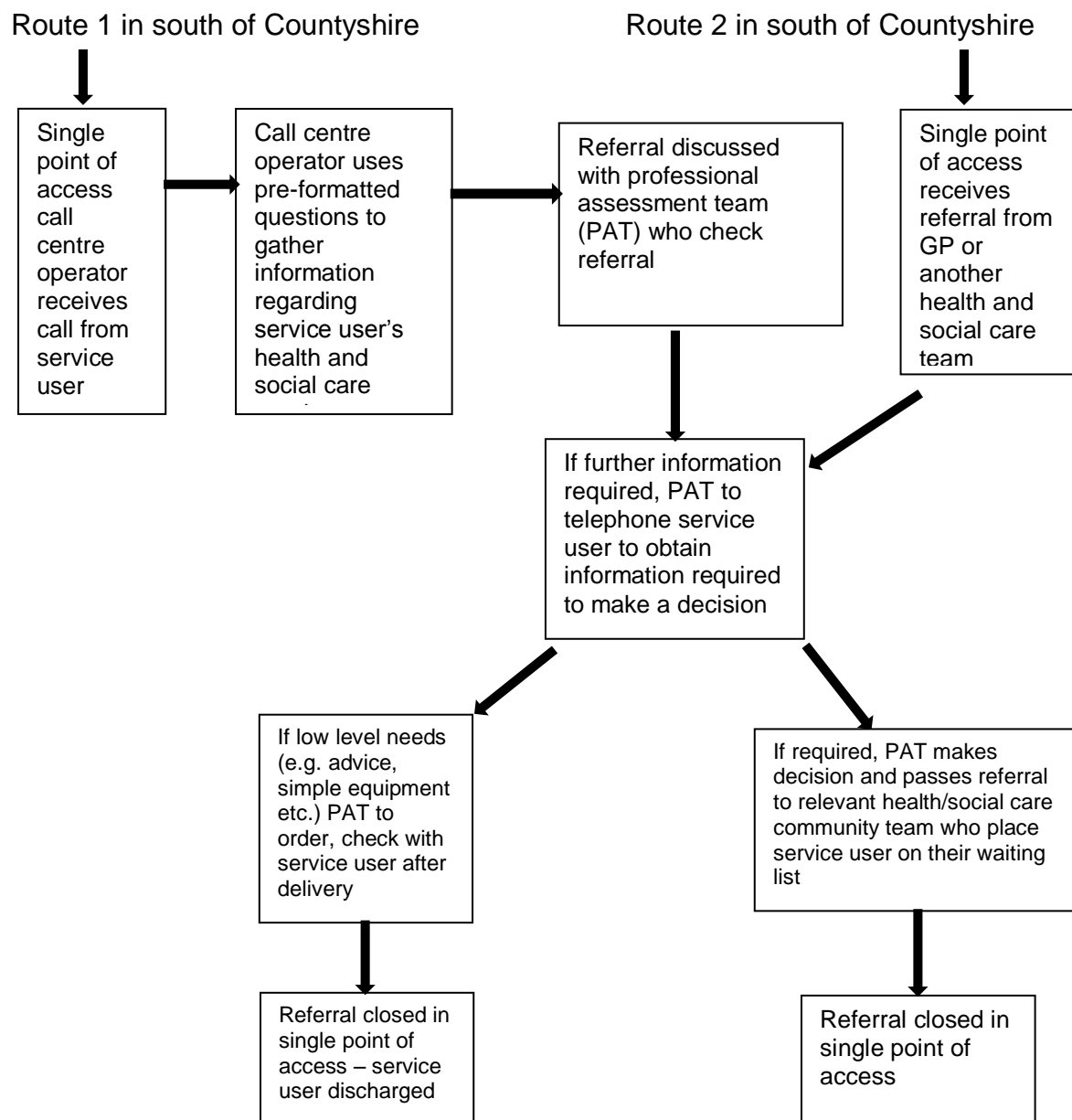


Figure 2. The referral process in the single point of access

Figures 1 and 2 demonstrate that there were differences between the referral routes in Countyshire. The north of the county continued to use the traditional route as demonstrated in Figure 1, whereas the south of the county began to use the single point of access referral route as demonstrated in Figure 2. GPs had less of a decision making role within the south of the county. Ultimately, the professional assessment team within the single point of access decided where to send the referral. As the single point of access had been deemed a success in the south of the county, based on discharge figures that were collected by the professional

assessment team, the service was planned to roll out to the north of the county, thereby replacing the traditional GP based referral route throughout the county. This had not been achieved at the close of my fieldwork, due to a variety of issues, which will be discussed at length within subsequent chapters.

Staff in the single point of access in Countyshire

According to the single point of access business case, the single point of access team manager and other members of staff whom I interviewed, the following staff were planned for and funded within the single point of access:

- 1 Social Services occupational therapist
- 2 social workers
- 1 PCT community nurse
- 1 PCT occupational therapist
- 2 administrators

At the time of my fieldwork, within the single point of access team, there were 2 social workers, plus 1 student social worker on placement until May 2011. There was 1 Social Services occupational therapist covering both Social Services referrals and PCT referrals, as a PCT occupational therapist had not been recruited into post. As my fieldwork progressed, a bank occupational therapist joined the team to cover the PCT post until a rota was devised for PCT community occupational therapists to rotate² in and out of the single point of access. A community nurse had not been recruited at the time of my fieldwork, but a bank member of nursing staff was employed for a week at a time to cover nursing referrals. This was not continuous cover and frequently any requests for nursing had to be processed by other members of staff within the single point of access. There were 2 administrators, one of whom left shortly after I began my fieldwork. The other helped with nursing referrals by sorting and forwarding these to the relevant team of community nurses. As such, the team was under-staffed, with a small number of core team members who were all staff employed by Social Services, apart from the administrator who

² To 'rotate' into the service refers to all Band 6 community members of staff taking turns to spend time (a day or a week dependent upon the team in question) in the single point of access whilst continuing to visit service users in the community on other days.

was from the PCT bank of administrators. The full complement of Social Services staff demonstrates how much more successful the single point of access had been with regard to Social Services compared to the PCT. According to staff in the locality, and analysis of my data, Social Services staff had been fully engaged with throughout the process and as a result had bought into the service. The use of a single point of access was also less of a change for Social Services than it was for the PCT staff. This will be discussed as the thesis unfolds but is an important point to note at this stage.

Chapter summary

This chapter has set the context for the study contained within this thesis. Within this chapter I have outlined the background to the single point of access within Countyshire including my rationale for carrying out a study in this locale and regarding the single point of access to services in particular. I have discussed the relevant literature regarding a single point of access across England and have demonstrated that within health and social care across England, the single point of access is not a new service, and has existed for some time within mental health and learning disability services. I have shown that within the literature the single point of access is viewed more favourably by some groups of professionals than others, which could potentially have repercussions for the service when implemented elsewhere. I have also discussed some of the identified benefits of the single point of access within the literature such as improved integration and communication between services, a reduction in duplication and an increase in self-referral to services. I have also suggested that although a single point of access may present a united front to services, the complexity behind the services will still exist.

I have outlined a number of other single points of access services within England and some of the argued benefits, including a reduction in the uptake of hospital beds and a reduction in spend. I have compared these other services to the single point of access within Countyshire. Only a small number of services are comparable in terms of the services provided within Countyshire. I have also outlined the commissioning intentions, policy and strategy documents behind the single point of access within Countyshire and have highlighted that joint commissioning is

supported within national strategy documents, but that issues such as IT also feature.

Finally, I outlined the context of the study contained within this thesis, beginning with a consideration of both Countyshire and the single point of access in Countyshire. I have discussed the ageing population of Countyshire and the prevalent pathologies within the county. I have also outlined community health and social care services available in the county. I have suggested that Countyshire is home to a disproportionate number of elderly people, most of whom remain at home rather than being admitted to residential or nursing homes. As such it could be suggested that the demand for community health and social care will increase in coming years.

The following chapter considers the methodology utilised within this thesis. I will discuss the methodology and underpinning epistemology of the current study, as well as the selection of methods. The use of ethnography as a method of data collection, and an approach similar to grounded theory for analysis will be considered. Methods utilised to ensure trustworthiness are then outlined, as well as the use of reflexivity. The chapter closes with a note on transferability.

CHAPTER FIVE – METHODOLOGY

Introduction

This chapter describes the methodology and design of the ethnographic study contained within this thesis. It aims to be an individual and reflexive account of my approach to studying the single point of access in Countyshire. The chapter begins by considering the epistemological underpinnings of the study, justifying the selection of a constructionist epistemology, social constructionism as the primary element of the theoretical framework supported by social identity theory, and ethnography as a methodology. The chapter subsequently moves on to describe and analyse the methods used within the fieldwork phase. Following this is a discussion of the use of grounded theory as a method for analysis as well as a detailed account of how analysis was carried out. Methods used to ensure trustworthiness of data collection are next discussed. The chapter will close with a note on transferability. The insider and outsider perspective, and the use of reflective practice within research that has been carried out by a partial insider will be considered in the concluding chapters of this thesis as a reflection on my research study.

A note on language

A note on the language and the decision that motivated the use of this language is needed. Before pursuing doctoral studies in health and social care I studied Psychology at undergraduate level. For the majority of these three years I was trained in quantitative research methods. As a result I learned more about validity, reliability and generalisability than I did about qualitative methods and quality assurance issues such as trustworthiness and transferability. I have struggled to move away from my positivistic and quantitative background, both in terms of my paradigmatic leanings and use of language. I have used a mixture of methods, combining qualitative methods of interviews, observations, focus groups and documentary analysis with a quantitative comparison of waiting times. I have therefore opted to use a language that feels comfortable to me as a researcher but is also appropriate to the mixture of methods I have used within my studies. With reference to using a mixture of methods, Andrew and Halcomb (2009) state that the language used when writing up research should be contingent on the approach that the researcher has taken. As most ethnographic research (c.f. Van Maanen 1988;

Simmons 2007; Innes 2009) is written in the first person, this is the approach that I have taken within this thesis. In terms of analysis, I have utilised Morse's (2008) definitions of 'category' and 'theme' – the former allowing the sorting of data into logical sets and the latter defining what Morse refers to as, 'essence that runs through the data' (2008: 727). Finally, I have utilised the methods associated with trustworthiness, which concerns self-awareness of the impact I have had upon the data collection (Giddings & Grant 2009), and transferability, the extent to which the findings can be applied to other situations (Merriam 1998) to check credibility and quality of my data in line with the dominant qualitative approach.

Epistemology

'All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (Crotty 1998: 42).

I have chosen the above quote from Crotty to illustrate my epistemological positioning within this piece of research, which is the belief that an individual creates meaning socially through one's interactions with one's peers. The sound of a tree falling in the forest is still present even if there is no-one to hear, however I argue that the sound is given meaning by the individual there who perceives it. The sound and consequential meaning is created socially and based upon the culture and society that surrounds us. Objects may have different meanings depending upon the culture they are present within and the individual within that culture whose perception is being studied, and this is the stance I take within this thesis.

Study design

I approached my doctoral research with the desire to examine the interactions between the different health and social care professionals but I found that beneath the broad umbrella of health and social care it was difficult to pinpoint an area to focus on. Health and social care research is a large area which is plagued by many issues, change, and is a continuing political problem. At the time of my employment

in Countyshire, one of my colleagues had gone to work in the single point of access, and I was interested in a team that would provide some sort of integration between health and social care. When carrying out initial scoping work for my doctoral studies I visited the single point of access team to examine whether a study would be possible. After conversations with many of the staff within Countyshire, I decided to examine interprofessional working between health and social care professionals within the county – and how this had been affected by the implementation of a single point of access. In addition I wanted to explore how high level policy transferred to front line staff. I conducted background reading into the integration of health and social care and was particularly influenced by the work of Peck et al. (2001), Hudson (2002), Barr (2002), Brown et al. (2003), Leichsenring (2004), Raine et al. (2005), Meads and Ashcroft (2005), Heenan and Birrell (2006) and Dickinson et al. (2009) all of whom described studies of integrated care and the complexities of, in particular, professional identity when integrating health and social care. Skelcher's (1993) theory of disempowerment during service re-development also became significant once I had started collecting data. One of the key studies of those singled out was Heenan and Birrell's study which was conducted in Northern Ireland and described a fully integrated health and social care system which had been in place for 30 years. This system worked due to what Heenan and Birrell described as the most distinctive feature – all professionals being employed by the same organisation and having shared goals and objectives. As I had been employed by the PCT and had experienced professional rivalry between PCT and Social Services occupational therapists, it was this statement that interested me most.

I wanted to carry out a study in Countyshire that would explore integrated care in detail, as well as a new way of working for health and social care professionals. I also wanted to explore the impact that a single point of access might have upon integrated working, as according to previous work from Watson et al. and Brown et al., a single point of access should aid the integration of services. As such, my research aim and objectives were as follows:

To explore the implementation of a single point of access within Countyshire with regard to integrated working, waiting times and outcomes for patients.

Within this broad aim, the study had the following specific objectives:

Objectives

1. To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful
2. To identify whether the single point of access had an effect on integrated working within Countyshire
3. To identify whether the single point of access met its objective of improving integrated working
4. To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working
5. To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

The research question was:

'Does a single point of access to health and social care have any effect upon integrated working?'

As a previous employee, and as discussed in the previous chapter, I had experienced frustration with the lack of integrated care in Countyshire which first sparked my interest in investigating integrated and interprofessional working in more detail. At the same time I was also very wary of my lived experience of this area and how my views and interpretations of the phenomena occurring around me might not be the same for other individuals. Other individuals would have had a different social and cultural experience in comparison with myself, which is a component of the social construction of reality as described by Berger and Luckmann (1991). I felt the only way to openly achieve my aims was to adopt a qualitative approach to collect the type of data that would help to achieve an in-depth insight into the daily interactions of the staff and how these affected their working lives, and reveal any insider bias by using a reflexive methodology. This was a technique employed within my fieldwork phase, not an objective per se. I also felt that a qualitative research design was most appropriate as I was unsure as to what I might find upon entering

the research site. I therefore wanted to adopt an exploratory approach for which Silverman (2010) argues qualitative research is most appropriate. McKie (2002) states that quantitative methods have been used in past research with the belief that quantitative research provides easy to follow results, which can provide guidelines that will lead to change. However, I argue that quantitative research cannot always explain why certain results have been obtained or necessarily illustrate the results in a way that is easily understood or provides future lessons. I wanted to produce a piece of research that would aid my previous colleagues with lessons learned so a predominantly qualitative approach was selected.

Having been a member of staff in Countyshire undoubtedly influenced the development of the study and the areas I wanted to investigate in more detail. Working for the PCT as a community occupational therapy assistant, I was trained and socialised within a specific culture, with specific sets of rules and regulations that were different not only from my other professional colleagues such as physiotherapists and nurses, but occupational therapists in the same locality who worked for Social Services. These specific rules and regulations frequently were a barrier to working together, as demonstrated in the previous chapter.

The issue of barriers between individual cultures is particularly pertinent in the current climate regarding change in health and social care and can have a very real impact on the way professionals work together, as demonstrated in chapter two. I turned to social constructionism to guide the development of the current study. I had struggled with locating my research within a research paradigm initially and my perspective has evolved and changed over time as I have become more experienced as a researcher. Upon experiencing the nature of health and social care in Countyshire from a researcher's point of view, I began to understand with more clarity the relevance of social interaction, and how this influenced not only the operation of the single point of access and community team working, but also how relationships between different professions impacted upon day to day working. I also realised that although each individual profession has its own culture, within those professions are different individuals who bring their own individual socialisation, personality and culture to the profession (e.g. Adams et al. 2006) which will be explored within the findings chapter. I had read Crotty (1998) in the early days of my doctoral studies in some attempt to place myself within a research paradigm, but once I had experienced the setting and the importance of social interaction within

this setting, I re-read the chapter regarding constructionism and finally understood where my study was located.

Constructionism according to Crotty is essentially both objective and subjective which further strengthens its influence within my study. As both insider and outsider to this study I found myself being both objective and subjective in my thinking with which came both positives and negatives. This will be discussed in the discussion chapter of this thesis. In the main, I am an insider to this research and as such had my own pre-conceptions on entering the field. Having had a specific emphasis on culture in mind from the early stages of my study design, I began to search for a methodology that would be appropriate to investigate professional culture, in the context of health and social care, within my study.

Why ethnography?

As discussed above, the current study is underpinned by a constructionist epistemology and a social constructionist theoretical framework, both of which are concerned with social interaction, social experience and how every day meaning is derived from these experiences (Crotty 1998; Berger & Luckmann 1991), as well as structure and agency theory (Giddens 1984). The next challenge was to select a methodological approach that was not only appropriate for the data collection I wanted to undertake but also complemented the theoretical perspective of social constructionism. The early months of one's doctoral studies consist of reading widely around your subject of interest which started for me with integrated working between health and social care professionals. The papers which interested me the most, and had the most depth of insight in my opinion were all studies that used an ethnographic approach such as Van Maanen (1988), Innes (2009) and Baumbusch (2011). I therefore began exploring ethnography and further ethnographic writings, such as Van Maanen (1979), Whyte (1993), Savage (2000), Hammersley and Atkinson (2007) and Simmons (2007) to evaluate the potential of using this method within my study.

The roots of ethnographic study can be found in anthropology and sociology (Van Maanen 1988; Cunliffe 2010). The aim of ethnography as defined by Van Maanen (1988) is to experience another culture, delving into the individual person's experience within that culture and understanding how they experience that culture,

along with the way they make meaning from their experiences. Culture can be divided into two areas – 'Big C Culture' which is defined as the culture of an overriding society, and 'small c culture' which is concerned with micro level interactions and life in particular settings (Cunliffe 2010). Observing this definition, the current study is concerned with culture with a small 'c', examining individual teams within and between 2 organisations, their interpretation of culture and identity, and how they work together and make sense of their surroundings. How these organisations interpret and implement policy, and how this has led to change was also examined.

Ethnography has been widely debated within methodological literature. Crotty (1998) argues that ethnography is so closely related to a phenomenological theoretical perspective that it is not possible to conduct ethnography unless an ethnographic study is underpinned by phenomenology, which is associated with an interpretivist epistemology. However, Savage (2000) states that ethnography has no particular epistemological grounding or theoretical perspective with which it is associated. Although I have adopted a constructionist epistemological standpoint with an emphasis on culture, I believe that ethnography was an appropriate choice for this research study, as Brewer (2000) states that ethnography is not a singular method of data collection, but rather a style of collecting data about the social meanings and actions of participants in a particular setting. Savage (2000) goes on to describe ethnography as being a mixture of methods, a process and a product. As I read around ethnography, I came to understand the method as the study of culture, individuals within a particular culture and how these individuals create meaning from their experiences, which is compatible with social constructionism. In designing and conducting the study, I was concerned with the ways in which individual staff members created meaning in their everyday working lives. I was also interested in how everyday phenomena such as social identity, belonging to a team, interactions and communications with other staff members influenced individual staff member's construction of a sense of self and a sense of belonging. Also, to observe the change to a single point of access, it must be recognised that change relies on people in a social milieu, so therefore ethnography was the logical choice of methodology.

There were a number of factors to consider with the selection of ethnography as the methodology of choice. Ethnography requires a big investment in terms of

time from both the researcher and the researched (McKie 2002). In some ways I would argue that a greater investment is required from the researched as I had chosen to assume the role of researcher whereas the staff had not chosen to be selected for study. My presence in the field caused extra work for staff, at least in the beginning. Not only would the staff have to find me somewhere to sit every morning, but they would also have to give up their time to talk to me, and cope with a new person, for some an unknown and a stranger, in their midst who would be observing them. Staff also took on other duties as a result of my being there, such as booking meeting rooms for me and allowing space in their meeting schedules to accommodate me. Observing and interviewing staff is also an intrusion into their working day and to some extent, their privacy. I was also concerned that due to the busy day-to-day lives of community health and social care staff, they would not have time to talk to me; however this fear was a preconception of my own from my previous experience as an employee and most staff were happy to take the time to converse with me.

A qualitative approach to research requires the development of a relationship between the researcher and the researched which requires further investment from both parties (McKie 2002). I felt that in terms of the single point of access I had already started to develop a relationship with the team manager so I was confident that she would be willing to take part in the study and encourage her staff to take part. However, there was a risk that the Commissioners, the relevant Research and Development team and the ethics service would not agree to, or try to stop the study. I had engaged in telephone calls with a representative from the Research and Development team who was concerned about my motivation for conducting the study and how Countyshire would be portrayed within this thesis. I allayed the fears of the Research and Development team by agreeing to anonymise Countyshire in my thesis and any subsequent outputs, and to provide a report of my findings at the end of my study.

Ethnography as a method has often come under attack from researchers working within the naturalistic and positivistic paradigms as nothing more than a method to use to collect preliminary data about an unknown subject before exploring in more detail with a quantitative method (Brewer 1994). Critiques of ethnography as a methodology have come from two different areas of the social sciences (Brewer 2000). The natural science critique states that ethnography is not a proper scientific

measure of human behaviour, and falls below the standards of science, a belief that is posed by Giddens (1984) who suggested that social sciences should use the same methods as the natural sciences. A variety of methods have been used throughout the years to try and meet the criticisms of ethnography from the natural sciences. Some ethnographers have attempted to make their practice more scientific, whereas some strongly oppose the criticism and state that human behaviour cannot be studied in artificially created experiments or in line with methods employed by the natural sciences (Brewer 2000).

Another approach taken by ethnographers is to transcend the boundaries between the natural and social sciences through postmodernism (Crotty 1998). These researchers take the approach that neither social nor natural sciences can address the issues of research adequately and that all knowledge collected through all science, whether natural or social, is influenced by the personal and cultural influences of the researcher (Brewer 2000). Based on this 'postmodern' criticism of ethnography, it is not possible to be objective to the data or represent a 'true' picture of Countyshire in this thesis. The 'truth' that is presented in this thesis is influenced by my insider perspective, as well as by my cultural and social background. To this end my personal influence on the data collection must be acknowledged in order to ensure the trustworthiness of my data. The data collected represents one group of health and social care professionals at one point in time and therefore is not necessarily transferable to all different situations. These issues are discussed in more detail later in the chapter under the headings of trustworthiness and transferability.

The exploration of this particular culture with a small c was conducted using a variety of ethnographic field methods, consisting of qualitative data collection techniques including observation, interviewing, and documentary analysis. This qualitative and ethnographic data was planned to be combined with quantitative data collection of waiting time data. This would enable a counterbalanced and deep level of insight into the issues surrounding the single point of access in Countyshire. Andrew and Halcomb argue that, 'a mixed methods approach is the optimal means of providing a balanced approach to understanding the relative issues and their impact' (2009: 66) and I wanted to ensure that I obtained an in-depth and holistic view of the day to day working lives of staff in Countyshire. Whether a specific emphasis on a mixture of methods is required in ethnography is debated by Brewer

(2000) who states that ethnography mixes methods such as interviewing, observation and documentary analysis as a matter of course. I did however have another motive for collecting a mixture of data. A mixture of methods allows for an iterative process between data collection and analysis, as well as triangulation, (Andrew & Halcomb 2009) which is discussed further in the following sections.

Methods used

The methods used to meet the aims and objectives consisted of observation, semi-structured interviews, focus groups, documentary analysis and statistical comparison of waiting times, discussed below.

Entering the field

I had carried out two preliminary visits to the single point of access team during the first year of my doctoral studies but before I could collect data, I had to obtain clearance from the university ethics service, the National Research Ethics Service and the local Research and Development team in Countyshire. For all levels of clearance I developed a protocol, information sheets and consent forms (see Appendix A). Access was initially negotiated with the team manager of the single point of access. Based on the information that this individual gave me regarding the structure of community care within Countyshire I then identified key stakeholders in community care to contact for further access to research sites. I undertook observation, interviews and focus groups at the following locations:

1. Single point of access service, based within the Social Services headquarters in the south of the county.
2. PCT Community team hub, based in the north of the county.
3. PCT/Social Services hub, based in the north of the county.
4. GP surgery, based in the north of the county.

All members of the single point of access team were approached to consent to taking part in my research study and were given the opportunity to ask any questions. Members of staff in the community teams within the other 3 locations

were only approached for consent if they took part in interviews or were directly observed by me, as the mixture of staff within the community hub office was such that many staff there were not within the staff groups I wanted to study. On the commencement of my involvement with the single point of access I signed a confidentiality agreement (see Appendix B). This confidentiality agreement covered any potential encounter with sensitive patient data and is signed by any student who wishes to visit Countyshire. This agreement permitted me to carry out observation and shadowing of health care professionals on their visits to service users as well as base myself in their offices where I may have overheard confidential conversations about or with service users. There were no restrictions placed on my research as a consequence of signing this form. I am not unique in having been asked to sign a confidentiality form. The National Institute for Health Research in their Research in the NHS - Good Practice Guide (2012) includes a confidentiality form that the researched can use when their organisation is the subject of a research study.

At the second preliminary visit I conducted prior to beginning my fieldwork, I was informed by the team manager that although the single point of access only operated in the south of Countyshire at the time, it was due to roll out to the north of the county within the timeframe in which I wanted to begin my fieldwork. I would therefore potentially miss the ability to capture teamwork without a single point of access and the comparative element of my study. I eventually took the decision to begin with the single point of access. There were two main reasons for this. Firstly, I felt as though I had developed a relationship with the team manager where I could not justify beginning my fieldwork anywhere else other than with the single point of access without causing offence to the team manager who had invested a lot of time in my study. Had this happened, my fieldwork would have been seriously limited in terms of what I was able to collect, both from her team members and in terms of policy and strategy documents. Secondly, due to the open and loose nature of the observation and interview schedules I had designed, and my grounded theory approach to the study (discussed further below), I did not know what exactly I should be looking for in the north without a baseline from the single point of access and team work in the south of the county. As it transpired, the roll out to the north did not happen during the timeframe that had been given by the team manager, and had still not happened at the time of writing this thesis, so my decision to begin my fieldwork in the south with the single point of access did not affect my fieldwork. The decision

to begin in the south of the county did have an effect on how I was viewed in the field however, which is discussed in more detail later in the discussion chapter of this thesis with regard to the insider/outsider perspective.

Of important consideration when entering the field is the power in the research relationship. As the researcher, I held a certain amount of power (Hammersley & Atkinson 2007). It would be my responsibility to interpret the interview transcripts and field notes and potentially my interpretation that would be heard throughout the thesis rather than the voices of the participants. In the early stages of my study the decision was made not to share transcripts with participants lest they changed their decision to take part or forbade me to use the transcript in my thesis. During my fieldwork however, I chose to share the transcripts with participants, seeking verification and credibility of the data collected which could be argued to restore some of the power to my participants (Laney 2002).

Observation

I began my fieldwork phase with a 2 month period of observation and informal talking with the staff from the single point of access. Hughes (2007: 90) describes observation as 'a promising alternative to interviews for seeing inside the 'black box' of health care organisations and understanding service delivery and change' as well as a useful tool to identify the gap between policies and procedures implemented by organisations and actual working practices carried out by staff in their day to day routine. Holloway and Wheeler (2010) describe observation as being a key tool in qualitative research due to the natural setting of observation in the field – rather than in an artificially construed environment. I therefore felt observation was an essential component to identify any gaps between what participants revealed about themselves in interviews and the way they behaved day to day.

To begin with, I aimed to understand the day to day experience of staff members in the single point of access as this was not a service I had any previous knowledge of. As such, I began my fieldwork by sitting with the single point of access team within their offices. I spent most of the day sitting at a desk in the office watching and listening, as well as engaging in information conversations with team members, in order to familiarise myself with the team. I was also offered the opportunity to shadow members of staff whilst being trained on IT systems and

observe staff carrying out their day to day work. I also began to attend team meetings and was offered the opportunity to discuss my research as part of team meeting agendas. Once I felt that I had a good understanding of the functioning of the single point of access and the day to day experience of staff, I then began to engage in formal interviews with key team members. I then repeated this pattern of activity in the community staff hub in the north, beginning with a period of watching and listening and then moving on to interviews.

The observation period ran concurrently with documentary analysis of all relevant current policy concerning integrated working in Countyshire and was used to generate themes for the interview period, as well as to complement the data collected during the interview phase. An example of the influence of themes generated from observation on the interview schedules was the notion of being in a team. I observed that although the single point of access team members were grouped together as a team, they worked separately and autonomously. On observation of this, the theme 'being in a team' was added to the interview schedule and I questioned staff about whether they felt part of a team during the interview stage. I had not considered team dynamics in the interview schedule I had developed prior to beginning my fieldwork. I also used observation periods as time to get to know my participants and allow them to get used to me in my role as researcher. The observations took part during the normal working day as defined by staff members, which was between approximately 0800hrs to 1700hrs. After 2 months with the single point of access, I started the second phase of the fieldwork in the north of the county.

As I had been a member of staff in this county, this undoubtedly had an effect on how I approached the periods of observation. DeWalt and DeWalt (2002) state that particularly where observation is concerned, being a previous member of staff should enhance the ability to observe and understand the lived experience of the members of staff due to insider knowledge and own personal lived experience. Holloway and Wheeler (2010) argue that familiarity or previous knowledge and lived experience can lead to the researcher to arrive at the observation with assumptions and beliefs generated based on their own experience. Holloway and Wheeler go on to warn that in order to minimise the risk of misinterpreting events or skewing events and occurrences with their own views, the researcher's prior assumptions should be suspended. I erred on the side of caution and used my previous experience as an

'ice breaker', so if people asked me about myself I could reveal my previous role and discuss my experiences with them. I also kept a reflexive diary which was used to document any potential issues or bias I identified as a result of being a previous member of staff. The use of a reflexive diary is further discussed in the discussion chapter of this thesis within the context of the insider and outsider perspective.

Due to my previous experience as a health care professional in Countyshire members of staff there occasionally assumed that I wanted to participate in their day to day activities. I did not aim to be a participant; rather I assumed an unobtrusive position from which to observe, usually from an unused desk in the office. I made it clear to any member of staff that I observed that I was present as an observer only in a research capacity. My openness and clarity of position worked well and staff soon seemed satisfied with my explanation for my presence. It would have been both unethical and illegal for me to advise on any health and social care issues as I was no longer an employee. However, if I was present when a member of staff took a distressing phone call or had experienced a stressful visit I did offer emotional support.

Initially I aimed to observe the dimensions classified by Spradley (1980), outlined below:

Table 8. Dimension of observations adapted from Spradley (1980:78 & 82)

I had planned to use this table and then develop it further alongside my research to include how each of these dimensions related to my own experiences, but as the fieldwork phase began and I started to get involved with the day to day routine of participants, I found it was not possible to keep referring back to the table. Many conversations were 'on the hoof', and could occur anywhere and at any time. I would often engage in conversations with staff or observe them in the kitchens or hallways and have to write up my notes later. Using a table to record observations was too systematic without enough flexibility for these 'on the hoof' observations which was not in keeping with my qualitative approach. I therefore devised a system where I would leave a margin in the notes to identify themes arising in observations, and at the end of every day I would conduct analysis of the data that I had gathered from observations that day. I used colour coding and memo writing to allow for identification of arising themes. Over time my observations became more focused as issues become apparent and key activities and individuals were identified.

Eventually, I began to pick and choose activities to observe, progressively focussing on events and individuals as appropriate (Spradley 1980).

The information gathered during the observations were hand written field notes. These were analysed and coded into categories (referred to as nodes in NVivo) to guide the interview process by hand. I was careful to be sensitive to the implications of hand written information as Holloway and Wheeler (2010) state that writing notes may disturb the participants or make them feel self-conscious. For this reason, some notes were written up post observation with consideration for selectivity and memory lapses. If I encountered memory lapses when writing up notes after observations I approached members of staff and asked for clarification. Any note writing post observation was done as soon as possible after the observation session had concluded. Data collected during this time was augmented and supplemented by data collected during documentary analysis, focus groups and interviews, as Cutler (2004) suggests in his work that there is discrepancy between what people say they do and what they actually do. For this reason, periods of observation were combined with semi-structured interviews.

Interviews

Interviews are commonly used in qualitative research and allow the individual participant to describe their experiences, thoughts, feelings and perceptions in detail (Holloway 2005). Holloway argues that semi structured interviews take this idea a step further by loosening up the interview structure and allowing the flow and topics of conversation to be guided by the participant. Low (2007) states that interviews are particularly useful as they allow the researcher to gain a subjective view of an individual's experiences. The participant is able to give meaning to, and interpret their experiences, in their own words. Holloway further defines semi-structured interviews within an ethnographic context as informal conversations with specific individuals. Semi-structured interviews are particularly meaningful in an ethnographic context due the on-going and in-depth relationship that a researcher develops with participants when using an ethnographic approach (Sherman-Heyl 2007). There is some risk, argues Silverman (2010) that conducting interviews within a constructionist epistemology can lead to narrowness with a focus on participant's conversational ability rather than what they say. The 'what' that participants speak of

is argued to be more of a positivistic interviewing tool but within an ethnographic context I believe that 'what' participants speak of is of equal importance to the 'how' participants express themselves when understanding an individual's culture and experience. Therefore, I have aimed to avoid narrowness by considering both what participants said, and how they said it, looking for deeper meaning.

I initially wanted to interview all members of the single point of access team and their community team equivalents. As described above, when I started my fieldwork I had approached all members of the single point of access team asking for their consent to take part in the study. All members of staff signed and returned their consent forms, except one of the social workers, and I can only assume that she did not wish to be interviewed, however this member of staff did then later take part in discussions in team meetings, so it could be viewed that she gave consent verbally (Hammersley & Atkinson 2007). Despite one social worker not returning her consent form, I managed to achieve representation from all professions both within the single point of access and the community teams. Appendix C details who was interviewed, whether the interview was formal or informal, in which location, and how many times the individual was interviewed. After interviewing all staff who consented within the single point of access, I utilised snowball sampling (Searle 2001) to identify further interviewees. This approach was particularly useful when it came to interviewing high level staff - I was able to gain introductions prior to interviewing which also acted as an ice breaker and led to more insightful interviews, as has been found in other research studies (Hoffman 1980).

Interviews took part during the normal working day for staff, defined above as between 0800hrs and 1700hrs. Seventeen of the formal interviews were conducted in meeting rooms in private and lasted thirty minutes on average. Three of the formal interviews were conducted in 'break out spaces' within an office environment, which although did not offer the same level of privacy as meeting rooms, gave some protection from being overheard. In general as the office environment was populated by many people conversing with one another, the background noise level was high and therefore the break out spaces were to some extent private. Five informal, 'conversations with a purpose' (Burgess 1988) were conducted at an individual's desk, one on the telephone and one took part in an individual's car whilst we travelled to and from service user's homes.

I had initially designed a semi-structured interview schedule to follow (see Appendix D) when interviewing but as I carried out observations I found that many of the questions on the schedule were either not relevant or would not yield relevant information based on the themes that had arisen from the observations. Before carrying out any interviews I re-developed the semi-structured interview schedule in line with themes arising from the observation period. Additionally, I loosened the structure of the interviews, allowing more room for the participant's ideas and experiences to come through in the interview in line with Low's (2007) definition of interviews within an ethnographic context as well as Burgess's (1988) description of ethnographic interviews as conversations with a purpose. The changes to the interview schedule itself were however minor. The initial structure guided the interview process but was loosened to enable discussion of arising themes from analysis. I began each interview by introducing myself and the purpose of my research to the participant, and explained why I had asked to interview them. I reassured them that their participation would be anonymous and that they would have the opportunity to review their interview transcript if they wished to.

In order to become familiar with the data, I transcribed all data from interviews myself as soon as possible after the interview. Field notes were also taken soon after the interview to record non-verbal behaviours so as not to interrupt the flow of conversation or discourage the participant from speaking freely. In line with Sherman-Heyl's (2007) statement about interviews being particularly meaningful in an ethnographic context, I found that due to the deeper relationships I was able to develop with my interviewees during the observation period, participants were more 'open' in their responses. The openness that participants afforded me allowed me to access information that would not necessarily have been possible had I come in as an unknown. I believe this is reflected in my interview transcripts by the depth of insight and trust that participants gave me. This experience is referred to by Brewer (2000) as the interviewer effect and is described in more detail in the insider and outsider section in the discussion chapter of this thesis.

According to Brewer (2000), whether the participant's responses are a true representation of what they really think, feel or mean, and whether the questions posed are a reliable stimulus for the topic in hand must be considered when interviewing. Brewer goes on to state that other qualitative methods such as observation and documentary analysis can be used to verify whether the interviews

are trustworthy depictions of participant's experiences. It is to documentary analysis that the chapter now turns.

Documentary analysis

Documentary analysis was used to add to the data collected from both the interviews and observation periods. It also provided a depth of knowledge about the social and political environment into which the single point of access was born and then operated. By analysing documents such as strategies and policies put into place by both Countyshire Council and PCT I hoped to come to some understanding about how both organisations had planned to communicate with each other, their staff and the public. Holloway and Wheeler (2010) state that using documentary analysis can highlight important issues in the field of research, and I believe that running the documentary analysis phase concurrently with the interviews and observations was complementary to my research, and increased my understanding of the background behind both organisation's decisions regarding joint working and commissioning. Appendix E summarises the documents that were used in the documentary analysis. Of particular interest were the staff surveys carried out by the Care Quality Commission and NHS Staff Survey Coordination Centre, the findings of which will be discussed later on within the thesis alongside my findings.

I primarily used secondary documents, such as policies implemented by both Countyshire Council and NHS Countyshire, meeting minutes relevant to the single point of access dating back to 2008 at around the time of my employment, training slides used in any joint workshops, and other documents which were relevant based on my experiences as I interviewed and observed members of staff. I was aiming to collect documents that would enable me to obtain an overview of the beginning of the single point of access and the rationale behind its implementation. Although I had discussed the origins of the service with members of staff, I wanted to triangulate my findings. Some documents, such as the Joint Commissioning Strategy influenced my data collection. As the Joint Commissioning Strategy set out a vision for joint commissioning, I explored this idea in more detail with management staff and staff working on the front line in order to establish to what extent the single point of access had been a joint venture. I also compared referral forms, information technology, software and note keeping between the north and the south of the

county assessing any discrepancy or similarity and the impact, if any that this had on integrated working.

The information collected during the documentary analysis was predominantly analysed by hand because most of the information was made available in hard copy and the documents were large in size. Electronic documents were uploaded to NVivo along with the interview schedules. All documents were coded and used to augment any themes generated during the other research phases. Early themes of training and culture were developed from a training document I was given access to early in the fieldwork process. This training document detailed how to manage staff in a joint Social Services/PCT team and the differences between terms and conditions for these two groups of staff. It was noted where the documents came from and who the author was. Holloway and Wheeler (2010) state that where the documents come from and who authored the document may have a bearing on the content of the documents and the message they convey about joint working. When analysing documents, I was looking for any evidence of training that staff received, high-level decisions that were made with regard to integrated working, policies concerning integrated working and whether policies differed between the Social Services department and the PCT. I also looked for any discussion held about joint working in meetings and any evidence of discrepancy between what I was observing and being told within interviews. Many of the documents I wanted to analyse were available freely online however some I accessed during the course of my fieldwork from staff members.

Focus groups

After interviewing members of staff and beginning the analysis, I had many questions and clarifications that I wished to explore with my interviewees. Rather than re-interview all the participants, I made use of team meetings to run informal focus group discussions. I had been attending team meetings with the single point of access as a matter of course throughout the fieldwork period and the participants confirmed that they were happy for me to continue to attend. In total I attended ten team meetings, for five of which I had dedicated time on the agenda to run an informal focus group. Focus groups were recorded by hand during the meeting and more detailed notes were written immediately afterwards. Staff also approached me

individually and informally in the office to discuss issues that I had raised following focus group sessions if they were concerned about confidentiality or expressing their views in a group situation. Unfortunately I was not able to attend team meetings for the community occupational therapists or physiotherapists as service managers stated they would not be able to make space for me within their meetings due to time constraints; however I did receive feedback via email from staff within these teams.

The use of focus group sessions is particularly pertinent in health and social care settings where staff predominantly work in teams (Holloway 2005) and this style of meeting worked well, particularly in the single point of access team who had good working relationships and communicated openly with one another and myself in focus groups. The impact of team dynamics for the single point of access are discussed in the findings chapter, but of equal interest when running the focus group session was how individuals presented themselves, and the dynamics of the conversation (Holloway 2005). Dominant characters came to the fore in the focus group situation, using most of the time to talk about issues relevant to them, however all individuals had a chance to speak in turn.

Statistical analysis of waiting times

In order to analyse the effect of the single point of access on service delivery times, I had planned to carry out a statistical analysis of waiting times in the north and south of Countyshire. Unfortunately I was not granted access to waiting time information for all services in Countyshire when applying for Research and Development clearance. I was only cleared for access to waiting times for occupational therapy in the community teams. I had planned to collect waiting times across all services, including community nursing, occupational therapy, and social work. Physiotherapy was omitted from my request as the team had not joined the single point of access at the time of my application to carry out research in Countyshire. I was able to access waiting times for all groups of professions with regard to the single point of access with the exclusion of the physiotherapy team as this service had still not fully joined the single point of access at the time that I withdrew from the field. No explanation was given by Countyshire's Research and Development team for this decision other than a concern about how data would be used following completion of my thesis. Although I reassured the Countyshire Research and Development team that the

county would be anonymised within both the thesis and any future publications, as discussed above, I was not granted access to any further waiting time information. The waiting time information I was provided with by the occupational therapy team was not comparable with the single point of access data so therefore I was unable to carry out a statistical comparison of waiting times, despite my request for the data in a different format. However, descriptive statistics were possible based on the data I managed to obtain which provided useful information about the average waiting times in Countyshire.

Grounded theory

The methods used to collect and analyse the data were selected for their perceived ability to collect the information required as per the objectives, driven by the desire to ensure that the entire research period was guided and shaped by those who live and work in the county under study. I entered the field hoping to conduct an ethnographic study similar to those described by Van Maanen where I would, 'uncover and explicate the ways in which people in particular work settings come to understand, account for, take action, and otherwise manage their day-to-day situation' (1979: 540). An approach akin to grounded theory as defined by Corbin and Strauss (2008) was selected as the method of analysis, due to its bottom up style of entering the field with very few pre-conceptions and using an inductive approach to guide the development of the study. Grounded theory also allows both interaction with the field and the on-going development of theory (Corbin & Strauss 2008). Although a methodology in its own right, a grounded theory approach was deemed as an appropriate methodology to use for my analysis as ethnography and grounded theory can be compatible, and an ethnographic study can provide the detailed data that is required for grounded theory analysis (Pettigrew 2000). In turn, grounded theory provides a method of inductive theory building and can, 'formalise and extend the limited theoretical component of ethnography' (Pettigrew 2000: 258). The use of a single point of access within community care for older adults is a fairly new concept, therefore I entered the field as not only an inexperienced researcher but also without much practical, work based pre-conception of what I might find with regard to the single point of access team. I did have prior knowledge of life in the community teams which influenced my initial perception of the single point of access.

I had deliberately constructed my aims and objectives in such a way that would allow an open and inductive approach to data collection, and designed my fieldwork phase purposely with a view to further developing both observation and interview schedules based on what arose from the first few weeks of observation.

Broad areas of interest and relevance gained from previous background reading on issues related to co-location, a shared goal, professional identity and communication (Peck et al. 2001; Hudson 2002; Barr 2002; Brown et al. 2003; Leichsenring 2004; Raine et al. 2005; Meads and Ashcroft 2005; Watson et al. 2005; Heenan and Birrell 2006; Dickinson et al. 2009) were used to guide the initial observation periods but as I began to gather data my observation and interview schedules developed in line with arising themes in an iterative process described by Corbin and Strauss (2008). In essence, the on-going design of the study itself was grounded in the arising data. As such a grounded theory approach, in accordance with Corbin and Strauss's interpretation, was taken. Data collection started in a very broad fashion, becoming increasingly narrower and more focused as the study developed. The aim of using an approach akin to grounded theory was to begin to develop an understanding of how a single point of access affected health and social care professionals in the context of integration as little is known about this service in terms of older adult services.

Process of analysis

Hammersley and Atkinson (2007) state that analysis should be an on-going process throughout the fieldwork phase. I utilised the approach to grounded theory as described by Corbin and Strauss (2008) when analysing my data. I carried out analysis on a daily basis, constantly asking questions of the data and making comparisons with previously collected data, looking for similarities and differences between data in a process of constant comparison as described by Corbin and Strauss, and Charmaz (2000). I also looked for theoretical comparisons, where I made the use of metaphors and similes to draw conclusions about data (e.g. Corbin & Strauss). For example, one of my participants stated that she often felt like a detective when interrogating the IT systems. I interpreted the use of the word detective to mean that the participant felt as though she had to look into the IT

systems with great care and attention, and sometimes with difficulty, in order to find the information that she needed about a patient.

Observation notes were analysed manually each day for themes and key issues which informed the next day's observation and eventually contributed to the structure of the interviews as new themes developed such as teamwork (as described above). Interviews were digitally recorded on a Sony IC Recorder which produced an .mp3 file. This file was then transferred to a computer and transcribed using the Express Scribe software into a Word document. Transcripts were then printed and read through before being coded by hand. Initially on designing the study I had planned to analyse all the qualitative data by hand. It soon became clear that this approach was not going to be possible due to the sheer volume of data I had collected. When I began to read through my data and try to code it, I found it difficult to manage using manual methods or Microsoft Word alone. I therefore used NVivo Version 9 to store and analyse my data. Following the implementation of NVivo, audio .mp3 files were transcribed into Word as above then transferred into NVivo and analysed as soon as was possible after the event. The process of utilising NVivo is similar to analysis by hand, however, rather than having to cut and paste linked categories of data together, NVivo allows the electronic 'tagging' of data into categories or 'nodes'. This tagging also facilitates the process of comparison between nodes.

Analysis began as soon as the first data were collected and continued throughout the fieldwork phase in an iterative process (Corbin and Strauss 2008). I transcribed the interviews myself and all raw data except the field notes and some large paper documents were loaded into NVivo. Using the tools within NVivo, all documents were read through at least three times then coded into nodes. I considered not only the 'what' that participants had been recorded as saying but also the 'how' that they had said it with (Silverman 2010) which I had recorded in my hand written notes. When coding, I looked at the spoken language participants had used when talking about certain issues but I also considered their body language and tone of voice.

Once all sources had been coded I then re-read through all the sources again in a process of refinement. I then began to draw links and comparisons between nodes. Nodes were next developed into high level themes and the relationships between different categories were examined. A process of constant comparison

(Corbin & Strauss 2008) whereby data was classified according to differences and similarities was used, and relationships and patterns in the data were explored. For example, 'tribalism' started as a separate node to 'professional culture', however when comparing the two separate nodes, it was evident that tribalism was part of a wider theme of professional culture as many of the data for both nodes was the same. The ability to easily draw links between nodes was one of the main advantages of using NVivo, and I was clearly able to see relationships between nodes on screen, as it was possible to view all the data I had assigned to individual nodes.

Electronic and paper memos were created throughout the analysis process as ideas started to emerge from the data to guide further fieldwork. Memos were also used to incorporate analysis of paper documents that had been entered manually into NVivo. Re-visits to Countyshire were then carried out to test, refine and verify some of my ideas with staff. A further literature review to clarify the positioning of my findings within the current body of knowledge was also carried out searching for key terms such as 'tribalism in the NHS' 'professional identity in health and social care' 'disempowerment in health and social care' and 'change management in health and social care' on Coventry University's library database, the King's Fund library database and Scopus.

The high level, overarching themes that arose from my analysis were disempowerment, professional culture, communication and change. These high level themes arose after I had engaged in the process as described above. I also tested these themes with participants through focus groups with some examples from my fieldwork, such as the level of change and communication experienced by PCT compared to Social Services staff (disempowerment), the barriers between different groups of staff such as PCT and Social Services occupational therapy (professional culture), methods of communication within the single point of access such as IT (communication) and the apparent lack of stakeholder engagement (change). The testing of themes with participants also enabled me to check for trustworthiness. The chapter will now move on to consider trustworthiness in more detail.

Trustworthiness

In order to assess whether the findings were credible a variety of methods were used. A reflexive diary was used throughout the research period to record any thoughts about my previous experience and how this may have affected my personal perception of the service with a single point of access, and the service without. Over time I found reflexive styled notes making their way into my working field notes as I became more aware of the effects my dual insider/outsider status was having on both my interactions in the field and my thoughts about the services in Countyshire. Previous nursing research describes being reflexive when conducting an ethnographic study amongst colleagues, when some participants have been known to the researcher in a management role prior to the research study (Baumbusch 2011). Baumbusch describes using reflexive field notes, memos and recording any issues in the analysis. I found that doing the same to record any possible bias involved by my insider perspective with participants already known to me, or with shared working experience, beneficial. This also allowed quick identification of these incidences when engaging in reflective practice away from the field.

Any events or conversations had with staff members were documented verbatim as far as was achievable, so anything recorded was as accurate a record as possible rather than a personal interpretation of events. Personal interpretation was left for later, when away from the field. Field notes and diary entries were written daily and analysed for recurring themes and issues on a daily basis. Taking verbatim notes was not an easy task, and it has been documented that even very accurate note takers will get it wrong occasionally (Fine 1993). Other methods of verification have been used to assess whether my analysis of my notes were a trustworthy depiction, such as member checking, seeking a negative case and triangulation of methods which are described below.

Member checking has been used to assess the trustworthiness of the fieldwork phase. I discussed my findings and analysis with participants who had taken part in the study to check that my interpretation was an accurate representation of working life in this area (Giddings & Grant 2009). The approach of testing my findings and ideas also tied in with my method of analysis, an approach similar to grounded theory. I had not planned to offer participants the chance to review their transcripts as standard, in order to minimise the risk that participants

might censor the data. This decision was taken due to the restrictions placed upon the study by the local Research and Development department. I was concerned initially that the organisational nervousness surrounding a research study would affect the participant's views of taking part. However, as my relationships with the participants began to develop I began to offer them the opportunity to review their transcripts. Only two participants requested to review their interview transcripts, and neither requested censoring or withdrawal. However, I feel that by not offering all participants access to their transcripts I missed an opportunity for comprehensive member checking of my data. Differential member checking took the form of further interviews with members of staff for testing of ideas and further interpretation of arising themes and issues. I also attended team meetings on a monthly basis throughout the analysis and used these meetings as focus groups to not only test arising ideas, but to gain further insight into the themes I had identified during my analysis. An example of this is the use of the words 'time' and 'pressure' which were used consistently by participants throughout the interview phase. I ran a focus group session within a team meeting where these words were further defined and their meaning discussed to ensure that the participants' interpretations of these concepts, rather than my personal interpretation was captured. I discovered through member checking that both 'time' and 'pressure' meant different but related things to different individuals, which will be discussed further within both the findings and discussion chapters.

As will be discussed in the discussion chapter of this thesis, in the context of the insider and outsider perspective, I found myself beginning to become biased at one point in favour of the single point of access. To counteract this, I actively sought members of staff who were not in favour of the single point of access – or in other words, a negative case. Evidence that is contrary to the majority of the findings was sought in order to disconfirm the arising and potentially biased theory from the analysis (Giddings & Grant 2009) and to seek alternative explanations to the conclusions that I had drawn from the data (e.g. Corbin & Strauss 2008). Once I had interviewed these members of staff, I compared their interpretation of the single point of access with the interpretation I had gathered from pro-single point of access participants to ensure there was no bias in my interpretation and a balanced view was represented.

Linked to checking and verifying identified themes with participants is the triangulation of methods. The triangulation of methods has been used in the form of using multiple methods of data collection. Interviews, observations, focus groups, documentary analysis and waiting time data have all taken place concurrently. Any analogous data arising from these methods have been analysed further and checked through further questioning, further observation or policy/strategy analysis. It has been argued that this method of data collection is often used solely to increase the validity of research methods (Sim & Sharp 1998), which admittedly was one of the aims of using triangulation in this study; however seeking validity was not the only motivation. The study was designed to include a mixture of methods in order to provide an in-depth insight into the working lives of the staff in this area, which one method alone would not have provided. Triangulation has been critiqued by Richardson as being rigid, fixed and two dimensional. Crystallisation, which is, 'a deepened, complex, thoroughly partial understanding of the topic' (1997: 92) is suggested by Richardson as an alternative to triangulation in postmodernist research. Crystallisation is preferred by many researchers due to the metaphorical nature of the crystal as a multi-faceted prism. However, in ethnographic texts such as Brewer (2000) and Hammersley and Atkinson (2007) triangulation is the preferred method. As this research study is grounded in constructionism, not postmodernism, triangulation is the method for trustworthiness that I have selected.

The extent to which my findings supported or challenged existing literature was also checked to assess for the trustworthiness and credibility of the study. Comparison of my findings to other related studies in this area was conducted to look for consistency or inconsistency, any individual differences and where my findings fit with the current literature regarding integrated working in the UK and elsewhere in the world. This will be discussed further within the discussion chapter.

Other methods used to check for credibility and trustworthiness which have been used during the fieldwork phase are auditability – where effectively an audit trail has been left through field notes and the research diary, along with timetables of research activity and memos (Giddings & Grant 2009). I had been careful to place myself in the research in such a way where I remained very self-aware that my world view would not necessarily correspond with others, even those who had similar experiences to myself (Berger & Luckmann 1991), and that each participant's view on reality will be influenced by their own individual experiences. I hoped to capture

this by seeking background information on each interviewee and by maintaining a reflexive and reflective insight into my own interpretations. This information will not be presented in the thesis for each participant as this could lead to the participants becoming identifiable.

I have also considered 'the ten lies of ethnography' (Fine 1993) which consists of three elements as demonstrated in the table below:

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Table 9. The ten lies of ethnography (adapted from Fine 1993)

I argue that particularly for a novice researcher carrying out ethnography for the first time, it is possible to cycle through all these interpretations of an ethnographer and move backwards and forwards between them throughout the study. Where I have found myself being any of the less desirable ethnographers I have been open and reflexive as far as possible in my analysis, discussed further in the discussion chapter of this thesis.

Transferability

I have attempted in the trustworthiness section of this chapter to demonstrate how I endeavoured to ensure the data I collected were representative of the phenomena I observed in Countyshire but I feel I cannot conclude on my methodology without a consideration of transferability. Although it may transpire within this thesis that many of the issues that arose throughout my fieldwork do fit within the jigsaw of current national and international research surrounding integrated working, my research is a personal, insider's account which comes with a message for fellow insider researchers. I have also, within this fieldwork, conducted a study of a multi-disciplinary team which is relatively new and does not have much coverage in the literature with reference to the population of older adults. In addition, Countyshire has never been subject to a research study so in this respect it is unique.

Also, by researching a relatively small group of staff within a relatively small county in England I accept that the findings within this thesis may not be transferable to the wider population of health and social care staff within the rest of the country, nor worldwide (Brewer 2000). With this in mind however, I hope to demonstrate throughout the rest of the thesis that the themes that have arisen from my ethnographic study do resonate within the wider research literature in this area.

Chapter summary

This chapter has outlined my journey from a novice researcher at the beginning of my fieldwork and the development of my understanding of epistemology. I have discussed social constructionism and the use of ethnography as a method, as well as the advantages and drawbacks of this approach. The development of the aims, objectives and research question have also been considered. I have discussed the methods used throughout the study – observations, interviews, documentary analysis and focus groups and the reasons for using these methods. I have also discussed my attempt to gain waiting time data and the issues that I encountered whilst trying to access this.

The use of grounded theory has also been discussed. I have argued that grounded theory and ethnography can be complimentary to one another as ethnography can produce the rich data required for grounded theory. I have outlined

the process of analysis, including making constant comparisons, theoretical comparisons and the use of NVivo (version 9). I have also discussed methods used for trustworthiness including member checking, seeking a negative case, triangulation of data and seeking the extent to which my findings supported or refuted previous findings in the area. I have also considered the issue of transferability and suggested that although the study contained within this thesis relates to a study of a small county in England, there is some evidence that the findings can be compared with similar research that has been carried out previously.

The issue of having been a previous member of staff and the effect that this may have had upon my data collection has also been touched upon, as well as methods that I have used to ensure my data is trustworthy. I have been open and reflexive in my description of the selection of methodology and the factors that I considered when designing the fieldwork stage of my doctoral studies. It is in this vein that I continue throughout the thesis.

The next chapter moves on to my findings. The chapter is framed around the four high level themes, disempowerment, professional culture, communication and change. I will discuss my findings within each category in detail. I will argue that a perceived lack of communication, and the perceived lack of shared goal led to professionals withdrawing from the single point of access into their professional tribes, citing that they felt disempowered by the change. I will suggest that this may have been due to early issues surrounding the change management strategy, particularly with regard to the PCT staff.

CHAPTER SIX - FINDINGS

Introduction

The fieldwork took place over 11 months from March 2011 to February 2012. To provide an account of the working lives of the staff in Countyshire, twenty formal interview transcripts, ten focus groups, email exchanges, extensive field notes on observations, waiting time data and entries in a research diary have been utilised (see Appendices C and E respectively for a full list of interviewees and documents analysed). In addition to formally recorded interviews and focus groups, I also engaged in a large number of informal conversations with members of staff throughout the period of March 2010 to December 2011. Five of these informal discussions were classified as interviews due to the nature of these 'conversations with a purpose' (Burgess 1988).

The fieldwork phase started with a visit to the single point of access team in March 2011. I was introduced to each member of staff by the team manager. I handed out an information sheet and a consent form for each staff member to read and sign respectively. As the aim of the study outlines, my original priority when entering the field was to examine integrated working in Countyshire and whether the presence of a single point of access had made any difference to how staff worked, or felt about, working together in an integrated way. This was my focus throughout the fieldwork phase. The overarching themes that arose from the data were communication, professional culture, change and disempowerment. The data have been organised thematically below within these themes. Communication was a key category and recurring theme that underpinned all of the other themes; as such this section is the largest with the largest amount of data. Communication is also highlighted within each of the other themes. In terms of meeting the aim of the study to explore whether a single point of access had any impact upon integration, it seemed that a lack of communication about the shared goals of the single point of access during the implementation (or change process) of the service led to professionals retreating to their professional groups or tribes. The perceived lack of communication may also have contributed to staff feeling disempowered. Therefore, the single point of access may have had the reverse effect from the one intended. Within this chapter I will outline my findings in detail and demonstrate how I have come to this conclusion.

Communication

The chapter will begin with a consideration of the importance of communication. Communication was a key theme that underpinned all of the major themes (professional culture, change and disempowerment) within my analysis and was a category of its own right when I conducted analysis. Furthermore, communication was raised as an issue by all participants within the study. This included the way that IT had been implemented, the way that referrals were received, the way in which staff were able to communicate with one another and the perceived lack of communication regarding the implementation of the single point of access and the effect of this upon self-esteem and empowerment. As such, this section contains distinct but related areas within the overarching theme of communication – IT, duplication and telephone access. I will consider each of these areas in turn, and relate each area to the impact that the single point of access had upon integration within the county. I will argue that communication was a key issue that affected the implementation of the single point of access and ultimately affected the way that integrated working between health and social care was perceived by staff members within Countyshire.

The vignette below outlines a 'day in the life' of a member of the single point of access, in the first person, in order to illustrate working within the single point of access as a member of community staff who had been asked to rotate into the service. The vignette is based upon information given during interviews and conversations with staff, as well as data collected during my observations. This vignette will provide a focus and a context for my findings, and highlight the issues surrounding communication within the single point of access and how this affected integration in the county.

A day in the life of a community staff member in the single point of access

I arrive at the Social Services building at approximately 0830hrs. I have been given a key card so that I can let myself into the building. The first thing I do upon arriving at the desk that has been allocated is to turn on the computer and wait for my profile to load. Whilst waiting, I receive a telephone call, but although I can hear the person on the other end of the line, they can't hear me. I have to end the call and ring back from

another team member's phone line, which means I have to leave my desk. This means that I could potentially miss an urgent call from my colleagues. In the meantime, my computer hasn't loaded properly because my single point of access computer 'profile' hasn't been set up properly by the IT team. I have to use someone else's profile. Furthermore, as I haven't been in to the single point of access in over seven days, I can't remember how to access referrals and send them on to my team, so I have to ask someone else to help me. The single point of access team members are friendly and helpful, but I can tell they're frustrated because they have their own workload to deal with and I had to ask them to help me last time I was here. Eventually I manage to sort out what I am supposed to be doing and steadily start to work my way through referrals. In order to process a referral, I have to search through several databases, both PCT and Social Services, to find information on a particular service user which takes time. It also requires being able to recollect how to use all of the different databases. Throughout the day I receive a constant stream of phone calls from members of staff which I can't answer as my phone still doesn't work. If I want to make a phone call, I have to use someone else's phone. Also, I am approached several times by call handlers with queries which interrupt me from working on my list. I have access to the kitchen to make drinks, but I have to pay for hot drinks because I'm seen as temporary member of staff, whereas other members of the 'core' team help themselves as they've paid into a kitty for tea and coffee. I can see the permanent members of the team interacting with one another, but I have not spent much time in this team and I don't know the team members as well as I would like. I would rather be out on visits and going back to my team base where I know everyone and have more in common with them as they're on my team. The single point of access team manager approaches me at lunch time and reminds me to take a break, and says that the IT team have been contacted about my profile and telephone line. It's quite frustrating to have to go through this every time I come here, and it wastes a lot of time. I've heard that some GPs are not even using the single point of access – they're faxing referrals straight to the community teams instead. I don't see the point in me sitting here if they're going to do that – I'd much rather go out on visits and see patients. Anyway, at least it is home time soon then tomorrow I'll be back with my proper team and won't have to come back here again for seven days. Hopefully I'll be able to get someone to swap with me.

It must be noted that this vignette is constructed as a 'worst case scenario' of a day in the life of a member of staff in the single point of access but it is based upon real data that I collected during my fieldwork. It highlights many of the problems that were raised by staff during interviews and focus groups. I have grouped data together underneath the headings IT, referral management, duplication and telephone access which capture staff's frustrations with procedural issues within the single point of access. Based upon the data that I collected, it could be argued that the issues highlighted within the vignette contributed to the overall negativity towards the single point of access.

Information technology (IT)

As highlighted in the vignette above, from my first visit to the single point of access until my last visit, staff repeatedly raised issues around IT and their ability to use and access this during interviews, observations and team meetings. I had been informed by management staff that one of the desired changes in Countyshire was the implementation of an interface between the Social Services IT system and the PCT IT system. As well as separate systems for Social Services and PCT staff in the single point of access, the Social Services teams also had to duplicate service user information into a previously existing Social Services IT system. The local health and social care equipment supplier also had a separate IT system which staff could access to order equipment and track service user's equipment deliveries. These IT systems were not only used to record service user information, such as standard administrative details, e.g. name, address, date of birth, etc., but also to track service user's use of and involvement with health and social care services within Countyshire. At the time of my fieldwork, an interface between the systems had not been achieved, and subsequently could be argued to contribute to major issues in the successful implementation of, and staff buy in to, the single point of access.

Indeed, when interviewed, one of the occupational therapists who worked within the single point of access stated, "I think what doesn't help us (the single point of access) is the (IT) systems". 'Us' refers to the single point of access and its ability to influence integrated working positively. This individual had previously worked within another county where integrated provision of health and social care was the norm and the IT systems were, in her view, better equipped to support integration:

"where I've worked before you click on the top bit, it shows you all the referrals, all the people that have ever been involved, all the services and their end date sits all on one page whether it's new old or whatever... Whereas on this system it just shows somebody, you've got a name at the top and you're like, they don't even work here anymore..." (Social Services occupational therapist).

The Social Services occupational therapist, who worked in the single point of access as a permanent member of staff, was clear that an integrated IT system was vital for successful integrated working. This was based upon her previous experience of integrated working in another county. She was critical of the IT set up in Countyshire, which she felt was dated and inefficient, and believed that the lack of joined up IT had a negative effect on the view of the single point of access held by community staff:

"I think for the teams when you send stuff across, not so much for health because they don't use the system very well but for Social Services they'll say 'Oh why haven't you done this?' and you'll say, 'well I have done that, it's written on here', 'Oh we can't see it'. Well that's not my fault, you know... some of the most frustrations have been around either the systems that we have in place or not being kept up to date by health and what they are changing and what they are doing. It comes back as an afterthought or you get a thing saying 'don't forget to do this' and you're like 'well when did you start doing that?' I do think they, for health in lots of ways, I do think they see it as a secondary, or they have seen us as secondary sort of like, 'oh yeah, SPA, have we told them that? Just not really keeping us in the loop on certain things that are going on'" (Social Services occupational therapist).

This individual introduced the idea of the single point of access being seen as a less desirable 'them' for community staff within Countyshire. Reading into the above quote, the individual in question believed that community staff saw the single point of access as a secondary service to community care, not part of the same team. She attributed this to the, "the systems we've got and also health (PCT occupational therapy) just not really keeping us in the loop on certain things that are going on", thus referring to PCT occupational therapy as an 'other' and reinforcing the

differences between the two groups. The single point of access had been designed to overcome these differences, not reinforce them.

Community staff were also conscious of issues around the way that the IT in the single point of access operated, and how the systems in place were not aiding integration:

"it does make it really, really difficult and if you've got, you've got some people in that team who are a bit slower and not as computer literate as others so they slow things up and you've got to allow them the time but I mean it's like, yeah, frustration!"
(Deputy nurse manager).

Furthermore, due to the lack of interface between all the IT systems in operation, data often had to be input multiple times, into separate systems. Staff reported in interviews that they spent a large proportion of their working day trying to complete administrative fact finding work, as highlighted by one of the single point of access occupational therapists interviewed:

"...sometimes you know we do call ourselves detectives because (a referral will) come in and then... I will look on (IT system 1) to see what else is known, I'll look on (IT system 2) when it's working, and you'll find that the world and their wife are involved and you're like, why have we got this... sometimes (I'll look) on (IT system 3) to see what equipment has already gone out and you can try and figure out which teams are involved... and how recent so you can do that, or sometimes look on (IT system 4) and look at all the different contacts... you do have to sort of investigate a little bit... on (IT system 4) we don't all write in the same place... and trying to figure out who's involved because it'll be old information" (Social Services occupational therapist).

Although it could be argued that the Social Services occupational therapist told me the above with a degree of humour which was in keeping with her personality, I did observe members of staff using the various different systems in order to process referrals. There was no communication process in place that enabled the Social Services systems to communicate with the PCT systems. I managed to find, through word of mouth, an IT engineer who seemed as bemused as some of the professional

staff when it came to the lack of interface between the systems. I was informed that the Commissioners for each service had made a decision prior to the implementation of the single point of access that they would pursue different IT systems, and the reason for this was a cost saving for the PCT.

Whether or not this information was true or purely delivered in a cynical way, the complications with using the IT systems led to community staff such as GPs effectively bypassing the single point of access and reverting to paper based referrals such as fax due to their lack of trust in the single point of access IT systems. The single point of access therefore was not being used as it was intended, and it could be suggested that this was due to the frustrations experienced by staff as outlined above. The management of sending and receiving referrals will be considered in more detail later in the chapter.

There were also issues surrounding how changes were made or requested for the IT systems due to a reported lack of communication between the IT departments regarding responsibilities for maintaining IT systems. The example given in the vignette is based upon a real observation in my first few days in the single point of access, where a temporary member of staff had issues with her telephone where she could not be heard by callers but could hear them. The team manager became incredibly frustrated with the IT engineers from both Social Services and the PCT. Neither wanted to take responsibility for fixing the problem as there was no service level agreement in place for the single point of access regarding which IT team should respond to IT incidents. There also seemed to be a lack of motivation to resolve the situation amongst IT staff in the locality. Certainly, the engineer I spoke to demonstrated bemusement at the lack of organisation and communication between the PCT and Social Services but did not seem to want to change this. The issue with changing the IT systems is highlighted in the quote below, where the Physiotherapy manager describes the process whereby the Physiotherapy service joined up to the single point of access IT systems:

"...when you first think about the concept of putting a referral process through a single point of access, you think that's easy, you just ask people to send their referrals here and we'll deal with them, but actually it's not as easy as that... each step in that process has its own little small steps of process, and it's trying to make sure you've thought of everything, and first time round I didn't think of everything, you

know, things have cropped up... The process that I set up was based on using (IT system 3) which is an electronic records system and creating electronic referrals that could have been sent from the single point of access to the receiving team. We started off with just two community teams plus rapid response, plus community physio, and so I asked for receiving buckets in each of those teams to be set up and we've got the one for community physio so we can receive referrals electronically from the single point of access into community physio. It still hasn't been set up in the two original community teams, let alone the ones that have followed on, and this is three months down the line. I asked for that to be set up quite early on in the process because it was obvious that we're using (IT system 3) as a system, that's obviously their (the Commissioners) preferred route because we want to streamline things as much as possible, and yet that still hasn't happened... I think some of it is about communication, the request has gone but I'm not sure it's gone to the right person, I don't know whether that person has actioned it, I don't know if it's actually filtered down to the people who need to make the request from the teams, but again that's a process beyond what I was asked to do... and for instance the single point of access can't request changes to the set-up of (IT system 3) in other teams because you don't have access to do that. You can only request changes to your own team so that's why the request went higher up so that that request could be filtered down to the appropriate people" (Physiotherapy manager).

As the Physiotherapy manager explains, the addition of Physiotherapy to the IT systems for the single point of access at first appeared a straightforward task, however it became complex due to the lack of communication and clarity over which organisation was responsible for changes to the IT system.

Recurring themes which arose during observations were the difficulties that staff experienced when attempting to access systems, and creating IT profiles for newcomers to the single point of access team. New staff who arrived in the single point of access during my observations often had not had IT profiles set up for them and could not access the IT systems in their own profile. A physiotherapist I spoke to stated that, "IT access from different bases isn't always that easy" but was unsure as to why this should be the case. I discussed the issue of IT with various members of staff throughout the period of my fieldwork and interview period and not one person seemed to have a definitive answer as to why accessing the IT systems was such an

issue. I raised the IT systems as an issue with a senior PCT service manager who stated that a new project looking at how systems could interface was to be launched and that any issues should be resolved within the next year, however this may have been an attempt by the manager to present the single point of access and the PCT in a positive light to me as an ex-employee and out of concern for how the single point of access might be portrayed.

Although the issues with accessing information may well be resolved by the introduction of an interface between the IT systems at some point in the future, the frustration that many of the staff encountered with using the IT systems seemed to cause long lasting damage to the profile of the single point of access in the minds of community staff. Problems with IT subsequently contributed to many of the other problems that staff reported, such as referral management, which in turn may have led to many of the community staff rejecting the change to a single point of access altogether. Many of the issues experienced by the single point of access can be traced back to a lack of adequate process mapping and communication about responsibilities for changes in the single point of access. According to change management guidelines contained within Managing Successful Programmes (2011), these procedural issues should have been mapped out early in the change management process to ensure that staff within IT from both the PCT and the Social Services department were clear about which team was responsible for which actions. Frustration at, "things not working the way they should" (community nurse) prevented staff from carrying out their day to day work and reportedly affected how staff felt about going into the single point of access. The failure of basic processes such as being able to log in to a computer terminal and carry out the core part of the role of single point of access team member affected the community staffs' view of going in to the single point of access. Not having access to the same equipment as the permanent members of staff in turn may have affected team dynamics, which ultimately affected the perception of the single point of access in the eyes of the community staff. Furthermore, the lack of a clear communication trail between different systems also led to the single point of access team often not being communicated with about changes to the referral process. This could be argued to contribute to feelings of 'us' and 'them' as highlighted by the Social Services occupational therapist. Data was also being duplicated on all of the different

systems, often by the same member of staff. Duplication was raised as an issue, which will now be considered in more detail.

Duplication

Due to issues with IT processes as described above, as well as some staff being less computer literate than others, staff reported that they did not believe that their referrals were reaching the single point of access. Rather than reduce the number of referrals in circulation within Countyshire, staff were reporting that GPs in particular were duplicating referrals, sending them to both the single point of access and community teams. One community nurse revealed to me in an almost conspiratorial manner that GPs were creating duplication within the referral process as a result:

"they (the GPs) feel that their referrals don't get through as they should and we have a lot of problems and in fact what's happening now with them is, when they put a referral through (to the single point of access) and we've actually done it and actioned it, we're writing on the form and we're having to fax that back to (surgery name) to tell them we've been visiting. That's another time consuming activity".

The nurse in question supposed that GPs wanted reassurance that their referrals were being actioned as they did not have confidence in the single point of access. Furthermore, I was told by some of the nursing staff that there had been instances where:

"they (the GPs) get quite cross that this patient's not been seen or there's been a delay because they've sent it off at 9 o'clock in the morning and we've not received it until half past 4, by which time some of the nurses have probably already gone (home)" (community nurse).

I queried this with management staff in the locality, one of whom I had become quite friendly with during the course of my fieldwork. This individual stated that unfortunately there had been recorded instances of, "faxes falling behind the side of the machine which is bought up (by GPs) sometimes" (PCT manager).

Issues such as urgent referrals not being received and referrals going missing had a detrimental effect on both service users, who would suffer due to the lack of urgent care, and staff, who reported that receiving additional calls from GPs to undertake urgent visits on top of an already hectic workload was stressful. The GP's anxiety about the referrals not being received or treated appropriately also led to an increase in the number of referrals being labelled as, "urgent" when they were in fact routine, as one of the nurses described:

"A lot of the referrals we get through, if they've come from the GP, the GP will phone the receptionists and say, can you put a call into the single point of access for me, I need the nurses to see this person, and you find that it's always put as urgent and quite often there's not a lot of information so you go there and actually it wasn't urgent, it could have waited a day, it could have waited two days it wasn't desperate... that's a big problem" (community nurse).

During further conversations with management staff about the behaviour of GPs when it came to referrals, I was told that the suitability of electronic referrals (from herein referred to as 'e-referral') was being investigated within the county. E-referrals, I was told, could be emailed to the single point of access and community teams, thereby leaving an electronic trace of when and where a referral had been sent, thus introducing an electronic audit trail. However, following a meeting with GPs in the county, the Physiotherapy manager stated that GPs had not responded well to the idea of an e-referral:

"There have been meetings with the GPs about how best for them to access the single point of access. The original plan was that they would email referrals on an electronic form that was devised, but I understand that they weren't happy with the security of that route".

It could be suggested that the concerns that GPs expressed about the concerns of security for e-referrals demonstrates a lack of trust in the high level management of the single point of access and a disinclination to change. Eventually, e-referrals were substituted for a new fax machine which was in the process of being purchased during my fieldwork. The rationale for the fax machine was that faxes from the GP

surgeries would be converted into email. However, the process of converting fax to email was not qualitatively different from an e-referral. This suggests an inherent hostility amongst GPs towards any attempts at conciliation by the management. Although the end point of receiving e-referrals would be the same, the route through which the referral was received would be different. When I raised this fact with one of the members of management staff I was told:

"We need the stakeholders, you know we need the GPs, the hospitals, the professionals that are using, we need them to use to the technology otherwise there's no point. We need them to use it, a) use the SPA and b) use the methods we've introduced to refer in".

As such, the management staff felt that they had to acquiesce to the demands of this important and influential group of stakeholders within the county by purchasing a new fax machine rather than introducing new technology and risk alienating the GPs further. It could be argued that the reluctance of GPs to partake fully in the single point of access was a result of the lack of communication with these stakeholders:

"I mean we haven't spoken to all the GPs yet but the messages we get... the GPs and the nurses they sort of see SPA as a bit unnecessary in a sense... they're just like 'oh well if I need to speak to the community matron I'll just pick up my phone and phone her, why do I need to be going through SPA?' which if the patient is already with the team that is the model we're aiming to anyway... I don't think that message has really gone out yet that that's sort of what we're aiming for so I guess they don't really understand though we have tried" (PCT manager).

Again, this quote highlights the status of the single point of access in Countyshire. As the manager above alludes to, GPs and nursing staff saw the single point of access as, "unnecessary". This could be argued to be as a result of a lack of understanding about the function of the single point of access within Countyshire. However, the manager does state that, "I guess they don't really understand though we have tried" which suggests that there may well have been an inherent hostility towards any attempt to communicate with stakeholders such as GPs. It could be suggested that GPs already saw the single point of access as an undesirable 'them' which they did

not wish to recognise or become involved with. This may be due to a perceived threat to the status quo with GPs at the top of the hierarchy and was reflected in a conversation that I had with a nurse about the role of GPs in the single point of access:

"GPs are less happy because they don't see the nurses so often. Or that's their perception that they don't see them that often" (Community Nurse).

GPs were reportedly unhappy that the single point of access resulted in nurses being moved away from the surgeries and into community teams without their consultation. Nurses had traditionally been based in surgeries with the GPs. Stakeholder buy in from high level staff such as doctors has previously been identified as an issue when implementing change within health care (e.g. McNulty & Ferlie 2002), and GPs in other studies have expressed concerns about become deskilled as a result of a single point of access (e.g. Raine et al. 2005). GPs in Countyshire may therefore have viewed the single point of access as something that threatened their position within the hierarchy, and as such rejected the service in the hope that it would fail.

Telephone access

Telephone access and the use of telephone numbers were also raised as an issue by participants within my study. Service users had been surveyed during the POPP project (as detailed in chapter four) and expressed a preference for one route into services and one telephone number. Previously there were various telephone numbers for different teams and different professionals, even within the same team. For example, within community occupational therapy, there were separate telephone numbers for each PCT community occupational therapy team by locality (north or south), a separate number for Social Services occupational therapy, a separate number for the falls occupational therapists (specialists in assisting those at risk from falls), and a separate telephone number for the neurological occupational therapists (specialised in neurological disorders such as dementia, Alzheimer's etc.). As such, service users reported that they found accessing services confusing.

"...the single point of access was partly created, was partly for the patients, on numerous surveys who said they hated speaking to answering machines, they wanted to speak to people so of course they do now..." (community nurse).

One telephone number was provided at the commencement of the single point of access for all users, including members of the public and members of staff, to contact community services across health and social care. The idea of providing one number was to encourage the flow of information through the single point of access, and to avoid duplication or repetition of information, which is outlined in the single point of access objectives (Single Point of Access Business Case). However, in practice, it seemed that one telephone number to reach all services had proved problematic as one community occupational therapist explained:

"you go from being in (name) health centre when a district nurse knocks on the door from the office next door to refer someone, to literally saying sorry, you've got to phone the call centre... that's when I think it (the single point of access) can be perceived to be a barrier. Because it's well how come you're phoning outside of the building and I'm stood here talking to you!" (community occupational therapist).

As the occupational therapist above states, rather than being able to accept referrals directly from other teams, the single point of access required community staff to telephone the call centre and make the referral to a non-professional call handler. The call handler would then pass the referral to the professional assessment team, who would assess the referral and pass on to the appropriate community team. However, staff were still able to have informal conversations with colleagues regarding referrals. Nonetheless, community staff expressed frustration with the single point of access process, as described by the community occupational therapist in the quote above. Informal discussions with professional colleagues would lead to a formal referral being made through the single point of access, rather than being passed directly by hand. It could be argued that community staff saw the single point of access as an added bureaucracy. Individual community teams were no longer in control of the referral process and no longer made team decisions regarding the suitability of referrals for their team. As discussed earlier in this section, community staff had expressed anxiety about referrals reaching their

colleagues through the single point of access, as the system had not always worked as it should due to issues with the process. This anxiety may have contributed to the staff's attitude when it came to making referrals through the single point of access. If a health or social care professional's remit is to care (as described by Menzies 1960), then being uncertain about whether a referral would be processed would perhaps be viewed as in contradiction of caring, as treatment or assistance may not be received.

Furthermore, staff expressed concerns about having to convey to the call handlers the depth of information required for health and/or social care referrals:

"I myself and other colleagues have also experienced trying to phone with referrals and almost being cut short, almost being rushed through the call. So if we do want more information... (for example) a nurse alerted me, saying 'I made a referral but just to let you know it'll come through (from the single point of access) really vague so you'll need to speak to me about it because I was given limited opportunity'. She said, you know, 'I felt I wanted to make a referral directly to you (rather than through the single point of access) and I could have given you much more information'..." (community occupational therapist).

The call handling staff in the single point of access had originally been Social Services call handlers, trained to take referrals for social care teams, give advice and support to both health and social care staff, and liaise with service users, providing support and signposting to services. I carried out observations of call handlers taking referrals and witnessed the depth of information that they captured which was similar to an initial assessment that I would have carried out as an occupational therapy assistant. However, within the first year of the single point of access, the call centre was outsourced to a private, third party company. Although the members of call handling staff remained the same, the employing company changed, along with the objectives of the call handling staff. The move to an outsourced call centre occurred during my fieldwork, and some of the frustrations that staff experienced were related directly to me during informal conversations.

As expressed by the community occupational therapist in the quote above, members of staff both within and outside of the single point of access team felt that the phone calls were rushed, and did not gather the required amount of information

to triage a referral effectively. There were daily target numbers for calls received and handled, and target telephone call lengths for the call handlers which may have contributed to this issue. It could be suggested that the community staff saw members of the call centre team as a less desirable 'other' or 'them' who did not understand the nuances of health and social care provision. Indeed, where the call centre notice board had previously had thank you cards from service users hung upon it, there were now graphs showing average call length, number of calls received and performance measures. Where average call lengths were now shorter, and therefore it could be argued that staff would have more opportunity to access a call handler, the quality of the information obtained by the call handlers had, in the opinion of community staff, decreased.

To demonstrate, within my field notes, the name of the call centre (not named here due to anonymity issues) appears on nearly every page along with issues such as call length and quality of referrals which had been mentioned to me by staff. I had several informal chats with the team manager of the single point of access regarding the outsourcing of the call centre, and she related information to me regarding individual cases that she had become aware of. Eventually, the issues around the quality of information being gathered and the length of the calls were raised with the call centre by the single point of access team manager, and progress had been made to resolve the concerns of the community health and social care staff. Towards the end of my fieldwork phase, the call centre staff were working closely with the single point of access staff to ensure the systems were operating in symbiosis, as far as could realistically be achieved. Representatives from both sides attended one another's team meetings and high level management meetings were held on a monthly basis to resolve any further complexities.

A further issue identified by the community staff regarding telephone access was the abolition of a direct telephone line to the community nursing staff. Community staff expressed concern that they would have to contact the single point of access call centre to access community nursing staff, even for an informal, professional discussion regarding a service user. Ultimately, this was a lose-lose for management in Countyshire. Staff repeatedly raised the lack of access to nursing staff as an issue until a telephone line was re-instated to enable direct contact with the nursing staff, but only for professional health and social care staff. Service users would still have to contact the single point of access to contact the nursing staff.

Even this was raised as an issue by some of the nurses who found the constant interruptions of a ringing mobile phone whilst working a distraction; however, as pointed out by one of the community nurses, the issue of the telephone lines was a double edged sword:

"...they are being interrupted whilst they're out seeing patients with lots of phone messages from the single point of access saying can you go and see so and so... whilst they're trying to work their way through their managed caseload for that day, so... all the staff will probably say to you there hasn't been a benefit but then I think they have also forgotten that they used to come back to an answering machine full of messages from patients often who haven't even identified themselves so it's, 'Hello, can you bring my dressing tomorrow' or 'I've got a hospital appointment tomorrow' but they don't leave a name or contact number so it's purely 'Oh yes I recognise that voice'..." (community nurse).

During my employment as a community occupational therapy assistant, I was based in a health centre where the majority of staff were community nurses. I often heard the nurses' telephone ringing throughout the day, and the messages that were left by service users, and had received anonymous telephone messages myself. By requiring all telephone calls from service users to go through the single point of access, the risk of receiving anonymous telephone calls was removed, as the call centre staff were trained to obtain a name and date of birth before proceeding with the call. However, due to the negative attitude towards the single point of access that was present amongst the majority of nursing staff, the perceived benefits of the single point of access seemed negligible to these members of staff. This is demonstrated in the quote below from another community nurse:

"...probably an undesired impact of the perception, if not the reality ...I do think to a degree the reality of more work... for the clerical staff, they spend an inordinate amount of time printing off messages, receiving messages, printing them, checking if they've been phoned if it's urgent and things like that" (community nurse).

Although the above member of staff highlights the amount of work received by clerical staff from the single point of access as an issue, it is debateable whether

printing off messages, receiving messages and making phone calls is a real issue for clerical staff. Administrative tasks such as these can be considered clerical tasks, which one might expect to undertake as a clerical officer. If anything, the raising of clerical tasks as a problem only highlights the dissatisfaction of the nursing staff with the single point of access, even where steps had been taken to resolve arising points of contention. The argument of dissatisfaction with telephone numbers reinforces the idea that the single point of access team were seen as an out-group, a less preferable, 'them' than the, 'us', in-group of the community nursing team.

I have suggested within this section that there were issues with IT, referral management, duplication and telephone access which contributed to poor communication in Countyshire. These issues with process and 'things not working the way they should' appeared to create a negative view of the single point of access. Staff working in the community seemed reluctant to staff the single point of access, preferring to stay in their professional groups within the community. As such, I will now move on to consider the impact of professional culture upon the single point of access, and integration within Countyshire.

Professional culture

Professional culture was a theme like communication that was interwoven throughout all of the major analysis themes. One of the underlying concepts behind the development of the single point of access was to support the development of closer integrated working within Countyshire (Single Point of Access Business Case). Despite this, during conversations and interviews with staff, observations of working practices, and in focus groups I was given the impression that the single point of access team was seen as a separate service from the rest of community health and social care within Countyshire. Although the aim of creating a one stop point of access for health and social care had been achieved with the creation of a multi-disciplinary team to process referrals, it would seem that the reality was, "we're all sat in the same place, realistically" (single point of access team member). This section of the chapter will focus on the different aspects of professional culture as highlighted by participants throughout my data collection period, including the sense of being in a team, the creation of 'us and them', and being able to perform their professional role in a way that was conducive to their professional culture.

Being in a team or 'us and them'

Being in a team was an early category that arose during interviews with the single point of access staff. I was told that particularly within the single point of access, "...there's no continuity as you've got different people coming in all the time" (social worker). Furthermore, staff identified that there were issues with the way that community health and social care staff saw themselves and their role, with membership of a profession taking precedence over team membership:

"...people do not seem to say, I work for (a) Community Team and I happen to be a nurse. They are a nurse who just happens to be in (a) Community Team and (it is) the same for therapists" (community nurse).

It could be suggested that part of the problem with feeling in a team came from staff being on a rota. As highlighted above, at a maximum, community staff would only spend a few days a week working in the single point of access. It seemed that rather than seeing the single point of access as part of their day to day job, community staff felt as though they were a member of an individual profession who just happened to have to spend time in the single point of access team, highlighted in the above quote from a community nurse. I discussed this point with a member of management staff within Countyshire, who stated that the rotas were set to change to enable longer rotation times into the single point of access team due to feedback from staff. I had also received a lot of feedback from staff regarding the length of time of rotation into the single point of access. Community staff were aware that I was in conversation with higher level staff and as such often fed back their frustrations with the way things were to me, perhaps in the hope that I might be able to affect change:

"if they (community staff) were in there for longer, say they were in there for 6 months at a time and then came out and then did a bit on the district and then went back in that would make a difference" (community nurse).

However, whether just putting bodies onto seats within the single point of access would be tantamount to creating a single point of access team is questionable. On the one hand, a member of occupational therapy staff within the single point of

access stated that, "it is a very good team here, very strong, solid team; I think there's a lot of respect for others too". However, another member of occupational therapy staff from the single point of access stated:

"(Feeling like a team) depends on the day I think, depends on the personalities who are in, sometimes I think it does work as a team, other times... I don't think I feel part of a team, I feel quite separate at times".

As such, it seemed that staff within the single point of access itself did not always feel like they were part of a team, rather there still seemed to be an element of working within silos. Although the single point of access had been created partly with the intention of improving integrated working within Countyshire, in practice this seemed to depend on the day and upon the individuals within the team on that particular day. However, on a positive note, one of the social workers within the single point of access team highlighted the lack of continuity of staffing within the single point of access as an issue, but was hopeful, "once the team is properly established I think it will be fine".

Based upon the data that I collected, it seemed that feelings of being in a team were also affected by location as well as amount of time spent in the team. In order to staff the single point of access, community staff had to go to a Social Services building where the single point of access team were located. Although this building was in close proximity to the Social Services staff, it was separate to the PCT buildings. This separateness was mentioned by one of the community nurses as one of the issues contributing to, 'us and them' as demonstrated in the quote below:

"(In my previous job) we had more of a team approach and the (single point of access) team was based in with the (community) teams so if a phone call came through and there was a question around capacity or anything else they would always go and see the team leaders, whether that would be the resettlement team, the rehabilitation centre, the rapid response. Because they were there, they weren't isolated away elsewhere, they were still very much seen as part of the team and therefore I think that's why it worked better" (community nurse).

In the quote above, the nurse mentions the word, 'isolated'. Community staff, particularly from the health care side, felt that going into the single point of access isolated them from their teams as performing the role involved working elsewhere with individuals whom they did not consider to be part of their team - therefore going from 'us' to 'them'. The feelings of isolation, and being isolated away from their 'own' team were confirmed by permanent members of the single point of access team, who were employed by Social Services. These permanent members of staff openly admitted on questioning (both in interviews and in focus groups) that they treated incoming health staff as outsiders, with one individual on the single point of access team stating during an informal conversation that they did not, "bother to ask newcomers their name" as it was unlikely that they would see them again.

The single point of access Terms of Reference quoted within the business case state that the single point of access was formed to assist community staff with their day to day roles, but this was not recognised by community staff, who reported feeling as though the single point of access was just another bureaucratic tool put in place to complicate their day to day working. As a result of this, permanent single point of access staff felt under-valued by their community colleagues, and a feeling of, 'us and them' developed. Although both the single point of access team and the community teams had a shared goal, which has previously been suggested in literature to be essential for integrated working (e.g. Dickinson et al 2009; Maslin-Prothero & Bennion 2010; Braithwaite 2011; Widmark et al. 2011), the goal of providing an efficient and effective service to service users seemed to be lost in translation.

Table 10 demonstrates the average number of referrals closed in the single point of access within Countyshire for Social Services occupational therapy, PCT occupational therapy, social work and nursing, as well as the number of days that the single point of access was staffed for that service. It must be noted that the percentage of referrals closed for Social Services and the PCT are very similar but days staffed varies. The Social Services occupational therapist occasionally performed informal cover for the PCT occupational therapy services whilst there was no PCT occupational therapist in post, and as such the actual days covered may vary from the statistics that I was given.

	Social Services Occupational Therapy	Primary Care Trust Occupational Therapy	Social Work	Nursing
Average number of referrals received over 3 months	170	75	342	1605
Average number of referrals closed in the single point of access over 3 months	46	19	25	1
Percentage of total referrals closed in the single point of access	27%	25%	0.6%	Not significant
Average percentage of days service staffed over 3 months	91%	53%	82%	70%

Table 10. Average number of referrals closed within the single point of access over 3 months for community services

There is a noticeable difference between the number of referrals closed between the Social Services teams and the PCT teams, as well as the number of days staffed. The figures suggest that the number of nursing referrals closed in the single point of access are the lowest; however the number of referrals received for the nursing team are the highest across all four services. However, it could be argued that the 'treatment' administered by nurses is qualitatively different to that of the other three services – to 'nurse' could be argued to refer to some form of actively 'doing' i.e. applying dressings, administering drugs etc. (NHS Choices 2014) which cannot be given in the absence of a home visit. Occupational therapy and Social Services could prescribe equipment that the local equipment supplier could issue in the absence of a practitioner. This may account for why the number of referrals closed in the single point of access for the nursing service are not significant, despite the relatively high level of staffing (70%). This 70% level of staffing is also not consistent with the story that I was told about the staffing levels for nurses within the single point of access by the single point of access team manager, who had painted a very different picture of the nurses as totally opposed to the service. However, the team manager had experienced some issues with the nursing staff at meetings with service level managers which may explain her negative view of the nursing team's

feelings towards the single point of access. Furthermore, the total numbers of referrals closed for the social work team is only 0.6 of all referrals received over the period, but the number of referrals is high. However, social work referrals had always been processed by a member of staff 'on duty' which is not qualitatively different to how the single point of access operated, therefore this may have been perceived as a normal service level by staff in the county.

Table 10 also highlights the lack of communication around the benefits that a single point of access could have for health and social care within Countyshire. I had to request these figures specifically from the team manager, and, had I not established a close working relationship with this individual I may not have had access to these figures. Few of the community staff I spoke to were aware of how many referrals were closed within the single point of access and it seemed that many staff in the county were unaware of the main functions of the single point of access, including a senior member of the social work team who believed the single point of access only dealt with PCT occupational therapy referrals. However, it may be possible that this misunderstanding was due to individual staff members' lack of interest in the service rather than any miscommunication. The figures in the table indicate that in theory, the workload received by community staff should have been reduced due to the number of referrals closed in the single point of access. However, staff in the community largely appeared disinterested in the single point of access and may not have been aware of this reduction in referrals received.

Staff within the single point of access reported that they believed that the service was seen as a separate and secondary service from the rest of community care, "I do think they (non-single point of access staff) see it as a secondary, or they have seen us as secondary sort of like, 'oh yeah, the single point of access'..." (single point of access occupational therapist). As such, it could be argued that feelings of, 'us and them' began to arise between community staff and staff working within the single point of access as a result. A demonstration of the manifestation of the feelings of, 'us and them' is illustrated by a change that occurred whilst I was conducting my fieldwork. The single point of access team had a tea and coffee fund that each member of staff would pay into monthly. Hot drinks were made throughout the day by a staff member who would volunteer themselves. About 4 months into my fieldwork, as I had started to spend more time in the north of the county with community staff, I came in to the single point of access building one day to meet with

the team manager. I was invited to make myself a hot drink whilst I waited for her to finish some administration. Whilst I was in the kitchen, I noticed that a sign had been put on the single point of access cupboard stating that, 'temporary' members of staff would need to pay 20 pence per hot drink. The permanent single point of access team members had decided amongst themselves that this was the best way to deal with 'outsiders' who would only come in for up to two days a month. It seemed to be a shift in the way that single point of access team members felt about those who rotated in to their midst and then left again the next day. The single point of access staff had always been happy to provide hot drinks to those who were outsiders before, however it now seemed that this was no longer the case. What may seem like a small change to the implementation of a pay as you go hot drink service was a noticeably large shift in the attitude of the single point of access team to incoming staff. I argue that the single point of access team were behaving in a tribalistic way, creating barriers to protect the tribe and the tribe's resources from outsiders. Tribalism has been noted as an issue in health and social care previously (e.g. Beattie 1995; Atkins 1998) and was recognised as an issue by the staff in Countyshire:

"I think that we've got a lot of custom and practice and culture to change so in the interim that's going to be the really long hard fight" (community nurse).

As discussed within the previous chapters, it has been argued that the development of professional identity begins at university, and continues on entering the workplace through socialisation with professionals within the same profession (e.g. Lingard et al. 2002). However, it has also been suggested that the individualistic nature of health and social care professions is further reinforced through experience in the workplace (Baxter & Brumfitt 2008), and may be one way of protecting the 'in' group from outsiders (Braithwaite 2011). It could be suggested that rather than aiding integration, in groups and out groups began to form within Countyshire as a result of the single point of access and confusion around its goals and benefits, and particularly around the role that one performed whilst working within the service. The chapter will now move on to consider the nature of the professional role performed within the single point of access, and the impact that this may have had on the perception of the service.

The community staff in Countyshire had indicated to me throughout my fieldwork that they were reluctant to enter the single point of access. One of the reasons given was the nature of the role of the single point of access, and its likeness to what was, in their view, a "call centre" (community occupational therapist). It could be argued that referring to the single point of access as a call centre did not afford the service the same status as other community services within the county, and reinforced the view that it was a, "secondary service" (single point of access occupational therapist). Furthermore, it suggests that professionals working within community services did not recognise those who were working within the single point of access as equivalent to other community workers if they were working in a 'call centre'. This feeling appeared to be endemic amongst community staff, who repeatedly spoke flippantly and dismissively about the single point of access service. According to a member of nursing staff who worked in the single point of access, it was believed that professionals felt that they should be getting on with their 'proper' job. It could be assumed that the single point of access role was not understood by staff working within community teams, and the role was seen as a junior administrative function, if it was merely a 'call centre'. This in turn could be seen to affect not only the single point of access staff's self-esteem but also their job satisfaction, and may have contributed to tribalistic behaviour as discussed above.

During a frank conversation with one of the community nurses, I was told that professionals did feel that the single point of access took them away from their 'proper' job of carrying out home visits and providing care and assistance, as alluded to by the single point of access nurse above. Additionally, during a focus group, a community physiotherapist stated that he felt that the single point of access took him away from his clinical work, and that staffing the single point of access made him feel like a messenger, another flippant comment which seemed to undermine the status of the single point of access and confirm its place as a secondary service. The idea of being a messenger rather than a health or social care professional raises the question of whether going in to the single point of access was seen as de-skilling, and therefore acted as a further barrier or even as an excuse for staff not wanting to go into the single point of access service.

Furthermore, professional staff working in the community reported that they did not see any benefit from the single point of access service. Also, staff did not appear to understand that the single point of access was working towards a shared goal of providing effective and efficient care for service users in the county, seeing it as something separate that prevented them from carrying out their professional role. As if to reinforce the idea that the single point of access was a separate, extra piece of work, professionals reported that the single point of access increased their workload and contributed to feelings of stress:

"volume of work... I mean I have to say that despite the implementation of the single point of access our waiting list continues to grow" (lead social worker).

Table 10 above highlights that within Social Services occupational therapy, PCT occupational therapy and social work, the single point of access decreased the number of referrals received by community teams, particularly for the occupational therapists. As such, staff may have used the excuse of additional work to create a barrier between themselves and the single point of access. It is possible that issues with IT, referral management and team dynamics only served to reinforce the view that the single point of access was a waste of their time and a less desirable 'other'.

Many of the staff I interviewed or talked to during focus groups and observations stated that they felt under pressure most of the time during their working day. Staff cited "pressure" as being one of the key factors in not wanting to staff the single point of access. However, it must be acknowledged that pressure meant different things to different participants that I spoke to. Some described pressure as being related to the sheer volume of referrals that came in during the day. Other members of staff stated that pressure was related to the level of care that they were able to give, based on expectations from their profession and those of high level management. Countyshire is home to a disproportionate number of older people (Countyshire PCT 2011) and in recent times it could be argued that there has been increased pressure from the top down to deliver efficient and effective health and social care (e.g. Department of Health 2011; Department of Health 2012). This is reflected by conversations that I had with staff in Countyshire, who expressed an internal battle between carrying out their job role in a way that did not contravene their professional code of conduct and moral judgement, and carrying out their job

role in a way that would appease the targets set by upper levels of management staff:

"there is lack of time to do things properly, in the way you'd like to do things... you feel you have to compromise. You know, do you clear the backlog and just look at specifically what a person's referred themselves for... and you just do that and clear them off the list, or do you actually do a holistic assessment, and I think that's a constant, constant battle" (Social Services occupational therapist).

This internal struggle was expressed by staff as a major cause of stress in their working lives, and was not aided by the lack of community staff, county wide, in Countyshire. Indeed, one of the PCT managers was hopeful that, "...it (the pressure) should get better with more staff". The reduced number of staff resulted in community staff having additional workload which could be construed as adding to the level of pressure that these staff experienced. For example, the Social Services occupational therapist in the single point of access had to cover both Social Services referrals and PCT referrals, increasing the levels of 'pressure' that she experienced. The lack of staff was intensified by budgetary constraints. In an interview with the original Social Services project manager for the single point of access, budgetary constraints were cited as a major issue for staff and that in times of hardship, professionals were effectively, "battening down the hatches" (project manager) as if going into battle, and focussing on their individual professional team. It could be argued that staff in Countyshire were reverting back to their professional groups in a tribalistic retreat:

"...that we're all in this together is rubbish you know, it just really does go in to sort of that pressure and tribalism. When things are going well and things are positive you get a much better sort of, 'we're in this together' feeling" (community nurse).

Continuing the idea of going into battle, community nurses within Countyshire had also raised going into the single point of access as a 'risk' to their service and had placed the single point of access on their risk log. The nurses stated that losing staff to the single point of access would result in workload requirements not being met due to, in their opinion, a lack of nursing staff in the county. The nurses in particular

used words like 'risk' to increase their power in rejecting the new structure of a single point of access. The word 'risk' can invoke fear within an organisation, and therefore potentially acts as a saboteur to change. The action of placing the single point of access on the risk log also caused the relationship between the senior nursing staff and single point of access team manager to deteriorate, further reinforcing the barriers between 'us' and 'them' for the two services.

The nurses were not the only profession using risk as a term to reject changes to their structure. An occupational therapist working within the community stated that where an individual profession was at risk, professionals could not rationalise going into the single point of access and leaving their team. Due to the on-going procedural issues within the single point of access such as lack of staff, some members of staff were:

"...sitting waiting (in the single point of access) to prioritise the referrals and they're not there and the ones that are coming through, they can't process in the way we expected because there hasn't been the admin support because the recruitment has had to happen. So they've been doing lots of administrative tasks rather than the clinical skills of prioritising the referrals so that's been a frustration and quite rightly so" (physiotherapist).

Leaving clinical colleagues to, "sit waiting" in an office whilst the team's waiting list was long, and colleagues were under pressure to visit service users was reported to be a difficult choice, "...it's hard when you see your team under pressure to wave them goodbye and go off to the single point of access" (PCT service manager). Based upon the data I have collected, I argue that the single point of access role was not seen as equal to a professional role, which influenced staff's perception of working within the service. Staff did not wish to leave their 'in group' of preferred colleagues to join a less desirable 'out group' or what they saw as a secondary service. Furthermore, the view of the single point of access as 'other' was reinforced by the lack of understanding regarding the role and benefits of the single point of access in community care. I believe that the lack of understanding can be attributed, at least in part, to the way that the change to a single point of access was managed.

Change

A vignette will be used in order to demonstrate the effects of change management for the staff in Countyshire. This has been written from the point of view of a front line member of staff within the single point of access. This is based upon my previous experiences and knowledge of the setting as well as interviews with front line staff in Countyshire.

As a member of staff in the single point of access team within Countyshire, I have experienced many changes within the last two years. Firstly, between March 2010 and September 2010 the PCT occupational therapist in the single point of access resigned from her job. This vacant post resulted in those who remained in the single point of access having to take on additional work to cover the referrals coming in for this service. Although there was a recruitment campaign to replace this member of staff, it was unsuccessful and a permanent replacement was not found. As a result, the PCT provided a temporary member of staff to fill the post. This results in a different person from the occupational therapist bank working within the single point of access every few weeks. Having to train someone from the bank every few weeks is time consuming and increases the amount of pressure that myself and my colleagues experience. In the same time period, an End of Life team has been created and staffed, which was to be an expansion to the single point of access due to the End of Life Strategy (2008b) which has resulted in a whole new team of professionals working alongside the single point of access team. We have all had to move around to accommodate this new team and have less office space as a result.

Also, between the time period of September 2010 and March 2011, Social Services outsourced their call centre to an external provider, so although the call handling staff within the single point of access remained the same, the terms and conditions of the call centre service has changed. This has caused a variety of issues such as concerns from my professional colleagues both within and outside of the single point of access that calls from fellow professionals and service users are being cut short in an attempt to meet a target number of calls in one day. During team meetings we are always discussing concerns about the adequacy of

information being collected by call handlers, as we are making more return calls to service users in order to collect the information required.

A number of changes had occurred, all within the time period of one year, all within the single point of access. Change was also occurring elsewhere within Countyshire for both the PCT and Social Services with the introduction of community wards, discussed in chapter four. It became apparent throughout the course of my fieldwork that these changes had a real impact on staff working within the county. In the words of one of the managers I spoke to, "...they're like the Hawthorne experiment – lights on, lights off, lights off". The Hawthorne experiment itself relates to behaviour being influenced through the knowledge that one is being observed (Leonard & Masatu 2006), however the manager in Countyshire was referring to the many conditions that participants in the original 'Hawthorne' experiment (so named for the company under study) were subjected to. The level of change within Countyshire's PCT and Social Services had been continuous, like the conditions in the Hawthorne experiment, and was set to continue despite the introduction of the single point of access. This 'continuous tinkering and modification' is concurrent with Hayes' (2007) definition of change as discussed in chapter three. This section will focus upon the change to a single point of access and how it was managed in Countyshire. I argue that many of the issues within the single point of access and its impact upon integrated working can be traced back to the change management strategy within Countyshire.

Level of change

It could be argued that the implementation of a single point of access was less of a change for Social Services staff than it was for PCT staff. I was informed by the single point of access team manager that the single point of access had been based upon an already existing Social Services call centre. Prior to the single point of access, a Social Services occupational therapist and social worker would be on a rota to carry out 'duty' every day. 'Duty' consisted of a member of staff receiving and triaging referrals before sending them on to the appropriate team. In 2009 this duty rota was no longer in existence as it had been replaced by the single point of access. All Social Services occupational therapists and social workers would have

experienced performing the duty role prior to the implementation of the single point of access.

The experience of a call handling role had never been in existence for the PCT staff. Prior to the single point of access, referrals were received directly by the individual community teams in the form of fax, letter or telephone call. With the change to a single point of access, PCT staff were being asked to perform a role that they would never have performed before. Referrals received by PCT teams had always been triaged, however this was carried out by members of staff working together as a team, or by senior members of staff. With the implementation of the single point of access, PCT staff were also being asked to go into unfamiliar surroundings as part of the single point of access call handler role. As part of the duty role, Social Services staff were used to going to the call centre which was on Social Services property. Going to a call centre was unfamiliar territory for PCT staff who would have to become familiarised with working in an unfamiliar environment with individuals of whom they had little prior knowledge. This feeling of being out of their comfort zone was reflected in interviews with staff:

"it is a duty job... they don't like doing it in the teams so why would they want to come up and do a day in an environment they're not familiar with" (social worker, single point of access).

"as a clinician it's sometimes hard to rationalise when your service is maybe at risk, whether you're meeting basic patient care in the community, how going into a call centre overrides that" (PCT community occupational therapist).

Overall, in terms of the role requirements for the single point of access, it could be argued that Social Services staff had less of a change to cope with than PCT staff. In addition, Social Services retained a project manager throughout the change process, whereas the PCT project manager resigned only a few months after the change process began, which seemed to have a lasting effect on how PCT staff felt about the single point of access. At the time of writing, the single point of access was very much a tale of two halves. The Social Services half, despite experiencing on-going technological issues was fully staffed with permanent members of staff present. The PCT half did not have the same level of staffing. The lasting impact of these different

levels of change will be discussed as this section of the chapter progresses, however I argue that rather than encouraging the closer development of integrated working, these differences exacerbated the barriers already in place and contributed to the feelings of 'us and them'. Based upon reports from both front line staff and managerial staff, there was no joined up working between Social Services and the PCT where the implementation of the single point of access was concerned. As stated by Ball, Forbes, Parris and Forsyth, 'if the partners are not working together effectively it is very unlikely that effective services will be delivered' (2010: 390).

During interviews with both PCT management staff and Social Services management staff, the initial implementation of the single point of access was described to me with various accounts of how the service developed. In keeping with what the single point of access team manager had told me, a member of management staff within Social Services stated that the PCT, 'bolted on' their call handling system to an existing Social Services single point of contact call centre. The call operators were trained to take extra information when they received a call that would then be passed on to the single point of access team. This view was confirmed by a member of PCT management staff in a later interview. This second member of management staff stated that they believed the bolting on of the PCT to an already existing Social Services process was the cause of many of the issues with the single point of access with regard to the PCT, such as the IT systems and process flows. However, the idea that the PCT merely used 'bolt on' to become part of the single point of access was disputed by another, more senior, member of PCT management staff who stated that this was not the case, and that the single point of access had been a joint venture from the beginning. There was no mention of the single point of access in any of the Directorate or high level team meeting minutes I was able to access so I was unable to verify the reported beginnings of the single point of access through documentary analysis of minutes. The member of staff who stated that the venture had been joint from the beginning may have wished to present a positive view and unified position on the single point of access. They may have been conscious about the view that I, as a previous member of staff, may have been developing of the service. However, whether or not the single point of access was developed as a bolt on, or as a fully integrated venture did not appear to be the main issue. Rather, the way that the change was managed and communicated seemed to be the issue.

Project Management

Unfortunately, the project manager who had been in overall charge of the single point of access in Countyshire from a PCT point of view resigned after only a few months, and a replacement was not found. The single point of access team manager became responsible for any changes to the service until a member of management staff was recruited to assist. In addition, during discussions, PCT management staff stated that the project management staff had changed throughout the roll out of the single point of access project. During an interview with a manager with whom I had become friendly, she revealed that the initial project manager who had been involved with the project from the PCT side had not performed the job role to the full requirements and therefore may have contributed to some of the early problems with communicating about the single point of access:

"they'd... rubbed people up the wrong way... I don't think people were that sort of, I think that they had done some good work, but I think maybe doing not what they (PCT management) wanted them to, if that makes sense? They were sort of doing helpful stuff but not really concentrating on what it was... they had done some flow charts and things but then actually when we looked into it, it didn't seem to be working" (PCT trainee manager).

I had lots in common with this person, which I believe led to fairly frank and honest conversations about the way in which the single point of access had been implemented. As such, I was more inclined to listen to and trust in her side of the story. I met with various other members of management staff during my fieldwork, and felt that the more senior the staff member interviewed, the less reliable their story. It was fairly well known that I was an ex member of staff turned researcher, and I believe this coloured the story that I was told by senior staff. Those who I had known prior to beginning my research study tended to be less open than those whom I had not known. When considered alongside the issues that I had when trying to get the study up and running, these variations in attitudes speak volumes. Previously known senior staff painted a different, more positive picture than those I had not known prior to beginning my study.

Based upon the interview with the trainee member of management staff, I explored the development of the single point of access in detail with participants, and interviewed an individual who had acted as a project manager for the single point of access in Social Services. This individual stated that, "there have been issues with managing change and ownership of the single point of access... it's been sporadic and communication has been poor, as has the level of buy in". This individual attributed the lack of a permanent PCT project manager for the single point of access as one of the main issues with the implementation.

The lack of continuity in terms of how change was managed did seem to have some impact on front line staff's perception of the single point of access. During a discussion with the single point of access team manager, I was told that as the service was being set up based upon the Social Services single point of contact, many PCT staff mistakenly believed that the single point of access project was Social Services owned and Social Services led. This may not have been the case had a project manager been in place and communicating regularly with staff about the project. As a result, there appeared to be a lack of ownership for the PCT staff, and the view that the single point of access was something separate from their employer began to develop amongst community staff. Based upon my discussions with staff from all levels of both the organisations involved, it could be argued that the lack of clear and continued project management contributed to the poor communication about the single point of access project which in turn contributed to the lack of buy in and lack of ownership from staff in the county. This in turn could be argued to have influenced the development of 'us' and 'them' within Countyshire between community staff and the single point of access staff.

Communication regarding change

"I'd say we're guilty of very poor communication" (PCT management staff).

Upon my discussions with front line community staff, it appeared that many of them were uncertain about the single point of access, its origins, the benefits and what would be involved. One of the social workers I interviewed seemed confused about the PCT side of the single point of access, stating, "I think on the health side it's only operating in relation to occupational therapy" which was factually incorrect. The

majority of the front line staff interviewed stated that they were uncertain about most of the changes that were occurring around them and the benefits of these changes:

"It's like somebody's got a good idea and they've bunged it in and let's see what happens" (occupational therapist).

This particular quote demonstrates the attitude of many of the staff and how they felt about the change to the single point of access. The language used is particularly telling with the use of the word, 'bunged' to describe how change was implemented in this participant's eyes. To, 'bung in' something implies to initiate a change or a programme without much thought or care as to how it may affect those who will have to cope with the effects of the change on a day-to-day basis. Although this may not have been the intention of those who implemented the change, this is how it the change appeared to be perceived on the ground.

Although staff seemed uncertain of the details of, or reasons for many of the changes that were happening in Countyshire, both through national policy and strategy (Department of Health 2010; Department of Health 2009) and locally (Joint Commissioning Strategy for Older People Services 2010-2013; Service Strategy for Adult Care 2011/12) they were nevertheless aware that, "there are changes going on all the time" (single point of access social worker). Change had been a constant theme within Countyshire and at the time of my employment it was planned for all of health and social care to become integrated. However, "it never happened. Not, never, ever happened... they (front line staff) don't feel anything is going to change... nothing happened last time, so what's going to happen this time?" (community nurse).

Therefore, it could be reasonably assumed that staff were unenthusiastic about yet more change in the form of a single point of access, when large scale change at a macro (Leutz 1999) or full integration level (Ham & Curry 2011) had previously been proposed and then cancelled. Staff reported that the change to a single point of access had been communicated to them via email, both throughout the planning and consultation. Communication continued to be in an electronic format once the service had rolled out. As some staff were still uncertain about the function of the single point of access, it is questionable how successful the strategy of communicating by email had been and whether there had been opportunities to

ask questions or find out more information if staff were unsure. Communication via email could also be easily ignored as computer terminals were at a premium:

"...at the moment they (nurses) haven't got access to the computers, they can't even read their emails at the minute because there's like two computers in that room" (community nurse).

The importance of communication with key stakeholders who were required to use the single point of access became apparent as I carried out my fieldwork. As the main function of the single point of access was to receive and prioritise referrals from GPs and other referrers, it could be assumed that it was critical that GPs and other professionals used the single point of access to make referrals. However, from discussion with various members of staff, GPs were not consulted before the single point of access went ahead. Some GPs reported that they were concerned about the single point of access service as, "they thought it was potentially going to be more work for them" (community nurse). Members of the PCT management team stated that the implementation of the single point of access had not been a consultation with stakeholders, and rather than being consulted about taking part, GPs and other stakeholders had been told that they were going to be using a new referral system. This is reflected in a conversation I had with a physiotherapist who stated, "GPs haven't been in agreement about sending referrals to the single point of access, or the route that they send referrals to single point of access". This lack of agreement led to, "bad press... with the GPs, they're not happy with the service" (PCT management). Another member of the PCT management team explained:

"it was an imposed model on the GPs which explains a lot of their antagonism towards the service. It wasn't a collaborative model. I get the sense it was quite quick from inception to delivery. The elements around the IT, around the pathways, around the call centre scripting, the relationship between the call centre and back office (professional) staff and how do we ensure that referrals come in safely wasn't ever done at that point. We needed to back track. And that's why it hasn't rolled out as well".

The opposite of GP engagement with regard to the single point of access was the physiotherapy team. I had spent a lot of time with the single point of access team manager discussing the attractiveness of the single point of access as a job role, particularly with the inclusion of physiotherapy to the single point of access.

Physiotherapy joined the single point of access for both the north and south of the county whilst I was carrying out my fieldwork, which considering they were the service most reluctant to join in 2009 is very significant. I believe that the willingness of the physiotherapy staff to join the single point of access can be related to the enthusiasm shown by the member of staff from physiotherapy who was tasked with implementing the change. This member of staff worked tirelessly and with great enthusiasm and drive to promote and support the use of the single point of access for physiotherapy. This finding is echoed in research by Carpenter, Ring, Sangster, Cambridge and Hatzidimitriadou (2000). Carpenter et al. argue that supportive management styles through times of change is key to reducing the level of stress experienced by staff members. According to conversations I had with physiotherapy staff members, the physiotherapy manager in Countyshire spent a great deal of time in consultation with their senior, Band 6 staff, who reported that they appreciated this level of care and consideration, which supports Carpenter et al.'s work. I had a conversation with a physiotherapist about the way that change was communicated to the team, and she commented that usually staff were not consulted with or given enough time to trial new ideas. Due to the support from the physiotherapy lead, staff felt that they had been given plenty of opportunity to discuss any concerns about the single point of access with their manager.

Social Services staff reported a similar experience to the physiotherapists when it came to communication about change. According to the Social Services project manager and Social Services manager, Social Services staff experienced more consultation than PCT staff. Indeed, staff who worked within Social Services in Countyshire reported that they were appreciative of the level of consultation that they had experienced, and being engaged in the change process had been valued.

When questioned about the overall communication strategy with PCT staff from the outset of the single point of access project, PCT management staff stated that, "We did not consult with anybody. Less of a consultation, more of a, this is happening" (PCT manager). However, the reasoning given by high level managers within the PCT for the lack of consultation was that permanent staff had been

specifically recruited into the posts of the single point of access, and therefore consultation was not believed to be required. This view is not supported in the literature where communication with staff, whether key stakeholders or not, is highlighted as a key issue in successful change (Kotter 1996; Lewin 1964; Lussier 2008; Office of Government Commerce 2011). Despite this, on discussing the change management strategy and apparent lack of consultation with staff, management staff stated that there were two sides to the story:

"there is a lack of communication... but if you do communicate and there's feedback and they moan, then that stops you because how can you then move forward when they've already voiced their opinions to you. I mean you've listened but you can't just batter them and carry on" (PCT management).

Communication was a key issue that arose throughout my fieldwork, both in terms of how professionals communicated with each other and the single point of access as discussed earlier in the chapter, but also when it came to change. The lack of communication appeared to lead to confusion for many members of staff. There was a lack of clarity about how the single point of access interacted with community care in Countyshire, and the role that staff would play when it came to staffing the service. In some cases, staff reported that they felt they had become disempowered. I began to explore this concept in more detail with participants in the later stages of my fieldwork after carrying out analysis of the data I had already collected.

Understandably, disempowerment was a difficult subject for many of the participants to talk about. I was extremely fortunate in collecting the detailed data which follows, and I believe that this was due to my efforts to work very closely with participants and gain their trust.

Disempowerment in Countyshire

So far I have presented information relating to communication, professional barriers and change management within Countyshire. The overall effect that the implementation of a single point of access had upon staff and the impact of the service upon integration of health and social care within Countyshire will be discussed within this section of the chapter. After carrying out initial coding of the

data I had collected from my observations, interviews and documentary analysis of policies, strategies and minutes, I began to question how much participants felt valued by their organisations. I also wanted to know how this affected their self-esteem (and therefore their self-worth and feelings of empowerment) and experiences in their day to day work. Issues around self-esteem and empowerment arose as a recurring theme, so I went back to Countyshire and the single point of access to hold focus groups with staff to discuss these arising themes and triangulate my data. Many participants had referred to being told what to do in a top down manner, or had shown exasperation at the lack of communication from their managers. One of the community nurses confirmed that disempowerment was a key theme worth investigating further:

"I think (health and social care staff are) quite a disempowered group of staff... which generally front line staff are everywhere, they do feel like they just have to do what they're doing because the manager's told them to do what they're doing" (community nurse).

I began by returning to the single point of access team. I was allocated a slot in the team meeting to utilise as a focus group which enabled me to talk with all members of staff at the same time. I started with an outright question about feeling valued by their organisation. Most members of the team were reluctant to answer the question directly, however the body language displayed by staff during this focus group was particularly revealing. Members of staff seemed visibly uncomfortable by the question and many exchanged embarrassed and awkward glances with each other. A number of staff looked at their feet, or out of the window, or at their hands, and were reluctant to answer the question directly in front of one another, which surprised me. I had up until that point considered the single point of access team as very closely knit, but it appeared at that moment that this was a group of closely guarded individuals. Their behaviour also indicated that disempowerment was a key issue. Had the concept of empowerment not been an issue, participants would have dismissed the idea immediately and talked openly within the group setting. It could also be argued that once I began asking questions that were more personal in nature, I became an outsider rather than an insider; a less trusted 'them'.

However, after the meeting I was approached by individual members of the team, notably those with whom I had already developed close relationships. These individuals indicated to me that they felt valued within the single point of access team, but did not feel valued by their organisation or their colleagues in the community teams. A particular problem for these members of staff related to not feeling valued by their community team colleagues, which had a negative effect on the single point of access team's day-to-day work. There appeared to have been a vicious cycle of feeling disempowered across both the PCT and Social Services, where neither saw the benefits of working with the other. This in turn could be argued to contribute to staff feeling as though they had no control over their day to day work, and were not valued by their organisations.

The majority of participants, when asked, stated that they had been told, not consulted with, either via email or by a senior team member that the single point of access was being implemented and that they would be expected to staff it. Within one of the single point of access team meetings I attended, the single point of access end of life nurse commented that community nurses had been told that they were to rotate into the single point of access to triage phone calls, and that 'being told' had contributed to a negative feeling amongst the nurses about the single point of access team. I also queried with members of staff their involvement in the development of change. All staff, apart from one manager, stated that they had not been consulted and that they did not really understand how changes were going to affect their day to day work. This is interesting as the high level service manager that I interviewed from the PCT felt that front line staff had involvement in, and knowledge of, change whereas front line staff felt that they had no input. This finding supports Skelcher's (1993) assertion that not being told what is happening about service development is disempowering.

Furthermore, staff members reported that they were being asked to perform a role outside of their comfort zone, and therefore outside of their competency:

"you've got some people in that team who are a bit slower and not as computer literate as others so they slow things up and you've got to allow them the time"
(community nurse).

Being asked to perform a role outside of one's perceived personal competency has previously been identified as disempowering (Lee & Koh 2001) and I argue that this is particularly relevant when considering change in Countyshire. The majority of staff reported that they were not comfortable with using IT, having been used to using paper patient records with little requirement for working on a computer. Being asked to perform a job where a good level of IT skill was required caused a lot of the staff to worry about being able to perform the role.

Another requirement of working in the single point of access was to undertake telephone assessments. As one manager pointed out, "performing telephone assessments is a specific skillset", and not all staff were happy or felt competent in completing this type of task. The Social Services manager also highlighted that the Social Services staff within the single point of access had formally applied to join the single point of access, whereas PCT staff had been told to staff it. He himself wondered whether this had impacted upon how staff felt about going in to the single point of access and whether PCT staff felt out of their comfort zone. The complexities around the recruitment of staff into the single point of access was also recognised within the business case, which stated that, "the development of front end assessments requires a specific skill separate from clinical qualification and as such should recruit into the role according to ability to conduct the new type of work", however, "...the coordination of rotation would have the potential to disrupt the development of the back office processes and could impact on consistency of response" (p. 12). It could be argued that this demonstrates a conflict between *quality*, and the *consistency* of response that those implementing the change to a single point of access faced when staffing the service. Indeed, the business case goes on to state, "...there may be resistance from clinical staff adopting this role" (p. 12).

As discussed earlier in the chapter, community staff working for the PCT reported that they saw the single point of access as a call centre which took them away from their professional work. However, it is possible that these individuals felt out of their comfort zone, and as such attempted to increase their lowered self-esteem by viewing the single point of access as a less desirable 'them'. This, it could be argued, was as a result of community staff not fully understanding the role of the single point of access and communications about the service being misunderstood or misdirected. Individuals working on the front line, both within the single point of

access team and in the community reported that they had not been communicated with about change and as such felt disempowered. However, management staff in the county reported that they believed they had communicated appropriately with staff throughout the change process.

Based upon the data I have collected, it seems that by the time a rota was required for the single point of access and staff were consulted with, the damage had been done. Community staff's feelings of disempowerment, which built up through a lack of communication throughout the process and then the service not operating as it should, had become too great. I argue that staff rebelled against the single point of access, exercising their power as agents to reject the structural change and thus empower themselves. Any consultation about the single point of access was greeted with an unenthusiastic response as staff preferred to stay in the safety of their professional tribes, protected from disempowerment and low self-esteem, reflecting findings from previous studies (Menzies 1960; Pastor 1996; Atkins 1998; Lee & Koh 2001; Hall 2005). As such, rather than encourage integrated working as had been the aspiration for the single point of access, the service was not effective in encouraging closer working between health and social care, which contradicts previous findings (e.g. Brown et al. 2003). Based upon my findings, this may not have been the case had the change to a single point of access been implemented in a different way with more communication about the benefits of a single point of access with emphasis on how the single point of access would support effective care.

Chapter summary

Within this chapter I have outlined the findings from my ethnographic fieldwork. A variety of methods were utilised during the fieldwork of this study including interviews, focus groups, observation and documentary analysis. The number of referrals closed in the single point of access was also considered. Four main themes were identified from the grounded theory approach to analysis – communication, professional culture, change and disempowerment.

Communication was a key theme that underpinned all of the other themes, whether this referred to methods of communication within the single point of access, referral management, IT or how the change to a single point of access was

communicated. Based upon the data I collected, I have argued that the method of communication within and about the single point of access was not effective. There was some confusion amongst community staff about the single point of access including its function, how it fit in with the rest of community care, and how and why it had been implemented.

Due to the confusion surrounding the single point of access, staff did not seem to see any of the benefits surrounding the service, and as such professional barriers began to form. The single point of access service was seen as a less desirable 'other' which prevented staff from carrying out their day to day work. It could also be argued that these feelings were exacerbated by the single point of access service not working as it should, with problems surrounding the IT in place and the way referrals were managed, including how telephone calls were routed through the service.

Practical issues such as referral management and how change was communicated can be traced back to the change management strategy in place. The project manager in charge of the single point of access from the PCT side left shortly after the project commenced. As such, communication about the service was irregular and misleading, often relying on higher grades of staff feeding information down which was sometimes misconstrued. Individual teams and members of staff began to form their own views of the single point of access which were not always positive. Furthermore, it was reported that GPs in the county were not engaged with throughout the process, which influenced how they engaged with the service. GPs were the key audience for the single point of access, and without their support the service struggled to obtain recognition. The confusion surrounding the single point of access, and the perceived lack of communication led to staff reporting that they felt under pressure and disempowered. This was particularly true of staff within the single point of access who did not feel valued by their colleagues. Community staff reported that the tasks within the single point of access were out of their comfort zone and not in keeping with their 'proper' job which exacerbated the low level of value and self-esteem experienced by the single point of access staff. PCT staff also highlighted that they had been told, and not asked to go into the single point of access which could be construed as disempowering.

In conclusion, one of the main aspirations for the single point of access was to encourage closer working between health and social care within Countyshire. The

aim of my study was to investigate whether a single point of access could aid integrated working between and within health and social care. Rather than encouraging and promoting integrated working, based upon my findings within Countyshire the opposite was true. The single point of access had the reverse effect upon integration and led to professionals choosing to remain within their professional groups rather than staff the single point of access. These findings do not support previous work (e.g. Brown et al. 2003). Chapter seven will examine my findings in the context of surrounding literature and make suggestions for those wishing to implement a single point of access within their service.

CHAPTER SEVEN – DISCUSSION

Introduction

The previous chapter outlined my findings in Countyshire with regard to the effect that a single point of access had upon integrated working within the area. I suggested that the single point of access within Countyshire did have an impact upon integrated working. However, this impact was not the one intended by the business case. Rather than encourage integrated working, the single point of access resulted in professionals creating further boundaries between their professional 'in group' and the 'out group' of the single point of access. The creation of boundaries did not appear to be as a result of the single point of access itself; rather it seemed to arise as a result of the way that the service was implemented. Within this chapter I will discuss my findings in light of my original aim, objectives and research question, the surrounding literature, and highlight whether my findings align with previous work conducted in this area. My findings will be discussed within the same four themes presented within the previous chapter - communication, professional culture, change management and disempowerment.

I will demonstrate that my findings support some previous studies in the area of professional culture and tribalism, but contradict other findings with regard to the single point of access, which have previously suggested that a single point of access encourages integrated working (e.g. Brown et al. 2003). Furthermore, my findings support previous research about the development of professional identity, particularly in terms of the creation of 'us' and 'other' (e.g. Beattie 1995; Du Toit 1995; Lingard et al. 2002). My findings also support previous research into the management of change, both within health and social care (Goodwin et al. 2011) and the wider public sector (Worrall et al. 2000) specifically in relation to the importance of communication and effective project management (Ferlie et al. 2005; Pilbeam & Buchanan 2012). I will suggest that staff in Countyshire began to feel disempowered as a result of the implementation of the single point of access. I will argue that Skelcher's (1993) model of service user disempowerment can also be applied to staff within Countyshire and suggest a model for integration between health and social care.

Finally, I will outline my own personal reflection of the study, with particular focus upon my unique position as both insider and outsider. I will suggest that my position as what I have termed 'peripheral previous member' had both positive and

negative effects. However, I will argue that as both an insider and outsider I was perhaps best placed to undertake the research, particularly where the single point of access was concerned. As I seemed to be accepted as 'one of us', I was party to information that I may not otherwise have been, and was able to gain rich ethnographic data that an outsider may not have had access to.

Within this chapter the aim, objectives and research question, re-stated below for ease of reading, will be considered within the context of the findings.

Aim and objectives

Aim

To explore the implementation of a single point of access within Countyshire with regard to integrated working, waiting times and outcomes for patients.

Objectives

1. To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful
2. To identify whether the single point of access had an effect on integrated working within Countyshire
3. To identify whether the single point of access met its objective of improving integrated working
4. To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working
5. To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

The research question was

'Does a single point of access to health and social care have any effect upon integrated working?'

Integration and policy

To set the context, the level of integration within Countyshire will first be considered. My first objective was, 'To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful'. Integration within Countyshire was on a virtual, meso, horizontal level where integration was provided through multi-disciplinary teamwork to a specific section of the population (obeying the definitions from Curry & Ham 2010, and Ham & Curry 2011) or through coordination (obeying the definition from Leutz 1999). Furthermore, the single point of access could be viewed as integration at the normative level, with coordination of delivery of care through back office functions (obeying Fulop et al.'s 2005 definition). Pathways of care remained separate, as did clinical provision therefore the integration was at the mid-point (Leutz 1999; Curry & Ham; Ham & Curry). The organisational integration was virtual through contractual agreement between the two services.

Within chapter one, I discussed the levels of integration. Curry and Ham argue that there is no evidence to suggest that any one level of integration is superior to others (Curry & Ham 2010) and my findings in Countyshire would seem to support this. In line with my research question, 'Does a single point of access to health and social care have any effect upon integrated working?', the single point of access, at the mid-point level of integrating services, did not improve integrated working between health and social care within community services in Countyshire. However, it does not follow that the single point of access is an inappropriate method of providing integrated care. Rather, it seemed that there were underlying issues about the way the service was implemented which may have led to the poor outcomes that were observed.

Within chapter one, I presented evidence from the literature that suggests integrated services can help to improve information sharing, enable continuity of care and help to deliver packages of care to individuals (Glasby et al. 2011). As outlined in chapter four, Watson et al. (2004) found that a single point of access had a positive effect on integrated working, and led to reduced waiting times and a reduction in inappropriate referrals. Brown et al. (2003) reported that a single point of access can lead to improved communication between community teams and increased knowledge of team member's roles. My findings do not support these

previous findings. Within Countyshire, the single point of access seemed to have a negative effect on integrated working and did not appear to significantly affect waiting times, particularly for the nursing service and social work teams, answering my second and third objectives, 'To identify whether the single point of access had an effect on integrated working within Countyshire' and, 'To identify whether the single point of access met its objective of improving integrated working'. Communication was highlighted as a particular issue within the single point of access in Countyshire, and was not improved with its implementation, according to reports from staff working in the area.

However, in terms of my objectives, it does not follow that the single point of access is not an appropriate tool to aid integration. My findings have also demonstrated that the implementation of the single point of access presented issues which may have contributed to the negative effect that the service had upon integrated working in Countyshire. If the single point of access was to be implemented elsewhere, it would be prudent to consider change management and how the change is communicated to staff in more detail. Communication routes both within the single point of access and between the single point of access and community teams were important issues in Countyshire. I will discuss this idea in more detail below.

My study does support previous work examining barriers to integrated working, such as work carried out by Atkins (1998), Hollingsworth (2013), Stirling et al. (2013), BPIB (2013), Ham et al. (2013), Langford et al. (2013), all of whom argue that professional barriers can have an adverse impact upon integration. Furthermore, it has previously been identified that when not fully engaged with efforts to integrate services, particular professions such as GPs can be more adverse to change (Tudor Jones 2013) or can even block change (Ferlie et al. 2005). Within Countyshire, I have identified a similar aversion to change amongst health and social care professionals, particularly where these staff did not feel that they had been engaged or communicated with.

Communication

Within chapter six I highlighted that communication was raised as an issue by staff working both within the single point of access and those working in the community

health and social care teams. Communication was an overarching theme that captured both the way that change was managed and the more practical aspects of the single point of access including referral management, telephone access and duplication. This may have arisen due to the perception of poor communication and project management by the staff working on the front line. Within chapter three, I argued that clear communication and consistent project management is required for successful change (Mannion et al. 2003; Peck & Crawford 2004; Bamford & Daniel 2005; Ovretveit et al. 2010). As the project manager for the PCT side of the single point of access had left the project shortly after its approval, many of the steps in the process were missed. Subsequently, it appeared that the communication channels within the single point of access did not operate effectively and duplication occurred. This section of the chapter will consider the importance of communication, specifically through the media of IT. IT has been frequently mentioned as an area of difficulty when attempting to integrate health and social care services, both in terms of my study and the work of other researchers (Goodwin et al. 2011; Rosen, Mountford, Lewis, Shand, and Shaw 2011).

The single point of access business case stated that the single point of access service would allow information to be 'taken once' thus removing the risk of duplication. During the course of my fieldwork, I found that there were issues with the way that IT profiles had been set up in Countyshire. I was informed that this issue arose as a result of confusion over ownership of the IT systems in the single point of access, which did not appear to have been communicated to IT staff adequately. Subsequently, many staff were unable to access the IT systems, four of which existed in Countyshire. All were required in order to work effectively in the single point of access team.

Additionally, the way in which telephone numbers were used did not appear to have been given appropriate consideration as the direct telephone line to nurses was removed. As a result many nurses reported being disturbed by mobile telephone calls from the single point of access whilst visiting patients. Consequently further changes to telephone lines were made. Furthermore, referral routes into the single point of access became problematic as key service users such as GPs did not trust the chosen method (fax) and created more duplication by requesting a receipt of each referral, and marking all referrals as urgent.

Information systems and the associated technology have also been identified as barriers to integrated working within the literature. Goodwin et al. (2011) cite the lack of a shared electronic patient record as a barrier to integrated care provision, which echoes the views of the staff within Countyshire:

'The absence of a robust shared electronic patient record... is a major drawback to supporting a more appropriate and integrated response to people's needs' (p. 7).

Rosen et al. (2011) reviewed four integrated health and social care systems and found that information sharing was a key enabler. Rosen et al. state that:

'shared electronic information between two of the case study organisations and their member clinicians was particularly useful for supporting coordinated clinical practice, monitoring the performance of integrated services and providing feedback to reinforce progress with integration' (p. 7).

Previous research suggests that having access to a shared information system can support effective and integrated service delivery. Local issues in Countyshire with the interface between information systems are also echoed at a higher, national level. The National Programme for IT was introduced in 2002 nationally within England. The aim of the programme was to create an integrated electronic patient records system which would enable patient records to be transferred between NHS providers across the country (Commons Select Committee 2011). However, the project ended abruptly in 2011. A Department of Health circular letter written by the Chief Executive of the NHS at the time, Sir David Nicholson, stated that the decision to end the National Programme for IT was made to enable local control over information systems. The Commons Select Committee (2011) revealed that £6.4 billion had been spent on the programme between 2002 and 2011, yet the aims of the programme were beyond reach. In addition, the committee paper stated, 'the Department could have avoided some of the pitfalls and waste if they had consulted at the start of the process with health professionals' and, 'one factor which contributed to these failings is the Department's weak programme management' both of which are issues that are echoed by my findings in Countyshire. The failure of the National Programme for IT could be seen to reflect the situation surrounding the

implementation of IT within the single point of access in Countyshire. A failure to effectively plan the implementation of IT systems, and how they would interface with one another ultimately led to the failure of the IT systems to support the work of the single point of access. Although the single point of access had not ultimately failed, the IT systems did not interface with one another and led to issues for staff and their work. Issues such as accessing the systems and duplication would either not exist, or would not have had such an impact, had the IT been planned and managed in a more effective way. The increased use of IT and electronic records is an on-going theme in national policy and strategy documents, therefore developments in this area are on-going, and are subject to on-going change through political input and service development. However, it could be argued both from my study within Countyshire, and through analysis of national strategies and other research that IT is one of the key components of integrated working. As such, it could also be argued that IT should be given adequate consideration when implementing any method of integrated working.

Although health and social care services in England may be some distance away from a single, national electronic patient record, my findings and other research suggest that IT infrastructure and local data sharing arrangements underpin effective integrated working. Based upon my findings in Countyshire, I argue that an integrated IT system would have been beneficial for integrated working between health and social care in the county. In Countyshire, the existence of multiple IT systems, none of which communicated effectively with one another reportedly increased administration work for health and social care professionals and distracted from their frontline work. As a result, staff reported lower morale. The IT caused confusion between professionals which added to hostility between teams.

Finally, having various IT systems left health care professionals who staffed the single point of access on a rota feeling helpless and ignorant – which relates to structure and agency theory (Giddens 1984) whereby rejecting the single point of access helped health care professionals to regain some power and self-esteem. Countyshire is an example of how non-integrated IT systems can significantly undermine a project such as the single point of access, and supports previous findings (e.g. Goodwin et al. 2011). The poor communication within and around the single point of access could be argued to have resulted in the strengthening of professional barriers, and staff in Countyshire used the term 'us and them' when

describing their relationship with other professions within the county. The discussion will now turn to consider my findings in terms of professional culture and whether these support previous findings.

Professional culture

Within Countyshire, professionals appeared to prefer to stay within the safety of their own professional team rather than enter the 'other' of the single point of access, answering my fourth objective, 'To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working'. This finding supports previous work into 'in' groups and 'out' groups by Tajfel (1974). I discussed social identity theory (Tajfel & Turner 1986) within chapter two, and argued that individuals strive to belong to a group in order to maintain a positive self-identity which is influenced by group membership. Social comparisons are made between favourable in-groups and less highly ranked out-groups. Comparisons in favour of the in-group are made to further bolster confidence and positive identity within the group. Additionally, Tajfel and Turner (1986) argue that the process of the development of a social identity results in the creation of an in-group and out-group.

Tajfel and Turner's assertions link with other literature that examines the development of professional identity such as Lingard et al. (2002), Hall (2005) and Barbaro-Brown (2010). My findings from Countyshire support this previous work, as health and social care professionals preferred to stay within their professional silos, actively creating barriers between the 'us' of the in group and professional team, and the 'them' of the single point of access. Other examples of 'us and them' between professions in Countyshire took the form of the differences between Social Services occupational therapy and PCT occupational therapy, between front line staff and management staff, and between Social Services and PCT staff with the latter reporting that they believed they had been given less information than the former about the change to a single point of access. Staff working within the PCT across Countyshire also reported that they had been told, not asked, to staff the single point of access, which they construed as disempowering (e.g. Lee & Koh 2001).

Retreating into professional 'tribes' may have allowed the restoration of power that 'being told' to staff the single point of access had taken away. Giddens (1984)

argues that change within social structures is implemented or influenced by those 'agents' who have power within the social structure. Agents operating within the social structure at a lower level also have the ability to influence change by resisting or sabotaging it. Within Countyshire, although the management staff - the agents who had the most power in terms of resource - implemented the change, front line staff subverted the change to a single point of access. Staff had power in that without them using the single point of access, it could not function. By refusing to staff the single point of access and remaining within their professional teams, it could be argued that members of staff empowered themselves and protected their self-esteem.

As discussed in the findings chapter, professional staff expressed that they were reluctant to staff the single point of access when they felt that their own professional team was at risk, which supports Gersick's (1991) punctuated equilibrium theory. Gersick argues that the deep structure of an organisation can lead staff to reject change in favour of maintaining the status quo. Another key issue identified by Gersick are the obligations of the organisation. Obligations refer to those who depend upon the organisation (such as patients who rely on nurses to provide care) and the delivery of a service. Gersick argues that if a change is perceived as preventing an organisation from delivering to its dependents it will be resisted. As highlighted in chapter three, Gersick states that in order for change to occur:

'...deep structures must first be dismantled, leaving the system temporarily disorganised, in order for any fundamental change to be accomplished' (1991: 19).

Uncertainty and disorganisation may contradict the professional code of conduct to provide care in a consistent way (Menzies 1960) and thus result in resistance to change. This is echoed within Countyshire where one of the Social Services occupational therapists that I interviewed stated that she felt under pressure when it came to providing care, "properly" compared to what was demanded of her in the new environment of the single point of access:

"there is lack of time to do things properly, in the way you'd like to do things... you feel you have to compromise. You know, do you clear the backlog and just look at

specifically what a person's referred themselves for... and you just do that and clear them off the list, or do you actually do a holistic assessment, and I think that's a constant, constant battle" (Social Services occupational therapist).

This, "constant battle" may account for why health and social care staff were reluctant to staff the single point of access. Feeling unable to care for service users in the way demanded of them by their professional codes of conduct may have made professionals feel uncomfortable with the new way of working in the single point of access. Menzies (1960) argues that the core component of the role of a health care professional is to provide care. However, due to a lack of understanding, or wilful misunderstanding of the role of the single point of access, professionals within Countyshire reported that they did not see how, "going into a call centre" (PCT occupational therapist) was conducive to providing care and thus resisted the change.

Within the literature, the language used to describe health and social care professional's reaction to change is strongly emotive. For example, Atkins (1998) argues that professionals feel emotions such as loss and grief when experiencing change, and Luo (2006) argues that health and social care professional's reaction to change can be compared to Kubler-Ross' (1969) model of grief. My findings in Countyshire would seem to support both Atkins and Luo's suggestion that the reaction of health and social care professionals to change is strongly emotive and staff referred to being, 'taken away' from their team. The way in which professionals reacted to the change appeared to impact upon how staff felt about working together in a new way in integrated teams. Team dynamics within Countyshire will be considered next.

Team dynamics

With the creation of barriers between 'us and them' within Countyshire there seemed to be little opportunity for a cohesive single point of access 'team' to develop. In chapter two, I discussed theories of team development within the existing literature. Table 11 outlines each team theory in light of the findings from the current study.

Theorist name and theory	Stage names and processes in stage	How theory applies in Countyshire
Tuckman Forming Storming Norming Performing Stages of group development	Groups orientate themselves through testing both interpersonal and professional, task related boundaries and developing relationships with team leaders and other team members (Forming). A period of conflict and resistance to group influence and task requirements (Storming) which leads to a development of in-group feeling, interpersonal sharing and team cohesiveness (Norming) and a resolution of structural issues. Roles become flexible and functional (Performing).	Permanent members of single point of access staff formed relationships with one another and the team leader, however for community staff on a rota this stage took longer due to minimal contact with team members. As a result, the team could be argued to be stuck in the 'Storming' stage of this theory where there was conflict and resistance due to deep feelings of 'us and them', caused by poor communication and a lack of buy in during the implementation of the single point of access. Additionally, Tuckman's theory does not allow for any influence on group development from external factors.
Gersick Time and Transition model Phases of group development	Formulation of team's approach towards their task and development of a framework within which work is completed. Further exploration and discussion of the task at hand. Development of a plan (Phase 1). A period of change based on the group's experience where the approach can be altered or developed (Midpoint). A period of working based on the plans and directions developed at the midpoint. Completion sees positive and negative consequences of past decisions coming to the fore (Phase 2).	A framework/approach for the single point of access team was developed through the outline business case and single point of access team meetings. Also, changes were being made to the working patterns of community staff as a result of feedback which is accommodated within Gersick's theory. However there was no 'completion' stage as the single point of access was still in a state of flux at the time of my fieldwork with no permanent arrangement for PCT nursing or occupational therapy cover.
McGrath TIP model Consists of a number of modes that define group development	Inception and acceptance of a project - goal choice (Mode I: Inception). Resolution of technical issues - means choice (Mode II: Technical Problem Solving). Resolution of conflict of political issues - policy choice (Mode III: Conflict Resolution) and Execution of the performance requirements of the project - goal attainment (Mode IV: Execution)	Within McGrath's theory, the single point of access would be stuck between Mode II and Mode III due to the technical and political issues surrounding the single point of access. Additionally, McGrath's theory accommodates variable membership which is in direct contradiction to my findings in Countyshire.

Table 11. The development of teams according to Tuckman (1965), Gersick (1988) and McGrath (1991) and how these theories apply in Countyshire

In conclusion, none of the team development theories outlined above are able to fully account for the team dynamics within Countyshire. Issues with processes such as IT and referral management resulted in the team development being unable to progress to completion in Gersick's theory at the time of writing, nor past Mode III in McGrath's

theory. Furthermore, according to Tuckman's theory the single point of access would be stuck within the 'Storming' phase. This may not have been the case had the change to a single point of access been managed more effectively. As community staff did not buy in to the single point of access, their attitude to the single point of access was poor. The perception of a poor attitude resulted in the single point of access staff feeling undervalued by their community colleagues, and an 'us and them' began to develop.

Gersick's Time and Transition model is the most accommodating of all the theories of team development when it comes to considering the single point of access team within Countyshire. McGrath's TIP theory, which allows for variable membership, is not supported by my findings in Countyshire. Rather, staff in Countyshire expressed that longer term membership would be beneficial for building feelings of a team, as supported by both Gersick and Tuckman's models. However, both Gersick and Tuckman's models state that in order for effective team working there needs to be a shared goal or 'single vision'. This was not the case in Countyshire. McGrath's theory does allow for a variety of goals but this is not supported by my findings in Countyshire where the perceived lack of a shared goal contributed to the development of an 'us and them' between single point of access staff and community staff. The need for a shared goal when integrating health and social care is supported by findings from previous research and has been argued to be a key component of effective team working in integrated settings (Fulop & Mowlem 2005; Dickinson et al. 2009; Widmark et al. 2011).

The lack of visibility of a shared goal for the single point of access with the rest of community care appeared to be due to two main issues. Firstly, PCT management staff within the county admitted that communication with front line community staff had not been as effective as it could have been, partially due to a lack of project management from the PCT side. Secondly, and related to the lack of communication was the rejection of the service by health and social care staff who preferred to stay within their individual 'in' group within the community teams and thus did not appear to wish to have a shared goal with the single point of access. It could be suggested that community staff in Countyshire made the decision not to staff the single point of access due to perceived stress and the desire to protect the self-esteem and position of the preferred in group.

Furthermore, within Countyshire it was reported that nursing staff in particular were not buying into the single point of access and that leaders in the nursing teams had a poor view of the service. I was told by one of the newer community nurses that these leaders were influencing team members to have the same view and were highlighting the negative aspects of the service to junior staff. This supports Janis and Mann's (1977) description of directive leadership. Younger and newer members of staff being influenced by more senior members of the team also supports Janis and Mann's previous work around groupthink. Additionally, the action of nursing staff regarding their desire to maintain agreement within the group further supports Janis's (1972) theory of groupthink. Nurses believed in the 'correctness' of the in group, and maintained the status quo rather than looking for the best outcome.

I have demonstrated so far that my findings in Countyshire support previous research relating to the barriers to integrated working, including issues surrounding communication, professional culture and team dynamics. The single point of access did have an impact upon integrated working; however it was not the impact that was desired by the Commissioners within Countyshire. Based upon my findings I do not believe that this was due to the single point of access per se; rather it could be viewed to be a result of how the service was implemented within the county. I will now move on to consider change management in Countyshire with reference to the relevant literature.

Change management

The implementation of a single point of access in Countyshire was an operational and reactive change to national policies and strategies (Lorenzi & Riley 2000; Hayes 2007). As demonstrated in chapter three, within the literature, reactive changes can result in a number of problems including a lack of time for planning and insufficient time to engage individuals, experiment and respond to shifts in technology (Hayes 2007). An issue identified by management across both the PCT and Social Services during interviews was the speed of the implementation of the project. Managers stated that the implementation was quick and happened without clear change management, which has earlier been highlighted as important for successful change (Kotter 1996; Kotter & Cohen 2006; Hayes 2007; Office of Government Commerce 2011). Without time or dedicated staff to effectively plan for change, issues that

arose for the single point of access had to be dealt with retrospectively and reactively. This in turn could be argued to have led to delays in the single point of access rolling out countywide. Additionally, due to processes not working as anticipated, further changes took place within the single point of access team. One such change was the introduction of a rota for PCT staff, discussed previously. Change was therefore continuous over a period of time and largely reactive, identified within the literature in chapter three as ineffective and problematic ways of managing change (Kotter 1996; Kotter & Cohen 2006; Hayes 2007) and consistent with Hayes' (2007) definition of change as, 'continuous tinkering, adaptation and modification' (p. 12). As such, my findings in Countyshire support the previous literature in the area of organisational change management, highlighting issues around reactive change that is implemented at speed without clear and continued project management (Lorenzi & Riley 2000; Hayes 2007).

Change and the way that it was managed in Countyshire was a recurring theme throughout my fieldwork. Staff reported feeling disempowered by both the level of change they had experienced, and the way in which these changes had been implemented. As discussed in the previous chapter, PCT management staff in particular stated that there had been very little communication with any staff about the implementation of the single point of access. However, communication and stakeholder engagement in particular are identified by Hayes (2007) as fundamental to successful change. Previous research has found that neglecting to engage key stakeholders can potentially lead to blocking of the project or project failure, particularly where health and social care staff are involved (e.g. Ferlie et al. 2005). The lack of engagement with the GPs in Countyshire had further repercussions later on in the development of the single point of access which supports findings by other researchers within this area (e.g. Tudor Jones 2013). Indeed, within Countyshire, when I first visited the single point of access in March 2010, I was informed that although the single point of access was currently only serving the south of the county it would soon be rolling out to the north of the county. My fieldwork phase came to an end in February 2012 and the roll out to the north of the county had not taken place. According to the PCT management, "GPs kind of kicked up a bit of a fuss so we halted". The lack of engagement with the key stakeholder group of GPs therefore appeared to contribute significantly to the delay of rolling out the single point of access service.

McNulty and Ferlie (2002) describe a similar effect in their study of a project designed to change the care in an Accident and Emergency department in a hospital in England. As a result of poor communication, clinical staff distrusted project team members and did not believe that clinical best practice was at the heart of the project, rather they viewed the project as an attempt to save money. Due to this distrust, clinicians did not support the change project and the project was unsuccessful. In Countyshire, the nursing staff actively sabotaged the change to a single point of access by placing the service on their risk register, exercising their agency and rejecting the change (Giddens 1984). Although the single point of access in Countyshire was deemed to have been a success at a management level within the PCT and Social Services, they stated that they viewed their stakeholder engagement as poor, particularly with regard to GPs.

The rejection of the single point of access by GPs in Countyshire could be argued to reflect their power and agency within the health and social care community in the county. GPs have traditionally have been viewed as the profession with ultimate responsibility and authoritative power (Leipzig, Hyer, Ek, Wallenstein, Vezina, Fairchild, Cassel & Howe 2002). Indeed, with the move to GP commissioning, GPs held increased power in terms of planning and commissioning service provision within Countyshire. Without the support from this group of professionals, the single point of access could not function to full capacity. The situation in Countyshire where GPs were not engaged with the process also seemed to contribute to issues with communication in Countyshire including duplication and the subsequent pressure experienced by the single point of access and community teams.

It has previously been suggested within the literature that some GPs are less open to partnership working than other professions (Glendinning 2003) and have concerns about becoming de-skilled due to a single point of access (Raine et al. 2005). Fears due to perceived threats to status, autonomy and legitimacy have also been identified as barriers to integrated initiatives (Glasby et al. 2011). However, without having interviewed GPs it is not possible to gauge to what extent GPs felt disempowered with regard to the single point of access. Once a new member of management staff was recruited with responsibility for engaging with GPs, GPs were said to have improved their attitude towards the single point of access service, and I was told, "we don't hear so much from GPs nowadays" (PCT management staff).

This further supports the importance of communication with staff in order to overcome cultural barriers to change.

When questioned about their failure to communicate effectively throughout the implementation of the single point of access, management staff stated that communication had been lacking due to the level of resistance to change that was present amongst community staff in Countyshire. However, Ford and Ford (2010) argue that rather than blaming resistance to change as a factor in impeding change, the resistance should be used to the project's advancement. Ford and Ford go on to state that blaming resistance leads to three different outcomes. The first is that blaming resistance ensures that managers retain a positive self-image and defends a lack of communication with staff. Secondly, blaming staff resistance assumes that staff must be in the wrong and should change their attitude towards change, whereas staff may feel that they are acting in the best interest of the organisation and those who use the services that the organisation provides. Third, resistance is seen as a purely negative experience, rather than an opportunity to learn and develop the change strategy in response to staff engagement. Ford and Ford therefore believe that resistance to change can be used to a positive end, through communication and involvement with staff.

Alternatively, Scott et al. (2003) state that too much communication with stakeholders, and the imposition of constraints by these stakeholders, can stand in the way of change and act as a barrier to progress. As the majority of front line staff that I spoke to in Countyshire were against the introduction of the single point of access, offering them numerous occasions to consult on the single point of access may have only served to act as a further barrier to progressing the service as raised by the members of management staff within Countyshire. However, as suggested by Ford and Ford (2010), rather than attempting to bypass any resistance from the staff by not communicating with them, staff could have been communicated with, then any complaints used to develop and strengthen the change.

Indeed, Pilbeam and Buchanan (2012) describe an approach akin to Ford and Ford's in a change programme in Burnside hospital in the UK. During an update to infection control policy, 'communications were authoritative, compelling, frequent, and appealed to professional values' (Pilbeam & Buchanan 2012: 217). Pilbeam and Buchanan argue that regular communications with stakeholders at Burnside hospital, and demonstrating the benefits of the change programme secured the success of

the change. Staff were reassured during the change that professional values and provision of service to their dependents (or service users) was of key concern for the change project. These issues have previously been highlighted as concerns for health and social care staff with regard to service change in other research (e.g. Menzies 1960). Pilbeam and Buchanan's work supports the importance of communication with key stakeholders when implementing change in health and social care services. Communication is often the responsibility of the project management staff (Managing Successful Programmes 2011), the lack of which was identified as an issue in Countyshire. The chapter will now move on to consider project management within the literature.

Project management

Goodwin et al. (2011) argue that project management is a key component of successful integration between health and social care, but often is limited in its application with a lack of time and resources allocated:

'Without the time and resources to demonstrate change, research results often report that integrated care has failed to achieve its desired goals' (p. 7)

This could be argued to reflect my findings in Countyshire. Without sustained project management from the PCT side of the single point of access, the single point of access did not achieve its desired goal of improving integrated working between health and social care. Rather, the single point of access resulted in further barriers being created between health and social care teams. Based upon my findings, I suggest that the failure of the single point of access to improve integrated working can in part be attributed to a lack of consistent project management and communication from the PCT.

Communication is a key component of theories of change (e.g. Kotter 1996; Kotter & Cohen 2002; Ford & Ford 2010) and change management strategies such as Managing Successful Programmes (2011). Staff in Countyshire, particularly those working for the PCT and thus without continued project management support reported that they did not feel that they had been communicated with. My findings are consistent with previous studies which highlight the importance of

communication and project management (e.g. McNulty & Ferlie 2002; Ferlie et al. 2005; Pilbeam & Buchanan 2012). However, it must be acknowledged that although staff did not feel that they had been communicated with, management staff did report that some attempts to communicate had been made. Staff seemed unaware of the impact that the single point of access was having upon the number of referrals received in some of the community teams, which could be attributed to poor communication around the goals of the single point of access. Within chapter six I demonstrated that the single point of access diverted a quarter of all occupational therapy referrals, answering my last objective, 'To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

Style of communication and how it is perceived by staff may therefore be an area of exploration for further research into organisational change management in health and social care. The examples of physiotherapy staff and Social Services staff in Countyshire both having a strong and positive leader throughout the change process strengthens this argument. Staff who did not have this continuous and positive style of leadership and communication were more likely to report that they felt disempowered by the change to a single point of access. As such, the discussion will now move on to consider disempowerment within Countyshire in light of the surrounding literature.

Disempowerment

As discussed in the previous chapter, an emerging theme from my analysis that I identified was disempowerment. Within conversations, interviews and focus groups, staff indicated that they felt fatigued by the level of change that had occurred within the last three years, and that they did not feel as though they had control over the issues that affected their jobs day to day. To demonstrate, a community nurse stated that these decisions were made, "at a management level higher than me and we were just sort of told that this (single point of access) was going to be implemented".

Being told, rather than asked, is identified by Skelcher (1993) as disempowering. Additionally, feeling as though one has no control over their work and is unable to make decisions has also been identified as disempowering

(Greasley et al. 2008). Furthermore, Skelcher (1993) identifies the following actions as disempowering during service development:

- Being told, rather than asked;
- Being treated less favourably than others in a similar situation;
- Not being given any choice;
- Being promised that something they have requested or struggled for will happen, and then at the last minute being told (or discovering at second hand) that it will not; and
- Being kept waiting and/or knowing that decisions affecting them are being made, but without being told what is happening.

Although Skelcher proposed the above points with reference to service users, I argue that the same factors could be applied to staff working within Countyshire. Single point of access staff felt as though they were not kept informed of changes or given the information they felt they required about service developments. Additionally they felt that they were not valued by their community team colleagues. Also, PCT staff believed that they had received less information about the change to a single point of access than Social Services staff. Skelcher's assertion regarding a lack of information and choice, and not being informed about change potentially resulting in disempowerment can also be applied to staff in Countyshire. PCT staff within Countyshire felt as though they had been told, rather than asked, about the change to the single point of access, and had not been given any choice. My findings suggest that these beliefs were exacerbated by poor change management, poor communication and a lack of buy in from community staff.

Managers in Countyshire stated that they had consulted with staff when it came to implementing a rota for the single point of access but not prior to implementing the single point of access service. Front line staff reported that they did not feel that they had been adequately supported or communicated with and therefore felt disempowered. This supports Skelcher's argument that a lack of communication with individuals about decisions that will affect them can lead to feelings of disempowerment. Although managers may have felt that they had discussed the change to a rota adequately, the message did not appear to have

translated to staff, in line with Pastor's (1996) assertions. My findings support Pastor's work regarding the difference between how managers view empowerment and how staff view empowerment. According to Pastor, management staff may feel that they are empowering staff but in reality staff feel disempowered. In Countyshire, rejecting the single point of access seemed to enable disempowered staff to begin to feel more empowered through their rejection of the new integrated way of working.

Indeed, although staff in Countyshire did not use the word 'empowerment' when describing their feelings about the single point of access, they did describe having been 'told' to staff the service, rather than being asked. This finding supports Greasley et al.'s (2008) assertions about perception of autonomy and control over one's own work. Participants within the study conducted by Greasley et al. did not use the word 'empowerment' with reference to themselves and their job roles, but instead referenced concepts such as pressure, personal responsibility and control over their work, which is similar to my findings in Countyshire,.

Additionally, within Countyshire, the amount of control that staff members felt that they had during the change process appeared to be closely linked to whether staff experienced disempowerment and depression during the change to the single point of access. This can be demonstrated by the differing attitudes of Social Services staff who had applied to staff the single point of access and the PCT staff who had been instructed to staff the single of point access. The single point of access had been more successful in terms of the level of Social Services staff in post and community services utilising the service, whereas for the PCT the service struggled to become established. Therefore, level of change for groups of staff and the perception of control appeared to be of key importance when implementing the single point of access service.

I have demonstrated within this section of the chapter that Skelcher's theory of disempowerment, although originally developed with service users in mind, could also be applied to staff. My findings also support previous research into employee disempowerment, particularly surrounding a lack of communication or communication that is misconstrued or perceived differently to how it was intended (Pastor 1996; Greasley et al. 2008). An annual survey of NHS staff is carried out with the aim of, 'ensuring that the views of staff working in the NHS inform local improvements' (NHS Staff Surveys 2014). I carried out a thematic comparison of questions asked of staff in Countyshire both in 2010 and 2012 to examine whether

the findings from the survey supported findings from my analysis. I particularly examined questions that were relevant to the themes I had identified within my analysis in order to assess whether the single point of access had resulted in any difference in staff survey results.

Staff survey findings

In 2010, the annual NHS staff survey was conducted by the Care Quality Commission (CQC), a Government led organisation responsible for inspecting hospitals, services in people's homes, care homes and dentists within England with the aim of ensuring that these services comply with Government standards (CQC 2012). In 2012 this survey was conducted by the NHS Staff Survey Coordination Centre, examining the same dimensions as previously examined by the CQC. The survey is completed anonymously by staff and the results are available online on an open-access basis. Results are available for each NHS employer across England on a year by year basis. The 2010 findings for Countyshire PCT are compared against the 2012 findings below. 2010 has been selected as the survey would have been carried out during the initial implementation of the single point of access and directly prior to my fieldwork. I have contrasted this with the 2012 survey which would have been carried out towards the end of my fieldwork.

In 2010, the number of staff surveyed in Countyshire who felt satisfied with the level of care that they were able to provide to patients and service users was 66%. This suggests that the majority of staff believed that they were providing effective care in line with their professional duties. The survey results also indicate that 83% of staff felt valued by their work colleagues. The score for feeling valued is high, which is an interesting figure in light of the findings from my fieldwork. Within Countyshire, the majority of staff stated that they did not feel valued by their colleagues. However it must be noted that at the time of the 2010 staff survey, the single point of access was still in its inception. Additionally, the survey is carried out across the PCT, and the majority of staff who stated that they did not feel valued by their colleagues within the findings of this thesis were based in the single point of access, a small team compared to the number of staff across the PCT.

The majority of staff (74%) surveyed stated that they were working extra hours to cope with their workload. Less than half of staff surveyed (47%) felt that

they had good opportunities to develop their potential at work, and less than half (43%) reported that communication between senior management and front line staff was good. This last finding in particular regarding communication is pertinent in light of the current study. In 2010, the majority of the staff surveyed reported that they did not believe that management staff communicated with them effectively. This supports the findings from my analysis about a lack of communication between management and front line staff.

The 2012 survey of those working for Countyshire PCT found that the Trust performed well in the percentage of staff receiving job-relevant training, learning or development in the last 12 months (83%). However, in the 2012 survey, the percentage of staff suffering work related stress in the last 12 months was 38%. 77% of staff surveyed reported that they were working extra hours, and 21% of staff surveyed reported that they felt under pressure to attend work when feeling unwell. Furthermore, the level of staff reporting good communication between senior managers and front line staff in Countyshire had dropped from 43% in 2010 to 32% in 2012. The reasons for this lower score in 2012 would need further examination with staff in Countyshire but it indicates that communication, in the eyes of the staff completing the survey, had not improved since the implementation of the single point of access. This finding also supports my findings in Countyshire. However, it must be noted that completion of the survey is not mandatory. Therefore the sample of staff that completed the survey may be biased and consist of staff who were unhappy with their employment. The survey would offer an opportunity to convey this dissatisfaction to their employer anonymously. Nonetheless, even if this was the case, less than a third of staff in Countyshire reported good levels of communication with senior members of management staff, which supports my findings in Countyshire.

Based upon the findings from both the staff surveys and the findings from my thesis, it would appear that a single point of access to health and social care had not alleviated the work pressures for staff working in Countyshire, and members of staff did not feel as though they were communicated with in an effective way. The objectives of the single point of access in Countyshire could therefore be argued to have not been met. The single point of access did not have a positive impact upon integrated working within Countyshire. In 2012, staff reported that they felt pressured to work even when unwell. Having to work even when unwell supports Skelcher's

(1993) assertion that, 'not being given any choice' is disempowering. This notion was alluded to by a nursing manager interviewed towards the end of my fieldwork phase:

"We are talking about I think quite a disempowered group of staff" (community nurse).

A model for integration

Within this chapter I have discussed the key themes that arose from my findings within Countyshire – communication, professional culture, change management and disempowerment, as well as the concept of integration itself with reference to the previous research literature. Of the four key themes identified, I have argued that the three aspects that impacted upon the successful delivery of an integrated service in Countyshire were communication, professional culture and change management. Disempowerment occurred as a result of a perceived lack of communication and poor change management, and professionals retreated into their professional tribes to protect both their self-esteem and the position of their in-group. The model in figure 3 below demonstrates the equal importance of staff and their professional culture, how change is managed, and communication when attempting to integrate health and social care. I argue that successful integration will happen at the middle when all three components are present. This is supported by my findings in Countyshire as well as findings from previous research (e.g. Tajfel 1974; Tajfel 1978; Tajfel & Turner 1986; Becher 1989; Beattie 1995; Atkins 1998; McNulty & Ferlie 2002; Peck & Crawford 2004; Carlisle, Cooper & Watkins 2004; Ferlie et al. 2005; Forbes & Evans 2009; Ball et al. 2010; Blackmore, Chambers, Huxley & Thackwray 2010; Barbaro-Brown 2010; Goodwin et al. 2011; Glasby 2012; Pilbeam & Buchanan 2012; Dickinson & Mannion 2012; Ham et al. 2013). My findings also support Fulop et al.'s (2005) assertions that as well as the level of integration, professional and organisational culture should also be considered.



Figure 3. A new model for integration between health and social care

I have argued within this thesis that all three components had an impact upon how the implementation of the single point of access was perceived by health and social care staff within Countyshire. Based upon my findings, I suggest that these elements may have the potential to threaten any new change initiative within health and social care and should be taken into account when attempting to integrate health and social care services. A failure to fully account for any of these factors may result in tribalism or disempowerment, demonstrated by my findings in Countyshire and findings from elsewhere (e.g. McNulty & Ferlie 2002; Ferlie et al. 2005; Cameron et al. 2012; Pilbeam & Buchanan 2012).

It has previously been suggested that health and social care staff will not buy into any attempt to change how services are delivered if they do not believe the change is in the best interest of those within their care, and will reject the change and retreat into the safety of the tribe (e.g. Becher 1989; Beattie 1995; Carpenter et al. 1996; Atkins 1998; Hudson 2002; McNulty & Ferlie 2002; Hind et al. 2003; Ferlie et al. 2005; Pollard et al. 2006). This can be exacerbated by poor communication about the change and poor change management (e.g. Heinemann et al. 1994; Lenham 2009; Ovretveit et al. 2010; King's Fund 2012; Buljac-Samardžić et al. 2012; Dickinson & Mannion 2012; Pilbeam & Buchanan 2012; Lennox-Chhugani 2012). Additionally, there is the risk that groupthink will occur when professionals feel under

pressure (Snell 2010) which may arise as a result of poor communication and poor change management.

The model proposed in figure 3 highlights areas of important consideration for those wishing to integrate services within their locality, and may also be considered lessons learned from the attempt to integrate services in Countyshire through a single point of access. The single point of access itself did not appear to be the cause of the failure to integrate services – rather, it was the way the change to integration itself was managed. The study contained within this thesis offers some guidance for those wishing to implement a single point of access within their locality, with the areas highlighted in figure 3 as key starting points. My own starting point for this study was as a previous member of staff turned researcher, from which further lessons learned have arisen. In the next section of the chapter, I will move on to consider my unique position as both insider and outsider to this study.

The insider and outsider perspective – personal reflections and methodological consideration

As stated within chapter four, I worked within Countyshire as a PCT occupational therapy assistant for 14 months prior to beginning my doctoral studies. Between my employment in Countyshire PCT and beginning my PhD, I worked for 12 months within another public service. Although I had worked for the PCT for some time, over 2 years had passed before I returned to conduct my fieldwork. This left me in a strange position. Although I was known to many of the members of staff there and was accepted as an insider in some respects, such as being welcomed back into the team, I also had a new status as an 'outsider'. Bearing in mind the 'us and them' that was already present in this locality, my dual status held some challenges. This section of the chapter will consider this dual perspective and the effects, if any, that this had upon my data collection.

Insider or outsider?

Having been a professional in the field, argue Corbin and Strauss (2008), can enhance the sensitivity which one has for the data, but the researcher must ensure that it is the data collected that speaks and not just insider knowledge. Corbin and Strauss elaborate further, 'It is not the researcher's perception of an event that

matters' (2008: 33) but 'experience provides a comparative base' (2008: 34).

Traditionally the term 'insider' is given to a researcher who researches her own kind – that is, a person who studies a cultural group to which they belong (Van Maanen 1988). I had left the community team some time before returning as a researcher, so to what extent I was still viewed as an insider is questionable. I certainly found that I was welcomed into the research setting, especially with reference to the single point of access team who seemed keen on having a researcher in their midst. The single point of access team had reportedly been experiencing problems for some time with being accepted by their community based colleagues and my research was to put them at the centre of a study, the results of which would be seen by their colleagues and managers. I can only assume that they hoped my study would help to raise their profile within Countyshire and earn them recognition from their managers and colleagues.

As well as being an insider, I also held the role of 'outsider'. Outsider is defined by Hammersley and Atkinson (2007) as an individual studying a group to which they do not belong, and have no previous knowledge. As I had left the setting over two years before beginning my fieldwork and had minimal contact with my previous colleagues I could also be classified as an outsider. The single point of access team did not exist prior to my resignation, so I had no prior experience of this team or way of working. It is debatable to what extent being a researcher also furthers the status of 'outsider' – that is, whether being a researcher in itself sets you apart from the group under study and makes you different (Allen 2004; Hammersley & Atkinson 2007). Reactions from the staff in Countyshire were varied in terms of how they treated me at the beginning of my fieldwork. In the literature, this reaction appears to be dependent on one's status as insider or outsider. Researchers deemed to be insiders have previously been accepted more warmly than researchers seen as total outsiders (e.g. Simmons 2007; Innes 2009; Baumbusch 2011). In the initial stages members of staff with whom I had worked very closely appeared to be more suspicious of my return, in that I must have had some hidden agenda for wanting to return to study a group of people I had worked with previously and they were uncertain how to treat me in my new role. Staff in the community occupational therapy team had initially been pleased to see me and reacquaint themselves but once I started handing out information sheets and asking for consent from members of staff they suddenly became more wary of my presence. Some

expressed the concern that I was spying on them, or vocalised anxiety that I was counting their daily work load, or keeping check on them. In contrast the single point of access team, which did not exist prior to my resignation, and consisted of staff members whom I had never met, appeared to be a lot more open and accepting of a researcher within their midst. In this regard my previous experience as an occupational therapy assistant seemed to make them feel more at ease with my presence as I had first-hand knowledge of how it felt to work in this setting and had experienced the mixture of frustration and anxiety, as well as personal fulfilment and reward of working in public services. In some ways it was as if my previous colleagues were uncertain as to why I would want to return to a previous work setting especially as I had 'left the team' to go to an unrelated profession prior to beginning my doctoral studies. This was exacerbated by my being re-introduced to the team by the manager as a researcher. My outsider status was confirmed to my previous colleagues by this introduction and barriers were created. I was no longer 'one of us', rather I was 'one of them', and 'other'.

Community staff expressed the concern that I had been employed to check up on their performance, especially as the first two months consisted of observation of those at work and participants may have felt as though I was watching them and scrutinising their actions. I learned quickly that participants felt more comfortable if I appeared to be 'doing something' whilst conducting observation, so I ensured that I always had some reading or writing to do which seemed to satisfy participants. The simple act of communication - explaining myself, what I was doing there that day and my reason for being in the field also seemed to reassure participants that I was not there to monitor performance, rather I wanted to try to experience their day to day work. The reaction of the staff to my presence suggests a lack of trust in management, which is reflected by the lack of faith in management staff as demonstrated in the findings chapter. My arrival and observations of staff at a time already fraught with change and pressure may have been construed as an attempt to monitor performance and force members of community staff into the single point of access. Once I had explained that this was not the case, and I was merely investigating the impact of a single point of access in integrated care, community staff seemed more accepting of my presence.

Accessing participants

Accessing research sites and individuals to interview is a source of difficulty for many ethnographers (Hammersley & Atkinson 2007) but having prior knowledge of the setting and individuals within could be argued to be a strong footing. Hoffman (1980) argues that accessing participants can be particularly difficult unless one has prior knowledge of the setting and individuals within. Searle (2001) states that interviewing known individuals then asking for their advice or recommendations for further participants can lead to a web of interviewees, through snowball sampling as each participant recommends a further person to speak to. Hoffman (1980) argues that using snowball sampling can lead to more insightful and detailed interview responses. I utilised snowball sampling within my study, as discussed in the methodology chapter. By approaching individuals already known to me, I was able to access members of staff who held the relevant knowledge for interviews and focus groups, in a way that an outsider may not necessarily have been able to.

Baumbusch (2011) questions whether it is ethical to engage with members of staff in a research study where one has prior knowledge of the area of study, as participants may feel obliged to participate. I argue the opposite, in that discussions held with these staff members allows dialogue and information gathering that would not be possible with participants with whom this experience was not shared. Although I was a lower level member of staff as an assistant practitioner, I felt some solidarity with this concern about the ethics of conducting research amongst those who I knew well previously, in that I worried participants may have felt obliged to take part purely because they knew me, some of them personally, or that I may behave differently or in a too familiar and informal manner. I was also concerned about the balance of power in the interview situation (e.g. Laney 2002). I found managing this potential dynamic when conducting interviews, especially as first, quite difficult and I did become nervous. This was more of an issue for me personally rather than the participant. I found managing the participant's expectations of me challenging where they had already known me as a junior member of staff and an insider. I now had to converse with staff on a different level and as an outsider. A particular example of this is demonstrated in my interview with a member of staff who had previously been my supervisor. I approached this interview with a certain amount of trepidation as in our previous encounters the power had lain in my supervisor's grasp and I had been

subordinate. However in the interview situation the power had shifted to me as researcher and outsider and my ex-supervisor looked to me to lead the conversation and take control. It was a complicated dynamic but I found the level of insight I could gain from both what the participant said and her body language deeper than with participants I had no prior knowledge or relationship with.

Although prior knowledge of the interviewees may help to break down the barriers and lead to more meaningful conversation (Holloway 2005) I argue that interview techniques can also be used to the same effect. During the interview phase of the current study I found that my previous experience of the field was of great benefit when it came to relating to staff members and being able to communicate with them on an interpersonal level. One staff member, of whom I had no prior knowledge was very nervous, and started the interview in a very tense manner, with closed body language and a very quiet voice. As I spoke to her, and related some of my own experiences as a health care professional, she became visibly more relaxed, adopted a much more open posture and began to speak in a more normal, audible tone. Although it could be argued that this is down to interview skill rather than being insider dependent, on re-listening to the recording of the interview and re-reading the transcript, it is almost possible to track the participant becoming more relaxed as she realised that we had a shared experience.

Issues encountered

Being included as an insider did become an issue as my on-going association with the single point of access resulted in access to the north of the county and the teams in this locality taking longer than was initially planned. As discussed, there were internal political issues between the single point of access and community teams, which I have termed an 'us and them' mind set. These political issues undoubtedly had an effect as I seemed to become associated with the single point of access team in the minds of the community staff. This was particularly true of the community management staff in the north who seemed to be more wary of allowing me into their midst. Also, by being associated with the single point of access in this way I was concerned that I was becoming seen as the answer to all the single point of access's problems. The perception amongst staff seemed to be that by carrying out research there I would 'fix it'. Hammersley and Atkinson (2007) state that issues such as this

could be due to the title of 'researcher' having connotations of being an expert, holding solutions to problems in the field and having a certain level of power. The main issues for the staff working within the single point of access at the time of my fieldwork were working with their community colleagues effectively and being accepted as a service in their own right. It seemed like the single point of access team members hoped that I would be able to help them solve these issues with my research.

Once participants had satisfied themselves with my explanations for carrying out a study in their midst and began to accept my presence in the field, I started to take on more of an insider role. I was included in the setting so much that I became concerned I was 'going native'. Going native is defined as ceasing to have a participant – observer distinction (Hammersley & Atkinson 2007). After spending nearly three months with the single point of access team I felt I had essentially become accepted into their team. I was included on tea and coffee runs, members of staff talked to me about everything and anything, I was included on the signing in and out board and I was given access to the everyday experience as if I had joined as a full time member of staff. This brought with it some positives and some negatives. By being accepted into their culture it may be that staff felt able to open up to me and allow me access to information that would not be permitted for an outsider. A similar experience is reported by Innes (2009) in his study of Native North Americans. Innes was both partial insider and partial outsider to his participants. At first, participants in this study were reluctant to talk to someone they believed to be a total outsider. Once assured of his insider status as a legally recognised American Indian, Innes states that participants began to trust him, and subsequently gave him information that would not have been received by a complete outsider.

Within my study, the negative aspect to this familiarity was that I felt I was becoming less objective than I had aimed to be at the start of the study. The more time I spent with the single point of access team, the more I sympathised with the members of staff there and the difficulties they experienced in trying to carry out their day to day jobs. I was careful to document my feelings in my reflexive diary and on a day away from the field whilst reviewing my notes I realised that I had become embroiled in the lives of the single point of access team and was starting to lose focus. It was at this point that I withdrew from the single point of access team and focused on the community teams in the north of the county, returning to the single

point of access only when carrying out interviews with staff members or focus groups.

Once I began fieldwork in the north of the county I found that having the opportunity to talk to staff members in the north and other community health and social care teams helped to break down any barriers and inform them of the purpose of the study. Being in the north of the county and talking to members of staff there also allowed me the opportunity to see the study with a fresh pair of eyes and re-analyse the data I had collected so far. As well as problems in the field with gaining access to certain groups because of my association with the single point of access, I also felt like I was losing myself beneath a mountain of information. I became very focussed on the practical aspects of the single point of access and started to try to 'fix it', in line with the expectations from my participants.

I took the decision to withdraw completely from the field for a period of quiet reflection. Using physical distance is a tactic that has been used by other researchers (e.g. Whyte 1993). I planned the next phase of my research by listing staff I wanted to interview from both the north and south and then contacting these individuals to arrange interviews. I also made contact with an identified gatekeeper in the north who was a previous colleague of mine and arranged to begin my observation of the community teams in the north. I did make return visits to the single point of access; however these were focussed visits where I returned only for team meetings, focus groups or interviews.

Insider on the outside

Throughout the fieldwork period I found myself at times on an invisible tightrope between insider and outsider with both positive and negative outcomes. There was some benefit to being seen as an insider and I was party to some information that I may not have had access to had I been seen as a total outsider. However, being an insider also resulted in the Research and Development team being wary of my motives when returning to study the setting. When considering my position in the research, I found it useful to consider Adler and Adler's (1987) three distinctions between insider and outsider:

- 1) Peripheral member researchers, who do not participate in the core activities of group members;
- 2) Active member researchers, who become involved with the central activities of the group without fully committing themselves to the members' values and goals; and
- 3) Complete member researchers, who are already members of the group or who become fully affiliated during the course of the research.

It is difficult to distinctly assimilate my participation into Adler and Adler's categories but in essence as I had officially left the organisation two years prior to beginning my fieldwork I began the research as a peripheral member researcher. My role then became blurred between being an active member and a complete member in the middle of the research period. I had not committed myself fully to the values and the goals of the staff in Countyshire but I began to become affiliated with them as the study continued and was included in day to day working life as if I was a complete member. In order to manage this dual perspective I employed a number of methods to ensure that my study was trustworthy. I ended the research period with a return to peripheral member researcher. Essentially a fourth category is required, perhaps a 'peripheral previous member' researcher which would acknowledge my insider yet outsider, non-participant stance.

Some interesting conclusions can be drawn through my successes and failures throughout my fieldwork. I was trusted by members of management and front line staff to interview members of staff, both from the single point of access teams and the community teams, observe their working days and access policy and strategy documents, but I was not trusted to access service user information by the Research and Development team which consisted of higher level management staff and Research and Development staff. It could be viewed that this restriction of access was caused by a wish to protect service users and their anonymity from my research, an unknown at the time of my ethics application. Conversely, my previous status as an employee was known at the time of my application, and I was subject to queries throughout the Research and Development approval process about why I wanted to return to study a setting I had left previously. Members of the Research and Development team were suspicious of my motives and it was only through reassurance and agreement to the terms and conditions of not being able to access

waiting time information or service user data that I was allowed to commence my fieldwork. To the Research and Development team therefore I was firmly in the outsider group, an 'other' not to be trusted due to my previous insider status and I had to be contained in order to protect the 'us'.

This was quite different from my experience in the field where I was welcomed as an insider. Front line staff were much more open to accepting me in their midst and affording me trust and access to information. I was able to communicate more freely with front line staff and answer any of their queries face to face with clear communication, whereas the Research and Development process was completed via letters and telephone conversations. Perhaps if I had been able to meet with the Research and Development team I would have been given further access to information, or perhaps I would have been more successful in gaining access had I been a total outsider or an experienced, unknown researcher. However, I believe that an outsider would not have collected such rich ethnographic data as I was able to.

To summarise, I do feel that having been a member of staff previously was, for the majority, of benefit when collecting data. I had access to participants and information that would not have been possible had I been an outsider. Although I did experience some loss of focus mid-way through my fieldwork, I was able to overcome this in order to complete my fieldwork objectively. I do not believe that this loss of focus arose purely as a result of my insider/outsider perspective – rather I think that any novice researcher who feels passionately about their research could fall into the same trap. To overcome any issues with losing objectivity, I was reflexive in my approach to research and analysis. I will consider this in more detail in the concluding chapter, particularly in light of my having been a health care practitioner with experience in reflective practice. There was a drawback in having been a previously known, peripheral previous member in that I was not trusted with access to service user information or detailed waiting time information for all services, despite the promise of anonymity in publication and within this thesis. I therefore conclude that being an insider allows the collection of rich data when one has a shared experience with participants and can gain their trust by relating these shared experiences. However, my study also supports the assertion that the public sector and health services in particular are 'risk averse' (Marks & Hunter 2007) when it comes to information sharing. Researchers wishing to carry out research in health

and social care institutions in which they have previously been employed should heed this information and seek out a face to face meeting with local Research and Development teams if possible. Based upon my experience I argue that open and clear communication is key during the research process with organisations that are risk averse in nature.

Chapter summary

Within this chapter I have explored my findings in Countyshire in light of my original aim, objectives and research question with reference to the surrounding literature. I have suggested that my findings do not support previous work regarding the single point of access. In line with the aim of the study and my research question, I have found that a single point of access did have an impact upon integration within Countyshire, but not the one intended by the Commissioners or as previously reported within the literature. Previous research has found that a single point of access can positively impact upon integration (Brown et al. 2003; Raine et al. 2005). However, within Countyshire, my findings suggest that the single point of access had the reverse effect. Issues surrounding the implementation of the service appeared to contribute to feelings of disempowerment and ultimately a retreat into professional tribes, with staff exercising their agency to sabotage the change.

The existence of professional tribes and feelings of 'us' and 'other' is supported by previous work (Becher 1989; Beattie 1995; Atkins 1998; Carlisle, Cooper & Watkins 2004; Blackmore, Chambers, Huxley & Thackwray 2010). In Countyshire staff both within the single point of access and community teams made reference to 'us and them'. I have argued that the negative impact of the single point of access and professional barriers were related to poor communication, the failure to transmit values and thus the perception of a lack of a shared goal. A lack of sustained project management from the PCT side contributed to poor process mapping and implementation. These findings are consistent with other research regarding the barriers to integration (Kotter 1997; Hudson 2002; Peck & Crawford 2004; Dickinson et al. 2009; Goodwin et al. 2011).

As a result of poor communication the role of the single point of access itself was unclear and was viewed by community staff as a less desirable 'other' which took staff out of their community teams and thus out of their comfort zone, as well as,

in their view, potentially putting service users at risk of not receiving adequate care. Staff retreated into professional tribes in order to protect self-esteem, both of themselves and of the professional group itself, and protect the service delivered to service users. This led to staff in the single point of access not feeling valued by their community colleagues. These findings also support previous literature in this area (e.g. Menzies 1960; Lee & Koh 2001; McNulty & Ferlie 2002; Ferlie et al. 2005; Greasley et al. 2008).

The aim of this study was to examine whether a single point of access had any impact upon integrated working. I have demonstrated that, due to a variety of issues, the single point of access did have an impact upon integration but that this impact was negative. I have highlighted the importance of communication, both in terms of how change is communicated but also how processes for communication such as IT operate and function to support integration, which is also suggested within other research in this area (Goodwin et al. 2011). I have proposed a new model for the integration of health and social care, and have highlighted areas of concern for those wishing to integrate health and social care services. Communication, sustained project management and appealing to professional values are key recommendations based upon the findings from this study. Based upon the findings from this study and other research, all three are required in order to ensure the successful integration of services. Within this chapter I also considered my position as both insider and outsider. I suggested that my position had both benefits and drawbacks but ultimately I argued that my position enabled me to collect rich data which I may not have been party to had I been a complete outsider.

Chapter eight will move the thesis on to conclusion. I will consider whether I met my original aim and objectives, and the answer to my research question. I will examine the limitations of this study and make recommendations for future studies of the single point of access. The originality of this thesis will also be discussed. I will engage in personal reflection and discuss the parallel between reflective and reflexive practice, and suggest that my previous training in reflective practice enhanced my ability to be reflexive. I will also highlight the implications of this research for the integration of health and social care.

CHAPTER EIGHT – CONCLUSION

Introduction

This thesis has aimed to establish whether a single point of access had any impact upon integrated working between health and social care. I have argued that although the single point of access in Countyshire was implemented with the aim of encouraging integrated working, it actually had the opposite effect and may have encouraged tribalism and working in professional silos, which is not in keeping with other research into the service (e.g. Brown et al. 2003; Watson et al. 2005). I have suggested that a single point of access to health and social care services may have the potential to have a positive impact upon integrated working, however this may be contingent upon effective and continuous communication, buy in from front line staff and good project management, as has been reflected by other research into this area (McNulty & Ferlie 2002; Ferlie et al. 2005; Goodwin et al. 2011; Pilbeam & Buchanan 2012).

Within this chapter I will bring the thesis to conclusion. I will firstly address whether I met my aim and objectives in light of the findings from Countyshire. Secondly I will explore the limitations of the study and make suggestions for future research. I will discuss the postmodern critique of ethnography and my attempts to counter this through methods for trustworthiness and triangulation. I will also suggest that limitations of the study are a lack of waiting time data and limited data from service users and GPs. Further research could be carried out, both in Countyshire and across England to explore waiting times in the single point of access and community teams in order to assess the impact of a single point of access upon waiting times and work pressures for staff. Further work could also be carried out with service users and GPs in Countyshire in order to collect their views and feelings surrounding the service.

The third section of the chapter will focus upon my previous training in reflective practice. I will argue that I was able to enter the research setting with an enhanced self-awareness of my own thoughts, feelings and impact upon the research setting which increased my ability to be reflexive when carrying out research in a previously known setting. I will also consider the implications of my findings for future developments in health and social care.

Meeting the aim and objectives

The aim of this study was to explore whether the implementation of a single point of access had any impact upon integrated working within Countyshire. I wanted to explore this aim by meeting the following objectives:

1. To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful
2. To identify whether the single point of access had an effect on integrated working within Countyshire
3. To identify whether the single point of access met its objective of improving integrated working
4. To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working
5. To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

The research question was

'Does a single point of access to health and social care have any effect upon integrated working?'

In line with my research question, I have demonstrated within previous chapters that the single point of access in Countyshire did have an effect upon integrated working; however this was not the impact that the Commissioners in Countyshire may have wished for when implementing the service nor in line with findings from other studies of a single point of access (Brown et al. 2003; Watson et al. 2005). My findings also highlight the importance of process and culture upon integration, also highlighted by Fulop et al. (2005). The single point of access had a negative effect on integrated working and may have contributed to tribalistic behaviour amongst staff. Staff reported that they had not been communicated with about the change to a single

point of access and as such did not 'buy in' to the service. Without support from staff, the single point of access could not operate to its full effectiveness and could not meet its objectives. There were issues reported by staff around how the change was implemented, particularly surrounding the project management on the PCT side of the service. The lack of project management seemed to have an adverse effect on process mapping for IT and referral management as well as communication with staff.

Most staff within the county seemed to agree that integration was 'a good thing', but none of them felt that the single point of access was the most effective way of providing integrated care within Countyshire. Waiting times did not seem to be significantly affected by the single point of access but more referrals were closed before reaching community teams, thus in theory reducing the workload of staff in the community, particularly for those who worked in occupational therapy. My findings suggest that a single point of access could have a positive effect on integration, but only if the project implementation is supported by good communication and buy in from staff. This assertion is supported by findings from other research (McNulty & Ferlie 2002; Ferlie et al. 2005; Goodwin et al. 2011; Pilbeam & Buchanan 2012). Based upon the above, I have met the original aims and objectives that I set at the beginning of the research study.

Limitations and future studies

The study contained within this thesis utilised an ethnographic approach to data collection, exploring the day to day experience of participants working within the health and social care community within Countyshire. One criticism of an ethnographic approach is that the data collected cannot be objective and truly representative of the participants within the study. According to Brewer (2000) this is the postmodern critique of ethnography. Postmodern researchers would argue that my findings are clouded by my insider perspective, as well as my social and cultural background. I answer this criticism with the methods that I have used to ensure trustworthiness. I have attempted as far as possible to be objective when reporting my findings. I kept a reflexive diary throughout the fieldwork phase to record my thoughts and feelings about what I saw and heard which enabled me to identify any bias that may have arisen throughout the data collection and analysis periods. I

recorded interviews with a voice recorder and then transcribed the voice recordings in order to ensure that the participants' words were analysed rather than my interpretation of them. I also allowed participants the opportunity to review their transcripts in order to ensure that what I had transcribed was an accurate reflection of our conversation.

I revisited Countyshire after I had carried out an initial analysis to test my findings with participants. These visits were carried out to ensure that my analysis was a trustworthy depiction and reflected the day to day experiences of staff within the setting, as well as triangulating my data with interviews, documentary analysis, observation, and waiting time collection with small focus groups of staff which confirmed that my analysis was an accurate reflection of Countyshire. Perhaps the one limitation of the attempt to ensure trustworthiness is the small amount of waiting time data collected. Although I requested waiting time information from all services within Countyshire, I was limited to the single point of access and occupational therapy services waiting time information only by the PCT Research and Development team. Furthermore, when the data was provided to me it was not compatible and I was not easily able to make a comparison between the two sets of data. Future research could focus upon waiting times specifically, both within Countyshire and in other counties where there is a single point of access across England to assess whether a single point of access has any impact upon waiting times.

Another limitation is the lack of data from service users. Within the literature, it has been argued that the changes to health and social care have most impact upon service users, yet this group are under-represented within the research literature and little is known about the effect of integrated working upon this group (e.g. Dickson et al. 2009). As I was denied access to collect data from service users by the Research and Development team within Countyshire I was unable to examine the impact that the single point of access had upon this group. I collected a small amount of feedback from service users via the Local Involvement Network, however this was not used in the analysis as it did not provide any significant insight into service user's perceptions of the service. Nonetheless, I was able to collect some waiting time information as discussed above, which gave some indication of the impact of the single point of access upon service users. It could be argued that as more referrals were being closed within the single point of access, more service users were

receiving assistance more quickly. However it could also indicate that more service users were being signposted to third party services or being turned away without receiving assistance. Future work could explore the impact of the single point of access upon service users, to assess both service users' perception of the service, and whether their needs were being met where their case was closed by the service.

Additionally, during the course of fieldwork I made numerous attempts to contact GPs, both by writing to surgeries within the area, emailing GPs whose contact details I had been given by nursing staff and by asking staff to approach GPs on my behalf. Unfortunately none of the GPs in the area wished to take part in the study. This may have been a result of the reportedly negative view that GPs already had of the single point of access, and it is possible that my research study was seen as an extension of something that GPs already did not buy in to. GPs have previously been described within the literature as averse to a single point of access (e.g. Raine et al. 2005) which may offer some explanation as to why they did not wish to take part in my research study. However, in light of previous findings by Raine et al. which suggested that GPs were averse to a single point of access, it would have been an asset to my study to have been able to collect the views of GPs in Countyshire rather than relying on anecdotal evidence from other members of staff. The views of GPs could be the subject of future research to ascertain whether they believe that the single point of access is de-skilling as has been suggested by previous research by Raine et al. Whether GPs view the single point of access as having an impact on integrated working within the county could be explored.

Original contributions to knowledge

This thesis makes a number of contributions to the existing base of knowledge. These contributions are conceptual in nature. The first is the study of a single point of access for older adults within Countyshire. Very little research has been conducted into this area and even less on the impact that a single point of access has upon the development of integrated working. This study has demonstrated that the single point of access did have an impact upon integration but perhaps not the one that the Commissioners in Countyshire had in mind. Further research could be carried out to establish whether a single point of access could encourage integrated

working between health and social care as has been found in other research (e.g. Brown et al. 2003).

Being able to fully assess the impact of the single point of access upon integrated working was affected by the change management process within Countyshire. The management of change within the public sector is the second original contribution to knowledge that this thesis makes. I argue that further research needs to be conducted into change management within the public sector. Within the public sector are deep rooted, long standing professional cultures that cannot be changed at speed, particularly where the staff involved do not believe that the change is in the best interest of service users (their dependents) (e.g. Menzies 1960; Atkins 1998; McNulty & Ferlie 2002; Ferlie et al. 2005; Pilbeam & Buchanan 2012). Furthermore, this thesis adds to the existing literature of organisational change management and the importance of engaging stakeholders throughout the change management process if change is to be successful.

Reflexivity, reflective practice and sensitivity

'I support the autobiographical analysis of self, not as separate from or in competition with the ethnographic words of the (participants) but as a nurturing bed to place the research finding in and as part of the transparency of the research process.

Reflecting honestly and openly has helped me retain some integrity and develop insight and self-awareness, and it has given me a certain self-confidence' (Chesney 2001: 131)

A specific observation I have made about my own practice during my fieldwork is the use of reflective practice. All health and social care professionals are encouraged to use reflective practice, to varying extents, to identify any training needs, develop as a professional and identify how situations can be managed effectively (Jarvis 1992).

As I conducted my ethnography and encountered difficulties I found myself relying on my previous training from occupational therapy on being reflective in my practice as a health care professional, and developing this into being *reflexive* in my research practice. This in turn helped to identify bias and any other issues that had arisen.

Although reflexivity is part and parcel of conducting ethnography (Hammersley & Atkinson 2007), the unique nature of reflective practice as I was taught focuses on

the individual's behaviour in a specific situation and how this can be modified to achieve a different outcome should the situation occur again. Although reflexivity concerns an individual's preconceptions and individual viewpoint on entering a research situation (Hammersley & Atkinson 2007) I believe the previous knowledge and skills I had learned on being reflective in the work place enriched my ability to be reflexive, as I was able to reflect on my own performance and have a level of self-awareness that a researcher without a similar background may not have possessed.

Hutchinson (1993) argues that the researcher is inevitably part of the daily data collection due to the level of interpersonal interaction involved and I felt that this was exacerbated by the fact that I held a tenuous position between insider and outsider to the researched. There is some debate as to whether previous experience should be acknowledged and then discarded or whether following the approach of discarding previously known information is in keeping with a positivistic approach to research which is not appropriate in a qualitative, grounded theory approach (Hutchinson 1993). Furthermore, sensitivity as defined by Corbin and Strauss (2008) requires that a researcher places themselves in the research, having both insight and the ability to pick up on relevant issues, information and events in the data. It requires a level of understanding from which the researcher can pinpoint not only their own individual position within the research but also recognise the themes arising from the data. Corbin and Strauss (2008) go on to emphasise the benefit of understanding the impact of subjectivity. Understanding this impact, they argue, reduces the risk that the researcher's point of view creeps into the data unnoticed.

I believe that my previous training in reflective practice enabled me to recognise with more clarity my position in the field and whether my values and beliefs were having any effect on data collection or analysis. To deny personal knowledge, argues Cutcliffe, would leave the researcher asking themselves, 'does that thought originate from my knowledge, experience or beliefs or does it belong to the interviewees?' (2000: 1480). As I was trained to be reflective, I argue that I was able to have an increased level of self-awareness and constantly question whether my findings were influenced by my own socialisation, augmented by being open and honest about my previous experiences. Based upon my experience, and evidence from the literature, I argue that professionals who have received training in reflective practice, and have prior knowledge of the setting under study are better placed to achieve a depth of data than researchers with no prior experience, as long as they

are open and reflexive with regard to this previous experience. This, I believe, is one of the important messages from my thesis that I hope other researchers will consider when designing and completing their own research studies in health and social care.

Implications of the research

Based upon the findings of this research I suggest that a single point of access had a negative effect on integrated working, which is not consistent with findings from previous research (Brown et al. 2003, Watson et al. 2005). However, I argue that this negative impact was not as a result of the single point of access itself; but due to the way that the change was managed. It could be argued that professionals did not see any benefit to the single point of access due to poor process mapping (IT and referral management) and the perception of poor communication. These findings are particularly important in terms of the current climate with the change to GP commissioning. Staff will increasingly be asked to work together in integrated organisations which will result in further change for these individuals. The issues encountered within Countyshire with the introduction of a single point of access should provide some lessons learned for those wishing to implement a single point of access within their own county, in that the way change was managed in Countyshire led to barriers being created, rather than broken down, between health and social care professionals.

I also argued that the public sector and health and social care organisations in particular require a tailored approach to change, dependent upon the organisations in question with continued stakeholder engagement if staff are to buy in to and not reject change. Based upon the findings from my research, I have proposed a new model for the integration of health and social care, outlined in chapter seven. The model emphasises the equal importance of staff and their professional culture, change management and communication. All three are required if attempts to integrate services are to be successful, regardless of the level of integration that is to take place. Furthermore, I suggest Kotter's (Kotter 1996; Kotter & Cohen 2002) change management theory as a starting point for change in health and social care, re-iterated below, however with the caveat that change management should not be a one size fits all:

1. Establish a sense of urgency
2. Create a guiding team of change champions
3. Develop a vision of change
4. Share the vision, clear communication is essential
5. Empower
6. Secure short term wins
7. Consolidate change
8. Anchor change

Based upon my findings it could be argued that Kotter's change phases encapsulate many of the issues that were missing in the change management strategy within Countyshire, particularly in terms of sharing a vision, clear communication, and empowering staff which led to staff rejecting the change to integration.

Additionally, if change to integration is to be successful, it may be pertinent to engage staff in some form of integrated learning pathway. Although students who are currently studying health and social care at university experience integrated learning, those who have been in practice for some time may have already created barriers between their own and 'other' professional groups. It will not be a quick fix solution:

"I think that we've got a lot of custom and practice and culture to change so in the interim that's going to be the really long hard fight" (community nurse).

It has been suggested that professional cultures within health and social care are deep rooted (e.g. Atkins 1998) and may be hard to change. However, as stated by Kotter within his research into phases of change, and findings from other research (e.g. McNulty & Ferlie 2002; Ferlie et al. 2005; Pilbeam & Buchanan 2012) if staff are educated about the benefits and can see real, tangible benefits to integrated working for both themselves and service users then change should be possible.

Finally, consideration should to be given to the type of change that is prevalent in the public sector. It has been previously suggested that change in the public sector is often reactive and administered from the top down without consultation with front line staff (Dickinson & Mannion 2012). With the introduction of GP commissioning, this top down change is allegedly due to change, and give front

line staff more power over decisions made about health care provision for the community within their care (Department of Health 2011; Department of Health 2012). I have argued that health and social care staff will exercise their power as agents where they do not feel that structural changes are in the best interest of those for whom they care. Those wishing to implement change in the health and social care sector must engage with their staff and ensure that key stakeholders are consulted with throughout the process to overcome professional barriers if change is to be successful, which supports previous findings in this area (McNulty & Ferlie 2002; Ferlie et al. 2005; Pilbeam & Buchanan 2012).

Conclusion

Within this chapter I have brought the thesis to a conclusion. I have addressed my research question, aim and objectives in light of the findings from Countyshire and suggested that the single point of access did not have a positive effect on integration within the county. These findings do not support previous research into the single point of access (e.g. Brown et al. 2003; Watson et al. 2005). However, although a single point of access in Countyshire did not have a positive effect upon integrated working within this locality, it does not follow that a single point of access is not effective in improving integrated working. Further work would be required in order to establish whether a single point of access can positively affect the integration of health and social care. I have argued that the single point of access in Countyshire was affected by professional barriers, exacerbated by a lack of communication, and fragmented project management, and thus lacked in support from key stakeholders. This supports previous findings into change within health and social care (McNulty & Ferlie 2002; Ferlie et al. 2005; Goodwin et al. 2011; Pilbeam & Buchanan 2012).

Secondly I explored the limitations of the study and made suggestions for future research. I discussed the postmodern critique of ethnography and overcoming this critique through utilising methods for trustworthiness and triangulation. I also discussed the limitations of my study, including a lack of waiting time data and the limited data collected from both service users and GPs. I also made suggestions for further research, both within Countyshire and across England. Further research could examine waiting times in more detail to assess the impact of a single point of access upon waiting times. I also suggested that future work could explore the views

of service users and GPs in Countyshire with regard to the single point of access. I also discussed my previous training in reflective practice and my enhanced self-awareness of my own thoughts and feelings and how this could impact upon my research. I argued that this previous training enhanced my ability to be reflexive when carrying out research in a previously known setting.

My findings have implications for future developments in health and social care. Within Countyshire, community health and social care staff did not buy into the single point of access and as such were reluctant to staff the service. In turn, this led to the single point of access not being fully effective. I have suggested that the lack of buy in from staff was a result of poor communication and poor project management from the outset of the project, which supports previous findings in this area (e.g. Goodwin et al. 2011; Pilbeam & Buchanan 2012). Poor process mapping, such as how referrals would be managed and how IT systems would communicate with one another exacerbated the staff's negative view once the service had begun. The single point of access was seen as a less desirable out group or 'them', echoing previous research in this area (Becher 1989; Beattie 1995; Atkins 1998; Carlisle, Cooper & Watkins 2004; Blackmore, Chambers, Huxley & Thackwray 2010) and disempowered staff restored their agency by rejecting the structural change, supporting Giddens' (1984) structure and agency theory. I have suggested a new model for the integration of health and social care which highlights the importance of communication, change and acknowledgement of the deep rooted professional cultures within these organisations. Successful integration will happen when all three of these factors are taken into account. A failure to recognise these three components may result in the opposite of integration - tribalistic behaviour, or in disempowerment, as demonstrated by my findings in Countyshire.

The study contained within this thesis therefore has the potential to serve as lessons learned for future projects of this nature. Buy in from stakeholders, continued project management and consideration of the long standing professional cultures were all key considerations for the single point of access in Countyshire, and may be useful lessons learned for future projects concerned with integration. Although the single point of access within Countyshire did not have a positive impact upon integration, it has highlighted areas of concern for future developments in the integration of health and social care.

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APPENDICES

Appendix A – Protocol, information sheets and consent forms



Faculty of Health and Life Sciences

Research proposal:

The integration of health and social care – An analysis of joint working in the community with particular focus on the single point of access

Name of principal researcher	<input type="text" value="Linda Harris"/>
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This item has been removed due to Data Protection. The unabridged version of the thesis can be viewed in the Lanchester Library Coventry University.

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Names of other researchers	<input type="text" value="Not applicable"/> <input type="text"/>
Name of sponsor	<input type="text" value="Coventry University"/>
Sponsor's address	<input type="text" value="As above"/>
Sponsor's telephone number	<input type="text" value="024 7688 7688"/>
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Project funding

The project will be funded by Coventry University as part of a postgraduate research degree (PhD).

Background

1. Why is this topic important?

Integrated working between health and social services within England has been actively encouraged by Government policy in the last decade (e.g. Department of Health 2001; Department of Health 2004; Department of Health 2006; Department of Health 2007). Joint working between health and social care services arguably provides a joined up, seamless service for those receiving health and social care (Department of Health 2001). However, whether this is true in practice is another matter and will be investigated within this study, taking into account the first hand views of staff of all levels and service users within the locality of Countyshire.

Within the county of Countyshire a strategy to aid the integration of health and social care, the Single Point of Access (SPA) has been implemented in the south of the county as a one stop shop for referrals, information and advice for health and social care professionals and service users alike (Strategic Framework for Improving Health in the South West 2008/09 to 2010/11). This study will investigate the effectiveness of the SPA with special attention to its effects on joint working between the NHS and the local council within Countyshire, and whether the outcomes for service users are improved through the use of the SPA compared to the north of the county which does not yet have a SPA in place. Waiting times will also be compared between the north and south of Countyshire county.

This research is timely given that the health and social services within Countyshire are becoming increasingly stretched as the population of older adults increases year on year (NHS Countyshire Planning our Pharmacy Services 2009-2010). Countyshire has a large population (38,800 over 65 years of age) of older people which is likely to increase by 62% in the next 15 years (Countyshire Joint Commissioning Strategy Older People Services 2010-2013) therefore an efficient (value for money) and effective (good use of staff resources and desired outcomes for service users) adult health and social care service is critical.

2. Other projects/studies carried out in this area

The divide between health and social care which began in the 19th century is still evident today, in both practice and policy making (Thane 2009). The legacy of these historical arrangements for offering treatment and care remain today in the form of a national health service (NHS) which is free at the point of access, and personal social services which is means tested. These strategic level issues of funding are arguably a barrier to joint working between these two services (Weeks 2007). Further issues are separate policies and procedures implemented by the two services (Weeks 2007). These policies and procedures are implemented at a national level, which, in the case of the NHS, are then interpreted differently by the different local Strategic Health Authorities at a local level (Strategic Framework for Improving Health in the South West 2008/09 to 2010/11).

Despite these issues at a strategic level, health and social care professionals are increasingly being asked to work together, as a result of government policy (Department of Health 1997; Department of Health 2001; Department of Health 2010) developed due to acknowledged failures of joint working, such as the case of Baby P and Victoria Climbié in children's services. Failures also occur in adult services however these are not as well publicised. Interagency and interprofessional working is also becoming increasingly common with regard to older adults following the introduction of the National Service Framework for Older Adults (Department of Health 2001).

Although this study will analyse integrated working between health and social care, its primary focus is the difference between how community services operate their referral systems, with or without a SPA. Brown, Tucker and Domokos (2003) have conducted a similar study within a rural community setting, comparing service delivery and user satisfaction between a fully integrated, co-located health and social care team with a non integrated community team. The results of their study suggested that the fully integrated health and social care team delivered quicker assessments, as well as improved communication between community teams and increased knowledge of team members' roles. There was also an increase in self-referrals from service users, however, overall no real difference was found in service delivery or user satisfaction. These factors will be investigated in more detail within this proposed study in Countyshire, which will focus both on perspectives of both staff from all levels within NHS Countyshire and Countyshire Council, and impact on service users. In relation to the latter, outcomes data (based on quality of life measures) will be collected which will give an indication of the quality of service. These will be compared between the north of the county which does not yet have a SPA in place and the south of the county which has had a SPA in place for approximately 1 year.

3. How this study will add to any previous work

This will be a local study of local conditions and responses to the challenge of a SPA. Service user outcomes (based on quality of life indicators) from interventions which have not been previously assessed or compared between traditional referral systems and the single point of access will be sought rather than satisfaction levels.

4. Aims and objectives

Aim

To explore the implementation of a single point of access within Countyshire with regard to integrated working, waiting times and outcomes for patients.

Objectives

1. To analyse methods employed by the NHS and Social Services when initiating the change to a single point of access and whether these were successful
2. To identify whether the single point of access had an effect on integrated working within Countyshire
3. To identify whether the single point of access met its objective of improving integrated working
4. To investigate the views and perceptions of staff working both within the single point of access team and within the community teams on how the single point of access affected integrated working
5. To identify whether the single point of access had any impact upon the number of referrals passed to community teams within Countyshire.

Research question

'Does a single point of access to health and social care have any effect upon integrated working?'

Research Summary

1. Inclusion/exclusion criteria, numbers of people involved and their participation

All members of staff from the single point of access will be eligible and approached to take part. Other community staff will be approached based on availability and their experience of working in the community. If all members of staff from the SPA were to decline to take part in the study, a contingency plan will be in place. Further members of staff from community teams would be interviewed as well as further members of the Care Connect team to gain their views and opinions on the two referral systems. This information would then be analysed along with the documentary analysis, the comparisons of waiting times and the service user outcomes questionnaire responses.

The study will focus on community staff within Countyshire and the SPA. The numbers of participants are based on the roles and functions within the organisations and have been identified as the following – the five members of staff from the SPA, five members of staff from the community teams, (to include 2 social workers, an NHS occupational therapist, a social services occupational therapist, and a District or community nurse) along with a physiotherapist, two GPs and two Care Connect call handlers. Management/senior level staff will also be asked to participate, including the SPA team manager, a physiotherapy manager, and service managers from both the north and south of the area. In total there will be 19 members of staff (listed above) who will be asked to participate. All members of staff will be interviewed. Observations will be conducted with the SPA team members and community staff teams during their normal working hours as described in “Collecting Data” below.

All service users resident in both the north and south of Countyshire who are currently being seen by community health and social services will be asked to fill in the outcomes questionnaire. Staff will be asked to distribute the questionnaire upon their final visit to the service user. Due to the resource constraints of the study, service users with impaired mental capacity will be excluded. Community staff will be requested to remove any ineligible individuals from the data in accordance with stipulations laid out by the Mental Capacity Act 2005 and AMCAT (Assessment of Mental Capacity Audit Tool) website before it is made available to the researcher. AMCAT (2010) states that individuals deemed to have impaired mental capacity is unable to do one or more of the following:

- Understand information given to them
- Retain that information long enough to be able to make a decision
- Weigh up the information available to make a decision
- Communicate their decision

Staff will be asked to exclude participants based on these criteria.

In addition to those invited to complete the outcomes questionnaire, ten service users will also be invited to take part in an examination of the pathway from their initial contact with adult health and social care (five via traditional GP referral and five via the single point of access) through to discharge. These service users will be identified from their first contact with either the SPA or the community service via staff records and their interactions with community staff observed. Fully informed consent will be sought from the service users who are to be observed at the first visit and on-going consent from these individuals will be sought at each stage throughout their interventions.

2. Sampling arrangements

All service users only completing the outcomes questionnaire will be eligible to take part and identified by community staff on their visits, excluding those with impaired mental capacity (see 1. Inclusion/exclusion criteria, numbers of people involved and their participation, above).

The ten service users for observation will be selected at the time of observation via convenience sampling based on their needs by the researcher. These individuals will be matched for similarity in order to gain as fair a comparison as possible between the two referral systems. The two service users will be selected based on their needs which will be low level, for example osteoarthritis, rheumatoid arthritis or similar and their requirements, for example mobility problems, difficulty getting on and off a chair, need for grab rails or similar. As these conditions and requirements are relatively common it is anticipated that this will facilitate service users anonymity.

3. Location of study

The study will take place in Countyshire only.

4. Type of data to be collected

The study will collect both quantitative and qualitative data.

Ethical Considerations

The welfare, dignity and privacy of the participants taking part in the study is of the upmost importance. All participants will be fully informed of the purpose of the study and why they have been asked to take part. Participants will give consent via the consent form and on-going verbal consent will be sought where appropriate throughout the study and noted in field notes and interview transcriptions. Participants will be informed of their right to withdraw from the study at any time and reassured that their data will be removed from the analysis.

Any information given by participants will be confidential; however it may be possible to identify individual staff members from phrases or actions undertaken. Participants will be asked to review their data where any potentially sensitive subjects have been discussed for purposes of anonymity and participant protection. Participants will be fully informed of this. An individual's profession will be used in the analysis section to maintain anonymity at all times, however where only one member of that profession exists with a team the term "health professional" or "social care professional" will be used in place. A participant number will also be recorded via the consent forms. Pseudonyms will be used for service users who are observed. Countyshire will be anonymised within the thesis.

Paper data will be stored securely in a locked filing cabinet at Coventry University within the researcher's office, which is prox card access controlled. The data will only be available to

the researcher and supervisors throughout the study and will be archived for 3 years post completion of the study. Archived electronic data will be stored as a password protected ".zip" compressed file within the researcher's profile on the University network drive which will be accessible only to the researcher. Any electronic data will be removed from the researcher's laptop on completion of the study. Data will be available to participants throughout this time via the researcher. The data will not be used for any other purpose than for this doctoral research.

It is possible that some of the questions on the outcomes questionnaire may cause service users, particularly the elderly and frail to become distressed, however, none of the questions that are included on the outcomes questionnaire are any more intrusive than a standard assessment that would be carried out by community staff.

If service users become distressed during the observations then the observation will be terminated and appropriate reassurance and signposting to services given. Participants will be given a contact number for both the Patient Advice and Liaison Service (PALS) and Care Connect if they wish to discuss any issues that arise as a result of their participation, and will have the option to withdraw their data at any time during the study and up to 6 months following completion of the study. Contact details for the Chair of Coventry University Ethics Committee, Prof. Neil Forbes will be given as well as details for the Patient Advice and Liaison Service if any participant wishes to make a complaint or raise a concern with the researcher or the services they have received respectively. Participants will not be paid for taking part in this study. Coventry University insurance cover will apply to this study.

No-one will benefit financially from this study.

Collecting Data

1. Data collection

The study will use mixed methods with a predominantly ethnographic approach. Qualitative methods including observation, documentary analysis and interviews will be combined with a questionnaire and a statistical analysis of waiting lists for the single point of access and traditional referral methods to give a holistic view of the issues surrounding integrated team working in health and social care in Countyshire. Analysis will therefore consist of a mixture of methods, to include a statistical analysis of waiting times (a t-test), content analysis of the interview transcripts and observation notes, documentary analysis and statistical analysis of questionnaire responses (using guidance from the PSSRU).

The objectives will be addressed in the following ways:

Documentary analysis will be used to examine the local policy responses to legislation and guidance regarding the SPA: for example, training slides, meeting minutes, etc. used in the implementation of the SPA. Previous, current and future Government policy with regard to health and social care and how these were interpreted by NHS South West, NHS Countyshire and Countyshire Council will be analysed. Any training slides used will be analysed as will meeting minutes dating from the time of inception of the service right through to the time of the first service user going through the SPA.

Qualitative methods (observation and semi-structured interviews) will be used to address these objectives (please see appendix A for interview schedules). Thematic analysis of the semi structured interviews, observations and field notes will be made. Any digitally recorded data will be transcribed personally by the researcher and analysed and coded by hand. This will produce broad categories which will then be collapsed into themes using grounded theory.

Average waiting times over a 6 month period from both the community staff records and the single point of access staff records will be compared using a t-test via SPSS by the researcher to assess whether there is any difference between waiting times between the two services, exclusively with regard to Occupational Therapy at the request of NHS Countyshire.

Traditionally satisfaction scales have been used to monitor the effectiveness of health and social care, however there is growing evidence that outcomes are a more accurate reflection of the efficacy of health and social services (Malley & Netten 2008). Malley and Netten (2008) argue that the measurement of outcomes is more generalisable to a variety of settings than satisfaction measures, which are subjective and liable to change between individual users (Malley, Netten & Jones 2007). Outcomes are a similar measure to quality of life measures, specifically measuring social care related quality of life items, such as control over daily life, personal care and relationships with professional staff (Malley & Netten 2008). The ASCOT (Adult Social Care Outcomes Toolkit) SCT4 version 1.0 four level self completion questionnaire (enclosed) will be distributed to service users for completion and requested to be sent back to the SPA office within 1 month. This questionnaire will be returned with demographic information for each respondent. A telephone number and email address for the researcher will be included in case of any questions or issues arising with completion.

2. Use of recording equipment

Digital recording of interviews and observations of service users will be used. Any audio or other electronic data such as typed transcripts will be stored on the researcher's laptop, and password protected. A USB pen drive will not be used to store any data. Paper data will be stored in a locked filing cabinet in the researcher's office at Coventry University, which has prox card controlled access. Participants will be fully informed of the intention to digitally record their interviews and observations and both initial written and on-going verbal consent will be sought. If a participant indicates they consent to take part in the study but would prefer not to be digitally recorded this will be indicated on the consent form and written field notes will be recorded instead.

3. Rationale for choice of method

The methods to be used have been selected pragmatically based on the objectives of the study. The qualitative methods will provide a valuable personal insight into the everyday working lives of the community staff using different referral methods and will assist with commissioning and planning of services. A direct view of joint working between Countyshire Council and NHS Countyshire will also be gained and any gaps in training or communication that need to be addressed identified; these insights will be invaluable as adult health and social care moves into a new era of GP commissioning.

Outcomes data and the statistical comparison of waiting lists will indicate the efficiency, effectiveness of services and overall quality of life that service users in Countyshire are experiencing.

The documentary analysis will provide feedback for both Countyshire Council and NHS Countyshire for their training, planning and communication processes.

4. Use of data for other purposes

The data obtained from this study will not be used for any other purpose.

5. Confidentiality and anonymity of data

Data cannot be entirely anonymised but will be confidential. There is a risk of breaches to confidentiality because it may be that some members of staff might be only one of their profession within a team. To address this, if necessary, the staff member will be referred to as “a health professional” or “a social care professional”. Any data deemed by the researcher to be sensitive will be sanitised by use of a general title (e.g. “health/social care professional”) rather than specific job title or excluded from the analysis as appropriate.

Personal data obtained in this study will not be shared with others unless anonymised, however if a service user or member of staff makes a disclosure that they are intending to harm themselves or other people, or have done so, or that they are being harmed then the researcher will have to share this information with the appropriate agency, which in Countyshire will be the Safeguarding Adults/Children team, accessible via Care Connect. This will be made clear to participants in the information sheet.

Output of data

Data will be owned by Coventry University and will form the basis of a postgraduate research degree (PhD). Findings may be presented at conferences and in peer reviewed journals following viva voce. A summary of the main findings will be presented to Countyshire Council and NHS Countyshire (or equivalent) at the end of the study.

Linda Harris
Postgraduate Research Student
Coventry University



Observation schedule

	Information to be considered	Field notes
Background information		
Context	Location	
	Number/type of staff in office	
	Seating arrangements	

Description of session	Working hours of staff members	
	Which staff members are present and when	
	Lunch/coffee breaks, scheduled and unscheduled	
Any other considerations		
Staff activity		
Staff activity observed	What is member of staff doing e.g. in a meeting, on a visit, on the telephone, ordering equipment etc	
	Type of communication – verbal/non verbal, telephone or face to face	
	Formal/non formal communication e.g. coffee break chat or discussion to formally record in notes	
	Time spent doing activity	

Motivation	Why member of staff is completing this activity – what is end goal?	
Problems encountered	e.g. obtaining contact with other members of staff, difficulty in communicating with others, service users etc.	
Any other considerations		



Participant Information Sheet - staff

Information about the project/Purpose of the project

This project is part of a PhD thesis sponsored by Coventry University. Its aims are to examine inter-professional and interagency working in Countyshire between NHS Countyshire and Countyshire Council with particular focus on the effects of the single point of access on team working and service user care.

Why have I been chosen?

You have been chosen to take part due to your professional role in Countyshire. Your opinions and views on inter-agency working and the single point of access will give an insight into the daily working of community health and social care in Countyshire and any issues surrounding this.

Do I have to take part?

You do not have to take part in the research study if you do not wish to and this will be respected by the researcher. However it is possible that you may encounter the researcher during the observation period of the study. If you do not want any data relating to you or your role to be included within the analysis please alert the researcher to this at the beginning of the study and any information relating to you will be removed.

What do I have to do?

Your involvement will consist either of completing an interview with the researcher and being observed during your normal working day, or just being observed. It is possible that the researcher will ask to join you on some of your visits as an observer. The researcher will seek further consent from you if this is the case. The interviews will be digitally recorded and transcribed at a later date. Please inform the researcher if you would prefer not to be recorded.

What are the risks associated with this project?

There are no anticipated risks to taking part in this study. All data will be anonymised but it may be possible to identify you by things you say or do. To minimise the chances of this happening, possible identifiers – including specific job titles, will be removed from text.

What are the benefits of taking part?

By taking part in the study you will be helping to provide knowledge about how health and social care staff work together within and between agencies, not just in your locality but country wide following publication of the study. This will provide information for your employers to assess the benefits and drawbacks of integrated and non integrated ways of working, and contribute to improvements that could be made to the services, for both staff and service users.

Withdrawal options

It will be possible to withdraw at any time if you wish or up to 6 months following completion of the study – please inform the researcher who will remove all data related to you and ensure that it is destroyed. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision to not take part, will not have any adverse effect on your future relationship with your employer or Coventry University.

Data protection & confidentiality

All data will be treated as confidential and will only be accessed by the researcher and members of the researcher's immediate supervisory team.

What if things go wrong? Who to complain to

If you would like to make a complaint or require any further information at any point during the study, please feel free to contact the researcher on:

This item has been removed due to Data Protection. The unabridged version of the thesis can be viewed in the

or harri127@uni.coventry.ac.uk

If you would prefer, you can contact Coventry University on: 024 7688 7688

If you have any problems with the conduct of the study please contact the Chair of Coventry University Ethics Committee, Prof. Neil Forbes (n.forbes@coventry.ac.uk), for your concerns to be investigated. Any complaints will be handled through Coventry University Complaints Procedure.

Will my taking part in this study be kept confidential?

In compliance with the Data Protection Act (1998) all information collected about you during the course of the research will be treated as strictly confidential. To ensure confidentiality, all information including digital recordings and transcripts will be coded. However, if instances of sub-standard practice are identified during the course of this research study they will be reported to the relevant organisation. Electronic information will be password protected to ensure anonymity and paper copies stored in a locked filing cabinet. Recordings will be destroyed following transcription.

What will happen with the results of the study?

The results of the study will be analysed and will contribute towards a PhD thesis. It is possible that the results will be published in a peer reviewed journal.

Who has reviewed this study?

The study was been reviewed and given a favourable ethical opinion by the NHS South West Research Ethics Committee.

Further information/Key contact details

If you would like to know more about the study or have any questions about it then

please do not hesitate to contact me on harri127@uni.coventry.ac.uk (mob) or by email at

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due to Data
Protection. The

If any issues arise as a result of your participation and you wish to discuss these with your employer, please contact HR for your organisation on 01275 546807 (NHS) 01934 634 532 and 01934 634 737 (Countyshire Council)

Linda Harris Postgraduate Research Student Faculty of Health and Life Sciences, Coventry University

Consent Form – Staff members

This project is part of a PhD thesis sponsored by Coventry University. Its aims are to examine interprofessional and interagency working in Countyshire between NHS Countyshire and Countyshire Council, and the effects of the single point of access on team working and service user care.

**Please
tick**

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason | <input type="checkbox"/> |
| 3. I understand that all the information I provide will be treated in confidence | <input type="checkbox"/> |
| 4. I understand that I also have the right to change my mind about participating in the study for a short period after the study has concluded (insert deadline here). | <input type="checkbox"/> |
| 5. I agree to be digitally audio recorded as part of the research project | <input type="checkbox"/> |
| 6. I agree to take part in the research project | <input type="checkbox"/> |

Name of participant:

Name of Researcher:

Signature of participant:

Signature of Researcher:

Date:

Date:

Appendix B – Confidentiality agreement

Confidentiality Agreement

To be signed by anyone undertaking a short term learning opportunity with , i.e. shadowing, learning experience. Placement arranged through qualifications i.e. social work degree, masters and O.T. will be covered by their learning agreements.

I LINDA HARRIS [full name] understand that I during my time with a worker from I will be privy to information about individuals, families and carers accessing various services. I realise that this information must not be repeated and I have read and understand the provisions of the Data Protection Policy (available on the Intranet).

If I have to write or relate anything about my learning experience and wish to refer to any individual I have worked with, I will use job titles in relation to employees and names or initials that bear no relation to the actual persons details, making it clear how I have anonymised the work. I understand that if any breach of confidentiality, by me, comes to the notice of any council worker they will advise the Practice Placement Co-ordinator who will inform the appropriate people, including college/university staff. This may affect my ability to remain on the course.

I have also read and understand the Code of Conduct (also on the Intranet). I agree to act as appropriate to the code recognising that although not a member of the Council, during this learning opportunity I need to behave and present myself in a professional manner. As above, any behaviour or comments that suggest I am not fit to undertake courses in Social Care will be reported.

Signed

Witnessed /

(Council employee overseeing learning opportunity)

dated 16/3/2010

dated 16/3/2010

Full course details

Name of course PhD in Health & Life Sciences
School/College/University Coventry University
Tutor/Course Manager

Appendix C – Interview schedule

Who interviewed	Formal/Informal	Location	Number of times interviewed
SPA team manager	Formal and informal	Meeting room x 1 Desk x 3	4
SPA SS OT	Formal	Meeting room	1
SPA PCT OT	Formal	Meeting room	1
SPA Social Worker	Formal	Meeting room	1
Trainee Manager	Formal	Break out space	1
North PCT OT	Formal	Meeting room	1
North Physio	Formal	Meeting room	1
North Nurse Manager	Formal	Meeting room	1
North Nurse Deputy Manager	Formal	Meeting room	1
Social Services Manager	Formal	Meeting room	1
PCT Manager	Formal	Break out space	1
SPA Service Manager	Formal	Meeting room	1
SPA Programme Manager	Formal	Meeting room	1
Social Services Financial Manager	Informal	Phone call	1
North Community Nurse	Informal	Car	1
SPA Administrator	Informal	Desk	1
North Lead SW	Formal	Break out space	1

Table 12. Staff interviewed in Countyshire

Appendix D – Semi structured interview schedule

Interview schedule

Phase 1 - Commencement of study

Community staff (South – with SPA since June 2009)

1. What is your understanding of the single point of access and the reasons for it being implemented?
2. How do you feel the SPA has affected your day to day work? What was it like before the SPA compared to now?
3. What sort of training (if any) did you receive before the SPA service began?
4. How has your working relationship with other professionals been affected? Do you feel as if the SPA has had a positive or a negative effect on this? If so, why?
5. Do you feel as though you have a better understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria for receiving referrals or working with you for specific service users?
6. How do you think the other professional teams feel about the SPA?
7. In your opinion, how do you think service users have reacted to having a SPA?
8. What, if any, are the benefits in your opinion of the SPA?
9. What, if any, are the problems you experience with the SPA?
10. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

Community staff (North – without SPA)

1. What is your understanding of the single point of access and the reasons for it being implemented?
2. How do you think the SPA will affect your day to day work? What is your day to day work like now with regard to the referral process and working with other professionals?
3. What sort of training (if any) is scheduled for you before the SPA service begins in your area?
4. Do you feel as if the SPA will have a positive or a negative effect on your working relationship with colleagues from other professions? Why?
5. Do you believe you have a good understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria for receiving referrals or working with you for specific service users?

6. How do you think the other professional teams feel about the implementation of the SPA?
7. In your opinion, how do you think service users will react to having a SPA?
8. What, if any, are the benefits in your opinion of the SPA?
9. What, if any, are the problems you anticipate with the SPA?
10. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

SPA staff (South)

1. What were your initial thoughts about the single point of access? What did you believe were the reasons for it being implemented?
2. What sort of training (if any) did you receive before the SPA service began?
3. How do you feel the SPA has affected your community staff colleague's day to day work? What was your experience of it like before the SPA compared to now?
4. How has your working relationship with other professionals been affected? Do you feel as if the SPA has had a positive or a negative effect on this? If so, why?
5. Do you feel as though you have a better understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria for receiving referrals or working with you for specific service users?
6. How do you think the other professional teams feel about the SPA?
7. In your opinion, how do you think service users have reacted to having a SPA?
8. What, if any, are the benefits in your opinion of the SPA?
9. What, if any, are the problems you experience with the SPA?
10. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

Phase 2 – Towards end of study (6 months following initial interview)

Community staff - North

1. What is your understanding of the single point of access and the reasons for it being implemented?
2. How do you feel the SPA has affected your day to day work? What was it like before the SPA compared to now?
3. What sort of training (if any) did you receive before the SPA service began?
4. How has your working relationship with other professionals been affected? Do you feel as if the SPA has had a positive or a negative effect on this? If so, why?

5. Do you feel as though you have a better understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria for receiving referrals or working with you for specific service users??
6. How do you think the other professional teams feel about the SPA?
7. In your opinion, how do you think service users have reacted to having a SPA?
8. What, if any, are the benefits in your opinion of the SPA?
9. What, if any, are the problems you experience with the SPA?

Other staff

Physiotherapy

1. What is your understanding of the single point of access and the reasons for it being implemented?
2. What were the main reasons, in your opinion, for physiotherapy deciding to not be included in the SPA service?
3. How was the SPA service presented to you? Was the way it was presented anything to do with the reasons for not including physiotherapy?
4. How has your working relationship been affected with other professionals? Do you feel as if the SPA has had a positive or a negative effect on this? If so, why?
5. How do you feel the SPA has affected your day to day work, if at all? What was it like before the SPA compared to now?
6. Do you feel as though you have an adequate understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria?
7. How do you think the other professional teams feel about the SPA?
8. In your opinion, how do you think service users have reacted to having a SPA?
9. What, if any, are the benefits in your opinion of the SPA?
10. What, if any, are the problems you anticipate there would be with the SPA?
11. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

Manager interview schedule

1. What is your understanding of the single point of access and what were your initial thoughts about it? What did you believe were the reasons for it being implemented?
2. What sort of training (if any) did you receive before the SPA service began?

3. How do you think the individual teams feel about the SPA? Are there any which have reacted more strongly to this service?
4. How do you feel the SPA has affected community staff's day to day work? What are your beliefs about day to day work for staff was like before the SPA compared to now with regard to interprofessional relationships and the referral process?
5. Do you believe the SPA has had a positive or a negative effect on working between the different professions? If so, why?
6. Do you believe community staff have a better understanding of what their colleagues from other professions do, such as their inclusion/exclusion criteria?
7. In your opinion, how do you think service users have reacted to having a SPA?
8. What, if any, are the benefits in your opinion of the SPA?
9. What, if any, are the problems you experience with the SPA?
10. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

Care Connect call handlers

1. How long have you been working as a Care Connect call handler?
2. What qualifications do you hold, and what sort of training did you receive before you started working for Care Connect?
3. What were your initial thoughts about the single point of access? What did you believe were the reasons for it being implemented?
4. What sort of training (if any) did you receive before the SPA service began and you started to take referrals?
5. How do you feel the SPA has affected community staff's day to day work? What was your experience of it like before the SPA compared to now?
6. How has your workload been affected since the SPA began?
7. Do you feel as though you have a thorough understanding of what your colleagues from other professions do, such as their inclusion/exclusion criteria for receiving referrals?
8. How do you think the other professional teams feel about the SPA?
9. In your opinion, how do you think service users have reacted to having a SPA?
10. What, if any, are the benefits in your opinion of the SPA?
11. What, if any, are the problems you experience with the SPA?
12. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

GP interview schedule

1. What is your understanding of the single point of access and what were your initial thoughts about it? What did you believe were the reasons for it being implemented?
2. Was any sort of training received regarding the SPA service and the reasons for it being implemented?
3. How do you feel the SPA has affected your day to day work? What was your day to day work like before the SPA compared to now with regard to interprofessional relationships and the referral process?
4. Do you believe the SPA has had/will have a positive or a negative effect on working between yourself and other different professions? If so, why?
5. Do you believe you have a good understanding of what your colleagues such as community nurses, physiotherapists and occupational therapists do? e.g. do you know their inclusion/exclusion criteria?
6. In your opinion, how do you think service users have reacted to having a SPA?
7. What, if any, are the benefits in your opinion of the SPA?
8. What, if any, are the problems you experience with the SPA?
9. How do you feel about the coalition Government's plans for health and adult social care? (with explanation if required)

Appendix E – Documents used in analysis

Document name	Origin	Description	Information obtained
Single Point of Access Business Case	Team manager, single point of access	Outline Business Case for the service	Rationale and decision making behind the single point of access detailed as well as its origin in high level policy making
A Joint Social Enterprise for Countyshire	Director of Finance, Countyshire Council	Project brief for a joint health and social care social enterprise	Importance of joint working to health and social care services, plans for finance and communications with staff
Development of GP commissioning in Countyshire	Countyshire PCT	Brief for GP commissioning in Countyshire and the effects this will have on staff and services	Plans for joint working with social care, financial implications, transfer of PCT staff to social enterprise
Community Wards	Countyshire PCT	Document accompanying minutes from PCT Board Meeting February 2011	Detailing changes in Countyshire services with the move to community wards, the financial and staffing

			implications
Chief Executive's Board Report	Countyshire PCT	Document accompanying minutes from PCT Board Meeting February 2011	Detailing changes for Countyshire with regard to GP commissioning and the implications for information technology, integrated working and financial issues
Operational Plan 2011/2012 Update	Countyshire PCT	Document accompanying minutes from PCT Board Meeting February 2011	Plan for PCT over 2011/2012 with regard to information technology, change, management and integrated working
Operational plan principal objectives 2011/2012	Countyshire PCT	Document accompanying minutes from PCT Board Meeting February 2011	Objectives for 2011/2012 session with regard to change, integrated working, finance and management
Board Minutes	Countyshire PCT	Minutes from PCT Board minutes January 2011	Discusses financial issues for 2011/2012
SPA Team meeting November 2011	SPA administrator	Meeting minutes from SPA team meeting	Issues facing SPA team
SPA Team meeting	SPA	Meeting minutes	Issues facing SPA

October 2011	administrator	from SPA team meeting	team
Service Strategy for Adult Care 2011/12	Countyshire Council	Plan for Adult Social Services 2011/2012	Plan with regard to change, integrated working, financial issues and implications for staff
Physiotherapy referrals through SPA	Physiotherapist in charge of implementing SPA for community Physio	Flow chart describing the IT architecture for physiotherapy in SPA, codes for contacts, signposting for service users	Complex nature of IT system and the steps required
Service specification for SPA	PCT provider lead	Specification, quality and productivity report for SPA	Requirements and achievements for SPA, with regard to integrated working and service aspirations
Countyshire Council Team Plan Template	Countyshire Council	SPA team plan 2010/2011	Aspirations and problems facing the team with regard to integrated working, finance and communications
Joint commissioning strategy for Older People Services	Countyshire Council and Countyshire PCT	Plan for integrated services 2010-2013	Failure to provide integrated IT system, issues facing the integration of health and social

			care in Countyshire
HR Policy workshop	HR from both Countyshire Council and Countyshire PCT	Slides from a workshop describing how to manage an integrated team of health and social care professionals	Differences and similarities between policies for Countyshire Council and Countyshire PCT with regard to staffing issues

Table 13. Documents used in documentary analysis

Appendix F – Coventry University Ethics Application

REGISTRY RESEARCH UNIT ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Linda Harris
HLS.....

Faculty/School/Department:

Research project title: Integrated working in Health & Social Care

Comments by the reviewer

Evaluation of the ethics of the proposal: this project is very low risk in terms of potential risk of harm to participants. Anonymity is well considered. People with impaired capacity will not be included. However, it is not clear in the protocol who will decide who has capacity- if the staff members are nominating participants will they be expected to screen for capacity. if so , the criteria for mental capacity should be included, as well as the method for checking capacity. The only other issue is that I think all participants should be offered the option to view the transcript of their interview before it is analysed in case there is something that they wish they hadn't said, or something that was misinterpreted. The other factor to add is that some people may find talking about their experiences of needing care quite distressing especially if it relates to a sensitive or personal problem. There should be some caveat that addresses the issues of potential distress and how this will be handled by the researcher. In addition, there also needs to be some plan regarding disclosure of issues relating to harm or potential harm that may arise as a result of the interviews and how this would be communicated to the relevant authorities e.g elder abuse, child abuse. The researcher should include in the protocol a mechanism to inform relevant parties in situations such as this, and make this clear in the information sheets that in exceptional circumstances, confidentiality will be broken in the case of risk of harm to self or others. I also think that you should add that you will save data in secure archive (both digital and paper data) after the end of the project (as presumably you will be publishing after the viva and may need access to that

data). it needs to be safely stored for 3 years after the end of the project in a form accessible to a third party. In sum: address the assessment of mental capacity and clarify who will assess this how will staff identify suitable participants and how will they be approached to be invited to participate offer participants the option to read their transcripts address how individual distress will be managed by the researcher during interviews address the issue of the need to breach confidentiality in creation circumstances save data in archive for 3 years post end of project

Evaluation of the participant information sheet and consent form: On the whole, fine. I do think that the term PhD "sponsored" by Coventry Uni needs re-wording- the researcher is a postgraduate student of Coventry and that is sufficient. I wondered if more detail about the aims of the project and how participation may improve services not only locally but also nationally through publication. The information sheets don't have the researchers actual name, so please add. The reminder letter reads a bit clumsy- I think it should be more straightforward- e.g. firstly apologies for disturbing them, then point out that you haven't received the questionnaire. if they have already returned then thanks and ignore, then remind the person of the importance of their views for the improvement of services and how much their time is valued and ask again that they complete the questionnaire

Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

Approved - no conditions attached

Approved with minor conditions (no need to resubmit)

Conditional upon the following – please use additional sheets if necessary (please re-submit application)

Rejected for the following reason(s) – please use other side if necessary

Further advice/notes - please use other side if necessary

Name of reviewer:

Dr Liz Hughes

Date: 5th October 2010

August 2010 – v 3

TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

20 March 2015

Dear Sir/Madam

Researcher's name: Ms Linda Harris

Project Title: Integrated working in health & social care

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall

Deputy-Vice-Chancellor, Academic

Enc

CERTIFICATE OF EMPLOYERS' LIABILITY INSURANCE (a)

(Where required by regulation 5 of the Employers' Liability (Compulsory Insurance) Regulations 1998 (the Regulations), one or more copies of this certificate must be displayed at each place of business at which the policy holder employs persons covered by the policy)

1. Name of policy holder Policy No Y016796QBE0110A
Coventry University, Coventry University Enterprises, Acua Limited and Coventry University London Campus Limited

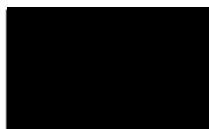
2. Date of commencement of insurance policy 01/08/2010

3. Date of expiry of insurance policy 31/07/2011

We hereby certify that subject to paragraph 2:

1. the policy to which this certificate relates satisfies the requirements of the relevant law applicable in Great Britain, Northern Ireland, Isle of Man, Island of Jersey, Island of Guernsey, Island of Alderney; or any offshore installations in territorial waters around Great Britain and its Continental Shelf (b): and;
2. (a) the minimum amount of cover provided by this policy is no less than £5 million (c); or
~~(b) the cover provided under this policy relates to claims in excess of [£] but not exceeding [£]~~
3. the policy covers the holding company and all its subsidiaries

Signed on behalf of QBE Insurance (Europe) Limited and QBE Casualty Syndicate 386 (Authorised Insurers)



Notes

- (a) *Where the employer is a company to which regulation 3(2) of the Regulations applies, the certificate shall state in a prominent place, either that the policy covers the holding company and all its subsidiaries, or that the policy covers the holding company and all its subsidiaries except any specifically excluded by name, or that the policy covers the holding company and only the named subsidiaries.*
- (b) *Specify applicable law as provided for in regulation 4(6) of the Regulations.*

Important

The Employers' Liability (Compulsory Insurance) Regulations 1998 requires that you keep this certificate or a copy for at least 40 years.
 Extra copies of the certificate will be supplied upon request.

The Insurers' obligations under this policy are several and not joint and are limited solely to the extent of their individual subscriptions. Please see the policy for full details.

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Commercial Insurance

158 Edmund Street
Birmingham
B3 2HB
Tel: 0121 253 3100
Fax: 0121 212 1200

TO WHOM IT MAY CONCERN

July 2010

Dear Sirs

COVENTRY UNIVERSITY AND/OR SUBSIDIARY COMPANIES
SUBSIDIARY COMPANIES: COVENTRY UNIVERSITY ENTERPRISES LTD, ACUA LTD AND
COVENTRY UNIVERSITY LONDON CAMPUS LTD

We act as Insurance Brokers to the above named client; we can confirm their Insurance Policies are in force and are arranged as detailed below:

Employers Liability

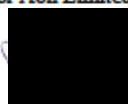
Insurer: QBE Insurance (Europe)
Policy Number: Y016796QBE0110A
Period of Insurance: 1 August 2010 to 31 July 2011 (both days inclusive)
Limit of Indemnity: £25,000,000 any one occurrence

Public/Products Liability

Insurer: QBE Insurance (Europe)
Policy Number: Y016796QBE0110A
Period of Insurance: 1 August 2010 to 31 July 2011 (both days inclusive)
Limit of Indemnity: £25,000,000 each and every occurrence - Public Liability
£25,000,000 each and every loss and in aggregate - Products Liability
Deductibles: £1,000 each and every Property Damage claim
Principal Extension: Students Liability

The information provided is a summary and is subject to the terms and conditions of the Policy.
If you have any further queries, please do not hesitate to contact me.

Yours faithfully
For Aon Limited



ALISON RAY CERT CII
CLIENT SERVICE ADVISOR
Direct Dial: 0121 253 3256
Email: alison.ray@aon.co.uk

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Glossary

e-referral – an electronic referral

GP – General Practitioner

Inter-agency – working between different services whether health and social care, government or local constabulary

Integrated –services working together in a coordinated way

Inter-professional – an attempt to encourage collaboration between professionals

IT – information technology

IPE – interprofessional education

Multi-disciplinary – Different professions working together within a team

MSP – Managing Successful Programmes, a Government mandated tool for change within public sector organisations

NHS – National Health Service

PCT – Primary Care Trust

Uni-professional – One singular profession working or learning alone