Integrated Care: using 'sensemaking' to understand how organisations are working together to transform local health and social care services.

DOI:

[10.1108/JHOM-03-2017-0057](https://doi.org/10.1108/JHOM-03-2017-0057)

Document Version

Accepted author manuscript

[Link to publication record in Manchester Research Explorer](#)

Citation for published version (APA):

Warwick-Giles, L., & Checkland, K. (2018). Integrated Care: using 'sensemaking' to understand how organisations are working together to transform local health and social care services. *Journal of Health, Organization and Management*. <https://doi.org/10.1108/JHOM-03-2017-0057>

Published in:

Journal of Health, Organization and Management

Citing this paper

Please note that where the full-text provided on Manchester Research Explorer is the Author Accepted Manuscript or Proof version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version.

General rights

Copyright and moral rights for the publications made accessible in the Research Explorer are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Takedown policy

If you believe that this document breaches copyright please refer to the University of Manchester's Takedown Procedures [<http://man.ac.uk/04Y6Bo>] or contact uml.scholarlycommunications@manchester.ac.uk providing relevant details, so we can investigate your claim.

Integrated Care: using 'sensemaking' to understand how organisations are working together to transform local health and social care services.

Journal:	<i>Journal of Health Organization and Management</i>
Manuscript ID	JHOM-03-2017-0057.R2
Manuscript Type:	Original Article
Keywords:	Integration, organisational change, Sensemaking

SCHOLARONE™
Manuscripts

Introduction

Integrated care is being promoted as offering a solution to the problems facing public sector services across the world (Cumming, 2011). It is argued that better integration of services is essential to manage the pressures associated with demographic changes, financial shortfalls, increased demand on the acute hospital sector and a rise of people living with multi-morbidities (NHS Future Forum, 2012). However, the best way to achieve integration remains obscure (Bardsley et al., 2013). This paper uses Weick’s (1995) concept of sensemaking to provide some insights into how integration might be realised in practice. We examine how several organisations in one conurbation in England are working together to develop a local integrated care programme, using sensemaking as a theoretical lens. Sensemaking usually focuses on organisations in isolation; however the aim of this paper is to demonstrate how sensemaking can be used to explore how several organisations are making collective ‘sense’ as they work together to improve the delivery of health and care services. This paper is divided into 8 sections. A brief description of conceptual and practical issues surrounding integration followed by an overview of the historical development of the integration agenda in England. We then introduce the theoretical framework of sensemaking and the research context and study methods are outlined. We use the concept of sensemaking to frame the results, and the paper concludes with a discussion and conclusion of the implications of the findings.

Integration: conceptual and practical issues

Integration is heralded as an important goal in many health systems, but its implementation remains complex (Armitage et al 2009). The issues are both conceptual and practical. Conceptually, there is no generally accepted definition of what integration means. In a systematic review, Armitage et al. (2009) found 175 different definitions of integration, whilst the British Medical Association (2014) called integration a ‘nebulous’ term, with a wide range of definitions and processes. Most current uses of the term include some idea of joining up services across organisational and professional boundaries, and suggest that the desired outcome of integration is for patients to experience more ‘joined up’ care (Stokes et al 2016). The mechanisms suggested to achieve this include structural integration, integration of funding streams or integration of work processes across boundaries (Armitage et al 2009).

Williams and Sullivan (2009) suggest that ambiguity surrounding the concept of integration provides an opportunity for local actors to interpret and implement an integration agenda that is appropriate for their local context, whilst Lloyd and Wait (2006) found that individuals interpret integration based on their personal position. Studying joint commissioning processes between health and social care, Dickinson et al (2013) suggest that local actors shape and provide the meaning of joint working locally; thus joint commissioning is context specific. National guidance may suggest meanings to terms such as joint working and integration but local actors will interpret that to suit the objectives they wish to achieve and the feasibility of such work in their local area. Furthermore, different professional groups have also been shown to respond to joint working in different ways. Martin (2010) found that managers tended to be primarily concerned with targets and areas of work that are of particular interest to their own organisation, whilst it has been claimed that GPs struggle to focus on broader population goals; instead they have a more micro and individualistic approach to work (Evans and Killoran, 2000). These differing orientations add an extra layer of complexity when trying to develop joint methods of working.

More practically, studies have explored the enablers and hindrances to joint working. Topics include identity, accountability and the governance surrounding a joint agenda

of work (Dickinson et al., 2013). Factors impacting upon joint working are said to include: the presence or absence of a shared vision with clear objectives; trust between the organisations involved in the work; a perception that all partners are perceived to be of equal value; clear communication between the organisations; joint ownership of the decisions being made with clear lines of accountability; a clear focus on what the expected outcomes should be with a realistic way of measuring them; and a person in place to manage the change as it is occurring (Wildridge et al, 2004). Leadership is often discussed as a factor that influences integration. However, leadership, like integration is a complex term that is understood differently by different actors Armistead et al. (2007) claim that leaders need to deploy different forms of leadership within a collaborative model of working. Overall, leaders within partnerships must work to create co-operation across the different stakeholders involved within the partnership (Weiss et al., 2002). Pettigrew (2003) suggested that the complex nature of leadership in collaborative working arrangements needed to be re-evaluated. Work by Huxham and Vangen (2005) suggested that hierarchical leadership is not applicable to collaborative work. Instead a shared leadership role and a flexibility which allows emergent leaders to develop were found to be enabling influences for successful collaboration, leading to actors feeling supported and empowered to carry out the work intended by the collaboration. These concepts were found to be underpinned by structures and processes (governance) within the collaborative model. Overall, Armistead (2007) suggest that leadership within collaboration is a paradox, between having a leader of the programme of work whilst implementing governance which allows the distribution of leadership within the programme.

Furthermore, there are structural factors that may influence practices and ways of working. Williams and Sullivan (2009) reported that characteristics of the geographical area could impede collaboration, whilst the structural separation in the NHS between 'purchasers' and 'providers' of care could be problematic. Differences in culture and approach to care between health and social care professionals can also be an issue (Glendinning, 2002). In addition, the distance between those constructing the strategy and those implementing it often poses problems within the programmes of work. Williams and Sullivan (2009) found skills to be an issue, with individuals often not provided with necessary training or development to support joint working. Charlesworth (2001) suggests that history between and across organisations affects both the development and progression of collaboration. Thus, if organisations have worked together previously this will influence the way in which they choose to work together again.

This very brief overview of the literature illustrates how complex collaborative working can be. Joint working and integration are presented within policy as a solution to complex issues; however working collaboratively can add further complexities and bureaucracy to established working practices.

The integration agenda in England

Integration is the current descriptor used by central government to promote and encourage health and social care services to closely align their work (NHS Future Forum, 2012). However, the idea of working in partnership and working more collaboratively within and across the English NHS is not a new phenomenon. The Audit Commission (1998) suggested that organisations come together to work collaboratively to tackle problems that transcend organisational boundaries. Collaboration has been on the policy agenda for a number of years, although the words and definitions used have varied over time. Terms used include: integration; collaboration; joint working; and partnership working. In the 1980s Joint Consultative Committees and Joint Planning

Groups jointly commissioned services between health and social care (Dickinson et al, 2013), although outcomes were mixed, with some evidence of more talk than action (Greig, 1997). In the 1990's the New Labour government emphasised partnership working, with an aim of 'breaking down the Berlin wall between health and social care' (Department of Health, 1998). Callaghan (2000) suggested that the term partnership and a move towards more collaborative forms of working across organisational boundaries arose out of the political emphasis being placed upon localism. Under the banner of 'partnership working', the New Labour government (1997-2010) introduced a number of local policy initiatives to try and improve population health and tackle health inequalities (Snape, 2004). Initiatives included: Health Action Zones, designed to support joint action to tackle inequalities; Local Area Agreements, in which commissioners from Local Authorities and Primary Care Trusts (PCTs) were encouraged to work with other local partners to create joined up plans to meet the health needs of the population; and Joint Strategic Needs Assessments, though which Local Authorities and PCTs were supposed to jointly agree an agenda for service development. . Services being developed collectively were portrayed as having the ability to increase efficiencies in the system. These were later replaced by Local Public Service Agreements. This is just a brief summary of how collaborative working has been developed and implemented locally in and across health and social care. In 2010, a new Coalition government varied the terminology again, focusing upon the need for *integration* (NHS Future Forum, 2012). However, the overall goal remained much the same: to promote collaborative working between health and social care services and across organisational and professional boundaries.

In May 2013, a shared document was published between the NHS, social care, and local authorities outlining the national shared commitment to integrated care (National Collaboration for Integrated Care and Support, 2013). Integration is proffered as a means to provide better person centred care by improving communication across health and social care and reducing fragmentation and duplication in a financially constrained system.

To support this agenda in England, in 2013, a Transformation Fund was announced, later renamed the Better Care Fund (BCF) (National Audit Office, 2014). It was claimed that a headline figure of £3.8 billion would be released by 2015/16 to encourage health and social care integration. This was not new money; rather, local commissioners were charged with identifying areas of their existing budgets which they would pool with social care budgets (held in England by the Local Authority) to support out of hospital care. It was assumed by policy makers that such care would enable savings to be made elsewhere, rendering the scheme self-financing. The BCF process includes a quarterly assurance process to monitor how local areas are trying to reduce non-elective admissions, reduce the number of delayed transfers of care and reduce unnecessary hospital admissions at the weekend.

Alongside the BCF, other national integration initiatives have also been introduced. For example, in 2013 the 'Integration Pioneers scheme' was announced whereby local areas were asked to apply to become pioneers and exemplars of local integration work: In total 25 sites were announced in January 2015. The 25 sites were supported by a small team of account managers in NHSE and some representatives from the Local Government Association. Support was tailored to their specific requirements, for example legal advice on contracting, workforce development and information about governance challenges. However, there was no funding available and no clear framework to evaluate whether or not they had been successful. Initiatives introduced under this heading included: multidisciplinary team working; raising awareness of local community support organisations; and the employment of 'care navigators' to support patients in finding the help that they needed. An interim report of the early evaluation of

the Integrated Pioneers claimed that it was too early to draw any firm conclusions on successes, two years after their initial announcement. A shared definition of integrated care and a focus on user experience was suggested to be helpful in the development of a local vision for the programme. However, to date there is limited evidence of any changes to service delivery (Erens et al., 2016). The local pioneer schemes were found to reflect national policy direction over time. With a need to produce quick wins, this in turn narrowed the focus of the local schemes (Erens et al, 2016).

The most recent integration initiative is the Five Year Forward View (NHS England 2014). This document sets out plans for the development of NHS services over the next five years, with a focus on new ways of delivering integration between health and social care, and between different health care sectors (i.e. primary, community and secondary care). Five 'new care models' were proposed: primary and acute care systems, bringing together acute hospitals with primary, community and social care providers (PACS); multi-speciality community providers, in which all types of community providers work together with their social care counter-parts (MCPs); extended care in care homes, in which local primary and community care providers work together with private and council-funded care homes to improve care for patients (CH); urgent and emergency care, in which different combinations of providers work together across a geographical area to rationalise and improve urgent and emergency care (UEC); and Acute Care Systems, in which providers of acute care work together to rationalise and improve provision of more specialised services. Volunteer groups of commissioners and providers were invited to come forward to test these 'new care models'. Fifty such groups were designated as 'Vanguards', and successful applicants were provided with additional funding and support, with the aim of leading the way and providing a 'blueprint' for the rest of the health care system. Whilst these sites are free to develop services in ways that they deem fit, the focus is upon integration, with the desired outcomes of improving efficiency and reducing costs.

Thus, through a proliferation of initiatives, pilot schemes and funding models, service providers in England are under pressure to come up with new ways to deliver integrated services. This paper explores the development and implementation of one such scheme. The contribution offered is twofold. Firstly, we offer some of the first evidence from the current round of organisational change in the NHS in England. Our detailed exploration of one site which embarked on this journey somewhat earlier than many ('Linfield') offers lessons which may be of value to those following the same path. Secondly, we explore the utility of 'sensemaking' as a theoretical lens through which to explore what is happening, finishing with some reflections upon what this adds to the analysis.

Theoretical Framework

Our brief summary of the literature has highlighted the extent to which shared understandings and shared meanings are important if organisations are to work together successfully across boundaries. Weick's (Weick, 1995) concept of sensemaking provides one approach to understanding these processes. Weick argues that within any organisational situation, collective storytelling underpins both the interpretation of situations and decisions about what should be done. Weick argues that 'cues' or situations are interpreted by individuals within organisations in the light of their previous experiences, and that those interpretations act to generate subsequent behaviours. Sensemaking describes a process by which organisations construct their collective identity. This is of particular relevance when organisations experience new circumstances or change. Weick (1995) argues that sensemaking is underpinned by seven properties, which can be used to explore how organisations interpret and manage change. Sensemaking is grounded in identity construction, both individual and collective. It is retrospective, with responses to change often occurring rapidly and

instinctively. Thus, interpretation of a situation or 'cue' often occurs as a retrospective reconstruction, in which the action that was taken structures the 'story' told about the nature of the problem. Sensemaking is on-going and continuous, with the noticing of 'cues', their interpretation, reaction and reinterpretation occurring simultaneously and continuously. What is noticed or not noticed as a 'cue' is determined by past experience and embedded understandings and interpretations of the outside world. Although sensemaking is established through shared values and understanding of 'cues', Weick (1, p180) emphasizes that the collective generation of 'sense' can depend as much on disagreement and the voicing of alternative viewpoints as it does on shared understandings.

A number of authors have used sensemaking as a framework within which to understand change in healthcare systems. Parry (2003) explored how executives in a local hospital trust made 'sense' of their professional lives, and found action, reflection and experience to be the key elements that shaped individuals' understandings. Parry argues that the more experience an individual accumulated, the fewer instances arose in which sensemaking was required. Coleman et al. (2014) explored the implementation of Practice Based Commissioning in the English NHS and showed that local sensemaking within NHS organisations was influenced by local history, with previous experiences NHS changes underpinning the conceptual schemata used to understand new initiatives. Norms and routines rooted in past experiences shaped response to the new 'cues' that arose when change occurred. Ericson (2001) used sensemaking to explore organisational change within a Swedish hospital. At the time, University Hospitals were being decentralised and hospital integration was encouraged. New central levels within the hospitals were created under the leadership of a centre manager, who held the responsibility for transforming initial ideas into a formal structure. Tensions and difficulties were experienced because no consistent understanding of the meaning of the changes was developed amongst centre staff; this in turn impacted on the development of the new formal structures.

A more recent study applied sensemaking within an NHS hospital trust to examine the implementation of clinical governance systems, focusing on how clinical governance was understood across different hierarchical levels within the hospital (Som, 2017). The concept of clinical governance was found to be complex, often meaning different things to different people based upon their professional experience and hierarchical level within the organisation. Collective leadership was found to be crucial in developing a shared vision of what constitutes clinical governance, with good communication the most important enabling factor.

Sandberg and Tsoukas (2015) reviewed the sensemaking literature, and argue that it tends to focus too heavily on retrospective understanding of what has occurred, rather than projecting forward to analyse how future plans may play out. They criticise Weick's 'properties' of sensemaking as too restrictive, failing to allow for active interpretation in advance of action. Furthermore they suggest that those using sensemaking in research often neglect to take into consideration the wider context within which sensemaking occurs; this paper therefore takes account of the wider policy discourse around integration, exploring how this has shaped sensemaking within an integration programme. Battles et al. (2006) support the importance of using both retrospective and prospective sensemaking to reduce or eliminate risk or hazards to patient safety. They highlight the three main mechanisms used to monitor risks and hazards in patient care, including root cause analysis (post event), failure modes effect analysis examining processes, and risk assessment implemented at system level. However, the best learning outcomes were found when conversation was utilised, drawing on individuals' expertise alongside formal monitoring tools. Risk reduction was more likely to be achieved if experiential factors were included in the analysis.

Within the wider sensemaking literature there is an acknowledgement that organisations do not only *react* to change; key individuals within organisations can play a pivotal role in driving a particular change agenda. Gioia and Chittipeddi (1991) suggest that organisational change provides an opportunity for leaders to articulate a new vision. This is referred to as ‘sensegiving’ and is defined thus: *‘Sensegiving is concerned with the process of attempting to influence sensemaking and meaning construction of others towards a preferred definition of organizational reality’* (p442). Hope (2010) looked more broadly across different levels within organisations, and argued that as well as leaders acting as ‘sensegivers’, middle managers could also manoeuvre themselves into specific roles whereby their interpretations of local ‘sense’ prevailed. Checkland et al. (2013) concur, demonstrating how organisational change provided proactive managers in a Primary Care Trust with an opportunity to introduce and embed new practices and elucidating the practical behaviours by which they achieved this. Meeting attendance (and absence), alongside the control of written materials such as meeting minutes and presentation slides were instrumental in enabling managers to shape sensemaking.

Our early data collection highlighted the importance ascribed to shared histories and the development of a collective identity. This, along with the findings from the literature related to partnership and integrated working suggested that Weick’s framework would be a fruitful lens through which to analyse the findings. In the rest of this paper we use Weick’s theoretical framework to address the following questions:

- How did local leaders seek to construct a collective identity for the programme?
- What local and historical social processes supported this work, and what was the impact of the wider NHS context?
- To what extent does the concept of sensemaking contribute to an understanding of the ongoing development of the programme?

Our discussion draws together the answers to these questions and reflects upon the implications for other similar programmes in the NHS and elsewhere.

Research context: an Integrated Care Programme in ‘Linfield’

The Integrated Care Programme (ICP) in Linfield is a collaboration between four organisations: a Foundation Trust (FT); Clinical Commissioning Group (CCG); City Council (CC); and a Mental Health Trust (MHT). The ICP was initially funded by a pooled budget of approximately £100 million between the CCG and the CC, with the intention of improving care for the over 65 population. Linfield has historically had poor health outcomes, and there are marked differences in health status dependent upon where a person resides. The ICP has a triple aim of delivering better health and social care outcomes, improving the experience of service users and carers, and reducing health and social care costs. These aims underpin three programmes of work. Firstly, a single point of access (SPA) has been established, providing a hub and single telephone number to access both health and social care services. The adult social care contact team and district nursing administrative support have been co-located to deliver the service. The SPA provides advice and sign-posting to services, with the aim of streamlining access to services, thereby reducing the use of urgent or emergency services. Secondly, there is a community development group (CDG) bringing together local community groups and charities to improve community resilience. The purpose of the CDG is to collate local information about specific groups and networks that are available for older people locally, strengthening the ability of these groups to offer support to older people to remain active and independent. Finally, multi-professional groups (MPGs) are a mechanism to manage people most ‘at risk’ within the population. Vulnerable patients are discussed by multi-professional groups at neighbourhood level, to support their care at home, reducing costly hospital admissions. The programme overall aims to ‘raise the aspirations of the population’, although there is a lack of clarity of what that actually

means. Performance targets for the programme include reducing emergency admissions and re-admissions, increasing satisfaction with care and support and improving the quality of life for users and carers.

Methods

A qualitative approach was adopted to explore how the ICP was developed and how organisations were working together to make changes in Linfield. Fieldwork took place from November 2014 to Dec 2016. Data collection included 44 hours of non-participant observations of ICP programme meetings; meetings included the high level strategic meetings, operational groups and MPG meetings (see figure 1).

Figure 1: Structure of the ICP meetings

In-depth field notes were taken. In addition, 28 face to face interviews were carried out with professionals working across all four of the key stakeholder organisations, who were closely associated with the ICP. Interviews lasted approximately one hour and were based on a loosely defined topic guide aimed at exploring the development, construction and implementation of the ICP. Documents were collected from the ICP and relevant meetings; these documents provided contextual information about the programme (see table 1).

Table 1: Data Collection

The longitudinal nature of the project allowed an iterative coding and analysis process. Analysis of interview and observation data was facilitated by a computerized data analysis package NVIVO. Initial coding was carried out using a priori codes derived from our existing understanding of the issues associated with commissioning complex programmes. These were supplemented by inductive coding arising from the data and potential themes were developed (Braun and Clarke, 2006). Analytical memos were written and discussed to develop a collective understanding of the issues represented in the data. Findings relating to the commissioning of the programme were shared with the wider research team and further explored in interviews with those responsible for the implementation of the project.

Results

The results presented in this paper represent one workstream in a large scale evaluation of Linfield ICP. This workstream focused upon the interactions between the organisations involved, including the development and commissioning of the programme. There were several themes that appeared to be crucial in the development of the ICP from an organizational perspective. This section of the paper aims to explore these themes in more detail using sensemaking as a framework.

The construction of a shared identity

Time and energy was invested across all of the organisations in trying to develop the shared ICP identity. Each organization worked with representatives of the general public to develop a ‘Linfield Together’ brand. Attention was paid to details such as logo design and colours, to ensure that the ethos of the programme was being captured. The construction of the ‘brand’ was intended to emphasise the needs of the community of Linfield rather than focusing on individual organizational requirements.

This was rhetorically situated as moving beyond the traditional commissioner/provider split, with a focus upon the greater good of the population rather than individual organisations being seen as ‘winning’ or ‘losing’:

'I think that mind set is really important, about not having to win every time. It's better sometimes to get a draw, than seeing it in terms of winning and losing. So I think the leadership mind set has been part of this as well'. ID 20

In the early stages of the programme considerable time and effort were expended on the development of this shared identity. However, we observed something of a mismatch between the scale of the rhetorical claims made and the reality of the three programmes of work that are being implemented. These programmes are relatively small in scope, focusing upon a small segment of the population (e.g. Multi-professional Groups focused upon older patients at high risk of emergency admission to hospital) or on a small part of the overall system (the Single Point of Access focuses mainly on the first time that older people seek community health or social care support). However, the rhetorical claims made in the process of developing the shared identity speak to a much broader 'transformation' of services;

ID 5: In the June and July, the Linfield Together brand was developed; this idea came from the [Community Development Group] working with older people in Linfield. Its starts in blue to represent the NHS and finishes in magenta to represent the city council. It is important that people sit us together... We have the expertise and so much coming into Linfield, the sky's our limit. If we develop [further initiatives] the services would be for the whole population not just the over 65s. We've had two people go to the Houses of Parliament to talk about our experience of the MPGs.

This suggests that, at this stage of development of the ICP, identity construction is at least as important as concrete action. The process of creating a shared identity helped provide a sense of clarity and side-stepped difficult questions as to whether this was functional, organisational or clinical integration.

Social processes

The creation of the ICP is embedded in historical relationships. There is a long history of joint working in Linfield which respondents told us led to the development of trust between the organisations delivering the ICP. Budgets had been pooled before, and service delivery had been managed across varying combinations of organisations. This experience provided a platform for organisations to start discussions about the ICP:

'So in Linfield, we've got a very strong record in terms of joint working. So from a commissioner only perspective between the council and the PCT that was and the CCG, we've got a track record of pooled budgets... So we already had pooled budgets in place for immediate care, for the equipment service, for learning difficulties. And we've got joint appointments. So we've got a pool of commissioning managers that work across the council and the CCG as well. So we've got some very good examples of how we've worked collectively as commissioners. So we've got that history'. ID 11

Local social processes have influenced how organisations perceive each other and helped to shape how they work together operationally:

'Well it's based on successes. We've stuck at partnerships for 15 or more years in Linfield, so we've got a baseline that proves we can make things work, if we stick at the joint working. So that gave all the partner organisations the confidence to push into this latest partnership'. ID3

It is interesting to see how a 'story' of local successes has been developed and told. This narrative of success implies that the success of the ICP is *inevitable* because of what has been previously achieved. There is no focus here on evidence and outcomes but more on the strength and resilience of local relationships, and the goals that can be achieved through them. This narrative was effective in generating the momentum required to get the programme underway. It supported leaders in persuading their individual organisations to commit the human and financial resources that were required to ensure that the implementation of the programme continued. This supports Weick (1995) claims that sensemaking is generally a group activity, built upon collective experiences and shared memories which are enacted via discourse. Thus, sensemaking is driven by what is deemed as plausible by local actors rather than what is accurate or evidence based.

Observations of meetings and interviews did not show significant disagreements between the stakeholder organisations during the period of the research. However, one manager explained that ideas and 'tricky decisions' were managed in a separate room by the leaders of the organisations:

'So the very senior leaders have a leadership group and they meet once a month...and they make a lot of agreements in that meeting about how things are going to happen, but it's not an open forum, it's not minuted and it doesn't have a formal agenda. So we all know [iff] it's been agreed at the leadership meeting and it's very likely it's going to happen'. ID 5

Thus, maintaining the narrative of 'inevitable' success required a non-public forum within which issues could be aired and agreed without public scrutiny. Relationships within this 'closed' group had built up over time during previous rounds of collaborative activity. Thus, current activity arises out of previous social processes.

The wider context

National policy and the current financial situation facing the health and social care system influenced how all four organisations were making sense of the integration agenda. The health and social care system in England, like those across the world, has been functioning in a time of austerity, rising population demands and centrally imposed budget cuts (NHS England, 2014). Individuals said that the financial constraints that were being experienced across the system had helped make local integration possible;

I think, being realistic, everybody recognises that integration is the only route through austerity. You cannot deliver services in the siloed way we have with the financial constraints in the future. It's just completely unsustainable. So there has to be a strong sense of, it's the right thing to do but it's the only thing you can do'. ID 10

However, although the direction of travel in Linfield was very much in keeping with the broader policy agenda in England (NHS England, 2014), it had developed in advance of the national policy agenda. The four organisations involved had started to work together before initiatives such as the Better Care Fund were introduced, giving a sense of local ownership as well as sufficient time to develop a shared plan:

'...with the older people's work we always owned everything as four organisations and that sometimes meant going around not in circles but lot of iterations of paperwork and documents and paper. So that everybody felt that, yes, that reflects what we...our contribution, we understand the language, it's not going to upset anybody, that sort of thing. ID 6

However, the development of national policy was felt to be helpful, in providing legitimisation for what they were planning:

'I mean, the policy stuff is in a different place now than it was 20 years ago. . National policy supports us; the Better Care Fund drives it. So, it's about timing really'. ID 2

Thus, when the Better Care Fund initiative was announced (National Audit Office, 2014), Linfield applied for BCF status to support their existing objectives. Thus, the BCF was subsumed into their existing plans, with local implementation efforts boosted by the sense that they were in line with national policy objectives.

Although policy support of the local agenda was found to be beneficial in providing financial resources to help support the programme, the process of applying for funding was found to be time consuming and often meant that local timelines and plans were interrupted. In some circumstances it was argued to be meaningless for the local agenda but a priority for the local stakeholders to ensure that more funding was available to support the programmes;

'Yeah, and we wouldn't necessarily have done things in an order we would have done things in in a logical...we were sort of, we've got to respond to that for the vanguard and let's not cobble something together'
ID 6

Beyond the practical need to align with national policy imperatives in order to obtain additional funding and meet national targets, the broader national policy agenda also appeared to act in more subtle ways. Thus, in meeting observations, rather than focusing upon evidence, a strong narrative was mobilised which tied the local agenda with the broader policy imperative to do things differently in order to cope with current fiscal and demographic challenges.

On-going Developments - sensegiving

The integration agenda has moved rapidly in Linfield and developed significantly during fieldwork. It was agreed that the integration agenda needed to move beyond the over 65 population originally targeted, covering the whole adult population. To deliver this broader integration agenda, an Integrated Care Organization (ICO) has been developed. This model of working has been supported by national policy which encourages innovation and new models of care (NHS England, 2014). The ICO consists of the FT being the lead provider, and staff in the provider arm of the CC now work in the FT. The CCG and CC co-commission the ICO to provide the majority of health, social and community care services for Linfield. The role of the FT as the lead provider is to provide the care that is being co-commissioned by the CCG and the CC either directly or by sub-contracting through a supply chain mechanism with other providers to provide care on their behalf. This model of working means that the FT is accountable to the commissioners for service provision for the whole of Linfield. However, what it means to 'be accountable' still lacks clarity, and there is potential for the new arrangements to have a significant impact on all organisations involved, with the role of the CCG changing significantly. In spite of the uncertainty surrounding the detail of what these developments will mean in practice, there is a general consensus that it is the right direction of travel;

Manager 6: The ICO will be more resilient and cost effective. We are aware of the risks; if this is not successful we are in trouble as we are putting all our eggs in one basket. We have given a slightly different angle from the providers. [ICO visioning event]

The development of the ICO was being discussed before the full implementation of the ICP, and before it was clear whether the programme was delivering any of its objectives. The ICO idea therefore rested not upon a rational exploration of outcomes achieved or problems encountered, but upon rhetorical claims developed by senior managers across all four of the organisations. These key individuals articulated a vision of what is needed, emphasizing the apparent inevitability of providers coming together in a single organization. In Weick's terms, these leaders were 'enacting a sensible environment' (p30) by their public words, setting a frame in which to dissent is to deny both the current narrative of 'success' and the forward narrative of inevitability. In other words, they were 'sensegiving' to those around them, seeking to influence the dominant construction of meaning in the new organization (Gioia and Chittipeddi, 1991).

Sensegiving is different from sensemaking, in that key individuals try to attempt to influence other people to perceive action and situations in a particular way. The 'sensegiving' enacted by the leaders in Linfield is an attempt to generate on-going enthusiasm and co-operation amongst all staff within and across the four organisations. The presentation of a particular narrative of existing and future success is used by key leaders to present the ICO as the obvious next step on from the ICP;

Councillor 1: We need to be proud of what we've achieved, we're an exemplar. It is important to get your ideas, as you're the ones that do the hard work, it is important that we should be proud of how we work together. In London, they are saying that they want Linfield to show other authorities what we are doing; this is because of all of you, thank you for what you do... The preciousness of organisations and departments has gone; we need to think about how we can work together. March Engagement Event

The fulsome praise and appreciation of staff that was articulated at the engagement event and the constant reiteration of the extent of the programme's success seems intended to generate good will amongst those involved and enthuse them to work harder in collaboration across all organizational boundaries of work. In Weick's terms the 'narrative of success' is a tool that is being used to enact an environment in which collaboration becomes routine and normalised. The practical effect of this in Linfield is to generate a situation in which rational appraisal of the *extent* of success is unnecessary, and the momentum behind on-going change (the developing ICO) makes it potentially difficult to stop. Sensegiving and the construction of the narrative of success is on-going and continues to be deployed by key leaders across all of the four organisations. An annual report has been produced, lauding the success of the programme so far, and is used as a tool to encourage the acceptance of a new working reality and to try and engage individuals working across all four organisations into the modes of thinking. Gioia and Chittipeddi (1991) refer to this as key leaders 'supplying a workable interpretation to those who could be affected by the actions' (p443).

The narrative of success was utilised in a number of different ways by the leaders of the organisations in addition to generating a local momentum to ensure that work continued on the programme of work. Thus, for example, it was communicated at public engagement events, illustrating to the public how well the organizations worked together, with a focus on the success of the relationships that were being constructed, rather than on more objective outcomes. The narrative of success was further used within a political arena both locally and nationally. Locally the local success was presented as Linfield leading the way on implementing an integration agenda; nationally, Linfield was recognised as succeeding with the ICP and this provided them with a foundation to apply for additional funding for developing new models of working.

However, at local level, the reality of the ICP's enactment was more nuanced than the official narrative implied. Whilst leaders were able to generate local momentum for the development of the ICO, there were a number of issues with its realisation. For example, GP engagement was far less extensive than the plans envisaged; in particular, GPs were concerned about the potential for domination by the local FT. To mitigate this, it was initially decided by the commissioners to discuss the potential of an ICO without specifying a particular secondary care provider, even though the decision that the FT would lead the ICO had already been made. It was believed that discussing the ICO in this way would provide the local GPs with an opportunity to understand the ICO model and appreciate it:

ID 6: For the engagement programme, we started what general practice would look like within an ICS or ICO. The approach we have taken is that we don't think that working with [Local FT] is the only option but it is an option. General practice need to look at feasibility, risk and benefits. We need to make them as proud to do it by following a bottom up approach. April Steering Group

One CCG GP, spoke of his/her concern about GPs interpreting the ICO model as a model of employment, whereby they would be employed by the main contract provider. This particular GP believed that this would cause tensions and worry for local GPs as being part of a wider organisation would remove elements of their independence and control: This model of working was perceived to go against what GPs have trained to do:

'I said would it better if we work for a big organisation they could recruit people better, I don't know if they would, you'd have a pay progression, people saying there could be benefits for working for an organisation...I'm not convinced on that because we're independent contractors as you know and I think one thing that you do get you have control over your life, An employee when you're angry you can't do anything'. ID 14

There was such concern about the lack of GP engagement in the ICO model that an independent GP was employed to try and understand why GPs had disengaged from the process:

'...A lot of work that had been done previously with the ICO before that, and it made huge assumptions about what general practice could and couldn't deliver, and this was based, all these things on a few peoples' opinions, GPs' opinions who are round the table of the commissioning group rather than actually who are the most influential practices and individuals within those practices. ID 26

Thus, whilst the sensegiving undertaken by the senior team was very successful in generating momentum for the establishment of an integrated organisation, it did not fully translate into successful enactment of all aspects of the model as envisaged. This highlights one of the dangers of this approach: the positive message required in the sensegiving to generate momentum may have impeded a realistic appreciation of the extent of grass-roots engagement.

Discussion

This study provides an examination of the issues surrounding the development of new, more integrated, models of care in an English city. It is timely, in that models such as this are currently being rolled out across England (NHS England, 2014), and are widespread internationally. We found that both sensemaking (Weick, 1995) and sensegiving (Gioia and Chittipeddi, 1991) were useful concepts in understanding what is happening in Linfield. Viewing implementation through the lens of sensemaking

highlighted the importance of social processes and associated identity construction. Enthusiasms around a local 'brand', rooted in a sense of exceptionalism and longstanding shared history was important in generating early enthusiasm and buy in, and creating momentum for the programme. More recently, a strong narrative of success (which is not yet rooted in any clear objective achievements) has been used by senior leaders in their 'sensegiving' in order to generate additional enthusiasm for a more formal structural integration programme. Both lenses highlight the importance of history, both as a rhetorical resource and as an anchor point from which closer integration is intended to flow. This chimes with the broader literature exploring partnership working, in which a positive history of previous collaboration is seen as an important enabling factor (Charlesworth, 2001), whilst historical problems can derail collaboration (Coleman et al., 2014). Taken together, this evidence emphasises the fact that searching for 'one best way' of collaborating or developing integrated care programmes misses the point. Organisations cannot simply replicate what has been implemented elsewhere; instead, integration, collaboration and partnership working are all context specific and embedded in pre-existing social environments. Both organizational working practices and key individuals play pivotal roles in enabling collaborative programmes of work.

The role of collective sensemaking and 'sensegiving' by leaders across all four organisations were important tools in the development of this collaborative programme. We found a consistent message and narrative of success from key leaders, which was designed to ensure that the momentum of the programme is maintained. This narrative of success was intended to enthuse and mobilise individuals working throughout the organisations. We have shown how senior leaders used 'sensegiving' both in private meetings and public forums (e.g. publication of the annual report) to create an identity for the ICP that was separate from the individual organisations. The importance of such a narrative was clear in our study. It provided a 'banner' around which those involved could rally, and provided a story which was used to generate momentum and sustain activity in the face of predictable difficulties and unpredictable problems. However, the development and sustenance of such a strong narrative brings with it issues not only for the programme itself but also for would-be evaluators. For the programme, a strong narrative of early success acted to limit the possibility of examining failure in any detail, and may have contributed to a failure to appreciate the lack of engagement amongst GPs which we have highlighted. Whilst at the operational level local problems were acknowledged and worked upon, at the more strategic level such difficulties tended to be minimized. Thus, for example, many outcome indicators were missed in the first year. The response to this was to write a narrative interim report which eschews indicators in favour of providing a story of successful inter-agency working. This raises questions as to what – if any – emerging outcomes might generate a more fundamental rethink as to the overall shape of the programme. Fischbacher-Smith (2015) evaluated a number of partnership initiatives in the NHS in Scotland, and highlighted the fact that, whilst useful in generating enthusiasm, the type of success narrative that we have identified – associated with an un-challengeable assertion that partnership working across boundaries was self-evidentially a good thing – should be married to a clear-eyed and detailed assessment of the cultural and social complexities associated with such work. Managing this balance is complicated, and requires managers to be reflexive and self-critical.

For evaluators, the dominant narrative of success can also generate issues. Whilst programmes such as this will ultimately stand or fall upon an assessment of the concrete outcomes achieved, formative and process evaluations must seek to probe beneath the dominant story that is being told. This study suggests that observational research methods provide an important tool in this regard. Observing meetings at different levels across the organisation allowed the researchers to compare interview narratives with the

day to day reality, unpicking the ‘story’ and testing the claims made. For example, the narrative of success developed by leaders was somewhat at odds with the daily realities at the implementation level of the programme. Staffing issues were an on-going problem within the MPGs which caused frustration for staff attending the meetings and prohibited the collaboration across different professions for managing patient caseloads. Observing such issues, alongside observation of strategic-level meetings and public events allowed us to see the rhetorical use of success narratives in context, problematizing them and exploring their uses.

Conclusion

Weick’s sensemaking framework provided a valuable lens through which to view this developing integration initiative, in particular highlighting the role of social processes and the importance of identity development. Sensegiving by senior leaders was powerful and consistent. However, it is also potentially problematic, as the need to project a narrative of success may act to minimise or deflect attention from any difficulties. This suggests an important lesson for others engaged in such projects – there need to be forums within which scepticism and challenge are encouraged and welcomed. Furthermore, from the perspective of the current international integration agenda, strong sensegiving associated with narratives of success may lead to unrealistic aspirations for healthcare commissioners and providers of what integration may actually achieve. It also highlights the importance of evaluators moving beyond evidence from interviews to include observations of meetings, both public and private. This approach allowed us to observe the rhetorical use of success narratives in context, problematizing them and exploring their uses. Such methods can be time-consuming, but we would argue that in a situation such as this where maintaining momentum and enthusing participants requires strong ‘sensegiving’ by those in senior positions, it is time well spent.

- ARMISTEAD, C., PETTIGREW, P. & AVES, S. 2007. Exploring Leadership in Multi-Sectoral Partnerships. *Leadership*, 3, 211-230.
- ARMITAGE, G. D., SUTER, E., OEIKE, N., D & ADAIR, C., E 2009. Health systems integration: state of the evidence. *International Journal of Integrated Care*, 9.
- BARDSLEY, M., STEVENTON, SMITH, J. & DIXON, J. 2013. Evaluating integrated and community based care. How do we know what works? . London: The Nuffield Trust.
- BATTLES, J. B., DIXON, N. M., BOROTKANICS, R. J., RABIN-FASTMEN. BARBARA. & KAPLAN, H. S. 2006. Sensemaking of Patient Safety Risks and Hazards. *Health Services Research*, 41, 1555-1575.
- BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- CHARLESWORTH, J. 2001. Negotiating and managing partnership in primary care. *Health & Social Care in the Community*, 9, 279-285.
- CHECKLAND, K., HARRISON, S., SNOW, S., COLEMAN, A. & MCDERMOTT, I. 2013. Understanding the work done by NHS commissioning managers: An exploration of the microprocesses underlying day-to-day sensemaking in UK primary care organisations. *Journal of Health Organization and Management*, 27, 149-170.
- COLEMAN, A., CHECKLAND, K. & HARRISON, S. 2014. Local histories and local sensemaking: a case of policy implementation in the English National Health Service. In: HILL, M. (ed.) *Studying Public Policy. An international approach*. Bristol: Policy Press.
- CUMMING, J. 2011. Integrated Care in New Zealand. *International Journal of Integrated Care*, 11.
- DEPARTMENT OF HEALTH 1998. Partnership in action (New opportunities for joint working between health and social services). London: HSMO.
- DICKINSON, H., GLASBY, J., NICHOLDS, A., JEFFARES, S., ROBINSON, S. & SULLIVAN, H. 2013. Joint commissioning in health and social care: an exploration of definitions, processes, services and outcomes. Final Report ed. Southampton: NIHR Service Delivery and Organisation Programme.
- ERENS, B., WISTOW, G., MOUNIER-JACK, S., DOUGLAS, N., JONES, L., MANACORDA, T. & MAYS, N. 2016. Early evaluation of the Integrated Care and Support Pioneers Programme. Final report. London: Policy Innovation Research Unit.
- ERICSON, T. 2001. Sensemaking in organisations-towards a conceptual framework for understanding strategic change. *Scandinavian Journal of Management*, 17, 109-131.
- EVANS, D. & KILLORAN, A. 2000. Tackling health inequalities through partnership working: Learning from a realistic evaluation. *Critical Public Health*, 10, 125 - 140.
- FISCHBACHER-SMITH, M. 2015. Mind the gaps: managing difference in partnership working. *Public Money & Management*, 35, 195-202.
- GIOIA, D. A. & CHITTIPEDDI, K. 1991. Sensemaking and sensegiving in strategic change initiation. *Strategic Management Journal*, 12, 433-448.
- GLENDINNING, C. 2002. Partnerships between health and social services: developing a framework for evaluation. *Policy & Politics*, 30, 115-127.
- GREIG, R. 1997. 'Joint Commissioning: Searching for Stability in an Unstable World'. *Tizard Learning Disability Review*, 2, 19-25
- HOPE, O. 2010. The politics of middle management sensemaking and sensegiving. *Journal of Change Management*, 10, 195-215.
- HUXHAM, C. & VANGEN, S. 2005. *Managing to Collaborate: The Theory and Practice of Collaborative Advantage*, London, Sage.
- LLOYD, J. & WAIT, S. 2006. Integrated care: a guide for policy makers.
- MARTIN, S. 2010. From new public management to networked community governance? Strategic local public service networks in England. *The new public governance*, 337-48.
- NATIONAL AUDIT OFFICE 2014. Planning for the Better Care Fund. Department of Health, Department for Communities and Local Government and NHS England. .
- NATIONAL COLLABORATION FOR INTEGRATED CARE AND SUPPORT 2013. Integrated Care and Support: Our Shared Commitment.

- 1 NHS ENGLAND 2014. Five year forward view. Leeds: NHS England.
- 2 NHS FUTURE FORUM 2012. Integration. London: Department of Health.
- 3 PARRY, J. 2003. Making sense of executive sensemaking. A phenomenological case study with
4 methodological criticism. . *Journal of Health Organization and Management*, 17, 240-263.
- 5 PETTIGREW, P. J. 2003. Power, Conflicts and Resolutions: A Change Agent's Perspective on
6 Conducting Action Research within a Multi-organizational Partnership. *Systematic Practice
7 and Action Research* 16, 375-391.
- 8 SANDBERG, J. & TSOUKAS, H. 2015. Making sense of the sensemaking perspective: Its
9 constituents, limitations, and opportunities for further development. *Journal of
10 Organizational Behavior*, 36, S6-S32.
- 11 SNAPE, S. 2004. Health and Local Government Partnerships: The Local Government Policy
12 Context. In: SNAPE, S. & TAYLOR, P. (eds.) *Partnerships between Health and Local
13 Government*. London: Frank Cass Publishers.
- 14 SOM, C. 2017. Sense making of clinical governance at different levels in NHS hospital trusts.
15 *Clinical Governance: An international Journal*, 14, 98-112.
- 16 THE AUDIT COMMISSION 1998. A fruitful partnership, effective partnership working. London: The
17 Audit Commission.
- 18 THE BRITISH MEDICAL ASSOCIATION 2014. What is social care, and how can health services better
19 integrate with it? bma.org.uk.
- 20 WEICK, K. E. 1995. *Sensemaking in Organizations*, London, Sage Publications.
- 21 WEISS, E. S., ANDERSON, R. M. & LASKER, R. D. 2002. Making the Most of Collaboration: Exploring
22 the Relationship between Partnership Synergy and Partnership Functioning. . *Health
23 Education and Behaviour*, 29, 683-698.
- 24 WILDRIDGE, V., CHILDS, S., CAWTHRA, L. & MADGE, B. 2004. How to create successful
25 partnerships—a review of the literature. *Health Information & Libraries Journal*, 21, 3-19.
- 26 WILLIAMS, P. & SULLIVAN, H. 2009. Faces of integration. *International Journal of Integrated Care*,
27 9.
- 28 ARMISTEAD, C., PETTIGREW, P. & AVES, S. 2007. Exploring Leadership in Multi-Sectoral
29 Partnerships. *Leadership*, 3, 211-230.
- 30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Figure 1

Table 1

	Number	Further information
Interviews	22 (22 initial interviews and 6 follow up interviews 1 year later)	6 with FT staff (provider), 6 with CCG staff (GPs and Managers-commissioners), 6 with LA staff, 1 with GP Provider organization and 3 with MHT (provider) staff
Observations	22 (approximately 44 hours)	Observations included: Engagement events (1) MPGs (3) Steering Group (8) Programme Board (8) CCG Board (1) Health and Wellbeing Board (1)