United Kingdom National Health Services:
A case study of workforce transformation in an integrated care organisation using
Actor-Network Theory

Abdelhakim Altabaibeh BSc, MSc, RN
Student number 2138543

A thesis submitted to Middlesex University
in partial fulfilment of the requirements for the degree of
Doctor of Philosophy

School of Health and Education
Middlesex University
December 2017

Abstract

Background: Since the 1950s the UK's NHS went through many changes. Those changes including the most recent one; bringing care as close as possible to patients home have affected the services provided as well as those who provide them. One of the local acute health care organisations has chosen to integrate with the community and primary care services in response to this policy. A gap in literature about the role of the frontline health care professionals in the health care policy process was observed.

Aim: The primary aim of this study was to examine the role that the health care professionals have in relation to health policy processes and the implications of the service integration to their professional practice.

Methodology: To overcome the limitation of a single snapshot of the integration process that continues to emerge over the time, an instrumental case study approach to data collection was selected. To maintain the scope of the study, the case study approach also delineated the boundaries of what was to be studied. For the purpose of this study, two methods of data collection were utilised; in depth semi structured interviews with purposefully selected informants and documentary analyses. Actor Network Theory (ANT) was used as a theoretical framework to guide the research process.

Findings: Though it could be explicit for health organisations integration as a special form of change, this study suggests that, neither the context nor the actors were the sole determinants of the outcome of the integration, it was rather the dynamic interplay between the actors, their context, the shared agency (social structures, rules, values, norms) and the resources available to them that shaped the end result.

Conclusion: This thesis addresses an important issue in UK health care policy in relation to the reciprocal effect of frontline health care professionals and other policy driver on the policy implementation process and result.

Contents

Tables

Diagrams

Figures

Abbreviations

ANT	Actor Network Theory
BACC	British Association of Critical Care Nurses
CCG	Clinical Commissioning Groups
C. Diff	Clostridium difficile
COPD	Chronic Obstructive Pulmonary Disease
COR	Community Respiratory team
DH	Department of Health
Dr	Doctor
FT	Foundation Trust
GP	General Practitioner
GMC	General Medical Council
ITU	Intensive treatment unit
MRSA	Methicillin-resistant Staphylococcus aureus
NVIVO	A qualitative data analysis computer software package produced by QSR International.
OPP	Obligatory Passage Point
PbR	Payment by Result
PCT	Primary Care Trusts
Physio	Physiotherapy/therapist
PR	Pulmonary Rehabilitation
NHS	National Health Service
NMC	Nursing and Midwifery Council
RCN	Royal College of Nursing
SPICe	the Scottish Parliament Information Centre
UK	United Kingdom

Chapter 1

1.1 The research prologue

Since its establishment The United Kingdom's (UK) National Health Service (NHS) has served the entire nation. Yet, if Aneurin Bevan the UK's first minster of health were to see the NHS of today, he may not recognise it, following the numerous changes it has undergone since the 1950s. Those changes affected both the services provided as well as the professionals who provided them. In general, the changes were incremental rather than dramatic or radical. When such a situation occurs like that of the current reform it is worth studying to understand the context in which the policy implementation occurs, the dynamics of the health care system, the impact of this policy change on the service provision and the professionals and the role of the professionals in policy process implementation. This case study research explores the impact of the current policy changes namely; the relocation of the services nearer to the patients home, delegating the responsibility of the health service purchasing and delivery as close to the patient as possible and the acute- community-and social services integration on frontline health care professionals and the role those professionals have in policy implementation process.

Those policy changes were in response to Lord Darzi's NHS Next Stage Review (DH, 2007). In his report Darzi recommended a shift away from reliance on the acute care to community services that had been a consistent feature of contemporary health care. These recommendations were adopted by the Coalition government (2010-2015). The Coalition as well as the following Conservative government went even further by suggesting a paradigmatic divergence from governing to governance by the Department of Health in relation to health care management and delivery. This transfer of power and delegation of functions from the central government to the local was happening nearly across all the

governments' departments (Localism Act, 2011). As a consequence, this has influenced how health care in general is practiced as it is inextricably linked to this new health and social policy (Bergen and White, 2005). Hence, this original case study fills a gap in information about the role of health care professionals in health care policy process as well as the interactive relationship between the policy makers and those professionals caring for patients.

1.2 The impetus for this study

The impetus for this current study arose from three sources. Firstly, an identified gap in the literature concerning the way health care organisation integration policy was implemented and the positionality of frontline health care professionals and local managers in policy implementation. Of particular interest was the role of nurses as the largest professional discipline working in the NHS as they are nearly invisible in the available literature. Secondly, was the integration as a phenomenon itself and how it is affecting the service delivery. Finally, as a nurse myself, it was of a personal interest to explore the implementation of this policy and to understand how it will continue to affect nurses as health care professionals and what their role is in the policy process of shaping of the service.

1.3 Thesis structure

The thesis consists of six chapters. This chapter contains the research prologue, outlines the thesis structure and presents the research theoretical orientation. Chapter two provides a critical overview of both the political and empirical context in which the research questions emerged, formed and framed. The first part of chapter two explores the NHS historical reforms and their implication for health care professionals focusing mainly on

professionalism and professional jurisdiction of nurse as the largest health care professional group in the NHS.

Chapter three details the methodological approach chosen to conduct this study, providing account of the research setting, the selection of data sources and how these were sampled, the process of defining the research topic and developing the research question, identification of ethical concerns and how they were addressed, methods of collecting and analysing the data, concluding with discussing issues of trustworthiness and rigour.

Chapter four details the case study storyline through a descriptive account of the policy translation. Chapter five reports the implications of the mobilisation of policy implementation to the professionals and the organisation. Chapter six discusses the study findings. Firstly, the discussion begins by questioning the health care professionals' positionality in relation to the health care policy process and the diffusion of change. The second part of the discussion is developed by locating the findings in relation to a theoretical concept of organisation change serving to expand the contemporary debate in relation to policy process and policy drivers. This provides a brief analysis and reflection on some of the traditional models of change and their ability to explain health care integration as a special form of change. Building on the existing empirical ideas found in related fields, the third part of chapter six offers a model for change through integration in absence of strategic leadership as a particular form of change based on the research finding. Chapter six concludes with a reflection on the adopted theoretical framework, theoretical implications of the research, implications for professional education and professional practice before highlighting the research limitations and possible areas for further research.

1.4 The theoretical orientation

Research methods themselves do not generate knowledge; it is the researcher's theoretical orientation and views of the world that guide the development of the theory (Morgan and Smircich, 1980). The inherently political nature of health policy deems the policy analysis to be greatly influenced by the researcher's position within the policy process. Walt et al (2008) argued that the researcher's theoretical orientation plays a great role in producing a meaningful study especially in such highly sensitive issues. Indeed, as a health care professional and a researcher in addition to the reciprocal role I played within the policy interpretation, adaptation, adoption, implementation and evaluation my views of the policy process had influenced the research focus and agendas.

Nonetheless, the policy analysis by its nature is very sensitive to changes in the temporal political, economical, socio-demographical systems and the intellectual environment (Scott and West, 2001) consequently, affecting the researcher's framing and articulation of the study. On the other hand, it is widely accepted that health care changes drew a broad attention of health care professionals, the general public, service users, government, political parties and private health care providers as well as the pharmaceutical industry. All of these sectors have vested interests in the change and are equipped with a range of knowledge, skills and access to the policy process thus being in the position to influence the policy process accordingly. Furthermore, Staeheli and Lawson (1995) claimed that in policy research, the question of power is present not only within the interview session but also in the interpretation of the generated data. Therefore, clarifying the researcher's own theoretical position aids not only the data gathering and investigation but also the interpretation of the generated data in light of the relevant policy. Linking the generated data with the relevant policy helps us to extend the research findings beyond the research settings in light of that theoretical position. Yet, Walt et al (2008) argued that researchers

often ignore the influence of their assumptions on the data generation, interpretation as well as the conclusions.

In the UK, health policy research flourished over the last 30 years (Scott and West, 2001). Nevertheless, there is no consensus on the definition of health policy. For the purpose of this study a health policy definition that was presented by Buse et al. (2005, p.6) "*embracing a course of action and/interaction that affects the set of institutions, organisation, services and funding arrangements of the health system*" was adopted.

The aim of this study was to examine the role health care professionals caring for critically ill patients have in relation to the health policy processes and the implications of services integration on their professional practice. Barrett and Fudge (1981) argued that enacting a policy encompasses negotiation between the resources' holders and the people responsible for the implementation. Accordingly, the analytical concepts of this study were the competing and conflicting values and interests of a wide range of policy process stakeholders. Hence, power was central to the policy process activities. Furthermore, the participants' roles (whether resisting or conforming) within the policy process were governed by their organisational affiliations (e.g. professional bodies, professional groups, area of practice), access to resources (e.g. knowledge, hierarchal position, budget and management), the policy networks people in these organisations interact with as well as the organisational context in which the participants act. Therefore, this study required an approach that viewed the policy process as a group of active events (Colebatch, 2002) rather than a snapshot of events that happened at a point of time.

Literature on health policy research provides a plethora of theoretical frameworks and theories that could guide researchers in their quest (Fischer et al, 2007; Walt et al. 2008). These public policy theories attempt to explain the relationship between the policy process variables. The most commonly used Public policy theories are punctuated equilibrium (Baumgartner and Jones, 2009), the multiple-stream theory (Kingdon, 1984) and top-down and bottom-up implementation theory (Sabatier, 1999). The punctuated equilibrium theory proposes that the policy cycles revolve between a very slow with minimal change period and a sudden transfiguration period. Hence, a policy remains dominant and stable for an extended period of time until a new problem or power monopolies challenge it, then, a rapid change could happen.

Kingdon (1984) on the other hand, contends that the policy process is a collective choice of combined structural forces that aim to deal with a context specific and temporal issue. Within his multiple-stream theory, Kingdon accommodated some elements of rationalism and incrementalism yet negated the traditional problem solving and the incremental problem solving model. According to this theory there are three streams; problem, policies and politics that run parallel and independent of each other governed by their own internal dynamics. The problem stream represents issues that the policy makers choose to identify as problems. The policy stream refers to the set of ideas and technical solutions that are provided by experts to address those problems. The political stream incorporates but is not limited to all the historical, temporal and contextual political conditions, the national mood and social pressure, the economic situation and the advancement in scientific knowledge (Brunner, 2008; Kingdon, 1984). A window of opportunity to formulate a multi stream policy occurs when the three independent streams merge together. Indeed, this window of opportunity to set an agenda appears when the political circumstances provide the opportunity for the politicians to address an issue that requires public attention to advance

their political cause/career using the available resource including the experts proposed solution. Accordingly, an issue moves up and into the decision agenda of the government only if it serves the interest of the three streams.

Proponents of the implementation theory raised their concern about the direction of the decision making (Sabatier, 1999). Lipsky (1980; 2010) claimed that frontline practitioners have a great impact over the decision making yet, Dye (2001) postulated that the governing elite have the upper hand not only in formulating the policy but also in monitoring its implementation. The British hierarchical political system with central government holding the power exclusively made this model of policy process dominant in Westminster for many years (Smith 1998). However, Mole (2002) and Barrett (2004) contested the unilateral direction of authority and maintained that it is a reciprocal relationship in which a formal authority that runs from the top down is faced with a bottom up resistance and vitiation from the ground level.

On the other hand, among the most commonly used frameworks that help identifying relationships and component involved in policy process are the stage heuristic (Lasswell cited in Walt et al. 2008, p310), policy triangle (Walt and Gilson, 1994) and policy network framework (Thatcher, 1998). The first two frameworks (heuristic and policy triangle) were driven by the traditional policy making process. The traditionalists see the policy process as a rational activity guided by a conscious decision of the policy makers who are elected democratically (Nakamura, 1987). According to the heuristic model of policy making, the public policy cycle is divided into four stages: agenda setting, policy formulation, implementation and evaluation. Whilst the stage heuristic sees the policy process as a linear process (Kelly and Palumbo, 1992), the policy triangulation champions argue that the policy process is nebulous as there is not a clear distinction between the four

stages. The policy triangulation champions argue that the four stages could happen simultaneously and could influence each other (Fischer et al, 2007). Hence, policy triangulation focuses on examining the interaction between the four stages in the process of policy decision making. Policy triangulation framework has been used widely in the investigating health care related issues (Gilson and Raphaely, 2008). However the wide range of actors and factors involved in contemporary health care policy process required a framework that accommodates all those factors and actors with their interest interplay within policy process.

Advocates of the policy network framework argue that the policy process is the product of interaction and interrelationship within a network of actors who have a wide range of backgrounds and interests. This network of actors is yet able to engage in a conjunctive action to negotiate and achieve a common goal (Fischer et al, 2007). This interactive engagement is influenced by factors like the local and global economic, socio-demographic and the general political environment. Moreover, the actor's distance from the nucleus of the policy process determines their involvement and influence on the policy making, implementation and evaluation.

On the other hand Van de Ven (1992) and Van de Ven and Poole (1995) introduced four basic theories to explain organisation change process namely: Evolution, Dialectics, Teleology and life-cycle. They argue that, Evolutionary change is non-linear, unpredicted, driven by adaptation to environmental forces (Darwinian), possibly also incorporating inherited learning (Lamarckian). On the contrary, Dialectic change is a linear, driven by conflict between rival forces, a catastrophic, oscillatory and unpredicted. Teleology on the other hand is similar to the life cycle theory of change as both are linear, deterministic, and sequential. However, according to Teleology theory, organisation change is progressive in

contrast with change in life cycle theory which is sequential and circular. According to those theories, changes are normally driven by either reinforcement or revolts of the existing trends within the organisation or by haemostatic correction to stabilise the situation (Baumgartner and Jones, 2002).

The underpinning assumption of the contemporary UK's health system is that of a multi-agency statutory structure that uses tax to provide health care for the nation on an individual basis. Though the rhetoric of health care policy and decision making has shifted recently towards the end user and the frontline management, the DH politicians have retained the ultimate accountability. Accordingly, though the government has delegated decision making at the meso and micro levels to the frontline stakeholders including the patients and health care professionals who have a wide range of professional and personal interests, the overarching macro management remained in the hands of Whitehall.

Despite the fact that local service providers have to comply with the general directions of the shifting governance, over the last decade we have seen a divergence of service models that were built guided by the local needs. In some places care provided at home resembled that provided in acute care settings (Mandal et al, 2013; Stieglitz et al., 2013; Funk et al., 2010). As a result, this emerging community adapted model of care reduced the reliance on the acute sector and to some extent began to turn the hospitals into huge critical care settings (DH, 2005a; DH. 2000b; Ritter and Tonges, 1991).

In light of this understanding, the Actor Network Theory (ANT) framework that incorporates components of the multi-stream theory has been adopted to help organise this study. This theoretical orientation fosters the identification of all aspects that should be

taken into account and the relationship among those aspects in the process of theory generation (Ostrom, 2007).

The research setting as an integrated care organisation represents a meso-network (the entire organisation) that encompasses a large number of micro-networks (areas of practice, professional groups and management). Yet, the integrated care organisation is an integral part of the macro network (the NHS) in relation to policy making and implementation. Actors within each micro network negotiate their role as well as negotiate the whole subunit's function within the meso and the macro-networks. As the integration phenomenon is still emerging, those policy networks are not yet fully formulated. Moreover, those networks continued to emerge and dilute according to changes in the roles and functions, resources, alliances and needs as well as other circumstances. Likewise, actors could belong to more than one network hence a potential for conflict within one's own role. Adopting this policy analysis framework aids understanding of the conflicting and competing interests of the participants. Hence, the ANT framework has value in exploring those emerging networks.

1.5 Actor Network Theory

Though it has been deeply contested, ANT is one of the most commonly cited approaches to study human interactions with their context. Originally, ANT was used to study innovation in science and technology in the 1980s (Callon, 1986a; 1986b; Callon and Latour, 1981; Law, 1987). ANT has been widely used in conceptualising social interplay in networks where both materials and semiotic environment were inseparable. Callon and Law (1997) explained that, in everyday life there are endless numbers of cases in which the division between human and nonhuman is not straightforward and would even raise ethical, moral and legal dilemmas such as when an embryo became a foetus.

10

The idea behind the ANT development was to abolish the prior dichotomic distinction between human and nonhuman actants/actors within a social context (Gherardi and Nicolini, 2000). Latour (2005) goes further by saying that we as humans belong to society as much as we belong to nature and that both humans and nature constitute each other. ANT views organisation as a heterogeneous social network of humans, textual and material actors that connect together with associations and alliances. An actor in ANT is "*something that acts or to which activity is granted by another . . . an actant . . . can literally be anything provided it is granted to be the source of action*" (Latour, 1996, p. 373).

ANT assigns agency to both materials and human and treats them symmetrically within a network as they are both responsible for the formation of the network irrelevant of the actors' size, psychological makeup, or the motivation behind their actions (Callon and Law, 1997). In this sense, ANT diverted the attention from the human as the sole actor in the traditional social discipline, to the nonhuman's significance in the social life context possessing an equally uncertain and ambiguous entity as the human within the network (Callon, 1986b).

Michael (2000) argues that social relations are context bound and should be seen in relation to their surroundings.

"*There are no humans in the world. Or rather, humans are fabricated – in language, through discursive formations, in their various liaisons with technological or natural actors, across networks that are heterogeneously comprised of humans and nonhumans who are themselves so comprised. Instead of humans and nonhumans we are beginning to think of flows, movements, arrangements, relations. It is through such dynamics that the human (and the nonhuman) emerges.*" (Michael, 2000, p.1*).*

New terminology such as actant /actor, actor network, translation, intermediaries and mediators, obligatory passage point (OPP), black box, inscription and irreversibility has emerged within the ANT to facilitate understanding how actor networks emerge, are composed and constructed, how they are made durable and maintained over time.

As explained earlier, ANT uses the term actor to refer to both human and non-human entities. Thus, in ANT literature, actant instead of actor is often used to reinforce this neutral analytical stance of ANT to both human and non-human and that the agency assigned to either is relational and as a consequence of their interaction within the network rather than inherent (Castree, 2000, Rutland and Aylett 2008). In this study, both human and non-human will be referred to by the term actor. This actor-network interaction continuously reshapes the network and the actor/s hence; ANT sees both actor/s and network as a flow of change rather than stable entities (Latour 1993a, p.262). Through this course of interaction, actor/actant translates its own will and makes other actor/s within the network dependent upon it (Callon and Latour, 1981). The term translation in ANT is borrowed from the French philosopher Serres (1982) and means to build connections (Brown, 2002).

 The concept of black box in ANT is "*a metaphoric representation for taken for granted situations which are no longer need to be considered"* (Latour and Callon 1981, p. 285). ANT provides a tool to open the "black box" of health care integration and restructuring process emergence and diffusion by offering a general analytical tool often not available in traditional diffusion theories. ANT gives actors the opportunity to re-think taken for granted ideas by problematising them. In a process Callon (1986a) called "*translation"* ANT explains how actors gradually form alliances, enrol other actors and use nonhuman

actors to strengthen the network and to secure their interests. This translation process

consists of 4 stages (Table 1).

Table1: Stages of translation

Problematization	This is the first stage in which the focal actor identifies other actors whose interests are in line with their own and the actor renders itself as indispensable by establishing itself as an obligatory passage point for all actors in an actor–network
Interessement	In this stage the focal actor persuades other actors to accept his definition by either coercion or reward.
Enrolment	In this stage other actors get aligned with the interests defined to them by the focal actor
Mobilization	At this final stage, the network mobilises a wide range of resources that warranty other actors' commitment to their side of the agreement and prevent betrayal. Those agreements are inscribed and black boxed to guide the future action and behaviours in the network.

Once a taken for granted reality is breakdown by problematisation, the black box effect

tends to cease and it becomes possible to see its components. During the proplematisation

the actors establish a set of rules and assumptions that other actors need to follow should

they want to join the network. Those set of rules and assumptions are referred to as

Obligatory passage point (OPP).

These translation process attributes of ANT make understanding of the integration process

diffusion within and across the organisation possible. ANT facilitates exploration of

negotiation and group formation between the actors. Accordingly, we are able to examine

the hindering and driving forces behind the actors' enrolment, adoption or declining of the

translation process through these four translation stages (Alcouffe et al, 2008) without

imposing a predetermined positions for the actors nor presumed structure for the network

(Latour, 1999). This active negotiation and dynamic shift of association and alliance between actors result in what is known as actor network. Hajer (2005, p. 303) referred to this continuous discursive formation and transformation of association and alliance between actors as *"discourse structuration"*. This continuous discursive formation and transformation of coalitions and alliance between the actors and actor network result in emergence of a new identity for both the actors and actor network (Latour, 2005).

Consequently, ANT has a vast potential for explaining the complex social interaction associated with the health care integration where human, space, time, materials, technology and other semiotics (visual, linguistic signs and symbols) are inseparable through tracking all actors negotiation and actions that influence the policy process. This ANT semiotic consideration bears a resemblance to grounded theory.

Central to the translation process are the intermediaries and mediators which actors circulate among themselves to secure their position within the network (Latour, 2005). Those intermediaries and mediators could be any entity such as conversations, services, materials, texts or any object of significance to the actors within a network. The difference between the intermediaries and mediators according to Latour (2005) is the role they play within the network. While intermediaries transport meaning and forces without transformation such as those taken for granted rules and policies, mediators do alter meanings they are supposed to carry hence, mediators have more impact on the actor network and more significant to the network direction. Indeed, mediators are essential to the network assemblage and translation would never happen without them. On the contrary, Intermediaries, play a major role in stabilising network by creating artefacts that secure the interest of the actor network and inscribe the role of the actors within the network by black boxing hence the translation becomes relatively irreversible. Hajer

(2005, p. 303) refers to this black boxing of the new reality as "*discourse institutionalisation"*. Both, Intermediaries and Mediators are context bound and can only be seen and understood in relation to their function within the network.

Yet, ANT is not without critics, Vickers and Fox (2005) contend that ANT cannot keep its promises to equal agency and tends to focus on the privileged. To avoid this shortcoming Vickers and Fox recommend focussing on the marginalised actors and cases of resistance within the networks.

However, it is worth mentioning that, ANT is only a framework for inquiries based on uncertainty (Gad and Jensen, 2010) and that the success of the translation process is not guaranteed as actors selected during problematisation may choose to rebut the interessement assigned to them, disapprove the enrolment of their representative (Callon, 1986b) or even decide to abandon the network at later stage. This failure to enrol or the abandonment of the network may lead to further reconfiguration of the network. Therefore, Latour and Woolgar (1986) maintain that organisations stabilise translations by black boxing them, hence making it very costly to revert or change. This inscription is a pivotal aspect of the ANT and should reflect the interest of all involved in the network. Moreover, the mobilisation should address a common problem rather than a marginalised beneficiary issue.

To this end, it is of importance to remember that in research practice, ANT is a tool kit that sensitises researchers to the multiple realities of a phenomenon rather than a research methodology (Law, 2004). Indeed, it enables the researcher to investigate the connectedness and interplay of the social and natural domains and the way they together constitute the phenomenon. Therefore, adopting ANT approach for the current study

essentially emphasises my ontological belief that social relations do not occur in isolation of their nonhuman context.

Furthermore, the symmetrical characteristic of ANT framework is what made it very significant for this research as it helped grasping the messiness of the health care integration. Certainly, the compartmentalisation and disentanglement of subject and object in health care system is only present in our thinking to help us make sense of its reality. To clarify, Tsoukas (2000) argues that reality can only be understood within our and their historical milieu and cultural based meanings and prior understanding. As a result, epistemologically, it is unattainable to understand social reality in its pure form as the mere attempt to investigate it would contaminate it with our previous conceptualisation which is even far from the phenomenon's own non-human context.

Methodologically, ANT's refusal of any pre-assumption about anything within the network provides the researchers with the opportunity to ground their judgment based on the actual performance of the actors. Action becomes the foreground of the network therefore, Latour (2005) argue that research need to follow actors and provide a thick description of the actors action and interaction in their effort to build and dismantle networks.

Though ANT has been used widely to understand how scientific or technical artefacts are integrated with social relations, ANT has a potential in explaining change process dynamics in general. Sarosa (2012) used ANT to examine the enabling factors that aid the success of making business using social media. Using a qualitative approach with semi-structured interviews Sarosa was able to explore all stakeholders' actions as well as factors that led to adopting social media for business conduct.

Moreover, ANT proved to be a useful theoretical framework to

 ''Explore the dynamics in the implementation of a process improvement methodology in the complex organisational setting of a UK National Health Service Trust " (Papadopoulos et al., 2011 p.167).

In their qualitative study, Papadopoulos et al. (2011) were able to track the way organisational players shifted their positions and network allegiances over time. ANT enabled them to identify objects and activities that were useful in engaging actors in networks to achieve the change goal. ANT has been broadly used in health care settings other than the NHS. In Ghana, Afarikumah and Kwankam (2013) deployed ANT to understand the implementation of e-Health in low resource settings. ANT enabled them to identify the actors and factors involved in the e-Health policy implementation process. Using observation, semi-structured interviews with human actors and policy analysis, Afarikumah and Kwankam were able to identify the actors and factors that contribute to the failure of policy translation process hence the failure of the e-Health implementation.

The next chapter addresses the political and empirical context in which the research questions emerged were formed and framed. Chapter two explores the NHS historical reforms and their implication for health care professionals identity and practice and the role professionals played in health care policy process focussing mainly on nurses as the largest health care professional group in the NHS.

Chapter 2

2.0 Literature review

2.1 Introduction

A well-established health care system such as that in the UK rarely undergoes an extensive reform (Alford, 1975), and governments usually approach reform with an incremental change to the status quo rather than a sudden abrupt modification to the responsibilities of services or professionals. However, the escalating cost of health care and the socio-demographic pressure resulted in a sequence of dramatic health care reorganisation in the UK during the last decade. Although the NHS restructuring has been an ongoing process since its establishment, this was the first time that the public service sector has seen this speed and scale of reform. This reform came in the wake of the "*New NHS: modern, dependable*" (DH, 1997). This New NHS document illustrated the past failures and the possible structural changes to tackle those failures and realised the Fit for the 21st Century (DH, 1998) health service. Combined with "*Saving Lives: Our Healthier Nation*" (DH, 1999a), this document initiated the declaration of the Labour Government's '*NHS Plan 2000*' (DH, 2000a). This plan presented the health care policy framework that hoped to materialise the government's vision for the health service through targets. These targets would be enforced centrally aided by massive investments (DH, 2004). Using this strategy, the government attempted to modernise the NHS in a way that would reflect all the encountered socio-demographical and technological changes in the wider society since the NHS act in 1946 (DH, 1997; DH, 2000a).

The idea behind this "*short-sharp-shock reform*"(Charlton and Andras, 2005, p. 111) was to strengthen the founding principle of the NHS by providing an economic, effective and fairer health and social care service (Charlton and Andras, 2005) that kept the patients as the focal point of the system (DH, 2001b; DH, 2010a). This rapid health care reform

coupled with a scarcity of public finances created profound pressure on the frontline health service to reconsider and change the service provision.

According to Lord Darzi, the restructuring of the NHS could be realised only through empowering the health care professionals and using them as change agents who would deliver the future NHS (DH, 2008a). Lord Darzi believed that obstacles facing the NHS were beyond the government's ability and that modernising the health service could only be achieved by cooperation. The coalition government (2010-2015) proclaimed no U-turn on the health care reform and thereupon embraced Lord Darzi's vision for the role of the health care professionals taking control and leading the innovation at local levels (DH, 2010b; Asthana, 2011). Patient choice, decentralisation of powers and increased independent monitoring remained at the heart of the Coalitions' reforms. The main difference between this reform and the previous ones is the weight it gave to the clinicians in improvising solutions to the shortcoming of the NHS rather than presuming structural solutions to its integral problems (Baker, 2000). This Darzi vision of the role professionals play in modernising the NHS reiterated the- Shifting the Balance of Power within the NHS – Securing Delivery vision (DH, 2001b). Yet, this reform places a greater importance on integration and partnership working between the NHS, social care, public health and other local services where the General Practitioners (GP) plays a greater role in commissioning the services for their local people (DH, 2010c).

Indeed the cumulative effect of the legislations arising from all of the NHS reforms has a substantial influence on both care practice settings and the way health care delivery is practiced. Although the NHS faced great demands for efficiency, cost cutting and value for money (Ashworth, 2000; DH, 2010a), the acuity of patients needs admitted to the hospitals has been steadily on the rise (Audit Commission, 1999; Wunsch et al., 2009) requiring

more dedicated critical care services (DH, 1999b; Winters et al., 2007; Wunsch et al., 2009). It can be seen that, the number of general critical care beds has increased proportionally in nearly all acute care settings (The Audit Commission, 1999; DH, 2002; DH, 2012a).

2.2 Study in historical policy context

Since the inception of the NHS, various ideological and pragmatic changes have driven the UK's consecutive governments to reform the health care system. Indeed, the foundation principal of "*free care from cradle to grave ...funded by taxation*" (Beveridge cited in Clark, 2013, p.300) was impregnated with dilemmas that challenged its founders, the managers and the successive governments ever after. The increasing needs and expectations of the population resulted in an escalating need to expand both the service and the workforce which created more strains on the finite resources available.

As a response to these uptrend demands and expectations, the health care system had to improve and modify the way resources were managed and to target where it is needed most. The Guillebaud committee claimed that the capital expenditure of the NHS was far behind the level of the service provided and the impossibility of making savings (Guillebaud report, 1956). The committee instigated the first major review of the NHS and its working in 1953. Since then, the NHS has gone through a series of changes that were driven by both pragmatic and ideological shifts introduced by both Conservative and Labour governments.

These pragmatic and ideological shifts reflected the advancements in the scientific knowledge, the socio demographic changes since the 1960s, the public expectations from the health system (DH, 2008a) combined with the ever increasing workforce size and

division of labour complexity. Despite the fact that health care is normally protected by the election manifestos and popularity polls (e.g., The Labour party manifesto, 2017) it has been affected by the recent intimidating global financial crises and the market meltdown. Certainly, these factors exposed the problems encompassed within the health act; mainly the financial burden it exerted on the tax system. Hence, this current NHS reform shares the common aims of all the previous transformations that took place; increasing efficiency and cost containment (Corey-Lisle et al., 1999; Barzelay and Gallego 2006; Boden et al., 2006; Doherty, 2009). The UK was not unique in this policy shift and convergence, Price et al. (1999) claimed that the United States and Europe had similar shifts in their health care policy.

A review of the policy changes and professionalism in Australia, the United Kingdom (UK), and the United States of America (USA) revealed that restructuring the health care service impacted on the health care personnel practice (Allsop, 1995; Rivett, 1998; Corey-Lisle et al., 1999; Rushmer and Dowling, 2000; Ritter-Telitel, 2002; Ryan-Nicholls, 2004; Doherty, 2009; SPICe, 2012), professional role and professional attributes (Burnum, 1994; Ryan-Nicholls, 2004). To meet the restructuring demands, professionals tended to increase specialisation of function and division of labour, delegate some functions or responded by creating completely new roles and functions (Leatt et al., 1997; Sibbald et al., 2004; Conway, 2007).

The philosophy underpinning the recent NHS shift of emphasis from illness to prevention and health promotion and from acute to community care (DH, 2006a; DH, 2006b; DH, 2010a) appears admirable to both the professionals and the health service users. Yet, some argue that this could be a way of budget trimming (Doetter and Götze, 2011). This left the

health care professionals specially nurses -as the largest part of the health care workforce-vulnerable in the face of cost containment (Wong, 1998).

Literature from the USA on hospital restructuring during the 90s indicated a typical negative impact on nursing staff and patient care (Aiken et al., 2000; 2001). In a survey study of nurses in 711 hospitals from 5 countries conducted by the International Hospital Outcomes Research Consortium nurses reported that the work load has increased due to unfilled vacant jobs and that many of them were not able to care for patient due to time spent on tasks outside their professional roles (Aiken et al., 2001). This in turn, led them to leave nursing due to both low job satisfaction and high work load. This result confirmed a study that compared 7,560 nurses responses to a survey done by the American Journal of Nursing with information from the national database (Shindul-Rothschild et al., 1996). Yet, Campbell (1992) argued that health care reforms in Canada resulted in professionalization of nursing through upgrading nursing education and enhancing nursing autonomy. Many would argue that this was true in relation to the evolution of the nursing profession in the UK (Longley et al., 2007). However, to accommodate the new advancements in nursing roles and levels of autonomy Campbell (1992) and Longley et al. (2007) contended that qualified nurses had to relegate the less skilled tasks to other health care personnel. This is not unique to nursing as USA orthopaedic surgeons delegated what Hughes (1958) called dirty job part of their role to other professionals like podiatrist and general medical professionals during the 1980s while focussing on the interesting part of their job (Heckman, 1998).

The extent to which the recent UK health care reform would overtime impact on nursing practice remains unclear. Literature search provided a wealth of information regarding the direction of the British coalition government health policies. Yet, the same search revealed

a scarcity of research regarding the effect of the reform on health care professionals particularly nursing practice. Therefore, a study examining the implications of the health care reform on nursing practice in UK appears timely and relevant. Influenced by the time and resources available, this study focused on three key polices of the late coalition government health reform.

- The relocation of the services nearer to the patient's home.

- Delegating the responsibility of the health service delivery as close to the patient as possible.

- The acute, community and social services integration.

In the rest of this chapter, the impact of previous health care reforms on health care professionals mainly nurses will be explored, commencing with an overview of the health care reform since the 70s. The next section will investigate the nursing professionalism. Finally, this chapter will conclude by highlighting the impact of previous health care reforms on health care professionals.

2.3 The NHS reforms

2.3.1 The NHS during the 1970-1997

The national approval of using taxation to fund public services began to erode during the 70s (Marshall and Bottomore, 1992). At that time, the newly elected Conservative government took a revolutionary approach that mile posted further reengineering of the NHS during the 80s and 90s. Ideologically, the Conservative government argued that the publicly funded welfare has undermined the- superior at organising production and distribution- free market and created a dependency culture among the poor (Marsland, 1996). Moreover, Margaret Thatcher's government emphasised the need to organise the

health service around the users' needs rather than around those who deliver it as highlighted by the Griffiths' report (Department of Health and Social Security, 1983). As a result non-clinical general managers were introduced to the NHS. This new approach to managing the NHS sparked forceful challenges with clinicians especially doctors (Klein, 2006). Though this imposed managerial control resulted in more effect on health care professionals other than doctors. Doctors were able to maintain their autonomy in using the NHS resources without accepting any accountability (Alaszewski, 1995). However, the National Health Service and Community care Act (1990) brought more restriction on the way doctors cared for their patients. According to this Act, health services needed to be contracted by the purchaser (the District Health Authority) form the service producers (the Community and Acute Care). Doctors no longer can get funds to what they believed is necessary for the patient care and only contracted services could be funded (DH, 1989a). Though, General practitioners were able to apply to be fund holders who could purchase hospital services to their patient. According to this (1990) care act, services could not only be purchased from privet sector as well as the NHS hospitals but also allowed some NHS hospital to achieve a self-governing status which blurred the division between the privet and NHS sectors. Alaszewski (1995) claim that, the hospitals self-governing status was a U-turn on the NHS and a go back to pre NHS voluntary hospital.

This funding restriction from the government was coupled by a mounting pressure from the patient on health care professionals (DH, 1991). The patient Charter (DH, 1991) gave the patients the right to have a clear expectation form health care and a full access to their health records. Medical professionals were under more scrutiny in relation to their practice as they became more accountable to the service purchasers as well as the consumers. This led to monitoring the services provided quality through auditing (DH, 1989c). The results of these audits were used in services contracting process. Furthermore, this charter gave

the patient the right to choose the care providers and the right to move between the General Practitioners which challenged the General Practitioners status (Thompson, 1989).

In 1972 the Briggs Committee recommendations brought a major change to the nursing profession that still influences nursing today (Committee on Nursing, 1972). The resulting Nurses, Midwives and health visitor act (1979) delineated the birth of the United Kingdom Central Council for Nursing, midwifery and Health Visiting (UKCC) in 1983. This new powerful body reorganised, unified and monitored nursing education and registration in the four UK countries through controlling the national boards (Nurses, Midwives and Health Visiting Act, 1979). However, the government still influenced the UKCC decisions through appointing 20 of its 60 members (Pyne, 1998). This governmental grip that enabled decisions to be made in the centre was reinforced through purchasing the pre and post nursing qualification programmes via the regional health authorities as nursing education moved to the newly established universities (Frances and Humphreys, 1998; DH, 1989b).

Although the structure of the 'purchasing consortia' has changed, the hierarchical approach to policy making regarding professionals and health care delivery as a whole remained the basis of the DH thinking through the 1990s. Goodman (2016) extended this argument by claiming that nurses practice in term of what they do and how they do is basically constructed by political decisions and frame by contexts. Wells and Cunningham (2017) explicate this based on nurses tendency to be overwhelm by day to day challenges rather than striking a balance between daily nursing care and engagement in the policy process.

2.3.2 The Labour government (1997-2010)

Once elected, Tony Blair's Labour government realised that spending on the NHS was below the average spending on the public health service in Europe and recognised that there was a growing demand to modernise the NHS workforce, services and care delivery efficiency. The Labour government committed itself to increase the spending on health in real terms. Part of these financial initiatives was directed at nursing services. This fund would be used to build campaigns to attract qualified nurses back into the profession through schemes such as Return to Practice (Hutt and Buchan, 2005). Moreover, a £5 million increment on none-means tested bursaries for students enabled the government to attract more students to study nursing. Nevertheless, the majority of the government's financial investment (£25 million) was allocated to ensure new and enhanced roles for nurses. According to the government, these enhanced roles in particular areas like extending nurse prescribing and nurse led primary care service suited the 21st century.

The continuous increasing demands on the NHS combined with the reduction of junior doctor working hours present in The New Deal (NHS Management Executive, 1991) forced the employers and the policy makers to convince nurses to extend the sphere of their practice aiming at increasing the range of services and output provided per nurse. The United Kingdom Central Council for Nursing and Midwifery (UKCC) responded to this external factor through the Scope of Practice (UKCC, 1992). Accordingly, nurse practitioners adjusted their role boundaries and embraced new responsibilities. This role adjustment involved advancing nursing skills in both decision making and practice (Norman, 2000). As a result, two nursing practice levels beyond the point of registration were recognised in the council's Post-registration Education and Practice (PREP); the Clinical Nurse Specialist (CNS) and the Advanced Nurse Practitioner (ANP) (UKCC, 1994). This was further extended later to appointing nurse consultants in the NHS

(Castledine, 1999). Thus, nurses worked in different ways and at higher levels (UKCC, 1999a). Nonetheless, sceptics use this scenario to illustrate how the central government elites exploited their network relationships with the UKCC to influence their decisions and to advance the central government's political cause.

Creating or re-introducing new senior nursing roles -the matron and the nurse consultant – reflected the significance of ward management and leadership in shaping the future nursing (DH, 1999b; Millward and Bryan, 2005). Dealey et al. (2007) and Redwood et al.(2007) supported this argument by claiming that leading by example and encouraging others to follow enabled the modern matron to address some of the issues raised by the Healthcare Commission Report- Caring for Dignity (Commission for Healthcare Audit and Inspection, 2007).

Similarly, to give students more opportunities to learn, a supernumerary status was given for the Project 2000 students. This project was in the form of a three year university diploma programme. To meet the requirements of the European Union Directives, the study was divided into two equal times for clinical practice and theoretical aspects of the course. Nevertheless, the government claimed that the Project 2000 structure reduced the student's clinical exposure and announced its ineffectiveness in the "Making Difference" (DH, 1999b). In this document the government praised the nurses' actual and potential contribution to health care but criticised the focus on the academic education. Furthermore, the UKCC mirrored this DH position (UKCC, 1999) and the nursing programmes were restructured accordingly (Rivett, 2007).

In "*Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and health care"* the DH (1999b) outlined the future contribution of

nursing to patient care, a contribution that could be realised through improving nursing education, continuous training, improving the working conditions, and enhancing job satisfaction (NHS Executive, 1998). The idea behind this policy document was to prepare nurses for the 21st century through loosening constrains on what nurses do as well as enabling them to work in new and innovative ways (DH, 2000a). Nevertheless, those new roles and innovative ways of practice were to be monitored carefully to assure meeting the core principle of the government policy- high quality care for the consumers (DH, 1998). This government policy shift drove the UKCC to restructure the pre- registration education and to suggest a more flexible education and training with more emphasis on the practice skills and practice support (UKCC, 1999). In fact this modernisation process influenced the statutory body that was charged with holding the registration of nurses, midwives and health visitors -the UKCC- which was replaced by the Nursing and Midwifery Council (NMC).

To accentuate the situation, nursing roles as well as the work load were further revolutionised by other mandates such as the introduction of waiting lists initiatives (Cameron, 2000). These initiatives forced many of the NHS to employ and train nurses to do certain roles such as surgeons' assistants (The Royal College of Surgeon in England, 1999). According to Boss (2002) leaving those new hybrids to perform certain surgical procedures and investigations freed surgeons to spend more time in the operating theatre. Physiotherapist and occupational therapist as well as other allied health care professionals have extended their role to deliver and monitor medical treatment in both community and acute care (DH, 2000c).

Likewise, the Labour government introduced a major restructuring to the health care professionals career pathways that linked the responsibilities and competencies to

remuneration in a process called "job evaluation" (DH, 2003a). As a result, healthcare professionals were placed into a new banding system along other health care service employees excluding the medical and the dentistry professionals based on the NHS Knowledge and Skills Framework (KSF) (DH, 2003b). In the KSF, the DH illustrated the level of knowledge and skills that the NHS employees needed to provide a quality service (RCN, 2005). Furthermore, practitioners needed to demonstrate their achievement of certain dimensions of the KSF to be able to develop and progress within the service (DH, 2003a).

Unfortunately, once implemented in 2004, the agenda for change and the KSF were not popular amongst nurses as much when they were proposed. Nurses and other allied health care professionals complained that they had to apply for the same job that they have been doing for years (Unites community, undated). Moreover, many nurses were unfortunate, as they did not go to the bands that they had expected to (Williamson et al., 2008). Even worse, in some cases nurses were made redundant. Simultaneous with the publication and implementation of the "*Agenda for Change*", a trend to reduce the number of the nurse practitioners who had a degree or a diploma was felt among the NHS hospitals (Longley et al., 2007).

Nursing and other allied health care professionals, according to the government initiatives were expected to take more clinical responsibilities with more emphasis on the leadership component of their roles. To facilitate this change, new graduate nurses at band 5 would be provided with appropriate post graduate courses to enable them to perform tasks and adopt responsibilities which were beyond their role remit previously e.g. admitting and discharging patients and initiating treatment independently (DH, 2000c). Furthermore, boundaries between medicine and other health care professionals become less defined as

doctors relinquished more and more responsibilities to them (Richards, 2000; Fisher et al., 2006,).

However, in recent years, the hierarchical model of the Department of Health has been criticized as being relatively closed to outside influence (DH, 2007). Indeed, this model was viewed as inappropriate in other departments in Whitehall long before that due to changes on the national and the international arena since the 1980s (Rhodes, 1997; Smith, 1999). Nationally, the introduction of the new public management as well as the delegating of central government's responsibilities to agencies and the private sector has loosened the government's control over the decision-making (Rhodes, 1997). Moreover, the globalisation phenomena alongside the growing influence of the European Union (EU) had restricted the national government's ability for decision-making (Schmidt, 1995). Yet, an increasing demand for accountability by a well-informed user in relation to the cost and the effectiveness of the care provided amalgamated with wide variations in the local needs rendered the patriarchal model of health care irrelevant to the temporary context in UK (DH, 2010d; DH, 2012b). Subsequently, health care policy process became more complicated and reliant on actors other than the central bureaucrats.

In 2007 Lord Darzi's NHS Next Stage Review, which resembled the Griffith's report (Department of Health and Social Security,1983) represented the future plan for the "*NHS; a shift away from a provider driven health service*" (DH, 2007). Coupled with the "*NHS next stage Review- a High Quality Workforce*" (DH, 2008a), set a new foundation for a health service that aspired to increase the quality of care, personalisation of the care and giving more power to the clinicians and the patients.

This attitude change from the central government control to governance (Smith, 1998, Localism Act ,2011) provided opportunity to networks of actors (e.g. the professionals, local organisations, managers, the consumers) to cooperate in making decisions regarding their coexisting interests. Whilst actors are interdependent (Nancarrow and Borthwick, (2005), each actor's distance from the decision-making and control over resources decides their contribution to the process (Smith, 1993). To achieve the government's plan; efficient and cost effective health care, a conceptual shift in the construction and skill-mix needed to take place in relation to critical care services and nurses professional roles in the organisation (Glen, 2004). As stated in the report, this reform should be implemented at micro, and macro levels. To emphasise, Lord Darzi's report recommended that, although we needed to think within the context of a national health care framework, the local management and the frontline staff needed to modify and adapt their services according to their local consumer needs. As a result, this change effected all the aspects of health care in the country ranging from the health care professionals pre and post training, employment, continuous professional development, financing, public expectations from the system, care pathways, innovation in service delivery and management as well as the quality assurance (DH, 2008a).

2.3.3 The NHS beyond 2010

Health and social care provision is highly politicised so NHS is always open to political challenge, debate and change (Edwards, 2007). Similarly to all previous British governments, the coalition Conservative-Liberal Democratic government introduced changes to the structure of the NHS in England. Despite the government's acknowledgement of the past success, both parties argued that England's poor quality of care compared with other countries resulted from meagre productivity (Black, 2010). The government asserted that this inadequate productivity correlated with poor quality and

resulted from the previous government's efforts to focus the clinicians' work on processes such as waiting times rather than outcomes. Likewise, allowing the interests of secondary care providers to dominate those of the patient and the primary care practitioners as well as the inadequate engagement of the clinicians in the management process affected both the quality and the productivity of the service provides (DH, 2010a).

This central government's control and bureaucracy combined with the weak attempts to use the market forces and the ineffective purchasing practices as the coalition government argued had contributed to the counter productivity of the NHS under the Labour government. As a result, the coalition government insisted in its White Paper" *The NHS Plan"* that the change was inevitable (DH, 2010a). Nevertheless, the government not only maintained its support to the foundation principles of the NHS- free at the point of use tax funded system- but also committed itself to increase funding by 1% above the inflation rate over the years 2011-2015. This representes1% above inflation funding commitment and was adhered to by the subsequent Conservative government.

This proposed change according to the coalition government was based on the belief that patients, the primary health care practitioners and the local elected representatives know more about the health care needs than managers, health service researchers and policy analysts. They argued that control should be held and decisions must be made as close to the patients as possible (DH, 2010a). This shift from central government to local control was seen to align with the financial and the clinical responsibilities of the local people and enabling the practitioners to provide not only cost effective care but also care that reflected the local needs. Furthermore, it was argued that this local decision making combined with expanding the use of the market force would improve productivity.

To achieve these aims, the government decided to replace both sides of the NHS internal market dichotomy which was introduced in 1991 to separate the purchaser from the provider of secondary care (Health and Social Care Act, 2012 p61-62). In this dichotomy, the primary care trusts commissioned care for their local people from the secondary care trusts. The health care practitioners influence on this process did not only vary but was also not clear (DH, 2012b). The emphasis in the government's new approach involved delegating decision making regarding local services commissioning and delivery to local people (Commissioning Board, 2012). These new roles required the development of new skills in dealing with budgetary and resources allocation. However, it could be argued that moving this responsibility to the frontline practitioners could force them to base their clinical decisions on their financial position rather than the quality and level of care needed. Even more, competition among acute care providers could result in reducing the cost of the services on the expense of the quality as well as the workforce. This competition between service providers and the numerous stakeholders that have varied and competing interests (e.g. General hospitals, specialist services, community based services, hospital Dr, GPs, nurses other health care professionals, managers, community services, other organisations and departments of public health) on patients and the quantification of the care meant that the vulnerable could lose out. Although much of the White Paper appears to have revolved around the community care, nevertheless, shifting the focus from the secondary to primary health care would result in a shift in the hospital bed demand from acute/chronic to intensive care.

2.3.4 The integration era

The focal point of the *NHS five year forward view* (Monitor, NHS England, 2014) was the re-establishing of care efforts to meet the nation's health needs. This involved a collaborative effort between acute care providers and other types of care including the

social services. This collaboration was aimed to address both the financial scarcity and the care needs of the population through bridging the gap between the services. Unification of health and social care services would be realised through developing networks between the acute, primary/ community and social services as well as building partnerships horizontally with other acute hospitals. The emphasis of the integration was to shift the care toward the community through developing new care models.

This *NHS five year forward view* (Monitor, NHS England, 2014) argued that both the social and health care system have failed to meet the growing needs and demand of the population especially those with multiple and complex health care needs. This failure became very significant during the services users transitional phase between the services. This transitional phase required more coordinated care between the services to help the service users settle back in their residence after a period of hospitalisation as well as to prevent existing chronic conditions exacerbating by improving support of people at home. This problem is not unique to UK, in Australia the Department of Health and Aging (DHA) claimed that, vulnerable mentally ill people with complex needs very often suffer a lot due to fragmentation of the services (DHA, 2013). As a result, services integration was proposed to bridge the gap between health and social care (Monitor, NHS England, 2014). This acute -community service integration aimed to not only achieve financially by reducing the need for acute hospital but also reduce human costs in relation to suffering and pain.

Service integration is not a completely new idea. Glasby (2017) suggested that the concept of health care integration goes back to the 1970s joint care planning attempts as well as the joint hospital discharges during the 1990s. Unfortunately, a recent report by the National Audit Office (2017, p7) claimed that

> *"Nearly 20 years of initiatives to join up health and social care by successive governments have not led to system-wide integrated services''* and that *"While there are some positive examples of integration at the local level, there is no compelling evidence to show that integration leads to sustainable financial savings or reduced hospital activity''*. (The National Audit Office, 2017, p7)

According to the Audit Office, these failures were due to NHS intrinsic barriers such as the service remuneration financial incentives as well as the workforce challenges.

Although it is recognised that frontline health care professionals played an essential role in evolution of the NHS, it remains a concern that traditional health care professionals allegiances and organisation might be hindering as opposed to assisting the change (Baxter and Brumfitt, 2008). A report commissioned by the Royal College of Physicians (2013) argued that, hospitals can no longer work in a silo and that doctors and other specialist teams are expect to engage in the service user care beyond the traditional hospital boundaries. Without doubt, frontline health care professionals needed to change not only the way they practiced but also the way they were trained as a consequence of these spanning roles across boundaries (DH, 2008b). Certainly, future health care professionals need to be flexible, agile and a adaptable in a way that enables them to look after complex patient needs across care settings (Addicott et al., 2015). For the integrating organisation to make difference to the service delivery, professionals needed to change the way they worked (Ham and Curry, 2011). The DH (2006a) asserted that the traditional demarcations between health care professionals form barriers in the face of health care service modernisation. For this reason, Smith et al. (2000) argued that removing these professional silos was a key to improving the health care services. Consequently, it could be argued that, a multi-sectors approach at national level was needed to prepare those who work in

the integrated service as well as to change the way health care professionals and health care services are managed and remunerated.

Contemporary literature on health care reform shows that integration happened at three distinct levels (Ham and Curry, 2011);

- Macro level in which the integrated organisation provides the population it service with the whole care needs.

- Meso level the integrated organisation provides care for a group of patients with certain condition such as dementia.

- Micro level, the integrated organisation provides care for individual/s through coordination between the organisations.

The setting of this study responded to the demand of the service delivery change by becoming an integrated care organisation. This innovative way of working -merging the acute and community services together – according to the Trust's vision, aimed to enable the trust to provide affordable and high quality care that meets users needs as close to home as possible. Furthermore, this new way of working aimed to meet its commissioners' demands of quality and cost effective care closer to the service users home. This way of working aimed at bridging the unreliable and inefficient gap between the services thus preventing undue delays and replications of the services that cost life and money (DH, 2010a; 2010b; Naylor et al., 2010, Naylor, 2012).

Nevertheless, according to the (National Audit Office, 2017) it appears that there is no consistency in the way organisation integrates, the role of the health care professionals in the integration policy implementation (Athié et al., 2016) nor the effect of the integration on the way that professionals practice in different settings.

2.4 The changing ground

Health care professionals train and work within a constantly changing environment. As a pluralistic organisation the NHS employs a wide range of different professionals. Each group of those professionals' views the goal of health care, and the process of achieving this goal in an effective manner from different perspective governed by the professional values and codes set by their professional bodies. It is the management's responsibility to bring all of those employees with their different and sometime conflicting views to work together as a team to achieve the organisation's goal. Therefore, the management process holds the key to the success or failure of delivering an effective health care service to the consumers.

In UK, the consecutive governments with their inconsistent ideologies have resulted in introducing different concepts of management. These oscillating management dogmas influenced the goals of health care as well as the process of achieving these goals. Hence, professionals had to modify their roles, work, as well as their training in response. Simultaneous with this evolution of management process in the health care, the social and economic contexts in which the NHS operated changed and health care professional work changed rapidly. To emphasise, the huge development in the scientific knowledge, and expansion of the alternative medicine as well as the public's access to information influenced not only the practitioners work but also the consumer's perception of health and expectations from the health care system. Moreover, the changing life style and the aging population led to changes in the trends of the health care needs represented by the emergence of new diseases and the resurgence of some of the old ones. Even if not immediate, those life style factors impacted upon the organisation of the NHS as well as the work of the health care professionals. The great media attention to health care issues amalgamated with the well-informed public forced the professionals to adopt a more user

sensitive and an empowering relationship with the consumers. This relationship moved the patient from being a recipient of care into an active partner taking greater responsibility for their health. Inevitably, this shift in power from professionals to users influenced the professionals work within the organisation as well as the profession as a whole.

Working with well informed and diverse consumers who held different views toward authority and hierarchal structure posed a challenge to traditional health care professionals especially nursing which could be argued values hierarchal authority. As a result, health care service users and their representatives as well as the media became more critical of what health care personnel did and how they did it. Indeed, recent inquiries highlighted the consumers and the general public's demands of a greater accountability from health care personnel (Francis, 2013).

2.5 Medical professionals and the NHS

Before looking at what doctors do in modern health care system, it is worth looking at the historical evolution of medical profession. Although, medicine has been a well-established profession for very long time, the way it has been practiced has change a lot since the dawn of civilisation (Porter, 1996). Despite the fact that, In modern history, the scientific revolution had a great influence on medical science, Wicks (1998) argued there was no direct connection between the medical theories and the way medicine was practiced. During the eighteenth century there was a wide range of practitioners who worked in the healing field including surgeons, physicians, regular practitioners, apothecaries, wise women, midwifes and nurses (Wicks, 1998). To maintain their income, the relatively lower status physicians at the time were forced to accommodate the powerful wealthy patient demands (Jewson, 1976). This upper class -doctor relationship focused on the totality of

the sick person including their spiritual, emotional and psycho-social aspects in comparison to the objective medicine that focused on the disease.

On the other hand, the healing practice at other levels of society was a mixture of both the formal medicine that cares for patients totality and the informal medicine provided by ritualistic practitioners (Ehrenreich and English, 1973). By 1858, the Medical registration Act gave the medical professionals both power and status (Jones 1994). Doctors had more control over their training and education. Medical professionals adopted the biomedical model and lab work became an important source of knowledge creation beside the bedside learning and education (Wicks, 1998). They became dominant in the caring professions over other care providers like nurses who became subordinate (Dent, 2003). Freidson (1975) claimed that patients were expected to grant doctors authority and control over their bodies in exchange for their expert knowledge and ability to act in the patient best interest. Doctors were able to charge the patient what they wanted, yet patients were able to choose the service they could afford.

By the 19th century, the state realised that poor people were not able to afford health care and that a state fund was needed to support those people. As a result The National Insurance Act provided state funded General practitioners medical care (House of parliament, 1913). This Act resulted in medical professionals worrying about the financial implications as well as its impact on doctors autonomous practice in contrary to nursing professionals who have been always within a state provision (Dingwall et al. 1988). According to this act doctors were to be paid certain fees for their services.

After the Second World War, the NHS was created aiming to provide free care for all at the point of delivery. Medical professionals felt that the NHS would restrict their autonomy

and control their pay. Yet, medical professionals were able to exert force to maintain their financial and autonomous status. According to this new contract, medical professionals were able to work for the NHS as well as privately and GPs were granted independent contracts within the established NHS (BMA, cited in Pater 1981). Indeed, these privileges alongside a promise of senior position within the NHS were given to the medical professionals to assure their support for the nationalisation of the health services (Leathard, 1990).

Most importantly, in the newly established NHS, local authority became responsible for managing their local population's health including children health, vaccination, maternity services, ambulance, ophthalmic, dental service, home care and health visitors, as well as the GP services, while hospital care was managed by the regional hospital board. The central government was able to maintain control of the way those services ran through allocating the funds. Yet, during this time, doctors as health care experts defined and controlled the purpose, delivery and development of health services and had the power to resist any changes that could affect their autonomy (Currie & Procter, 2005, Wicks, 1998).

Although the Guillebaud Report (1956) argued that NHS in reality is underfunded, yet there has been a growing concern about the continuous rising cost of the NHS. Over the next 50 years consecutive governments imposed many changes in the way NHS has been managed aiming to control the spiralling cost and improve efficiency. Even with the 1980-90s NHS managerialism discourse medical professionals were able to protect their professional autonomy. This medical professionals autonomy was maintained by the support of the NHS (Dent and Burtney, 1996) and by doctors taking more managerial roles (Dopson, 2009) hence maintaining control of division of labour within the NHS

(McMurray, 2010). Moreover, medical professionals and Dentists avoided the new banding system for health care professionals introduced by the Agenda for Change.

Since the establishment of the NHS, there have been many attempts to bridge the gap between the primary/community health and the acute services. Recently, Lord Darzi (2007) proposed a polyclinic model of care that offers services such as mental community services, urgent care and social care which is not available at the current GP practices and local health centres. This plan was put on hold by the coalition government health secretary Andrew Lansley (Quinn, 21 May 2010). As a result, the polyclinic idea was not adopted widely in UK. However, Lord Darzi key principle; bringing care and decision about care closer to the service users, has survived and resulted in community/primary and acute care organisations such as the organisation under investigation to integrate. This health care organisation integration has affected the way and the context in which medical professionals as well as other professionals such as physiotherapist, occupational health practice and nurses. Henceforth, this study will bridge the gap in literature regarding the effect of the health care integration on those professionals.

2.6 Nursing and professionalism

In the UK, nursing was not recognised as a profession until the middle of the 19th century (Allan and Jolley, 1982). To some extent and with some exceptions, nurses were considered little more than ignorant, drunken, and world servants with few or no training at all (Dean and Bolton, 1980, Abel-Smith, 1975). Modern nursing is a relatively new profession that has been held back by subordination to another profession, the historical apprenticeship -training on the job model and the gender of its professionals (Baer, 1997).

Historically, the nursing profession has been influenced by many forces such as training reforms, workforce shortages, recruitment and retention, changes in women employment conditions, technological improvement, policy changes as well as the natural development of the nursing profession (DH, 2000a; Williamsons et al., 2008).

The lack of medical and nursing support during the Crimean War provided Nightingale with the public and the government support to professionalise UK's nursing. During the two year war, Nightingale's work attracted a great deal of public and military admiration. This admiration was later translated into a fund in her name and with the help of St Thomas' hospital, Nightingale's fund was used to establish the first nursing school in the country (Allan and Jolley, 1982). Through this revolutionary apprenticeship like system of "in the job training", Florence Nightingale raised the status of nursing to be ranked as a profession in the public's eyes.

To ensure that student nurses mastered the basic skills, it was inevitable that they had to learn them through observation and continuously performing those skills under supervision. However, due to the shortage of qualified nurses, students were relied upon heavily to care for patients in the UK, hence, depriving them from the learning opportunities and keeping them relatively unskilled (Kay cited in Rivett, 1998).

As a female dominated profession nursing was seen as an extension to the traditional female housework role. Therefore, it was unavoidable to some extent to bring the gender based hierarchy into the doctor nurse relationship. In fact, nurses were often taught to think of the doctor-patient-nurse as a family where the doctor was the head of the triumvirate and the vigilant nurse assumed a supportive role (Gamarnikow, 1970; Savage, 1987).

Nurses have not always been accorded professional autonomy. In spite of what Nightingale had achieved, nursing as a feminine and subordinate role to medicine never reached an equal professional recognition (Bingham, 1979). In 1948 this nurse's feminine subordination to the male dominated medicine was confirmed by the powerful influence of the doctors in the shape and the management of the newly born health service under the Labour government (Rivett, 1998). These differences between doctors and other health care professionals including nurses were reflected by a huge pay gap, financial settlements and the clauses of the contracts (Rivett, 1998). Regardless, nursing status began to change after the Second World War and a more professionalised system of education and training was established. During this time new district general hospitals as well as nursing careers and management structures were established as recommended by the Salmon report in 1966 (Rivett, 1998). This standardisation of nursing career and training resulted in a growing recognition of nursing as a profession in UK as well as in most modern health care systems.

Despite the fact that nurses were trained as well as doctors, medical professionals in America demanded assurances that those newly well-educated females will not compete with them on their status or income (Bingham, 1979). Group and Roberts (2001) claimed that, Medicine superiority in America was enforced through the nurse practice act which determined what the nurses could and couldn't do. The picture was slightly different in the UK as doctors managed to secure their dominance through their interference in the training and appointment of nurses (Mitchell, 1984). According to Wicks (1998), in an attempt to resist nursing training, some doctors argued that nurses do not need education, they just need to do what they are told to do by doctors, as well as the rest of the house keeping services. This doctor's opposition of improving the nursing status could be viewed as a

precautionary measure to protect the doctor's jobs rather than stemming from concern about the standards of care (McKee and Lessof, 1992).

This subordinate relationship left nurses on both sides of the ocean striving to do the technical tasks delegated by the doctors (McKee and Lessof, 1992) through manipulating their professional roles and titles. Unfortunately, these delegated tasks did not always enhance nurses professional attributes (e.g. autonomy, control of decision making, responsibility, accountability, authority, and nursing-medical collaboration) as Stein (1967, cited in Wainwright ,1996) argued nurses still needed permission through protocols or prescriptions by the doctors.

2.7 Nursing jurisdiction

Moving nurses to fill the gap caused by the medical personnel shortage due to the reduction of the junior doctors working hours presented in The New Deal (NHS Management executive, 1991) transferred the problem of staffing shortages to the already over stretched nursing workforce. Alongside the restructuring of the NHS, the resulting shortage in nurses was used as an opportunity to dilute the skill mix by replacing registered nurses with health care support workers. Those health care support workers were not registered with the NMC like the band 5 nurses as they were trained in a two year foundation degree. The role of those health care support workers was to support the band 5 nurses with hands-on care (Cavendish, 2013). This move was endorsed by the British Association of Critical Care Nurses (BACCN) with the provision that these roles are supported via all ongoing training and development initiatives (BACCN, 2003). However, this BACCN position contradicts the traditional position which argues that, this move will outstrip nurses from the very reason for becoming a care giver; that is to bring direct comfort to the sick people. Forcing Registered nurses to become distanced from patients

could be argued deprive the patients form essential care components such as completely examining them during bathing, communicating their concerns as well as establishing a rapport with them (Walters, 1994). Moreover, losing direct contact with the patients will diminish nurses' mastery over their profession thus potentially resulting in a decrease in job satisfaction. Deskilling nurses and detaching them from the essence of being a care giver could limit the nursing professional jurisdiction (Dinesen et al., 2007). Indeed, these concerns were shared by first Chief Nurse Officer (CNO) in the 21st century about nursing losing its jurisdiction by taking medical tasks which could only reinforce the nursing subordination to medicine (Mullally, 2003).

On the contrary to this argument, in UK, the Briggs's report (Committee on Nursing, 1972) insisted that a nurse is the person who cares and coordinates care. Similarly, in a historical review of nursing in the USA, Olson (1997) challenged this traditional claim by suggesting that caring is just part of many nursing heritage passed across nursing generations. Olson further argued that historically, the nurses' role went beyond managing their patients and associates to encompass the work place setting as well as the doctors. Furthermore, Stewart (1991) argued that neither the details of the procedures nor the dexterity of the performers gave nursing its professional status. Indeed, it is the emotional sensitivity, the creativity and the discerning of the underlying reason of the procedures that differentiate nursing profession from a highly skilled trade. Thus, subsuming all of these nursing attributions to the idea of caring would extend the concept beyond its usefulness (Stewart, 1991).

Yet, according to Paley (2002) nursing leaders struggled to eloquently identify the nursing professional jurisdiction. Consequently, this conflicting position on what nursing is influenced the current division on what preparation one needs to have to claim the nurse title. Nevertheless, nurses have always used the caring concept strategically as an essential

element of the field of specialist knowledge to achieve the professional status (Finkelman and Kenner, 2013; The International Association for Human Caring, 2013).

2.8 Changes in practice setting

Over and above, the way patient care was delivered has changed over the same period. The shifting emphasis from the professionals needs to that of the patient as the health care consumers, required flexibility in both the way care practiced and the services organisation. Part of the nursing executive role is to help the organisation to achieve its goal through designing nursing models that accommodate both the continuous rising of disease acuity, the abatement of the operational costs of nursing labour and the growing services users needs. This has led to an increased employment of non-licensed practitioners (Richardson, 1999) and the introduction of the Nursing Associate Programme (CC3N, 2015). Those unlicensed health care workers took on tasks performed by professionals only previously (Richardson, 1999). This model of care sways the Professional nursing practice attributes. As a result, registered nurses are assuming more management and supervisory role. Furthermore, professionals like doctors delegated some of their role (e.g. prescribing medication) to other professionals like Advanced Nurse Practitioners (Appel and Malcolm, 2002).

In the UK, Canada as well as America the nursing care model design reflected the model developer's interpretation of the client needs with considerations to the socioeconomic, technology available at the time and the available workforce (Geege, 1995). While it may appear there is a plethora of nursing models nearly all of them revolve around tow concepts: the nursing team which uses a mixture of licensed and unlicensed care practitioners to provide care for the patients and the primary nursing in which the whole patient care management –from admission to discharge- is assigned to one primary nurse.

This primary nurse provides care for the patient when on duty and delegates' responsibility to another nurse during her/his time off.

2.9 Control of nursing role

Over the years the cost and the outcomes of the care process became an integral part of the accreditation and regulatory requirements of the health service providers (Sutherland and Leatherman, 2006). Even more, consumers and their representatives demanded more transparency about the care outcomes (Francis, 2013), hence affecting the hospital's competitive position and status (Jones et al., 1997). Nursing professionals play a major role in achieving outcomes for both the patient as well as the hospital (Aiken et al., 1998). Yet, at the time of increasing severity of the health problems (Winters et al., 2007) hospital managements tend to reduce the nursing workforce numbers (Longley et al., 2007) as well as manipulating the work of nursing professionals (The Royal College of Surgeon, 1999) as a means to cut the operational cost of the organisation. Consequently, the intrinsic autonomy that was given to professionals by the merit of their nursing knowledge and expertise (Wade, 1999; MacDonald, 2002) became inferior to the accreditation and the regulatory requirements (Maas et al., 1997). Moreover, in a discussion paper, Goodman (2016) argued that nurse's lack of analytical tools resulted in them being monopolised by the power elites. Using nurse moral and philanthropic characteristics such as compassion and commitment, power elite were able to convince nurses to provide care for free through unpaid overtime. This positioning of nursing work within ''the gift economy'' has led to not only undermine nurses' work but also nursing as a profession (Mauss cited in Goodman, 2016, p.225).

To take control over their work nurses have always sought to increase their involvement in decision-making. Alongside nurses' efforts, governments have supported nurses'

participation through expanding the managerial responsibility of senior nurses as well as increasing their involvement in the commissioning process and implementation of clinical governance (Commissioning Board, 2012). Nevertheless, this involvement in management left nursing leaders in a conflicting position. Indeed, nursing leaders had to strike a balance between two opposing roles: the role of senior members of the management team and the role of the nursing professional leaders. While the first role is often financially driven and focuses on the business side to meet the strategic goals of the hospital, the second role aims at providing a quality care through professional leadership. These binary roles became a sensitive issue during the service reconfiguration. Although, frontline nurses require, more than ever professional leadership during this turbulent time, the financial constraints on executive teams including nursing leaders might take precedent over their professional commitment. Undoubtedly, even if nursing leaders have a choice whether to participate in the change or not, their refusal could jeopardise their job and employment. Even more, the exact role of the nursing leader or the chief nurse might be part of the reconfiguration process (White, 1985; Calkin et al., 2011).

2.10 Hospital as critical care provider

The cumulative effect of the legislation arising from the NHS reforms has a substantial influence on the setting of critical care practice as well as the way critical care is practiced. Although the NHS faced great demands for efficiency, cost cutting and value for money (Ashworth, 2000), the acuity of patient's conditions admitted to the hospital has been steadily on the rise (Audit Commission, 1999) which requires more dedicated critical care services (DH, 1999b). Hence, the number of general critical care beds has increased proportionally in nearly all acute care settings (DH, 2001a; the Audit Commission, 1999). Furthermore, in the critical care the picture was intensified by a constant winter crises which forced patients transfer to other hospitals due to shortages of ITU beds in their local

areas. Therefore, the 1990s were a turning point in term of critical care provision (Audit Commission, 1999).

Indeed, the focus of critical care as a discrete unit staffed by specialist professionals who closely monitor the patients using an extensive and highly complex technology with a higher patient-staff ratio (King's Fund Centre, 1989) could not meet the evolving nature and needs of patients that are being admitted to hospitals (the Audit Commission, 1999). As a result, a shift in the critical care provision was introduced to encompass the hospital-wide approach that provided all patients with a critical care service disregarding their geographical location within the health service (DH, 2000b). Hence, critical care became a comprehensive patient management strategy rather than a designated place of work (DH, 2000b; DH, 2005a). In this sense, critical care provision entails supporting patients who are at risk of falling critically ill or recovering from critical illness beyond the critical care unit physical walls (DH, 2000b). Accordingly, out-reach services were established to support this wider provision of critical care.

The aim of the critical care outreach service (CCOS) was to improve the early identification and treatment of deteriorating patients hence avoiding critical care admission or a timely admission if enough support couldn't be achieved outside (DH, 2000b; 2001a). Furthermore, the CCOS helped to share the critical care expertise, knowledge and skills with practitioners at the ward level thus facilitating early discharge from critical care as well as obviating readmission (DH, 2000b; 2001a). Undeniably, Leary and Ridley (2003) and Pittard (2003) claimed that the outreach service has partially achieved its goals-improving patient outcomes- through direct patient care as well as through supporting staff at ward level.

Nevertheless, Esmonde et al. (2006) argued that the wide range of the service delivery made it difficult to identify a service typology hence the lack of sufficient evidence made it hard to demonstrate the CCOS's impact. However, it was clear that the CCOS has reduced the communication barriers within the organisation, helped in establishing a valuable cooperation and interdependency among the staff and made a substantial effect on training and education (the Intensive Care National Audit and Research Centre, 2007). Henceforth, the CCOS has improved the early recognition of deteriorating patients as well as improved the critically ill patient overall quality of care.

The Royal College of Nursing (RCN) as the largest representative of nurses highlighted the challenges that will face nurses in future (RCN, 2004) in a cognate manner of that of the DH *Modernising Nursing Careers* (DH, 2006c). To emphasise, the RCN expected nurses to build an empowering partnership with the patients, carers, communities and other team members. Through this partnership and by working across care settings, nurses could use their knowledge of people's experience of health related events to promote health and prevent disease, illness, injuries and disabilities.

2.11 Health care reform and nursing

Nearly all the government initiatives and policy changes were aimed at producing services that represent value for money from the tax payer's point of view. Traditionally, the management saw this as an opportunity to reduce the operational cost of the organisations by downsizing the workforce (Shindul-Rothschild et al., 1996; Leatt et al., 1997). On the other hand, the health care personnel interpreted it as, more scrutiny of their practice, training, employment structure and remunerations as well as the division of labour (Ritter and Tonges, 1991; Burnum, 1994). The nursing profession was not different from the rest of the health care professions in this sense.

Advancement in medical technology and the increased severity of the diseases transformed hospitals into huge intensive Critical care settings (Ritter and Tonges, 1991). Therefore, nursing in particular was challenged by focussing the health care process around the patient needs rather than their locality (DH, 2000b; DH, 2005b). This provision of critical care influenced the design, the skill-mix and the management of the service, hence the professional role of the health care personnel as well as their interrelationships. The comprehensive critical care (DH, 2000b) report and the quality care beyond the comprehensive critical care stakeholders report (DH, 2005a) provided an opportunity to redesign the provision of care to critically ill patients guided by their needs rather than their locality. Hence, this study focused primarily on the implication of the recent key health care policy changes on health care professionals mainly the role and professional practice of nurses caring for ill patients (between 2010 and 2015) and how to help those professionals to take a leading role in the current and future changes.

In practice, the coalition government proposed reform has never been tested in the context of the UK's health care system. Hence, policy makers, the public and the health care personnel needed feedback from the field to evaluate the reform and amend the policy accordingly (Oreszczyn and Carr, 2008) and to serve as a foundation for future planning (DH, 2009). However, in order to translate this reform into a healthy reality, more studies would be needed to understand the impact of this health care reform on the professionals. This in turn would enable the policy makers and senior managers to build a partnership with the frontline practitioners. Through this partnership, senior managers and policy makers would be able to empower the clinicians to deliver a quality and cost effective service to the nation (DH, 2010a).

This study aims to investigate the implication of the recent UK NHS restructuring to the care of the critically ill and the best strategies to help professionals to participate in the current healthcare policy process as well as future ones. For the purpose of this study nurses were chosen as they represent the majority of the NHS workforce and are affected by the many aspects of the reform. Implicitly, the reform challenges their professional role, its operationalisation and their professional relationships (DH, 2000b; Glen, 2004). However as the study progressed, it became apparent that professionals boundaries between nurses and other health care professionals are permeable hence other professionals became essential participants in this study.

The next chapter details the methodological approach chosen to conduct this study including research setting, the selection of data sources and how these were sampled, defining the research topic and research question, addressing ethical concerns methods of collecting and analysing the data, concluding with discussing issues of trustworthiness and rigour.

<center>**Chapter 3**</center>

3.0 Methodology

3.1 Introduction

This chapter aims to detail the research methodology and methods used in this study and to explore the theoretical underpinning of the research approach and design.

Adopting the ANT framework requires a methodology that enables us to gather data from and about an interdependent and dynamic net of actors who work collectively in a non-hierarchical manner with their multiple coexisting interests. Furthermore, the selected research method should enable us to explore the ongoing relationship between the actors within networks as well as exploring the interaction between networks. Literature on research methodologies presents a fundamental division between objectivist deductive reasoning - the quantitative research approach with middle range theory- and constructionist inductive reasoning- the qualitative research approach with grounded theory (Green and Thorogood, 2009).

Accordingly, the middle range theory has been linked to the macro social level and entails hypotheses testing (Rubin and Babbie, 1997). The objectivist (positivist) proponents view the world as stable and hence predictable. As a result, they argue that facts about the social entity and the universe are absolute and could be defined by careful measurement (Carter, 2000). On the other hand, critics of this approach, view it as not only unachievable but also inappropriate for the study of human beings. In essence, they argue that, human beings do not live in a vacuum outside their social and cultural context. Holloway and Wheeler (2010) maintain that human beings as social entities construct their reality by interacting with the world through interpreting their surroundings as well as reflecting on their own behaviours. Indeed, the social process is multidimensional and extremely complex.

<center>53</center>

Therefore, the most interesting questions about human beings are how they make sense of their world, how they interact with their surroundings and what is the effect of the context on the way they perceived it?

By focusing on the human experience, the qualitative research approach provides a holistic way to explore and describe the life/world as it is experienced (Munhall, 2001). The emphases of this careful attention to the details and the context of human experience and the assignment of meanings make it visible. Therefore, this focus on detail allows us to understand the interconnection of the different aspects of the social process hence enables us to comprehend those people's experiences. The primary aim of this study was to examine the role that the health care professionals have in relation to the health policy processes and the implication of the service integration on their professional practice. The naturalistic feature of the study in which the health care system was viewed as dynamic when the impact of these policy changes was unfolding, required the research findings to be interpreted within their specific historical and temporal context, Thus, the research design needed to be flexible and able to be modified to accommodate the changing situation. It was apparent that the qualitative research approach was the most appropriate approach to study this phenomenon within its potentially complex environment.

Denzin and Lincoln (2000) claimed that the context focussed approach is a fundamental aspect of qualitative research. This argument is supported by Miles and Huberman (1994, p11) who postulated that data collected through a qualitative approach is based on "*local groundedness*". Data are collected in close proximity to a specific situation in their natural setting hence; the focus is on a specific 'case' within its context. For that reason, the qualitative approach has a viable opportunity to unearth complexity through harnessing the perceptions and meaning that people associate with events and processes in their lives.

These characteristics of the qualitative approach

- interconnectedness of social processes

- context of human being

- meanings assigned by the actors to the events

cognate with the ANT framework approach.

This study was conducted through engaging with the daily experience of those who look after critically ill patients as well as those who influence the care of the critically ill patients within the integrated care organisation.

3.2 Defining the topic

Originally, this research was to focus on the changing roles and needs of critical care nurses in an NHS integrating organisation. Never the less, an initial literature review, talking to people in the field as well as discussing the topic with academic and clinical experts revealed a profound problem in this question as to what critical care nursing is and who the critical care nurses are as well as the context where in critical care nursing is happening.

This lack of a clear definition, the ever changing political and socio-economical context in which critical care is happening, the permeability of the boundaries and the different locality where critical care nursing is provided posed a complex set of issues that shifted the focus of the study. As a result, the focus of the study became the understanding of the implications of the current key policy changes to the role and practice professionals caring for critically ill patients. In particular, this study focuses on the role of those professionals in the implementation side of the policy process. Though, it was expected that the recent integration with the community services locally -which itself was a result of the reform-

added a further dimension to the state of flux and uncertainty over the shape of both the acute and community health services.

As a result, the central concern for this study was to understand the lived experiences of these health care policy changes as it was perceived and interpreted by those who care for the critically ill patients irrelevant of their working professional titles or geographical areas. This change in the research focus poses significant strains on the research method. Meanings were found through the subjects themselves which is inevitably context specific hence, naturally suggesting a qualitative approach for the data collection.

3.3 The research questions

In the light of the literature review, the adopted policy process framework and the discussion with diverse critical care service stakeholders, the following research questions were formulated

- What are the implications of the services integration policy to the health care professionals in relation to their practice and interrelationship?
- What is the role of those professionals in the services integration policy process?
- How do these professionals negotiate their role within the integrated care organisation?

Nursing was used as the main profession to examine the questions of this study. In this study critical care professional practice refers to the social engagement and interaction of nurses with their world and others (Ramsey and Miller, 2003) including those patients who are at high risk for actual or potential life-threatening health problems (Sole et al, 2009). During this engagement nurses enact, practice, embody or realize their empirical, aesthetic, personal, ethical knowledge (Carper, 1978) as well as the ''*skilful and ethical*

comportment''(Benner, 1991;1994, p. xvii) in dealing with the human's responses to potential or actual life threatening problems (Sole et al, 2009). This skilful and ethical comportment refers to the nurse's knowledge of what is respectful and appreciated in a particular situation.

The research questions were used as a working guide and were modified progressively guided by the emerging data from both literature review and the ongoing data collection (Hammersley, 2008) in an attempt to be as inductive as possible. As this study progressed, it became apparent that nurses were not working in isolation of the other stakeholders including other health care professionals and that the boundaries between professions were blurred. As a result the principal research questions this study answered became

- What are the implications of the services integration policy to the health care professionals in relation to their practice and interrelationship?

- What is the role of the health care professionals as policy actors in the health care policy process?

3.4 Research aim and objectives

To be able to answer the research questions and meet the primary aim of this study which was to examine the role that the health care professionals had related to the health policy processes and the implications of the service integration to their professional practice this study:

1. Examined the health care organisation- under study- response to the challenge of these health care policy changes through reviewing the local and national policies and documents that were produced in relation to the reform.

2. Investigated the health care professionals' perceptions of the implications of these health care policy changes to their professional role, scope of practice, attributes (autonomy, control of decision making, responsibility, accountability, authority nursing-medical collaboration) and work settings.

3. Examined the implications of these health care policy changes to the delicate professional and geographical balance within an integrated organisation.

4. Identified the factors that empower or restrict the health care professionals' participation in policy implementation process.

3.5 The research paradigm

The research paradigm is the philosophical assumptions that guide the research strategies, methods and analysis (Ponterotto, 2005). Indeed, for all disciplines, a paradigmatic framework represents the epistemological and the ontological bases to view and understand the social process as a phenomenon. Guba and Lincoln (1994) highlighted the importance of adopting a research paradigm to guide any research strategies, methods and analyses. Historically, health care research was dominated by the positivists "scientific paradigm" (Fox et al., 2007). According to this framework, the scientific knowledge could only be achieved through the logic of experiments; hence, the social process should be measured through objective methods as the social process exists externally. Critiques of this paradigm, argue that the human being as a researcher or as an inquiry subject exists within a context that he/she interacts with and is influenced by (Guba and Lincoln, 1994). Therefore, the interpretive paradigm was developed as an alternative approach.

This interpretive or post positivist paradigm adopted a more naturalistic approach to study human subjects. Advocates of this paradigm argue that science cannot be claimed by the

merit of its methods alone and suggest that facts could only be accepted within their perspective (Schwandt, 2000). This paradigm employs an iterative-inductive strategy to understanding the emic (insider) view of the inquiry subjects. Through this strategy -which is mostly phenomenological in nature- researchers could understand and interpret the participants' personal experience (Tedlock, 2000) and role within the phenomena. Never the less, the social constructivists as well as the post structuralists argue that participants use language not only to represent and describe the phenomenon as it is seen but also, to offer a meaning (Lincoln and Guba, 2000; Lindseth and Norberg, 2004).

Stake (1995, 2000; 2006) placed the qualitative case study approach within the realm of the interpretive- constructive paradigm. Lincoln and Guba (2000) explained that Stake built his case study on the ontological belief that it is context bound and constructs the reality in a way that represents the diverse perspective of those involved in the phenomena including the researcher. The active role of the participants in Stake's reality construction laid the foundations for the use of a policy network framework to understand the participants multiple coexisting interests.

Contemporary literature about grounded theory mirrors this view regarding the researchers by stressing their subjective role as the main research instrument. To elaborate, the researcher constructs "*the grounded theory*" through interaction with the participants, deciding what constitutes data, what to include or exclude from the report hence determining how the reality should be represented (Charmaz, 2006).

To be able to build on the strengths of the two approaches in this study, we need to ensure the congruency between both the qualitative case study and the grounded theory traditions. The fact that the researcher is part of the collective perspective in this phenomenon not

only as a researcher but also as a professional caring for critically ill patients in the same setting makes it difficult to identify the extent of his/her contribution to the shared experience. This dual role is concordant with the constructive approach.

The shift in the government's attitude from central control to shared governance (DH, 2007; 2008a) supported the choice of this research paradigm as it can take into account the viewpoints of all actors that are involved in the policy process. Indeed, the service provided at the endpoint of health care delivery represents shared decisions and actions of a wide range of networks of professionals, managers, civil servants, professional organisations (e.g. GMC, NMC, RCN, and BACC) as well as the key political players. However, this study focused at the implementation stage of the policy process at the local level and involved only those stakeholders who were involved in the policy implementation locally. Furthermore, since the boundaries between the phenomenon and its context were not clearly evident, the choice of a case study approach aided the delineation of the boundaries of what was to be studied.

Advocates of this paradigm contend that, researchers not only bring in their own interpretation of the social phenomenon but also can influence the field of the study (Porter, 2000). Anderson (2006) championed reflexivity in the research approaches as he suggested that researchers need to clearly state their involvement in the field as well as their pre-conceptual lenses.

3.6 Ethical research

The iterative- interactive characteristics of the qualitative inquiries leave it at large open to the researcher's personal influence (Ajjawi and Higgs, 2007). Locating this research within the constructivist paradigm ensures that the meanings of the experiences as well as the

reality were constructed by the participants including the researcher (Charmaz, 2006). The researcher's pre-existing knowledge, experience, assumption, race, gender and social background play a major role in directing the research process as well as influencing the interpretation of the outcome (Denzin and Lincoln, 2000).

As the researcher in this study, I have experience in caring for critically ill patients, I have been employed by the same Trust where the phenomenon was explored and I have a personal and professional desire to clarify the impact of the health care reform on health care professionals. These personal perspectives were considered whilst conducting this research. Therefore, my personal experience and assumptions were presented in this research in the form of an auto-ethnography (Davies, 2008).

The autoethnography was of a great value in illuminating my standpoint in relation to the inquiry even before embarking on the informant interviews. Furthermore, this autoethnography was gradually incorporated within the storyline of the integration. To avoid simplifying the content of the interviews which were based in the researcher and the research participant mutual history and the degree they know each other (Davies, 2008), the pre-existing and ongoing relationship with the informants and the organisation were explicitly identified. Although challenging the norm of the silent authorship (Coffey, 1999), this personal story helped to distance me as a researcher from the stories of other informants. Furthermore, this initial personal story was used as a preliminary point for a reflective journal. This reflective journal included analytical memos that reflected the changes in my understanding, impressions and interpretations of the phenomena before and during the data gathering as well as during the data analysis (Crowley-Henry, 2009). Hence, this archiving of the changes in my understanding of the phenomena aided the research transparency (Mills et al. 2006).

The focus of this study was to attain a clear perspective of the coalition government key policy changes to well-established health care professions and the professionals role in the policy process. This artificial delineation of the research boundary enabled me as a researcher to capture the wider perspective of the phenomenon as well as to keep the study focussed (Morse and Field, 1996). Working in critical care service provision helped me to understand the language and terminology used in health care service and issues alluded to by the participants which placed me in a unique position to conduct this type of research. Nevertheless, this level of familiarity with the informants and the setting could be argued to restrict the researcher's ability to objectively examine the phenomenon (Morse and Field, 1996). This concern about the researcher's objectivity to examine the phenomenon has been addressed throughout the research specifically in the theoretical orientation, ethical research, autoethnography, negotiating overlapping roles and in the research rigour sections.

3.7 Participant Protection: Ethical issues

Once the study has been approved by the University Research Ethics Committee and the Trust's Research and Ethical Committee (Appendix A), the potential participants were given a written explanation of the purpose and benefit of the study as well as any potential risks of participation. Participants were assured that their participation was completely voluntary and that they could withdraw from the study at any time without enduring any adverse consequences.

In view of the relatively small number of actors especially in managerial position, preserving anonymity could become a problem. Though participants were assured that their identity will remain anonymous and confidential (Clark et al., 2005,) potential problems were mentioned during the negotiation with the participants. All participants in the interviews agreed that their statements could be used in the research. Furthermore, participants were asked to sign a consent form before taking part in the interview.

Generated data records were given a code name and were stored in a password secured file to prevent any unauthorised access. The informants' biographical data records were kept safely in a different place from the rest of the documents. Personal data that could lead to an identification of the informants e.g. names, addresses that were not essential to the inquiry were not entered in any of the documents. My contact details were given to the participants to enable them to seek clarification of any issues related to the interview process or to raise any concerns related to the study as a whole.

3.8 Autoethnography

Autoethnography is a relatively new research strategy within the realm of qualitative ethnographic approaches. Although ethnography uses a flexible approach to data collection, it relies mainly on interviews and observation of real life experience. The aim of ethnography, in general, is to understand complex social phenomena within their own settings. Focussing on self-analysis, autoethnography combines both ethnography and autobiography strategies to collect and analyse data about one's self and its context to understand both self and others reciprocity within their social context (Reed-Danahay, 1997; Wolcott, 2004). As a result, autoethnography ultimately helps us to understand the how one's self has been reshaped by its context and how it reacts to its surroundings (Ngunjiri et al., 2010). Autoethnography has been used to explore researchers own

experiences with grief, loss, illness and other areas related to health (Lee, 2006; Lee, 2010; Murphy, 1990).

The autoethnography systemic approach to data collection, analysis and interpretation to understand self and its relationship with others within a social setting make it stand out compared with other forms of self-narration such as diaries and autobiography. Autoethnography allows researchers to explore their own deep emotional experience in relation to their socio-cultural context in a way that is difficult to reach should they be interviewed by someone else. This characteristic privileges autoethnography approach over other qualitative methodology such as phenomenology and ethnography. However, Ellis and Bochner (2000) argue that the attention to self, others and context in autoethnography depends on why we do autoethnography.

Historically, there have been always some components of autoethnography in qualitative research. These autoethnography components were in the form of methodological notes or diaries of field work (Van Maanen, 1988). Deegan (2001) argued that, though Chicago sociology students rarely exhibited a critical self-observation, yet, they did associate with some of the ethnography emerged from their works. By the second half of the 19th century, reflective self-observation of personal experience was noticed in sociological studies such as Sudnow cited in Anderson (2006, p376) self-observation of learning how to play the piano in his "*Ways of the hand* " book. Hayano cited in Anderson (2006, p376) personal experience as a poker player moved the ethnography tradition from observing others to self-centred observation.

Ellis and Bochner (2000) argued that scholars turned to autoethnography looking for ways to produce research that enables them to empathise with people who are different from

themselves. Hence, the focus of the autoethnography for Ellis and Bochner was to sensitise the reader to the personal feelings and emotions (Denzin, 1997). As a result, evocative autoethnography requires considerable narrative and expressive skills to invoke readers to enter into the *"emergent experience"* (Ronai, 1992, p.123). Since the key goal of evocative autoethnography is to resonate with the reader emotional experience and not to give explanation nor to theorise, it tends to distance itself from social science and move closer to that of novel and biography (Ellis and Bochner, 2000).

My interest in the research topic arose from being employed by the trust and that the trust was trying something that was not done before at least up to my knowledge at that time. Throughout the research, my personal feelings and worries were always present in all of the interviews and conversations with my colleagues. I tried to silence the inner voice, yet I was not able to separate my own experience of that of others. In social science, scientists are trained to separate research from their personal lives and interests, yet in reality, research is one of the many realities of the researchers' life. Denzin and Lincoln (2000, p. 6) argue that research as *"interactive process is shaped by personal history, biography, gender, social class, race and ethnicity"*. Lincoln and Guba (1985) emphasised the importance of making the researcher standpoint and assumptions explicitly clear to the reader as they has great influence on the study. As a result, I decided to integrate my personal narrative purposefully in the research storyline rather than denying it (Muncey, 2010).

However, I was troubled with the evocative autoethnography epistemology as it clashes with the very aim of this study which is to provide understanding of the phenomena. The purpose of autoethnography in this research was to share what I think is important to understand the whole social experience. Denzin (2006, p.423) argues that

" *Our research practices are performative, pedagogical and political. Through our writing and our talk, we enact the worlds we study . . . the pedagogical is always moral and political; by enacting a way of seeing and being, it challenges, contests, or endorses the official, hegemonic ways of seeing and representing the other".*

Therefore, autoethnography should go beyond the personal experience and provide an analytical tool to understand and theorise about the phenomena by connecting autoethnography with social science theories (Anderson, 2006).

Autoethnography, like many other qualitative research methods, relies on both verbal and nonverbal communication. Those communication exchanges and interpretations are dependent on the meanings associate to them based on actors past experiences and the context where they happen. This places the autoethnographies within the constructivist realm.

I approached this research as both a researcher and as a research subject and actor (Mitra, 2010). Despite the fact that I had to engage in all activities that research participants did, the research activities (e.g. recording the interviews, writing field notes and documenting events, and data analysis) intersected with my personal and professional life. These activities have occasionally diverted my attention from the embodied experience. This complex experience warranted my personal narrative extra attention. This personal story privilege was based on its ability to focus on improving our understanding of professionals positionality in policy process (Anderson, 2006) and the emotional consequences of organisational change at personal level. What made my personal autoethnography relevant to this study were my prior assumptions of the organisation, knowledge of the professionals, the service users, the local needs and the NHS as a whole. This prior knowledge and assumptions resonated with those of other actors. Although, a fair part of

the shared narrative was the lack of understanding of what we were to go through, these two characteristics, the knowledge of the context and the shared assumptions echoed Hayano cited in Anderson (2006, p 376) criteria for autoethnography.

In this study, data collected for the autoethnography was part of the whole research data collection process. Data about self, others, context and interactions between the three parts were collected through the interviews, personal journal and Memos, self-reflection, comments by colleagues and field observations. Davies (2008) championed ethnographic reflexivity by increasing the ethnographers' awareness to the reciprocal effect between the research, the researched and the researcher. The autoethnography account contextualised my personal policy translation experience by focussing on the social and cultural aspect of the phenomena before exploring and exposing my inner vulnerability (Ellis and Bochner, 2000). Adopting the symmetrical characteristic of the ANT made possible a smooth movement between the personal and the cultural experience.

Generated data were organised and imported into The NVIVO. The data were analysed thematically in a three stages process similar to that of the grounded theory. Firstly, data were read and reread for familiarisation. Then, data were open coded and themes were developed. Those developed themes were distilled into focussed themes that enabled me to construct my own reality. To make distinction between my authentic inner voice and my analysis of the personal experience, my personal voice was written in *'italics'*. Based on Ellis and Bochnoer (2000, p.739) definition of autoethnography " *a conscious trial to connect the personal and the cultural"*, this constructed personal reality helped identifying my role in the dynamics of the multi-reality storyline of the policy translation process as well as connecting the inner voice to that of the socio-cultural.

In summary, my use of autoethnography permits readers an insider view of the policy process ward which I was part of through my personal experience. This autoethnography was written as part of a shared social experience and to uncover discourses that contributed to the integration policy implementation in the trust. The distinctive advantage of adopting this research method in this study was its ability to augment the case study with interpretation and reflection on authentic personal feelings and emotions. This personal experience description and systemic analysis served as a building block to understand the wider cultural experience and to clarify my role in the dynamics of the phenomenon.

3.9 Negotiating overlapping roles

My roles as a health care professional and as a researcher were not discrete. The imprecise boundaries to these roles presented a challenge not only to me as a researcher but also to my colleagues. Indeed, studying our daily practice made it difficult for both sides to determine when I was acting as a researcher and when I was acting as a colleague and a professional (Fox et al, 2007; Garton and Copland, 2010). However, having a clear research protocol helped to negotiate what seemed to be a conflicting relationship between research and practice. Practically, it was always made clear that whenever research activities were carried out, whoever was involved in these activities were informed that it will be utilised in my research hence, their consent to do so was sought. Though, sometime a side conversation with other professionals could influence the direction of the consecutive data collection or even the way I understood the collected data. Invitation letter was given to those Professionals involved in those professional conversations and their verbal consent to use the contents of those conversations were obtained and they were assured of their anonymity.

Since it was not a neutral invitation, interviewing colleagues of senior or junior positions to me, especially managers, raised an ethical question (Fox et al, 2007). On one hand, seniors might have found it difficult to expose their negative experience in front of me. The organisation's consultation on most of the senior jobs at the time of data collection made some potential participants suspicious of the research and very hesitant to take part in the research in spite of all the assurances regarding the adherence to the ethical principles and the research governance. On the other hand, there was always a risk of the more junior staff sharing what they thought I would like to hear. Though, it is understandable that all research participants including the researchers have a degree of personal bias, never the less, conducting research in one's own work place with invitation that could never be truly neutral, could amplify the risk of getting 'untruthful information' (Fox et al, 2007). To overcome this potential problem, this dual role; the colleague and the researcher was incorporated into the research design by writing an autoethnography as discussed in the previous section.

To help archive the personal understanding of the reform and the imprecise roles, the autoethnography highlighted my relationship with the research participants before embarking on the research. This autoethnography archive recorded the two way research-researcher effect (Miles and Huberman, 1994). This reflective account of the continuous exchange between me, the research and the researched (the phenomena and the participants) was integrated into the research in a systemic and progressive manner. Furthermore, this reflective account constituted an integral part of the final report thus, aiding the research transparency as proposed by Mills, et al. (2006).

Adopting the ANT approach added more difficulties in relation to my positionality in the research. In ANT, the researcher is viewed as detached, collecting data from and about

both human and nonhuman actors either by qualitative interviews or observation. In this study, it was clear that my role was both, an informant as well as a researcher. To overcome this issue, as a researcher I was conceptualised as an integral part of the network not only because I had a significant say on how actors were chosen but also because I played a major role in constructing the ANT account (Lee and Hassard, 1999; McLean and Hassard, 2004). Even more, I worked as a linchpin that weaved all the micro-networks constructed accounts into a story line that tells the organisations integration experience (McLean and Hassard, 2004).

3.10 The case study approach

Stake (1995, 2000) argues that case study approaches are chosen based on the ontological and epistemological choices of the researcher, the nature of the case as well as their capacity to address the research question. As the aim of this study was to examine the role that the health care professionals had related to health policy processes and the implications of service integration to their professional practice through a case rather than the case itself (Luck et al. 2006), an instrumental case study (Stake, 1995) that encompasses interviews and documentary analysis was used to collect the data.

Caring for critically ill patients is carried out in a wide range of settings by multidisciplinary team members who have different professional backgrounds and personal and professional interests. This multidisciplinary team interweaves different alliances, networks and cooperation between the members. To understand the ongoing implications of policy changes to the practice of professionals caring for critically ill patients it was only logical to examine these interdependent relationships between actors in the multidisciplinary team. A holistic case study (Yin, 2003) with embedded micro-sub-units

enabled exploration of the case while also considering the influence of the reform on each sub-unit and across the subunits. The holistic case represented the macro network and the embedded sub-units represented all the micro networks within the case study. The data was analysed by each micro-network, between networks, and across all networks. This attention to the micro-network analysis has the advantage of increasing sensitivity to the data which aids our understanding of the case being studied.

This fracturing of the macro into micro contradicted the very principle of ANT- the symmetry. This ANT assumed symmetry refutes the dichotomy of macro and micro but nevertheless, it was only done for the purpose of practicability. Despite the fact that on the surface the organisation appeared to be stable and in order, the change in the integrated organisation was huge and overwhelming. Given the available resources, it was very difficult to track the interactions and changes happening all over the organisation as a single network. So, to make it manageable, at first, I have broken it down into small units at micro-network level. This enabled the exploration of negotiation between actors at local level and understanding how that contributed to the change of local practice. Therefore, to remain as close to the ANT generalised symmetry as possible, micro-level issues were viewed as a building blocks of the whole organisational integration story rather than a stand- alone unit of analysis.

3.10.1 Case study boundaries

The case study approach to data collection refers to the boundaries of what is to be studied rather than a choice of research methodology (Stake, 2000). Experts (Stake, 1995; Yin, 2003) agreed on the importance of confining the case within specifications that maintain the scope of the study. Accordingly, time and place (Creswell, 1998), time and activities (Stake, 1995) and definition and context (Miles and Huberman, 1994) were suggested to

delineate the boundaries of the case. To examine the research questions, it was deemed reasonable to use a combination of these boundaries to indicate the breadth and depth of the study.

The study participants were drawn from an urban teaching NHS trusts that had recently integrated with the community service. Informants were selected based on their role in caring for the critically ill patients during their treatment trajectory, or those who were perceived as major players in reforming the care of this group of patients whether they were based in acute or community settings. Each micro-network of the case was part of an integral system. These micro-networks were bounded internally by the policy and regulation of the NHS and externally by case centred boundaries. To explicate, each micro-network functions within the core principles of the NHS with a potential of being impacted by the local context. This local context encompasses a shared understanding and practice as well as a local set of expectations.

This boundedness (the NHS and the local context) of the case alongside my role as a researcher within the case underpinned the choice of the constructivist approach. Although it was reasonable to treat each profession or stakeholder group as a micro-network, nonetheless, some people were considered as a micro-network on their own within their context in the case as appeared to function purposively with a sense of unique activities or context (Stake, 2000). Fieldwork was undertaken between the period of 2012 and 2015 and the Trust's relevant documents were collected and reviewed over the same period.

3.11 The research design

Adopting the ANT framework to examine the implications of policy implementation to the health care professionals and their role in this policy process required a method that enables us to gather data from and about a large, interdependent and dynamic network of actors who worked collectively with their multiple coexisting interests. This study was conducted through contact with the daily experience of those who look after critically ill patients as well as those who influence the care of the critically ill patients within the integrated care organisation. Studying the lived experience necessitates a decision about the research method that enables the researcher to access the natural setting of the research subjects to fully capture the quintessence of that experience (Denzin and Lincoln, 2000). This closeness to the phenomena enables the researcher to understand the constructed meaning that the participants associate to their lived experience (Merriam, 1998).

Therefore, the recursive dialectic between the purpose of the study and the potential research methodology lead to the selection of the case study design to generate the data. The case study research method according to Yin (1984, p.23) is an

"empirical inquiry that investigates a contemporary phenomenon within its real life context; when the boundaries between the phenomenon and its context are not clearly evident; and in which multiple sources of evidence are use".

Case study research gathers and utilises a broad and a diverse range of evidences- interviews, observations, surveys, documents and artefacts- to provide a detailed, rich and deep data about the subjects being studied (Bowling, 1997). In line with the adopted theoretical approach, this diverse data encompass factors like time and history and are therefore useful from a contextual perspective (Yin, 2003; Holloway and Wheeler, 2010). In contrast to the experimental or survey methods, the dynamic multi-source evidence

characteristics of the case study overcome the limitation of a single-point snapshot of the change process which may continue to emerge over the time (Dyer, 1995). Furthermore, the wide range of data sources and methods of data collection gives the chance for the triangulation of the accounts that are provided by different respondents as well as the different sources. For the purpose of this study, two main methods of data collection were utilised; informants' interviews and identification of relevant documents detailing the policy and process underpinning the service integration. Alongside these two methods, field notes and personal experiences and reflection were recorded. Unsolicited data such as casual conversation with professionals, patient and their representatives enriched the research and has influenced the data collection and interpretation process.

Finally, case studies have been used with some success to understand the subjective meaning of social action, rather than to solely recount superficial characteristics, thereby it can help uncover the lived experience (Stake, 2000). Constant comparative Grounded theory on the other hand, was selected as a method of data analysis to allow for both an in-depth exploration of the implication of the key policy changes to frontline health care professionals within context and to generate a theoretical framework (Charmaz, 2006; 2000; Glaser, 1992; Glaser and Strauss, 1967; Strauss, 1987)

Based on my personal epistemological, ontological and the adopted theoretical stance a constructive case study approach was chosen to conduct this research (Stake, 2000). The phenomenon- the impact of the key policy changes on frontline health care professionals - as well as the case - the service users journey on a critical care pathway in an integrated health care organisation- could not be considered without its context; the NHS and more specifically the local NHS Trust which has recently become integrated with the community service. Furthermore, the phenomenon under study is innovative, complex, context specific

and represents various meanings to different stakeholders (Merriam, 1995). Moreover, it represents an ongoing evolutionary interaction between the profession, policy makers, the regulatory bodies (e.g. NMC, GMC) and the researcher, which in turn is influenced by socio-demographical needs of service users and the general public as well as the resources constraints. The implications of these policy changes to frontline health care professionals is both a contemporary issue and a dynamic process in which change become part of the routine daily practice.

As a result, the researcher as well as the research participants construct their reality from their own subjective experiences hence, the view point for each one of their reality is valid. This constructed reality, enables us to make sense of the world. The participants' subjective multiple reality experiences can only be understood and interpreted through the individual's views. Yet, those multiple realities should be examined in the light of the coexisting interests of the actors involved in the phenomena as well as the dynamic interaction among those actors.

Nevertheless, the effect of those policy changes on the delivery of care within the service was unfolding; therefore, the research findings could only be interpreted and understood in the light of their historical, temporal and contextual milieu (Stake, 2000; Engwall, 2003). This idea is supported by Cox and Hassard (2007) who warn against extricating the phenomenon from its context as meanings associated with phenomenon are embedded in its past, present and future. In this way, the research captured the essence of the national health care reform impact on health care professionals and the service they provided at a micro level. Therefore, the selection of the qualitative approach to study the phenomenon was appropriate.

Constructivist grounded theory on the other hand was selected as a method of analysis to allow for both an in-depth exploration of the implication of policy implementation on frontline practice within context and to generate a theory (Charmaz, 2000; 2006). Though the aim of the case study is to "thoroughly understand the phenomenon" (Stake,1995, p9), marrying both the case study design with the grounded theory approach could facilitate the development of an analytic generalisation which could contribute to theory building as Strauss (1987) argued. Conversely, using two different approaches to address the same phenomenon will challenge us to attest the harmony between their paradigmatic foundations.

3.12 Settings

Participants were drawn from an urban teaching NHS trusts. The trust under study was established in 2011by the integration of the acute care hospital with the community health services and social care in the neighbouring boroughs. With a budget of £273m (hospital £181m, community £92m) and a total of 4237 staff (hospital 2640, community 1597) the Trust operates a 384 bed acute hospital and 16 health centres as well as providing a limited range of community services in neighbouring boroughs.

3.13 Data Collection

To understand the impact of the health care reform on the health care professionals and the role of those professionals in policy implementation on any scale requires a method that enables the researcher to understand the difference between pre and post reform, why and how these changes have happened. This understanding therefore, requires either a longitudinal observation of the health care professionals and other stakeholders' behaviours, interaction and practices in the natural settings or direct face to face interviews

with the research subjects. The former approach is supported by Pope and Mays (1995) who suggested that people are complex and should be studied by watching them and examining their documentations. Nevertheless, reform does not happen over a short period of time where clear starting and finishing points can be identified and from which differences can be measured. Thus, using a longitudinal observation approach could confine the data within the time and space of the data collection process as well as being limited by the researcher's inability to be in more than one place. Furthermore, this limitation might narrow our understanding to the changes occurring within the boundaries of a single practice area such as critical care unit only hence, excluding any change to other areas where care for critically ill patients is provided e.g. acute wards and the community.

Therefore, face to face in-depth interviews with a wide range of key informants enabled me to explore their knowledge, understanding and opinions of both the historical and current processes of change to health care professional practice, particularly in this newly integrated NHS Trust. This approach to examining the emerging phenomenon allowed us to understand the experience of the health care reform as it is lived, perceived and interpreted by those professionals who look after critically ill patients and how it influenced their profession as well as to extend the study beyond the a single snapshot of the process.

Guided by the adopted theoretical orientation, the integrated care organisation was approached as a holistic case study (Yin, 2003) with embedded micro-networks. These micro-networks comprised a network of actors (human and non-human) who provided care or influenced the care of the critically ill patients along their health care trajectory on both acute and community setting within the integrated organisation. Actors of those micro-networks interacted and cooperated within and across networks to design and deliver the

care for the critically ill patients guided by central governance, available resources, local needs, and their professional and personal interests. Two main methods of data collection were chosen to explore the research phenomenon; face to face interviews with a wide range of key informants from those networks and policy analysis of public documents such as historical data from literature, professional journals, newsletters, Department of health's (DH) publications, the research setting related publication (e.g. mission statement, workforce strategies).

3.13.1 Sampling

3.13.2 The participants, access and recruitment

To examine the research questions, key Informants were selected based on their role in caring for Chronic Obstructive Pulmonary Disease (COPD) patients during their treatment journey or were proposed by others as deemed as major players in the care of those patients group care reform. Accordingly, the potential informants list was modified guided by the direction of the data gathered as well as the recommendations of the informants themselves.

For the sake of the interviews, actors in this study were defined as professional/s- individuals or groups- who take part in or were affected by the reform (Majchrzak, 1984). In this study critical care nurses and doctors (including the outreach team), acute ward nurses and doctors, community and district nurses, physiotherapist and managers at all level were among the actors that were identified(table 3). Members of these networks were selected through purposeful sampling based on "*information-rich"* potential (Patton, 2002: p243) and their ability to help me to understand the phenomenon (Stake, 1995). Key informants were therefore either well known knowledgeable in the field of caring for critically ill patients or held key office/s within these groups, or those whose decisions

influence the work of the former groups.

Once ethical approval and access were obtained from the relevant authorities (the Ethics Committee and the Medical Director of the research setting) , each prospective interviewee was contacted first by email, verbally or by phone to invite him/her to take part in the proposed study as well as to provide him/her with all the relevant information. These participants interviewed gave a wider perspective of professionals who have experienced the phenomenon (Ryan et al., 2007). Hence, the aim of this sampling strategy was to portray as a wide a range of views and expertise as possible and relevant. The interviews were held at the participants working place at both community/primary and acute care sites of the case study and at mutually convenient times.

Depending on the primary data analysis, follow up interviews of the informant/s were sought as required to clarify any issues arising from the initial interviews. The number of the interviews in each group or specialities was decided upon the content of the interviews. Oppenheim (1992) suggested that there should be no need to carry out any more interviews with participants from the same group once the information provided by the interviewees became repetitive. As a result thirty six interviews were carried out. Eighteen of those interviews were carried out during the outward journey between 2012 and 2013. The very first interview of the outward journey was used as a pilot to make sure that I was able to handle the interview, the audio recording and taking notes as well as to try the preliminary list of issues. The content of this interview was not used in the final report of this study.

The inward journey was done between 2014 and the beginning of 2016 and eighteen interviews were carried out. Nine interviews of the inward journey were held with new participants and the remaining nine were with participants who participated in the outward

journey. In three of the outward journeys and in one of the inward journey, other health care professionals were present and they took part in the conversation. Those professionals were briefed on the study and were consented to use their participation in this research beforehand. Only eight of the whole interviews participants were males.

In addition to the interviews, I had numerous conversations with a wide range of health care professionals of various grades and speciality include (doctors, GP, nurses, physiotherapist, occupational therapist, pharmacist, dieticians, speech and language therapist, ...), managers at various levels, professionals from other fields such as human resources, finance, facilities, information technology as well as patients and their representative/s during the study time between 2012-2016. Being an insider researcher, I had many opportunities to incidentally observe other professionals interaction as they perform their daily activities while I was performing my daily work as well as take part in those interactions. Although the contents of these conversations and observed interaction were not used directly in the study, yet they influence my understanding of the integration hence the contents and directions of the interviews and choice of the document collected as well as the data analysis and interpretation.

My background as a critical care nurse who worked for the same organisation served three purposes; first, it aided the choice of the key informants. Secondly, it enabled me to understand the informant's language, any hints that participants might refer to along to the local or global professional or organisational politics they referred to. Thirdly, though some professionals were hesitant to contribute to the study due to the ongoing job consultation at time, as one of the research setting employee professional, to some extent, I was not seen as a cause of threat for the participants.

3.13.3 Preparing the informants for the interview

The research informants were selected by virtue of their connection with the virtual COPD patient (Hays and Singh, 2012). The research interview guideline was adapted in accordance with the type of connection and the extent of contact informants had with those patients. The aim of the interviews was to collect well informed views of the participants. Therefore, informants were provided with a list of issues that would be discussed in the interviews alongside the invitation letter, the information sheet and the consent form 2 weeks ahead of the interview. This list included but was not limited to:

- How those groups of patients were looked after, where, who were involved in their care, and the participant's personal role?

- Whether anything has changed over the last 2-5 years/since the participant started his/her current job (role), what has changed (place of and type of care)? Why these changes have happened and who got involved? What his/her role was?

- What could change over the next 5-10 years, how? Why?

- How they want the care of those groups of patient to be? Why? What would their role be?

- Were they ready for this future? How? What were they doing personally? What was the trust doing? And what did they think should be done to meet the challenges of the future.

- How those patients are/were moving across the boundaries of care in the past, now and will be in the future?

- Inter/intra -professional working relationships and the permeability of the boundaries of the professions in the past, present and future and how it is changing, why it is changing if it was changing.

- How they access information, pass it on,

In the interviews, informants were asked to reflect on their experience of the changes rather than just to describe it. Indeed, these interviews enabled the participants to explain their understanding of their experiences, views and accounts to a third party as a colleague researcher. Therefore, careful attention was given to the way they presented themselves as to whether they were saying what they knew, believed, or what they wanted me to believe that they knew.

Since different informants have different levels and types of contact with those groups of patients each participant's interview was guided by the nature of this relationship. Furthermore, this list of issues was modified in the light of the accumulative knowledge gained from previous interviews, personal experience, field notes and the literature and the policy review.

3.13.4 Interviews

Although Yin (2003) and stake (2000) have failed to provide a theoretical model for the data collection process yet, both stress on its importance to guide the data collection in case studies. Indeed, a framework will keep the data analysis and interpretation in scope and will guide the structure of the final report (Yin, 2003). Nonetheless, a rigid approach could restrain the inductivity when exploring the phenomenon as it could pose a risk of becoming too driven by the approach rather than by the data. Therefore, Stake (2000) suggests a guideline that focuses on the issues of main concern in the phenomenon. In this study, this guideline continued to develop with themes that emerge from the data analysis as both data gathering and data analysis were commenced concurrently.

At the first stage, my personal experience, discussion with colleagues and literature review were used to build a list of initial ideas for exploration (Table 2). Charmaz (2006) argued

that this initial list could be used to guide the lead off interviews and the preliminary analysis.

To examine the questions identified, a one to one Semi-structured interview was deployed to explore the meaning and the experience of the health care reform as it was lived, perceived and interpreted by those professionals and how it is going to influence their role and profession. A loose framework to structure the interviews provided a deeper insight than a more structured interview (Green and Thorogood, 2009). A semi structured interview approach could limit the researcher's influence over the direction of the research, conjuring any meaning, understanding or experience upon the participants (Wengraf, 2001). Although, every attempt was made to remain distant from the interviewees' voice, it is worth mentioning here that the story line of the integration told in this research was a shared construct between all research participants including the researcher. The nature of the study and the relationship with the informants has sometime turned the interviews into conversations where participants questioned my personal opinions, beliefs, and interpretation as interviewers. In these circumstances, and to pursue information which otherwise would not be disclosed, a conversation was maintained which explain why some interviews were long. Indeed, as an insider, engaging with the participants in this exploration dialogue has helped in constructing a researcher-participant's shared meaning (Creswell, 1998).

Table 2. Initial ideas guiding research

1. Personal information.

2. Role and work description through life stories.

3. Exploring the interviewees level of understanding of the NHS reform and the nature of the reform impact (as they saw it); specifically, on their roles, attributes, the working environment and their attitudes to their work and to profession, the type of service they provide to their service users, their relationships with their colleagues, line managers, service users, and with other occupations on the care continuum of the critically ill patients.

4. Exploring the philosophies and values that shape the interviewees views on their work and role.

5. Exploring the interviewees' aspirations for the future of the provision of critical care nursing.

6. Exemplary of the nature of change in role and work. Participants were asked about the type of care they provide to the critically ill patients in their area of practice and if they have noticed any changes to their role, type of care or patients groups over time. What factors have influenced these changes? What factors will influence critical care in the next 10 years? And what strategies will be most useful in supporting critical care nurses (individually and collectively) to contribute in the existing and anticipated changes.

7. Participants were asked to cite a clinical case (professional exemplar) that could reflect their practice as well as the change in the practice.

The participant's biographical data was collected before interviews were commenced (table 3). The Semi-structured interview guide was used to probe as well as to keep the

narrative personal story focussed around the research issues and minimise the dross rate (Morse and Field, 1996). First time participant interviews took around 40-90 minutes with average of 70 minutes depending on the time available to the interviewees and the content of the interviews. The second time interviews were between 5-18 minutes with average of 12 minutes. Interviews were digitally audio-recorded, and notes to clarify any significant issues that cannot be audio recorded were written down as well. These initial ideas were refined and expounded over the course of the investigation. The continuous modification of the interview process was driven by the emerging themes, the adopted policy process approach and literature review. Hence, the final version formulated a theoretical framework of the health care reform through integration.

Table 3: Biographical data of the interviews participants

Profession	Outward journey	Inward journey	Re-interviewed during the inward journey	the sum
doctors	2	1		3
Nurses acute side including matrons	4	2	3	9
Nurses at the interface (A and E, Ambulatory care and virtual ward	3	2	2	7
Nurses primary/community care including matrons	3	1	1	5
Senior managers	1	1	1	3
Physiotherapist acute side	1	1	1	3
Physiotherapist primary /community care	1			1
Bed/site managers	2	1	1	4
The sum	17	9	9	35

3.13.5 The patient journey – shaping the interview

Informant interviews were carried out with the patient as the focus of the interview. Though it did not follow a particular patient's journey through their treatment, yet participant selection followed the common COPD patient (virtual) journey trajectory. The sampling strategy was based on the patient journey as they travelled through the micro-networks of the research setting. The originating micro-network of the patient's journey was the critical care unit. A COPD patient's journey was selected to facilitate sampling. Prior to the service integration, those patients who were identified as ready to leave the critical care unit, were reviewed by the outreach service in the critical care unit. Ideally, those patients were then moved to a respiratory ward where they were looked after by the respiratory team as well as the outreach team. Patients were then usually discharged from the respiratory ward to the community where they were looked after by the respiratory team and the community team who were most often the source of referral back to the emergency department if the patient condition subsequently deteriorated. From the emergency department the patients would be referred to either an acute respiratory ward or critical care unit depending on their care need levels. Individual patient would experience this circle of care on numerous occasions.

On their care continuum, COPD patients meet a wide variety of professionals. Some of those professionals provide direct care to the patients (e.g. doctor, nurse, physiotherapist, occupational therapist, speech and language therapist, nutritionist, pharmacist) and others who might never personally see the patients like managers and human resources. Nevertheless, those managers and human resources personals decisions impacted on the care of the patients through influencing the role of other professionals and through allocating resources. As a result, some participants had very little to say in certain areas of the research as it was marginal to their work scope while others had a great interest in the

research topic. Therefore, each interview needed a different set of questions depending on where these professionals got involved in the care of those patients and the extent of their involvement.

Each interview started with a very broad question regarding the care of those groups of patients and followed up on the participant's own experience and views hence; each interviewee gave a different perspective. Nonetheless, each interview was guided by the cumulative knowledge gained through all previous interviews. At the end of each interview, participants were asked to recommend other potential participants who could fortify the depth and the breadth of the data. To complete the health care trajectory of the patients, I reversed my interview journey (community- emergency- acute respiratory ward and critical care unit). Nonetheless, once the outward interviews journey was completed a stock take and an analysis of the emerging themes was carried out before embarking on the inward interviews journey. Thereby, this inward journey verified the data collected in the first part of the research as well as looked for newly emerging data.

3.13.6 Document selection

Though the policy network emphasises on the move from the global generalisations to the local context (Smith, 1993) yet, a perspective of the wider context needed be explored. Indeed, the context where this reform was happening was in itself dynamic and any changes in any dimension (economic, political, medical advancement) could have altered the network/s structure and in turn shift resources, control and power delegation within and across the networks. Weir and Skocpol (1985) emphasized the role of central government's policy aspirations in moulding other stakeholders' understanding of what is needed. Published data such as historical data from literature, professional journals, newsletters, Department of Health's (DH) publications, the Trust's publications (e.g. mission statement,

workforce strategies) informed the literature review as well as located the generated empirical data within a context and timeframe.

There is a lot of literature available online, and on the intra-organisation net in relation to the health care reform. In addition to the key word (explained later in Data extraction from documents) search using electronic data base; Med-line, Elton B. Stephens Company (EBSCO), Cumulative Index of Nursing and Allied Health Literature (CINAHL), the government website (www.official-documents.gov.uk), local organisation intra-net and library, influenced by the ANT theoretical frame work, two other methods to identify the relevant documents were used. Firstly, all documents mentioned in the interviews, hospital meetings such as bed management meetings and hospital wide communications and updates were collected. Secondly, similar to that of snowball, all documents referred to by any of the collected data that thought to be relevant to the health care integration were also collected. Some of the government reports and white papers would be a financial burden to purchase at around £10-15 each therefore they were accessed through the internet. Some of the documents were either not available or were not publically accessible. Unsurprisingly, most of these documents were not organised in a way suitable for analysis of the change process. As explained in the 'Data extraction from documents' section, an inclusion and exclusion criteria for document selection was drawn up to sift through the large set of documents collected.

Examining the documents of the case study shed light on the organisation's response to the health care reform as well as to its role in promoting this reform. The analyses of the government's policies played an important role in making sense of the government's health care restructuring. However, while studying this phenomenon there were three assumptions that we needed to keep in mind:

- Governments in general are bounded by their context and any proposed policy would be entangled with the existing and historical form of governance and policy.

- The coalition government's rhetoric tended to remain neutral towards the healthcare governance and tried to shift the burden of the services management and delivery to the frontline organisations and professionals.

- Frontline organisations (Hospitals, community health, GPs and social services) are at the forefront of the government's health care policy (Localism Act, 2011).

However, it worth noticing that these documents, special these available on the internet, were produced by actors who have their own political agenda and interest and not natural occurring artefacts. Those actors, most probably were trying to advance their political agenda on the public domain through those documents. Therefore, documents were approached with critical reflexivity in relation to the social, economical and political context of their construct.
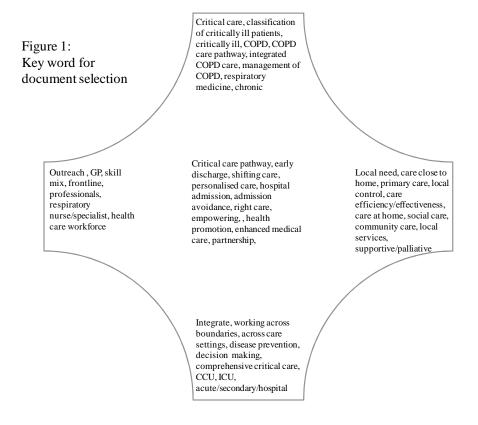
3.13.7 Data extraction from documents

Atkinson and Coffey (1997) argued that documents published by the government or by local organisations in response to the government's guidance are not an actual representation of the decision making process nor do they reflect the routine practice within that organisation. Abbott et al. (2004) claimed that local organisations often responded to the Department of Health's guidelines by producing local policies that try to marry the government's policy requirements with the local needs. Central government tend to provide under defined polices and guidance that accommodate local interpretation (Hunter, 1993). Yet, document analysis has been widely used to obtain data (Sibbald et al., 2002) that represent the aspiration and the contemporary strategic intent as well as the organisation's promises at the time of production and publication. Furthermore, health

organisations use those documents to audit their performance against, and public/interest groups and professionals use these documents to hold the health organisations to account (Age Concern, 2009).

The availability of a wide range of health policies in the public domain resulted in a practical dilemma in relation to the time and effort needed to collect, distil and analyse these documents. Hence, document collection and data extraction were focussed activities guided by the research aim.

These focussed activities were underpinned by both practical and ideological aspects. At the practical level an extraction sheet was produced to draw the inclusion/exclusion criteria. Content analysis of the documents was used to search for document's themes and words that match the research aim or theme. Documents were included if they contained certain words (Figure 1)

Figure 1:
Key word for
document selection

Critical care, classification of critically ill patients, critically ill, COPD, COPD care pathway, integrated COPD care, management of COPD, respiratory medicine, chronic

Outreach , GP, skill mix, frontline, professionals, respiratory nurse/specialist, health care workforce

Critical care pathway, early discharge, shifting care, personalised care, hospital admission, admission avoidance, right care, empowering, , health promotion, enhanced medical care, partnership,

Local need, care close to home, primary care, local control, care efficiency/effectiveness, care at home, social care, community care, local services, supportive/palliative

Integrate, working across boundaries, across care settings, disease prevention, decision making, comprehensive critical care, CCU, ICU, acute/secondary/hospital

These documents were categorised into 5 groups; those dealing with professional roles and attributes (professionalization), patient as the focal point of care, working across boundaries, COPD, home care or hospital at home as inferred from the complete texts. Yet, this categorisation did not divide the groups into definitive or fixed boundaries. Ideologically, the extraction sheet examined the documents regarding; why they were produced, by whom, under what circumstances, how they have been used, and who the intended audience/target were, how they were locally interpreted in relation to the research aim.

3.13.8 Data organisation

Considering the huge volume of the produced data (the interview transcripts and the documents), St John and Johnson (2000) recommendation of using a computer aided qualitative data analysis software (CAQDAS) to help manage the data was followed. NVivo 9 was used to aid the organisation and management of the generated data as I already have some experience in using it. This software provides unlimited bins in which data can be organised and stored. Moreover, this software enables researchers to time and date the entries as well as to search the data. These organisational functions of the software bring order to the data when developing a case study data base as recommended by both Yin (2003) and Stake (2006). Undoubtedly, harnessing the software's ability to organise, match and link enhanced the efficiency of the data analysis process (Bazeley, 2007).

 To facilitate organisation, the data from each network was stored together to help within as well as across network analysis, although it is worth mentioning that some actors belonged to more than one network. Keeping in mind the potential of losing the contextualised meanings, using this software aided the retrieval, deconstruction and coding of the data (St John and Johnson, 2000). Manual sketching and diagrams on paper enabled

me to visualise the relationship between the emerging themes and categories within the data.

3.13.9 Framework for data analysis

Grounded theory originally emerged from the work of Glaser and Strauss on health care professional's interaction with dying people (Hutchinson and Wilson, 2001). Since it was first described by Glaser and Strauss (1967) grounded theory has been very popular in health care research (Schreiber and Stern, 2001; Munhall, 2006; Holloway and Wheeler, 2010). This wide use of the grounded theory evoked a growing debate among the researchers about the best way to interpret and utilise this methodology hence achieving a grounded theory (Strauss and Corbin, 1998; Charmaz, 2006). Guided by the researchers' epistemological viewpoint, a wide range of approaches to grounded theory have evolved. At its earlier stage, grounded theorist claimed that reality is objective and can be observed and captured by a neutral observer (Glaser, 1992; Guba and Lincoln, 1994). On the other hand, post positivists argued that, understanding the emic stance of the inquiry can only be achieved by expounding the voice of the participants and by representing them as accurately as possible by limiting the observer's contribution (Strauss and Corben, 1998). Charmaz (2000; 2006) disputed both arguments on the base that the grounded theory is not discovered from the data independent of the researcher's influence as claimed by Glaser and Strauss. Charmaz argued that the researchers and the research participants bring their own perspectives to negotiate the construction of the data hence the theory. In the case of interviews, Murphy and Dingwall (2003) argued that interview talk is contextually bounded similar to any other form of discussion. Hence, should be interpreted in the light of their occurring context.

All of these different approaches to grounded theory share similar core characteristics. Indeed, it has been argued that using an iterative process, researchers should create analytical codes and categories from the deep and thick generated data. In essence, the researcher relies heavily on the primacy of the data rather than on the preconceived hypothesis in developing the grounded theory (Starks and Trinidad, 2007; Holloway and Wheeler, 2010; Hays and Singh, 2012). Moreover, the sample selection should aim at theory generation. This theory could only be produced by systemic inter and intra comparisons between the data, the emerging themes, categories, codes and theories. This study adopted a constant comparative method of grounded theory approach to both data collection and analysis. This reciprocity between the data generation and data analyses leads to the groundedness of a theory from which a hypothesis could be generated (Strauss and Corben, 1998; Charmaz, 2000; Patton, 2002; Holloway and wheeler, 2010).

Despite this agreement, it appears that there is a tendency among researchers to overlook some of those common characteristics of the grounded theory. Bringer et al. (2004) noticed that many researchers fail to provide a trail account of the research process hence, according to Hays and Singh (2012) endangering the trustworthiness of the results. Furthermore, researchers tend to generate the theories relying on a descriptive account of the concepts rather than examining the relationship between those concepts and categories (Charmaz, 2003). This superficial descriptive analysis results in a failure to attain the main purpose of the grounded theory- developing a substantive explanatory model that is grounded in the empirical data (Charmaz, 2003; Holloway and Wheeler, 2010).

Certainly, the possibility of undertaken any research in a theoretical vacuum is very naive assumption. Therefore, it was quite useful to bring my prior assumption and existing available literature into the research process. To start with, those prior assumptions and

literature helped me to formulate the research question. At the beginning, the research question was a working position that was modified progressively in response to the data emerged from the interviews and changes in the context in which the participant acted. Though the interview trajectory has followed the virtual COPD patient journey, the order of the interviews, some time, were modified to reflect the data emergence as I was tracking emerging networks or important changes. As a result, the data collection process was responsive to the emerging data rather than a preconceived theory (Liamputtong and Ezzy 2005). This approach is in line with both the grounded theory as well as the adopted ANT as they both don not require a pre-existing hypothesis.

This approach to data collection was a necessity for two reasons; first, literature review showed that there is no existing theoretical framework that explains the ongoing health care reform particularly in relation to the health care integration. The second reason was the lack of clarity in relation to defining the research topic as explained earlier. The adopted theoretical framework anticipated that, it was only through understanding the interrelationship between the actors and the networks that the intricacy of the theoretical explanation would emerge.

As explained later, data analysis was happening concurrently with the data collection. So, emerging themes from interviews and document analysis were investigated in the successive interviews. As I followed investigative threads and story line of particular interest, I was constantly crossing boundaries of networks. As a result, there was a continuous comparison between the micro-networks emerging data from both the interviews and documents analysis review. This critical analysis of the emerging data and the persistent cross checking of the concepts and emerging themes within and across the networks helped me to identify the research topic, focus the research question and added

the narrative toward developing a substantive explanatory model that is grounded in the empirical data. Empirical data in this research included data generated from the interviews, document analysis, field observations, and my personal autoethnography.

To conclude, the constructive grounded theory approach was followed throughout the research process from identifying the research topic, formulating the research question, data collection and data analysis. A substantive explanatory model was built inductively form critical analysis of the empirical data and continuous systemic comparison between the emerging concepts, themes and categories rather than superficial description.

3.13.10 Interviews analyses

Audio-recorded interviews were transcribed verbatim using Microsoft word, typed and double spaced. The transcripts were titled with the participants pseudonyms. In the text I was identified as interviewer and the participants were identified by their pseudonyms on the left side margin of the texts. To reduce the chance of research participants being identified, research participants were assigned random letter/s in the final report of this research. Given the small sample size from each area of practice and specialities and in order to maintain the participants anonymity, quoted actor's biographical details such as age, Gender, job role, years of experience, seniority, education, etc. were not displayed. This information could potentially give the reader some idea of the demographic background of the participants being quoted. However, weighing the potential advantages and disadvantages of adding these details and considering that some of the participants were very keen not to be identified, revealing the participants identity would Indeed, infringe the promise to maintain confidentiality hence, invalidating the participant consent. Consequently, I believe that, it would be a high risk compromise to disclose these informations.

Interviews were imported into the NVivo and then analysed thematically. This process involved reading and rereading of the data for familiarisation. Then, the data generated by each interview was coded per idea rather than line by line as suggested by Simmons (2010). At this stage of the analysis Charmaz (2006) and Simmons (2010) recommend that we should examine the texts for words of action and look for meanings through comparing data with data.

A quick review during this initial coding process helped to identify any gaps in the data that required further clarification by the participants or needed to be addressed in the next interviews. This openness to the initial coding enabled me to identify any significant points that the participants were trying to say and to avoid imposing own preconceived understanding of the emerging ideas. Indeed, this eye opening initial coding allowed me to see in the interviews what the participants themselves saw.

At this stage, codes were simple short and used the participant's words (in vivo) where possible to name each idea of the interviews (Gibbs, 2002) in an attempt to avoid imposing my own meanings on the data. During this initial coding, memos explaining my thoughts about each code and why it was selected were written alongside (Gibbs, 2002).

3.13.11 Documents analysis

Documents are not a neutral artefact (Bowen, 2009; O'Leary, 2014). Undoubtedly, they represent their author or commissioners version of the reality. They are used as a medium through which social power or power of persuasion is expressed. Accordingly, Charmaz highlighted the importance of doing a background research on these data as to why they have been produced, in what circumstances, who commissioned as well as constructed

them. Data gained form public reports and policies provided a wealth of information about the reform (Charmaz, 2006) as they were moved from the global generalisation of the NHS to the local organisation context (Smith, 1993).

Once the relevant published documents were collected they were organised into binders for analyses. Documents which were not available in a digital form were scanned. Each document was labelled with its name and placed in a digital binder. All of these binders were imported into the NVivo software. Segments of these documents that were related to this study were read and coded. This fracturing and rearranging of the data enabled me to label similar segments (statements) with category or theme names. These names were words from within the text (in vivo). This category and theme labelling facilitated comparisons between and within the data. The whole process was conducted concurrently with analytical memos of my impression and understanding of the themes and categories (Charmaz, 2006; Gerstl-Pepin and Patrizio, 2009). These memos contained my understanding of why those documents were produced, how they are connected, and their relevance and usefulness to the current study.

3.13.12 Data integration

Both interviews and documents analysis were carried out concurrently. Guided by the memos written during the data collection and the initial coding process, the primary codes were used to sift through the data to identify patterns and topics in this data (Charmaz, 2006). This comparison between the raw data and the initial codes and between the codes themselves helped not only in refining the codes but also in examining the original data with new understanding. This interaction with data transformed the codes into a more condensed and focused codes (categories or themes) that represented the data completely and clearly (Charmaz, 2006).

Each network was analysed separately to help understand issues and to develop themes from that group's perspective. To capture a holistic picture of the unfolding impact, the expected impact of health care reform on health care professional practice as well as to how to facilitate the participation of those professionals (individually and collectively) in current and anticipated policy changes, all the data was examined as a one set. NVIVO 9 qualitative data analysis software package was used to support the processes of coding and pattern identification.

Next, the relationship between these focussed codes was examined deductively and inductively on a conceptual rather than a descriptive level in a process called axial coding (Charmaz, 2006). To encourage this conceptualisation an advanced level of comparative procedures and analytical techniques were utilised. Furthermore, to capture the dynamic nature of the events, an in depth exploration of the categories facilitated by the NVivo relationship node tool examined any connections between those categories. Accordingly, categories were organised in a hierarchal order (categories and subcategories) in which data was reintegrated into cohesive and understandable concepts (Strauss and Corbin, 1998). At this stage, data was also explored chronologically to identify critical historical events that signpost significant changes that potentially have far reaching effect on the change diffusion trajectory within the organisation or even within a network.

All of these categories and subcategories were examined in light of the original research question and the overall studied phenomenon to select a core category. Using the model building function in the NVivo, a model diagram was built to illustrate a visual representation of the interconnectedness between the core categories and the rest of the categories and subcategories (Holt and Dunn, 2004). Finally, an analytical single storyline

that tells the conceptual and theoretical relationship between all of these categories and sub categories was developed. This story provided an explanation of the implications of the United Kingdom's key heath care policy changes for health care professionals and the positionality of those professionals in policy implementation. This storyline is grounded in the generated data (Glaser and Strauss, 1967) and leads to building a model for multiple health care organisation reform through integration (Charmaz, 2006; Corbin and Strauss, 2008).

The overlap between the data analysis process and the data collection served a logistic and a strategic purpose: at first it gave the analysis a head starts while still having a good recollection of the interviews. More importantly, it allowed flexibility to modify the data collection process-themes and tools (Huberman and Miles, 2002) in what is called theoretical sampling (Gibbs, 2002).

Findings of both policy analysis and empirical data were interpreted and compared with existing knowledge on the professional reconfiguration and workforce management theories. This attempted analytical generalisation hopefully will enable the reader to connect their own personal experience with that of the case study.

3.14 Rigour

Data interpretation is a key component of any research activity. Historically, qualitative research has been criticised for lacking rigour and being subjective compared to quantitative methods which use objective and experimental methods (Mays and Pope, 1995). This argument is far from truth as qualitative research uses different approaches to explore humans' experiences that are unique and context bound. The qualitative approaches emphasis on describing phenomenon, understanding human experiences and developing

theory (Vishnevsky and Beanlands, 2004) deems measures like validity and reliability inapplicable (Cutcliffe and McKenna, 1999; Denzin and Lincoln 1994, Lincoln and Guba 1985). In qualitative research the researcher is the main research tool and has no choice but to be part of the research, hence his/her own pre-knowledge and experience will influence the research process (Koch and Harrington, 1998). Therefore, a more imaginative approach to assess the quality of qualitative research is needed (Sandelowski, 1993).

As a result, a range of criteria and issues were raised in relation to assessing the rigour of qualitative research (Connelly, 2016; Polit and Beck, 2012; 2014; Tracy, 2010; Sinkovics et al, 2008; Koch, 2006; Long and Johnson, 2000; Mays and Pope, 2000). The most common raised issues are those proposed by Lincoln and Guba (1985). Lincoln and Guba used the term trustworthiness simply to demonstrate if the qualitative research is worthy. Lincoln and Guba (1985) and Guba and Lincoln (1994) argued that credibility, dependability, confirmability, transferability and authenticity are essential criteria to assess the trustworthiness of a qualitative inquiry.

Guba and Lincoln (1989) explained that credibility refers to the level of confidences that the research findings are true representation of the research participants constructed reality. Dependability, referred to the results stability and consistency over time given similar circumstances (Polit and Beck, 2012; 2014). Confirmability represents the ability of the researcher to demonstrate that the data is true representation of the research participants response and viewpoints and not that of the researcher (Polit and Beck, 2012; 2014). To explicate, the researcher needs to demonstrate that the inquiry data and interpretation are rooted in the phenomena rather that his own assumptions. The research transferability in qualitative research mirrors the generalisability of the quantitative research. Therefore, qualitative inquiries need to describe the context adequately to enable the research reader

to judge if the findings could be applied to similar context. The last criterion refers to the ability of the researcher to faithfully and fairly represent the participants' reality (Lincoln and Guba, 1985; Polit and Beck, 2012). Hence, authenticity essentially intersects with credibility, dependability and confirmability.

Issues of trustworthiness and rigour have been addressed throughout this chapter and the rest of the research. However, this is a summary of how the trustworthiness has been addressed in this research. To establish the credibility, working at the same establishment enabled me to spend long enough time in the field which gave me the opportunity not only to interview the participants but also to experience the phenomena itself. This also enabled me to observe how other participant lived the experience as well as to compare my observation with their story line. Issues raised in each interview were revisited with either the same participant during the second interview round or were clarified through the consecutive interviews. Moreover, a reflective journal of the research process, methodology, ideas generated, personal experience, and personal opinions changes was maintained to keep track of the research progress. This personal reflective account kept a record of the changes in my understanding of the research topic, the interaction with the research actors as well as my personal experience emergence. This reflective account helped me not only in data analysis and interpretation but also searching for alternative explanation as well as in constructing my own personal autoethnography story.

A detailed audit trail of the research methods in the methodology chapter including decisions about participant selection criteria and all activities related to the research process aided the dependability of this inquiry. To enhance the confirmability of the research, the research method log and memos were discussed with experienced researchers

regularly. A reflective journal of those discussions was kept to track the research process and data analysis progress.

Similarly, to establish both the confirmability as well as the dependability, the primary coding was done in vivo and the codes were given names from the actual words of the participants. To assure that the codes were true representation of the collected data, a selection of the interviews were examined by two experienced qualitative researchers independently, who then discussed and resolved any differences. Primary codes were subject to the validation of participants from each stage of the interviews. Dividing the data collection into inward and out ward journey enabled me to confirm not only the generated data with the participants, but also the codes generated from the first round of data collection.

Qualitative research transferability is down to the research reader's judgment to confirm or refute the research findings transferability to other contexts (Graneheim and Lundman, 2004). Thus, it has been quite difficult to demonstrate this research transferability. Yet, a detailed and rich description of the research context, participants, data collection and analysis should enable the reader to assess the findings applicability to his/her situation. However, discussions with non-participant health care professional colleagues revealed that the research findings do resonate with their own personal experience.

 Authenticity was demonstrated through a wide and extensive range of data excerpts that reflect the participants' including me the researcher, psychological and emotional experience. These numerous data excerpts should enable the reader to grasp the essence of the experience as we lived it. Research data were collected by semi-structured interview,

field notes, autoethnography, and documentary analysis. This multiple sources of data collection provide a more convincing and accurate case study according to Yin (1994).

In spite of the variations in the autoethnography approaches, it should be noted, that this flexibility is not a license to abandon strict research rigor. In this study I have followed the same criteria in my personal autoethnography. Nonetheless, autoethnographer researcher demonstrate their engagement in the phenomenon by providing the reader with a *"textual visibility of the researcher's self"* Anderson (2006, p 384). In this study those enhanced textual visibility clearly showed me concerned with the same issues as the rest of the health care professionals. Throughout this autoethnography, I spoke openly about my ambivalent experiences, feelings and emotions which at time left me vulnerable. Those feelings resonate with the feelings of other participants. However, it is worth mentioning at this point that, my autoethnography was to capture the experience at a personal level as an *"intrinsic part of the case study"* (Davies, 2008, p.5). This subjective experience enriched the inquiry with deep personal data which otherwise could not be reached easily with other participant interviews and observation. Finally, Literature review on the research topic and how this research topic has been approached by other researchers alongside the ANT framework has guided judgment throughout the research process.

3.15 Conclusion on the Methodology

The methodology adopted to address the research question was multi-method constructive qualitative approach. This approach was in line with the adopted theoretical framework. An instrumental case study that encompasses interviews and documentary analysis was used to collect the data as well as to define the case boundaries. My personal position as a researcher and actors within the policy implementation process has not only improved my access to the data sources (interviews, documents and field observation) but also increased

my chance to influence the research process and findings. My positionality and role within the policy process was explained in a personal autoethnography. Grounded theory approach was adopted to analyse the generated data. This multi-methods constructive approach was sufficient to answer the questions about the health care professional positionality in relation to the policy implementation process. Ethical and privacy concerned raised by this study were addressed in this chapter.

The next three chapters present the research findings from the methodology adopted. Chapter 4 presents the emerging story of the integration through policy translation process. Chapter 5 discusses the dynamics of mobilisation and how that mobilisation has been brought about. Chapter 6 locates the study findings in relation to the available literature on organisational change theories and models. Building on the existing empirical ideas found in related fields, chapter 6 offers a model for change through integration in absence of strategic leadership as a particular form of change based on this research finding. Chapter 6 concludes with a reflection on the adopted theoretical framework, theoretical implications of the research, implications for professional education and professional practice before highlighting the research limitations and possible areas for further research.

Chapter 4
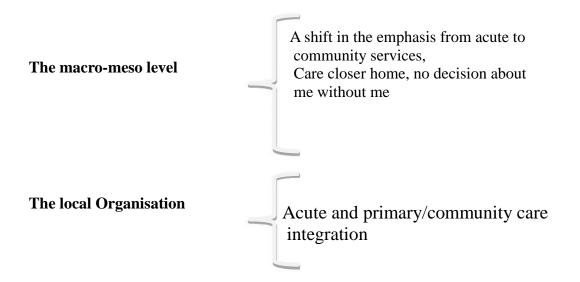
4.0 Findings

4.1 Service integration policy translation process

In this chapter, the findings will be presented in the form of policy translation process. This policy translation process presents an ongoing story of health care organisation integration and the health care professionals role in policy process and its implications to their daily professional practice.
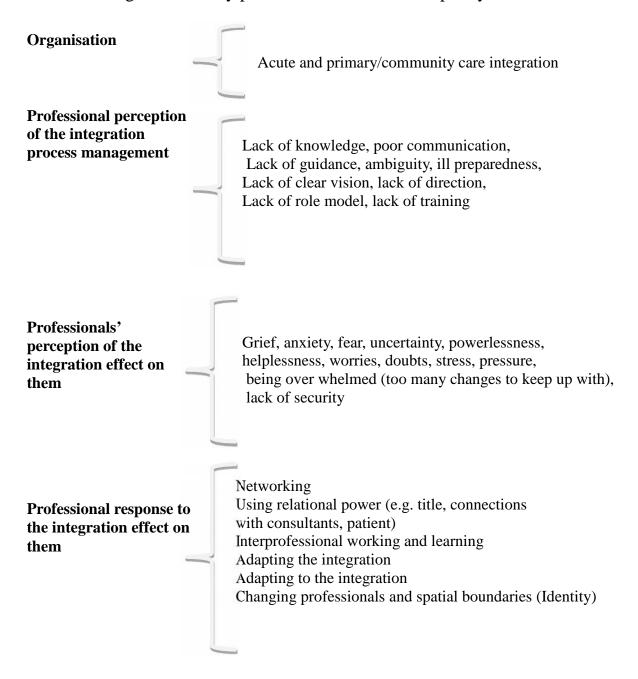
This integration process story attempts to capture the action, interactions and negotiations of the actors, the deconstruction and construction of boundaries in relation to space and time as well as the redefining of the actor's professional role and identity in a process Callon and Latour (1981) called translation. This translation process includes four overlapping course of actions; Problematisation, Interessement, Enrolment and Mobilisation (Callon, 1986a). This policy translation occurred at two levels; the first level was at the macro-meso level between the DH and the local management policy makers (diagram 1).This macro-meso policy process became the initial problematisation for the local policy translation as we well see later.

Diagram 1: policy translation at the macro-meso level

The macro-meso level | A shift in the emphasis from acute to community services,
Care closer home, no decision about me without me

The local Organisation | Acute and primary/community care integration

The second level was at the meso-micro policy deliverer level within the local organisation (diagram 2). This diagram represents the main themes emerged from the policy process at the Meso-micro deliverer level in relation to the professional perception of integration process management and its effect on them and the way front line professionals responded to integration in the light of those perceptions. Though there are not clear boundaries between these four components, yet for simplification, the findings will be presented under the headings of the policy process components.

Diagram 2: Policy process at the meso-micro policy deliverer level

Organisation

Acute and primary/community care integration

Professional perception of the integration process management

Lack of knowledge, poor communication,
Lack of guidance, ambiguity, ill preparedness,
Lack of clear vision, lack of direction,
Lack of role model, lack of training

Professionals' perception of the integration effect on them

Grief, anxiety, fear, uncertainty, powerlessness,
helplessness, worries, doubts, stress, pressure,
being over whelmed (too many changes to keep up with),
lack of security

Professional response to the integration effect on them

Networking
Using relational power (e.g. title, connections
with consultants, patient)
Interprofessional working and learning
Adapting the integration
Adapting to the integration
Changing professionals and spatial boundaries (Identity)

The data were generated from many sources. It is essentially a narrative of my personal as

well as my fellow professionals account of our experience of the integration between acute,

community and primary health care services. The findings are informed by and incorporate

data from annotations of my professional journey, policy documents and field notes.
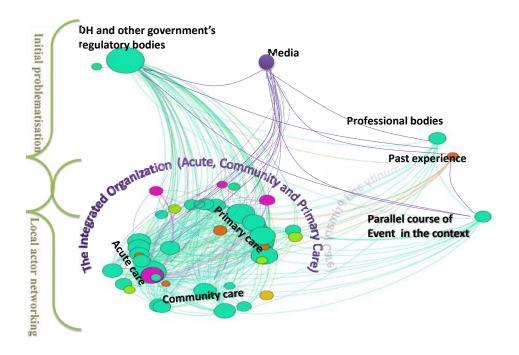
My general understanding of professionals role in the policy process has been enriched by reading on professionalization, theories of changes, social psychology, policy process (mainly actor network theory), the field of psychodynamic organisational studies, diffusion of innovation theories and marginal perspective such as disability theories (Barton, 1996). Readings on the marginalised perspectives helped me to understand how professionals experience being marginalised as well as main stream.

4.2 The translation

A virtual actor was chosen to examine the deconstruction of traditional boundaries separating acute and community/primary health care organisations and a construction of an integrated organisation boundaries. This virtual COPD patient was followed through his journey across the health care continuum. The starting point of this research was a policy from the DH. This policy aimed to move the delivery focus of health care from the acute to community and primary care settings and to bring the point of care contact closer to home. The local interpretation of this policy where this study was conducted was to become an integrated organisation. The local organisation management's interpretation of the central government policy became primary actor of the integration policy translation process. The virtual patient journey was followed between 2012 and 2016.

Analysis of local documents as well as the interviews data revealed numerous micro-networks and actors within the health care system and even more interrelationships between those actors within and across the networks. So, this study examined a cross section of the integrated organisation and did not extend outside the organisation apart from some related government documents analysis (figure 2). Hence, the focus of this study is the integration between acute and primary/community care services within a defined geographical location.

Figure 2: A cross-section nodes of the integrated organisation micro-networks and actors' interrelationship
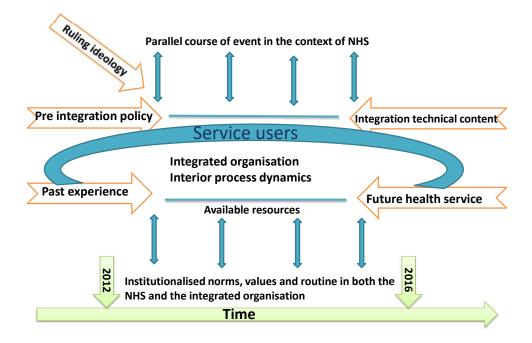
The study findings present a cross section of time and space of an emerging integrated organisation. This organisation comprised of numerous living micro-networks. As a result, the study came across each network at certain time of its life span. Hence, the study's aim was not to follow the life of a particular network but to build a picture of the role of the professionals in the integration process and how the integration is affecting them. This study would not be able to tell the full story of any of the networks as no one network was followed to the end.

One more thing is that, the policy translation process at all levels was not isolated as it was influenced by other contextual factors (diagram 3). Those factors include the health care professionals and managers past experience of local and national health services, local needs and the available resources both human and non-human. Furthermore, Health care service is only one part of the welfare system that needs to orchestrate their work together

for the integration to succeed (DH, 2012b). Though the idea behind the policy change was to increase efficiency and reduce waste, it worth mentioning that the change would increase the initial cost of the service. This became a main concern as this changes introduction came at a time of previously unseen austerity, where public sector budget cuts have been very hard. Moreover, the Coalition (2010-2015) and the following conservative government health and social welfare ideology was to transfer resources via taxation policy to frontline which is in line with that of the neo-conservative agendas. This resources transfer was accompanied with transferring the responsibility from the state to the realm of local provider and empowering of the services users by giving them choices as well as (Beech, 2015; Clarke and Newman, 1997; DH, 2012b).

Some of these contextual factors sound intended and calculated events, yet most of them are emergent. Each of those contextual factors exerts force on the direction and the intensity of the emerging change hence influencing its direction, speed and the intensity. Nevertheless, most of those factors are beyond this study's boundaries. However, as the boundaries between the networks were permeable to actors, the macro-meso and meso-micro-networks intersected and some actors belonged to both. The symmetrical attribute of ANT made it possible to move between the two levels networks to pursue the policy translation process. As the focus of this study is the policy translation at the meso-micro level, the macro-meso level of policy process will be discussed next as initial policy problematisation to set the scene for the local policy translation.

Diagram 3: Contexts affecting the dynamics of change process

4.3 The initial policy problematisation

The government's discourse in relation to the future of patient care over the last 5-8 years before the organisation integration process started suggested that health care services restructuring was inevitable (DH, 2012b). Around that time, the government oration was very focussed on the all health care organisations becoming foundation trusts. Considering the size of the organisation under study, the type of the services provided, the local financial situation, the cost effectiveness of running such a small local organisation made it difficult for the local acute organisation to justify its autonomous existence. At the same time, the proximity of the acute health organisation to two relatively outstanding organisations which had been recently granted a foundation status increased the local acute organisation struggle in the application for the foundation status hence shrank the chance to survive as an independent organisation. In one of the chief executive answers in relation to the future of the trust foundation status, the chief executive was very uncertain and gave

four different scenarios similar to what happened elsewhere (table 4). The only explicit

thing in the chief executive's answer was that, the trust would not remain the same. This

conjecture was in line with the 2012 health act regarding the NHS Trusts being abolished.

Table 4: scenarios for the future of the trust

A. Merger with another non FT.
B. Acquisition (takeover) by an FT.
C. Reconfiguration e.g. broken up with different solutions for the parts.
D. Management franchise by the private sector.

In one of the intranet communication that was accessible to general public, the Chief

executive highlighted the pressure that the trust was under at the time

"*Our commissioners have already told us that they cannot afford all of our services as*

currently provided. They want to buy less hospital services, and more services in the

community. They want quick, easy access (short waiting times) with great patient

experience. And if we do not change our service models in line with what they want to buy,

they will look elsewhere, knowing it is a competitive market out there. So, we have to

change the way we work, and how we deliver services, if .... is to be viable as a

Foundation Trust."(Chief Executive, the organisation Intranet, 2012)

In light of both the Government's policy and the demands of the local commissions and the

local organisation's own circumstances, the local acute health organisation management

scrutinised all potential options for the future of the organisation and saw an opportunity in

the new policy. As a result of this diagnostic framing (Suddaby and Greenwood, 2005), the

research setting management announced their intention to integrate with the community

and primary care. Though, this idea of integration was not completely new, as an actor

working at a strategic level claimed that she was involved in talks between both sides; the acute and the community/primary care of the new organisation long before the government rhetoric.
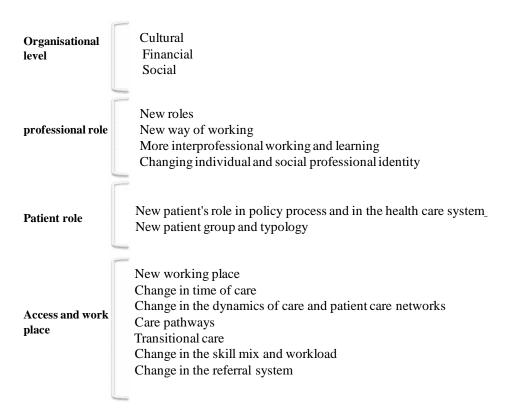
This policy translation between the government and the local organisation which resulted in the integration of the local organisations (the acute service, the community and the primary care) set the context for this study. However, the translation process between the government and the local organisation is beyond the sphere of this study as the study focuses only on the second stage; the local organisation policy translation.

The next section will provide a detailed account of the local organisation actor networking. In order to minimise the confusion that would certainly arise from the so many complex actors involved in so many multifaceted and interconnected networks within the local organisation, the translation process will be simplified. Though, the four components of the translation process overlap, in this section, the findings will be organised under the four components of the policy translation. Those four components will be presented separately along a continuum course of action.

4.4 Local actor networking

The intra-organisation policy translation resulted in a wide range of changes at the levels of organisation, professionals, patient care and access, the patients' role within the health services and patients role in health care policy process (diagram 4).

Diagram 4: changes due to the acute and primary/community care integration

Organisational level	Cultural Financial Social
professional role	New roles New way of working More interprofessional working and learning Changing individual and social professional identity
Patient role	New patient's role in policy process and in the health care system New patient group and typology
Access and work place	New working place Change in time of care Change in the dynamics of care and patient care networks Care pathways Transitional care Change in the skill mix and workload Change in the referral system

4.4.1 Problematisation

Once the management chose the route of integration, a series of intermediaries and mediators - emails, audio-visual broadcastings over the Trust intranet, newsletters as well as executives presenting at both public and local meetings were used to convey the hospital's intention to integrate with the local primary and community health organisations. Throughout those communications, the management insisted that integration is the only way forward if the trust is to remain independent and to have a viable future as a Foundation Trust (FT).

" With the pressure on public finances, our commissioners cannot afford to pay more. They want us to provide more care outside of the hospital at a lower cost and to reduce the amount of work delivered in the hospital. National policies on patient choice require us to provide outstanding patient experience if we want to attract patients, or lose them to other providers. Therefore, we have to change the ways we currently deliver services and we have identified four strands of work to achieve this: Redesigning care pathways to move more care into the community and patients' homes......................Working in partnerships to make substantial efficiency savings. We have to save a total of £85 million in the next five years. Our ambition to be the most efficient, innovative and high quality integrated care provider means being inter-dependent and working in partnership with GPs, patients, and other providers to provide joined up care across the patient's journey." (Chief Executive-Intranet, 22 April 2012)

This prognostic framing (Suddaby and Greenwood, 2005) raised lots of questions such as what is integration, how it is going to be achieved, what integration will achieve and how it will be monitored and measured. As this organisation was one of the very first organisations to integrate, there were no clear answers to these questions. Moreover, the government policies were not clear in relation to definition and enactment of the integration. These unanswered questions left the door open for speculation regarding the integration implementation process and its effect on the stakeholders including the professionals and the service users. These speculations brought me as an actor to generate this study's research question. What is the implication of the health care organisation integration to the health care professionals and what is the role of the professionals in the integration policy process?

To answer this research question I decided to follow a virtual COPD patient's journey through the service and to interview those who are involved in his/her care. This way, I identified the Virtual COPD patient as an essential actor in the research sampling network. The COPD patient journey was used as an obligatory passage point as well as the most important linkage to other actors and network/s. Patients in general were also considered as an obligatory passage point to all interactions and negotiations across the health organisation throughout all the documents and communications published by the organisation within the research setting e.g. the strategy, chief executive briefings and open letters. All of the questions raised by the integration intention as well as the published documents brought other actors directly into the story; the professionals caring for the patient, the managers, and the finance.

Personally, I presented myself as a researcher and a professional who is concerned with the implication of the integration to professional practice and how professionals enact the integration. This problematisation gained the research both the professionals and the management support. At the same time, I established myself as a linchpin that linked all the interactions and negotiations between all actors identified in the patient journey and across networks involved in patient's care through the virtual patient's health care trajectory. Therefore, the research question was enough to attract attention and to engage a wide range of actors. Furthermore, the COPD patient's journey trajectory enabled me to identify the research participants and to study the interactions between them.

Using the patient's journey as a vehicle to answer the research question brought other actors into the storyline in addition to the professionals and managers; the physical distance between both the primary/community and the acute side of the organisation, the

technology used in caring and communicating care, the physical space where the caring interaction is happening as well as the patients preference of care delivery.

Throughout the research, I maintained that participating in the research will contribute to the research participants understanding of the integration process and that the research as a whole would help understanding of how professionals engage in the integration process and how the integration impact professional practice. This professionals understanding could aid professionals commitment to integration. This research aspiration resonated with the management discourse to provide care closer to the patients home through organisation integration.

The integration was expected to increase patient's access to care, improve the patient's outcome and over and above improve patient's experience through providing care closer to home and ensuring a smooth transition across services yet, no insight was provided by the government on how professionals and managers were expected to enact the integration or function within the newly formed organisation.

Actor L: "*I don't know, I think as a unit, I think we very much run with the here and now and I think it's difficult to... you can just discuss changes that might happen but, I think it's difficult to prepare entirely because you don't know actually if something is going to happen or not........and until you get a green light for something, it's very hard to prepare fully,....does that make sense?* "

This ambiguity was felt across all areas of practice at that time as one frontline leader mentioned in a professional conversation.

Actor S:" *we have no clue where we are heading; I don't know what I should tell my team.*"

This opinion was further explored by the succeeding interviews

Actor I: "*with all of these changes happening... Do you think there was a clear plan of what's going to happen next month, year, in two years time or in five years? Or is it like we are making things as we go?*"

Actor A: "*Yes, I don't remember a clear plan. There might have been one but I never saw or heard of. More of it is just we'll see if this works and see how it goes.*"

Actor I: "*All right.*"

Actor A: "*Yes, that's how I feel anyway.*"

Actor I: "*Okay. Is that at the level of the unit or at the level of the whole hospital?*"

Actor A: "*Well, I wasn't aware of anything for plans, so I think probably at the level of the hospital.*"

Actor I: "*Do you think nurses were clear about what's expected from them or...? in relation to all of these changes whether it's at the directorate level or at the shop floor level.*"

Front line leader A*: "Yes, I don't ever remember them outlining thing at the shop level, no, no. ....Nothing is clear."*

Personally I did share the same experience of the Actor A at the time as I wrote in my journal

"*every day there is a new thing, over the last week I nearly spent good hour trying to find out what is new........... One of my juniors asked me last Thursday night about a new form and if we need to fill it now for every new admitted patient, as a frontline leader, I was not sure. I have not seen it before, so I said fill it for tonight and I will find out in the morning."*

This murkiness was not only at the daily practice level, for nearly a year and a half between 2013 and 2014, the organisation management was not stable and professionals felt

that the whole organisation was a sinking ship due to the lack of leadership and management such as the chairman, nursing director, general manager, and other directors

Actor K: *"everybody is jumping out of the sinking ship."*

In 2014 a staff survey confirmed that leader's visibility and communication with staff was a paramount issue in relation to clarifying the future direction of the organisation. This staff opinion was not far from that of the management in 2015 as they reflected back on the leadership of the organisation 2013-14.

Actor SL: "*......... and then there was a lot of change at senior level and the leadership across the executive broke down and they ended up being temporary interim staff at quite a lot of the management levels in the organisation which I think has had detrimental impact.. .... Leadership of an organisation through this sort of change is important…*"

This was confirmed by the (Ham and Alderwick, 2014) report on the organisation integration process which claimed that

"There was great innovative clinical care in certain areas across this organisation. But that almost happened in spite of what was happening in the senior leadership of the organisation." (Ham and Alderwick, 2014)

To conclude, for the management to successfully achieve the aspiration of the DH, care closer to home, for the organisation to thrive in a competitive environment, for the patients to have a good caring experience, for professionals to cooperate in the integration process, professionals needed to understand what was the integration and what was their role in the integration process as well as in the integrated organisation. At the research level, it was essential that professionals involved in the care of COPD patients participate in the study.

4.4.2 Interessement

The problematisation process helped to identify the actors that needed to be engaged with for the integration to happen. The level of engagement in this transformation process would show if the problematisation was successful or not. The aim of this interessement stage was to build a linkage between each actor and the actor network. Each one of the actors has his/her/its own identity. This identity is defined through the actor's own experience, goals, roles, interest, motivations, and current associations and alliances. Consequently, the interessement stage of the organisation integration process was to oblige a new identity on the actors involved in the change and to make them adopt this identity. This new identity could challenge the status quo depending on how much this new identity clashed with the original one. However, the actor's identity is dynamic and emergent and would be adjusted by each interaction hence is fluid and is continuously defined and redefined during the course of the interssement and the consecutive stages.

The problematisation process required both the management and the professionals not only to accept the new reality but also to seek alliances. The management knew that they cannot achieve the integration without the professionals adopting integration. For the professionals, it was not an option not to change. Simultaneously, health care professionals could not participate in the integration without the management and leadership support. Nonetheless, there was a plethora of impediments to their engagement in the integration process (Table 5). These impediments to the professional engagement added up to the state of flux the integrating organisation was undergoing.

Table 5: Impediments to professional engagement in the integration process.

Ill preparedness
Poor communication
Lack of role model
Ambiguity and lack of clear vision
Unclear expectation and direction
Fear of unknown/change /uncertainty
Lack of security

Though service integration intention was highly contested, participants uttered their understanding of the management motivation behind the change.

Actor L: "*I don't think we would survive on our own, we will be taken over by our neighbouring foundation trust, and we are unable to reach a foundation trust on our own.*"

According to a frontline leader this integration was purely about saving and reducing cost by discharging patients, at an early stage, to the community. This early discharge would result in a reduction in acute hospital beds demand hence reducing the number of health care professionals or even employing cheaper alternatives of the professionals.

Actor In: "*we all know that the NHS is trying to reduce number, reduce the cost........... and obviously in general reducing nurses number or ...., reducing professional number in general is one way of reducing the cost, ...and obviously they will look for cheaper alternatives and this is why I'm interested in this.*"

These speculations were not without ground as the acute side of the integrated organisation has already been reducing the number of the hospital acute beds since the integration started. This perception of the integration process was a source of anxiety to those professional at the beginning as will be seen later. In the contrary, the management rhetoric insisted on the capital gain highlighted by the government goals.

Actor SL: "*crude productivity, efficient use of given resources and easy customers access.*"

Despite the fact that, both the management and the professionals agreed on the importance of change, it seems that there was discrepancy on why the organisation needs to or should change. Yet, at a later stage and during the internal journey of the data collection, professionals saw the integration as a way of diverting the patient's from the acute service and keeping them in the community.

Actor T: *"The whole idea of having us as an integrated organization is to prevent patients from coming in if they can be managed in the community."*

Which is more in line with the government and the organisation discourse around *''care closer to home''*. In reality, this was already happening as expressed by nearly all the actors met during the inward data collection journey.

Yet, the first professionals' reaction to the introduction of the idea of integration between the acute and the community/primary health care sides was denial of the process as a whole at both the actors and networks levels.

Actor S: *"it is not going to happen, believe me."*

or that the change would be another document collecting dust somewhere on a shelf.

Actor K: *"here we are...it is another proposed change I have seen many of them, I have been around long enough........ it will not last."*

Undeniably, some professionals defence mechanism toward this intimidating shock as we progressed through the interview was the belief that the change is happening somewhere else and will not influence them.

Actor K: *"how it is going to affect us......we look after the very sick people,...... I think this will maybe affect the community, ..."*

Actors participated in the interview lobbied other colleagues including me the researcher to deny the integration process.

Actor L: *"I'm sure you know, they can't do it, I don't know what is in it for us."*

This initial response to the change appears to be a normal reaction to buffer the first wave of the distressing emotion. As we moved within the interviews and as the integration process progressed over time professionals recognised that change is certain. Yet, the anxiety due to lack of control over the change at this stage was manifested in the professionals scepticism of the integration worth.

Actor G: *"listen to me, this is Conservatives, it is one more step to privatisation.......... only beneficiaries would support this change."*

They only saw what was wrong.

Actor S: *"everybody is jumping out of the sinking ship, ...nobody likes it."*

Even more, they got angry and tried to sabotage all the change process

Actor S: *"..........look at those old consultants they wouldn't even listen. "*

and tried to capitalise on those glitches to gain support for their own causes.

Actor R *"there is an incredible resentment in GP land about enhanced recovery because they see it as bringing down the length of stay of the patient"*

This resistance appeared to be due to fear of the unknown as some professionals were reluctant to commit themselves to the interviews and referred to the ongoing consultation on certain jobs and the extant job cuts.

Actor S: *"I don't want to be identified please; you know lots of things happen at the time being.........they are looking at all senior jobs".*

This was a concern up to 2015.

Actor L: *"have you seen the new structure for the trust, lots of the jobs disappeared.......... , sister ..X.. doesn't know yet what she will be doing. .....they axed her role......., even here, in spite of sister..M.. amazing job .... it is up to Matron .... to decide what she want her to do, she is no more part of the education team."*

Talking to sister M revealed not only her own feelings of lack of security in her current role and its uncertain future but also, showed that some other professionals were preparing for the worst.

Actor M " *I'm doing this course, you don't know what might happen.........I'm trying to get as much as possible before it is too late.......I have been talking with .....he might retire next year you know.... I will keep my options open. All specialist nurses are worried, the ...nurse is already leaving*"

Interestingly, through exchanging those intermediaries and mediators, actors tried to lobby other professionals in networks of denial and resistance to change at this stage. Nevertheless, as they started exploring alternatives through networking, they realised that change is a one way trajectory and there will be no U- turns.

4.4.3 Enrolment

Though it seems that nearly the entire stakeholders were interested in the idea of integration for various reasons, this interest was not enough to get them engaged. Actors needed to be prepared to embrace the impending integration. However, there were huge hindering factors that made it difficult for the actors to accept as well as to enrol in the integration process. It was clear that before negotiating with professionals, innovation leaders who established themselves as OPP needed to clarify what the integration was, how it was going to be achieved, and what was expected form the actors. Furthermore, management was required to deal with other actors and factors such as the infrastructure like space and technology. Nonetheless, infrastructure was only one of the forces that hindered the health care professionals alliance. The success of the interessement stage can only be judged by actors adoption of the integration as well as their enrolment in the process. No matter how convincing the idea of integration is, it could not guarantee the

actors engagement. Therefore, enrolling professionals in the integration is dependent on the ability of the integration OPP to deal with all these predicaments mentioned in Table 5. Without a doubt those predicaments became major actors within the network/s.

Despite the fact that change was clearly inevitable, delivering the care closer home raised a practical question at all levels of how to achieve that. All actors including the professionals, managers, finance became responsible in outlining what they need to change, and how they need to do so to be able to deliver care closer home.

Given that most of the actors at the executive level left the Trust, the general impression was that the interim management was unable to cope with impending change. As a consequence of this leadership vacuum, professionals had to team up with their environment to understand what integration was meant to be and to identify and clarify the function of the integrated organisation and to elucidate the role each will play in the integration process and how they would function in the emerging services. To make things even more obscure, actors have to enrol in unidentified newly created roles.

As a result, several actors were engaged in negotiations within their service provisions locally and across boundaries. Those negotiations aimed at addressing the main concerns of the actors involved in each of them. Lots of the actors were engaged in negotiation across many of these networks, yet some of the networks were completely in parallel worlds in relation to each other. Throughout the interviews, discussions with actors, as well my lived experience I came across negotiations at different stages of the integration process hence, those negotiations addressed different issues. At the beginning, the process of networking was to clarify what the integration meant and how professionals would function in this new form of organisation.

In early 2013, I wrote in my diary:

" ....(a matron) came to the office after a meeting with one of the very senior

executives.   ....He was very serious. We were invited to this meeting, it was quite tough,

.... ,he stood up and asked us what we understand by integration, ...nobody has a clue.

We were shocked with the type of question. Even, he turned to one of the matrons and

asked her, you as team leaders how are you going to implement it............, once he left,

everybody started guessing.. ...., I talk to Mss..... (a nursing director). She said it is

huge, big change is happening, we are already joining with the community, we will be

delivering services across both side. I do not' know how that is going to affect us. I need to

speak with our director Dr .... it is moving fast "

Though professionals realised that change was apparent, and had started exploring their

options within the organisation and how the change would affect what they did, yet they

felt there was a lack of guidance on what they were expected to do and how they would

achieve what was expected of them.

Actor I: "*Do you think nurses were clear about what's expected from them... ?"*

Actor A: "*Yes, I don't ever remember them outlining thing at the shop level, no, no.*"

Professionals felt ill prepared to all of these changes and felt under pressure to cope with

them.

Actor T: "*there is a huge change. The management of the whole trust I think has changed*

massively. I think change is a good thing. Although it puts a lot of pressure on everyone

trying to achieve what has been set by the government in these targets. Though I would

think is a massive of change for the betterment of everyone."

Despite the fact that changes were for the betterment of everyone yet it was too much to cope with.

Actor I: "*lots of changes are happening in the hospital, how do you keep yourself updated about these changes*?"

Actor A: "*Obviously a lot, especially in this organisation; a lot of stuff is communicated via email. I think, it's difficult to check them every shift. But I do make sure, even if it's on my lunch break, I do not mind that. Changes in management structure and changes in the way the hospitals work, it's always communicated on the bulletin. So, I do make sure that I read that. I think it's very important. I'm going to keep up to date.*"

Actor I: "*All right. That's quite interesting.*"

Actor A: "*Yes. Our matrons do cascade lot of things during the handover time. General issues, not just in our department, but like you say in the whole trust. Trust-wide issues are communicated in morning handover......When they're at work... when they're on shift, yes. Otherwise it would be us, yes.*"

Actor I: "*All right. That is good. I'm asking these questions because I do work in ITU, and believe me, for the last maybe couple of months, every single shift I have done, there is a new paper.*"

Actor A: "*Oh really?*"

Actor I: "*You can't keep track and it's really... I mean, it's very important to keep up to date with all of these, because...*"

Actor A: "*There are a lot of changes in it. There's a lot of stuff, too much sometimes.*"

Professionals argued that there were no clear pathways not only for the patients care changes but also for the professionals' preparation for the integration process. There was no clear guidance and there was no body to turn to for advice at the beginning. It was not clear what integration meant, what the role of the professionals in implementing the change was, how their role in caring for the patients would change and what was expected from them during the transition period.

Actor L: "*so I do not think that you necessarily need a strategy........I think certainly making nurses aware of change is important .... but you have to do it in a way that will not terrify them because there's a fear, isn't there? And the NHS is sometimes very quick, it moves very quickly, before you know it this change is there ... so it's important to sow the seed...........but I think if you're going to have as you know strategy to tell the people you got to know the facts and like I said the facts can come very fast, you do not always know them.*"

This uncertainty was felt at all levels across the organisation. New posts were created and professionals were appointed in those posts without clear job /role expectations or job descriptions.

Actor M:" *We are still trying to find our feet and workout who is doing what.............. When I started in the head of nursing post for acute care integration, I really did not know anything about community care. I have done some research sessions in the community, courses in dental sessions, but did not really understand about service-mapping and patient-pathways and how to identify where care could be provided in a different environment or in a different way. .... When I spoke to Mr.........before he left, and some of the other heart failure nurses, I was really impressed with what we could do.*"

Even those professionals who were pro-integration and physically applied for the newly created jobs were faced with not only lack of a clear job description but also ambiguity in role expectations.

Actor Am*" When I went for the interview I did not know what I am supposed to be doing, it keeps changing. Since we open up the big unit we are seeing much more patient, more varieties. At the beginning, it was a lot of the DVTs, Cellulites, now we are seeing a lot more patients. We are doing blood transfusion, iron infusion, it is a big difference now form when we started."*

Furthermore, professionals had to make up their job/role descriptions and expectations as they went.

Actor Am: *"many things have change since we started here........we started very simple... every day we learn about patients' needs.... we came together and decided how we can best meet those needs and we build on that.............. We learn from each other .... if things do not work we change. So, we are in a massive learning curve. we take it case by case so we do have a rough guidelines of who we take but really we take on day by day basis or in case by case basis and see how we can help and how we can achieve the goal of reducing the hospital stay and avoid admissions."*

Hence, there was no clear role description or long term strategy. Services emerged as a result of the health care professionals evolving understanding of the patients needs.

Actor Vw*" ....The virtual ward started as the pilot that got funding and then, the enhance part has come from just feedback and discussion with the team with the physiotherapist, doctors and ambulatory care. Something was going wrong with the*

patient although we were concerned with our patients that we were seeing in the community we have to bring him back in to ambulatory care to have the medical review or to accident emergency if they demanded more. So, we said it will be great if we have the resource of a doctor that could go out and make clinical decision. Actually, I said that now I think we can change this around. The nurse can keep close eye on them. That definitely prevented people from coming back into A&E and being readmitted. So, it worked now really well. We started off as they would only see patients that had a GP need but, sometimes that could be very low volume. This is because that is only a very recent thing. So, now what we decided as of yesterday is that the GP goes out to every single visit we do with us."

Later on, this approach to service innovation was given the green light by the permanent management who was trying to design the governance around the emerging services.

Actor SL: "....*obviously, clinical director and the director of nursing will keep an eye on any changes in the care, model of the care, services, new procedures or equipment But, ultimately, it will be clinicians that would sign off the boundaries ....things like hospital at home for paediatrics. There has been quite a shift of skills into the community .... they are so brilliant and innovative. But they have gone on and done that and we have put governing systems around them.*"

As a result, professionals were experiencing multilayers of struggles. Not only were they struggling with the new roles and jobs but also, they were struggling in a role in the making alongside to the structural changes of the whole organisation in the absence of a visible leadership and guidance.

Actor Rw: "*You were told, there's a Virtual Ward service and you should use it but when I asked what exactly they do, I never got an answer.*"

Personally, at the beginning of the research, whenever I had an informal discussion with any of my co-workers about the integration, how it was going to affect us and what we could do about it as well as during the formal interviews I noticed that, I was always trying to convince them with the integration. Yet, every time I was challenged to talk about my role in the change and how the organisation change is going to affect me and where I saw myself in the future, I did not feel comfortable with the discussion and I either went silent or diverted the conversation to a different topic. Initially, I put this down to the dynamics of the group and that my role was to make people talk about their own experiences. After listening to the audiotapes, personal thinking and talking with my colleagues and experienced researchers about my feelings, I realised that the research as a whole was raising fundamental issue about my identity as a professional working in an organisation undergoing change. This anxiety intensified by fears of being exposed as lacking knowledge about the emerging changes. I thought that as a frontline leader and as a researcher, I should appear to be the expert, capable and in control. Talking about my own feelings of anxiety and fear of embarrassment to my colleagues helped me to learn about myself and paved the way for other actors to talk about their own fears and anxiety. This in turn led to a collective discussion about our changing identities not only at the personal and professional level but also at the organisation level.

Personal journal memo;
 "*Considering that most of the executives have left the trust, I do not think that I know where we are heading to nor what I will be doing this time next year, they are shipping people all over the place, will this change continue? Are we going to be taken over by*

.........foundation trust?..........do they think I am doing these interviews for the trust job

consultation?   .....what should I really tell them? How can I convince them

........everybody is thinking that.   .... There are serious concerns of leadership and

followership and I have been put to the test! The organisation appears unstable, the ability

to make a real changes is out of sight of most managers. I want the trust to carry on, all I

know is critical care and theatre, I cannot be working in the ward or community. Please let

me finish the study, I cannot look for a new job at the time being."

This resonated with other professionals experience a time.

Yet, six weeks later, the struggle was much less and I found myself easing as I wrote,

"It seems not only me but, everybody is struggling. Nobody has a clue, lots of people share

the same fear........ and this new general executive seems to be active and serious about the

change. I will wait and see as everybody says. Nobody knows anything, we take it day by

day,… the only steadfast in this place is the change. It is like the yoyo as ....said;

new policy new changes every day. Nurses are jack of all trade, filling gaps. What next?

Washing the linen and hanging up the curtains! "

Despite the fact that, nearly all networks dealt with the same before mentioned issues yet,

each network was practically troubled with different concerns at any given time. This

discrepancy resulted from the variation of the time, speed and rate at which change was

introduced at the different levels and departments. Professionals at the interface between

the acute and the community/primary care were introduced at early stage to the integration

process while services at the peripheries were introduced to changes later.

Actor Ph*: "Well all I know with the hospital at the moment is looking at 'Hospital at home'*

provision and they are specifically looking at COPD patients and half of other patients. A

long while in the past we looked at supported discharge, so taking patients out within a

couple of days. But that actually saved less in terms of length of stay than working with patients to prevent admissions and turn around quickly, so originally we looked at Respiratory early discharge and it did not work. It did not save the number of bed days that people hoped it would. It did not improve the patient care the way we hoped it would. So that is why we went to the chronic and respiratory support model where you are trying to get the disease management in before the admissions to prevent future patients admission. But I do know the hospital again is now looking at 'Hospital at home' for COPD and half of the patients, literally just now."

Actor I*: "All right"*

Actor Ph*: "They have got funding for three months to pilot it, to investigate it and consider it."*

This early and extensive exposure at the border between the acute and chronic services as well as the proximity in physical distance to where change was happening meant that professionals working in these areas were more informed hence were the early adopters of the change.

Actor Am *"the ambulatory care service was in a cupboard in A&E before they move to the new unit so we have a very good relationship with them in A&E."*

Moreover, People who had previous experience at both sides of the acute and the community services enjoyed the idea of having a both side advantage.

Actor Am *" I was working as a district nurse at ....hospital I was always interested in both Accident and Emergency but also community so, I thought ambulatory care well be a perfect job. I thought it is the community patients but in the hospital setting."*

and perceived it as an opportunity for advancing their career.

Actor Lh *" some people are really enjoying it.......they got the job and they are doing courses to advance their professional career."*

So they not only became early adopters but also knowledge generators and knowledge brokers within and across network boundaries.

On the other hand, due to the lack of preparation and fear of the unknown, professionals including innovators and early adopters of certain/similar interest came together to identify or clarify their roles in the integration process and how they would function within the new organisation. Actors joined these networks seeking information about the integration and how they could be part of the change. These emerging networks were functional and actors joined in across traditional geographical and professional boundaries.

Actor Rw *" I went to ambulatory care or the virtual ward, I found out what they could do... yah, they will visit him (the patient) at home for a two weeks period, up to two weeks period. ....they told me that they will come and go through things with us*."

Once the actors gained some understanding of their role in the integrated organisation the network focus shifted toward the main function of the health service; the care of the patients.

Actor Am "*the main changes since we started the ambulatory services is developing care pathways for lots of things, we design them around the patient needs considering the available resources including space and professionals. Then we adjust a bit here and there. Patients' movement between the services is much smoother."*

This took place across the organisation at a different pace.

To demonstrate, nearly a year later, we in the intensive care unit had many patients who needed a ward based level of care that could not be discharged for many days due to shortage of beds in the acute side of the service. I spoke with the clinical director of surgery as well as the matron about the services that the virtual ward provided. As a result, we invited one of the virtual care matrons to tell us about the services they provided, the criteria they have for accepting patients and the process of referral. Though the proposal was not widely accepted by the ITU professionals, nearly three months after first talk with the matron and the surgical director five patients were discharged to the virtual ward.

4.4.4 Mobilisation

Throughout the interviews, professionals tried to position and reposition themselves not only within the interview network but also within the wider network/s they associated with by translating their interest. Moreover, interviewees tried to set other actors within the network/s in an attempt to convince them to adopt their interest and act accordingly. To do so, patient's interest was used meticulously as a relational power to ascertain actors' importance and centrality to the network/s hence the policy process.

Actor SL *" but I believe I am very patient focused. So you know I come to work every day because I want to make a difference to people that we are caring for on the floor. .... And I think that is probably one of my strengths. Also, in talking to doctors and other nurses and other commissions, I think it gives you a degree of credibility with a clinical background.*"

Actor C *"We are able to refer people directly to ambulatory care. So, it takes a big volume of patients out of the emergency ....but even if we send one or two patients - it's still very helpful."*

During the translation process actors exchanged mediators and intermediaries in the form of materials such as literature, clinical evidence, conversations, and services as well as shared their worries and experiences and their hierarchal positions and services to support their cause and to stabilise their positions within the network.

Actor L" what *makes difference is the individual nurse who collectively with a group of other nurses take it forward to whoever can make a change or make their concern heard*."

Actor N *" Yeah, because even with the title, it's Integrated Respirator Consultant....."*

Once those actors gain the favourable outcome through various translations they inscribe this alignment of interests into a more stable way. For the management, these inscriptions were in the form of strategies" *Our Clinical Strategy 2015-2020*" and executive briefings in a process called "'*black boxing*". On the other hand, professionals were inclined to stabilise their accomplished discourses by inscribing them into policies, protocols and pathways or even into a title (eg. ambulatory care patients' pathways, the use of Non Invasive Ventilation (NIV) Machine protocol for COPD patient in acute ward, Integrated Respiratory Consultant).

Once inscribed, those intermediaries and mediators become actors within the network/s. Actor L" *a lot of these things are only able to happen because you got a protocol supporting you, behind you. So you're able to. If you like to justify actions of why you weaned or why you do something."*

Another example of those emerging actors was the ward Non Invasive Ventilation (NIV) machine and its use for patient outside the protocol. An observed professional conversation between one of the physiotherapists and the ITU team regarding a COPD patient in ITU who was already on one of the ITU NIV machines.

Actor kd: "*could you please setup a ward NIV for Mr .... *"

Actor Ri: "*We cannot set up a ward NIV Machine for this patient unless the respiratory consultant gives us the Ok, this is out of the protocol, and he hasn't been accepted, *"

Actor C: "*It is ok, we referred the patient to Dr.............., and the registrar will come down and review the patient.*"

Actor Ri: "*I need the respiratory consultant to bleep me fist, I only can do a patient who is on the protocol uses of ward NIV machine and if the patient is out of the protocol the physio cannot use it."*

To elucidate, though the physiotherapist decision might be under the influence of the respiratory consultant's power, she was able to challenge the ITU team including a sister and a consultant using the relational power of this new actor; the protocol. Yet, the durability of those inscriptions in the networks was relational and was abolished once the network shifted in another direction due to a new actor/s, intermediaries or mediators which could be merely a far reaching consequence oral statement.

In a professional conversation between one of the ITU sister (Actor Ar) and actor T.

Actor T: "*you need to take this patient into ITU, he is wardable *"

Actor Ar: "*you are taking my last ITU bed, what we are supposed to do if a really sick patient needs to come? *"

Actor T: "*yes I know, this patient is approaching the 4 hours target *"

Actor Ar: "*I cannot take a ward patient in my last ITU bed, I am not happy; I need to speak with the consultant on duty any way. .... *"

Actor T: "*speak with the consultant, and tell him it is the silver team decision........................*"

Within these interactions it is quite difficult to identify which one of those huge numbers of intermediary and mediator exchanges played a bigger role in the formulation of the final discourse. However, during this professional conversation, the most influential one was the Accidents and Emergency four hours target. Latour (2005, 40) referred to these prevailing intermediaries as "*faithful intermediaries*" as they played a major role in reaching mutual understandings or agreements. Though, these mutual understandings or agreements are provisional as they could change should new actor/s or mediator/s arise as we have seen in the two previous micro networks.

In general, actors at higher levels of the organisation hierarchy tend to translate and develop solutions for issues in their full extent complexity such as the overall strategies *"Helping local people live longer, healthier lives"*. Hajer (2006) refers to this level of translation as emblematic.

 On the other hand, professional actors tend to stabilise their position within the network through a condensed story line.

Actor RW *"I cannot discharge my patient early, I do not feel it is safe, he will come back next day, I do not know what they do out there............., I am not sure what they do, I am afraid if I discharge my patient to their care early, patient will bounce back soon, I do not want to fail my patient,......................"*

However, in one of the internal journey of the interviews, the same frontline leader was able to narrate a new version of the same story line regarding the early patient discharge in the light of new intermediaries.

Actor RW *"since I spoke with you four weeks ago I went there, I visited the ambulatory care myself, it is amazing, ..., I spoke with the virtual matron and the guys there........ it seems brilliant, ...once we referred the patient, they came and saw him here they showed me how to make the referral.......they will visit him on the same day............we are more confident Mr... Can finish his (Intravenous) IV antibiotic while at home, it is good for him, isn't it."*

Despite the fact that, there seems to be endless translations between the actors within and across networks, in most cases, it was difficult to give more weight to any of these translations in advancing the discourse of the policy formulation over others. This was not only because the networks are emerging nor the policy process was constantly shifting but also because the actor/s interpretation and understanding of the discourse was persistently changing. Hence, meanings were constructed within a contextualised conversation.

The respiratory consultant managed to influence the discourse of the policy process by translating her political interest and establishing herself as an obligatory passage. She secured acceptance for her argument for the Community Respiratory (CORE) group by the continuous exchange of mediators and intermediaries. For the senior managers and commissioner the respiratory consultant focussed on the financial gain of meeting the patients' needs outside the acute care which simultaneously achieves the original government policy "care closer home". On the other hand, the respiratory consultant used two story lines to gain a seal of approval from the professionals. The consultant focussed on both; the professionalization and autonomy, and the high quality care. This way, the respiratory consultant managed to dominate the policy process discourse and became a representative of the network.

Personally, by undertaking the research, I established myself as an obligatory passage point in relation to understanding the ongoing integration process within the research micro-network and across the meso-network. To answer the research question, a virtual COPD patient journey was followed over the health care continuum across the integrated organisation. The research question as well as the virtual patient trajectory enrolled new actors in the research network. Those new actors were involved in the care of the COPD patients. I worked as a connection between all the networks as well as a knowledge broker within and at the interface between those networks.

Once the new permanent management was in place, they found themselves as outsider actors who needed to gain acceptance by the already innovative mass.

Actor SL: *"I think the biggest that I have seen here in the last two years is the development of ambulatory care which has been completely clinically lead.......... the clinicians came up with the model, it was happening in other places ....but around older people's ambulatory care units or children's ambulatory care units. And what I noticed here when I came in April 2014 was that the clinicians, primarily the care of the elderly physicians and the A&E clinicians are already doing amazing job. Some of those clinicians were trained as GP's..."*.

Managers found themselves dragging behind the restructuring and even intruded into the already functioning networks.

Actor SL*".......And in a way, as managers, based in finance and in planning, we have had to work pretty rapidly with the clinicians to make sense of the model from a financial point of view. But actually this is something that has been very clinically lead and is now "*.

This remarkable infrequent frontline leadership and manager followership forced managers to lobby with the very senior clinical leaders and the innovators to re-affirm their grip and to rein the direction and speed of the integration.

Actor SL: "*there was a gap between the top of the shop and the frontline. So, we took that very seriously and that made us very clearly develop a clinical strategy with clinicians involved in the development of that strategy. So we ran workshops. We tried lots of different ways to engage people and some of them are successful and some of them are not. And I do not think we got as far into the organisation as we needed to but we got a lot of consultants involved. We got a lot of the senior nurses in the organisation involved. We got some GPs involved. We got some community staff involved. So the wards involvement at staff level in developing the clinical strategy. But the other thing we have done since clinical strategy in the planning, the other thing we have done through reorganising, we have reduced the operational management in the organisation and we have created seven business units instead of three divisions. And that means we have now got seven clinical directors who are at the decision making table, making decisions about the organisation, and we have flattened the management structure and reduced operational management to try and make sure that the distance between where decisions are being made and people on the frontline is much, much closer............as a result we have a clinical strategy owned by the organisation and stake holders. And then now absolutely have that platform where we know where we are financially, where we are with the strategy and actually now changing the structure to be more clinically lead and having a clear plan of how we operate over the next five years which is quite exciting.*"

This way, the management tried to redefine the direction of the integration and tried to become indispensable by offering very responsive governance that was built in cooperation

with the professional leaders. This further help impose the identity of the integrated organisation and herby allowed the alignment of interest between the management and the rest of the actors to be achieved. With this alignment achieved the management became more involved with the ongoing mobilisation.

Mobilisation process in this study is an ongoing process. Once the network/s constructed a common definition of the integration, which Hajer (Hajer 2005, 303) refers to as *"discourse structuration"*, it was used to embark into a higher level of the policy translation. These higher level policy networks whether they already existed, evolved from the existing ones or newly established were concerned with implementing the *"discourse institutionalisation"*.

Once the needs of the actors within these networks were met, those inscriptions became a representative of the networks as demonstrated earlier by the conversation between physiotherapist and the intensive care team. Though it is not clear whether all stakeholders involved in the *"discourse structuration"* process have understood or accepted the common definition or the integration as a whole at this stage yet, the virtual ward matron for example became a representative of the mass adopters of the integration at the interface between the community and acute services.

Actor Rs *"in fact community matron attend our MDT meeting or over the phone....... intranet is great ...., we know what is happening out there. We have one plan (pathway).............. no matter where Mr ..... everybody know what is happening. We can access patient's data via the RIO system .... we talk together."*
The virtual matron spoke to professionals from other services as well as managers in the name of the ambulatory services network in relation to its potential benefit to facilitating

early discharge and providing care to the patient closer to where they live. Though they cannot speak for themselves technologies, spaces and distances were represented by the Virtual matron as well. Parallel to the Virtual matron, Respiratory consultant represented the CORE service which looked after the patient at both sides of the integrated organisation. Though, one has to recognise that the process of appointing the representative to speak on behalf each actor cannot be attributed to one single event.

In the three scenarios, the representatives spoke on behalf of all the unaccountable actors including the service users who played a major role in the *"discourse structuration".* These representatives of the networks were selected through intense negotiation and conciliations among all the actors. As a result, representatives warranted the support of the network/s. Despite the fact that, at this point the network has been established and black boxes have been created successfully yet, the whole policy process continued to emerge. This spokesperson representation was temporarily true in most cases as it has had destabilised some time due to a shift into a different direction or complete disappearance of some networks. Though some actors tried to appear heuristic in the interviews by attributing the change to themselves yet, exploring deeper demonstrated the role that the context and networks played in the "*discourse structuration*" as well as *"discourse institutionalisation".*

As a consequence of these developed and functioning networks, a series of networks emerged at both community and acute sides of the service. These new networks included Pro-innovation actors from both sides of the services that aimed at finding out what is in this new model of care for them and their service users. Nevertheless, those resulting new networks had their own interpretations of the original government policy, the local management governance, as well as the original networks' *"discourse institutionalisation"*

of the adjacent networks. Those interpretations were guided by the local network's needs; customer, services, local circumstances, available options and resources.

As the network/s representatives gained a better access to communicate their discourse to the wider stakeholders over time either through show case or interprofessional work, integration became widely accepted.

Actor Ad " *We had an open day, we had people from the trust, the local community and other organisation. Were able to show case what we are doing and how things have change since we moved to this state of art ambulatory care unit. People were surprised...... Sister .. said definitely, their patients would benefit from our services specially the virtual ward service"*.

Despite the fact that, the integration process is still emerging, gradually, over the last five years the rate of adoption gained momentum and number of adopters grew up to the point that it became the norm and the integration process reached a point where it is to a certain extent difficult to go back but not impossible yet. The late mass adopters claimed that the support from the early adopters alongside the management's stability as well as the observed effect of the integration have swayed their opinion.

While it became less common to resist the storm, there were still few laggards who resented the change. Those latent blamed it on the lack of the technological infrastructure and training that is needed to support the integration as well as the fussiness of the boundaries and instability the change brought to the routine of those who already adopted the integration. Moreover, some of those latent argued that their distance from the centre of

the integration process made it difficult for them to find where they can fit within the integration.

Actor C:" there's a group that will be quite terrified. They can't get their head around it...they can't figure out where they fit in.... it is not for them, because there's a fear, isn't there..... about what might happen to the hospital or to their jobs. people start thinking moving somewhere else".

Callon (1986a) claimed that only few representatives take part for the most part of the translation process and those representatives existence is essential for the network stabilisation. However, it is imperative to keep all actors informed of the negotiations and take in consideration all actors interest in order to secure their support and avoid betrayal. Nonetheless, it could be argued that the spokespersons access to power within the networks, as well as the wide acceptance of the integration within the organisation, enabled them to silence the resistivity. Indeed, those spokespersons became very powerful as they became the voice of the service users, the professionals, the managers, technology and other nonhuman actors.

This alliances and strong interrelationships between the actors in the integrated organisation bounded the actors within the new reality. Though, it was not impossible to revolt against this new status quo yet, it would have needed lots of energy to break free of it. Moreover, as integration process progressed the physical reality of diverse actors enrolled in all networks were represented metaphorically in many forms such as posters, pathways, figures and achievements at all levels of the integrated organisation communication.

To conclude, this chapter presented the emerging story of the integration through policy translation process. The macro-meso level of the policy translation process gave emphasis to the research question and set the scene in which the meso-micro translation process happened. The policy translation process at the meso-macro level then was discussed in details. The ANT symmetrical characteristics made it possible to move between the macro-meso and meso- micro components of the translation process. Chapter five will discuss the dynamics of mobilisation and how that mobilisation has been brought about by a range of network formation and dissolution and what has emerged as a result of the networks mobilisation.

<center>**Chapter 5**</center>

5.0 The mobilisation dynamics

This chapter will explore the consequences of the health care organisation integration on the professionals and the organisation. Firstly, the consequences of the changing context to the professionals' psychology will be considered, and then the professional role changes will be discussed. This will be followed by highlighting the emerging networks and then focusing on the impact of mobilising services provision and the changing role of technology in both the integration process and in the integrated services. Finally, this chapter will explore how the integration impacted on the significance functions of the health care organisation.

5.1 In the midst of uncertainties

Although it is difficult to describe the professionals' experiences of this integration process, it could be portrayed as a state of turmoil. At the beginning, no one was entirely sure of what integration was about or the kind of actors involved in the integration process. Professionals had different experiences and back grounds; some of them were experienced in the community and primary care, some were experienced in acute care and very few were experienced in both domains.

During the early stages of the integration, most of the executive/senior managers were in interim positions and were more focussed on the day to day service management rather than developing and embedding a long term strategic vision. Yet, considering the local organisation's circumstances, the demands from the DH, the financial pressure and the commissioners expectations, managers recognised the need for change.

For health care professional who were innovators, integration became an opportunity to think differently and to explore new ways of doing things through changing networks. The newly

formed organisation was full of clinical expertise that was not fully exploited and significant frontline leadership skills that were not wholly recognised and were not being effectively utilised. The integrated organisation had an abundance of space, equipment and other infrastructure capacity that was used to help professionals deliver the service which was also under-utilised. This sheer abundance of underutilised skills and resources astounded the frontline innovators. This plethora of fragmented and poorly utilised skills and infrastructures became even more chaotic once health care professionals got involved in the integration process. Suddenly, everybody was doing something; people started talking to each other. Nobody had predicted the shape or the intensity of relationships that emerged among the whole range of actors including professionals, managers, patients, space, distance between the facility, and technology such as communication tools that would form during the integration. At this stage, during the early days, it was not clear what would happen during the integration process nor who would become involved or how.

Although, the integration process was slow to ignite, soon there was an upsurge in activities; new committees were formed, meetings held that were engaging staff across traditional boundaries and services had been both emerged and disestablished. New protocols and care pathways were being created and a change in the way that services were delivered was observed. This shift in service delivery was combined with a change in the Payment by Result (PbR) system from paying for activity to some form of a block payment from the commissioners' side to accommodate the reallocation of services to the community as well as the health promotion services.

Some professionals were reluctant to engage with the changes. Some innovators were frustrated with the infrastructure such as information and communications technology lagging behind the speed of the change.

Actor A: "Yeah, often it's the problem, if the patient say, got dementia or if they're just unwell, they can't really tell us much, we have to phone the GP or the community matron..... what is the actual issue with this patient, what is he referred in for, what did you find, what did you hear on listening to their chest" and that kind of thing.... it makes it really difficult... we should have one system where everybody can access and document their care..."

As the organisation was venturing into the unknown, health care professionals were left without guidance and were unclear of their direction of travel. Consequently, nobody was certain of what would be the outcome in relation to both the service itself and the professionals working within it. All they knew was that, the integrated organisation was to be the product of all the negotiations between the actors involved in the many networks.

Actor Vw: *"We sit down and discuss things.......doctors, nurses and physios...even community matron sometime join in via Skype....like we have this problem or type of patient what could we do. Everybody chip in and then agree. We try things, ... if did not work we talk about it again......some time we talk to the Ms ...* (Ms is from the management side) *or involve other professionals like the GP".*

This was confirmed by another actor during the inward journey

Actor I: "who has the biggest word in deciding what needs to happen

Actor Am: I think we all kind of know what is need to be happening you are talking we as nurse charge nurse physio, doctors. I think we are quite good in talking together if it is community then........ obviously I worked in community so I can sort that out , if it is medical then doctor and so on we all bring something to the team"

The success of the newly integrated organisation was tied to these actors' abilities to deconstruct and reconstruct the organisation's aims and objectives and to mobilise the networks to materialise them.

5.2 Grief and professional transition

Integration as a form of health care restructuring introduced changes that conflicted with the previous way of working or diverged from the status quo at both individual and organisational level, hence affecting the identities of those involved in the process. An analysis of the professionals' perception of the health care restructuring demonstrated a similar effect to grief. Despite individual variations, there was a wide agreement on the loss resolution process in this case study. Professionals could be seen to have experienced the main phases of the grief process (Maciejewski et al., 2007). At the beginning, they responded to the introduction of the idea of integration between the acute and the community/primary health care sides with shock, disbelief, and denial. This was followed by an intermediate period of acute discomfort as they were overwhelmed by the speed and intensity of the change. Professionals were not clear of what was expected from them in relation to both the integration process and the caring. Even more, professionals felt that, the security of their own jobs was at stake. Armenakis and Bedeian (1999) explain this negative reaction of employees to organisational change as a result of the increased pressure, stress and uncertainty associated with change.

Previous studies on organisational restructuring claimed that major change disrupts the status quo of the interpersonal relationships horizontally and vertically and entails reorganisation of spatial and personal boundaries (Paulsen et al., 2005). Accompanied with fear and anxiety (Terry et al., 2001), the introduction of new roles, skills, connections and relationships (Rubenstein et al., 1996) and uncertainty about the job may have exacerbated the professionals' lack of security. During change, some professionals struggled to -'let go'- of the old, as it was associated with a

sense of loss (Amiot et al., 2006). Although this sense of loss could be a natural consequence of change, it is worth mentioning that employees may have been resisting this undesirable secondary effect of the change rather than the change itself (Dent and Goldberg, 1999). These findings were consistent with the findings noted in earlier researches as imperative responses during change process (Ashford, 1988; Terry and Jimmieson, 2003; Bartunek et al., 2006; Rafferty and Griffin 2006).

Leaders' behaviours are crucial during organizational change. Health care professionals would expect to be able to look up to leaders to provide a vision of the change; offer directions and support to employees and demonstrate suitable behaviour. Schweiger et al. (1987) and Covin and Kilmann (1990) argue that, these leaders' behaviours provide sense of stability in the orgsnisation during change and improve employees' commitment to the intended changes. In a content analysis of a large-scale change program Covin and Kilmann (1990) identified lack of management support, unclear programme of change, poor communication and poorly identified responsibility for change as problems in change process. Communication was among the most crucial concerns in a study of eighty-nine organisational change implementers as reported by Lewis (2000). Rubenstein, et al. (1996) argued that their qualitative evaluation of hospital change during implementation of ambulatory primary care program resulted in extra demands on professionals due to the continuous need to negotiate their daily work in a changing organisational culture.

 In the current study, there was a vacuum in relation to management leadership support. Yet, in this study employees perception of how the changes' impacted them and the service went further and became a central actor that influenced the dynamics of the networks hence influencing the integration. Indeed, the lack of leadership guidance and the professionals' frustration with the change itself were precursors to creativity and expansion of the health care professional voice

(Zhou and George, 2001). The unstable context of the organisation, including the lack of visible leadership, created an environment in which the actors could frame their alignment and take the lead in organisational restructuring (Klandermans 1984; Diani, 1996).

Once the disgruntled health care professionals realised that the change has already started disturbing their existing practice routines and that it was them who had to manage it, gradually, they started exploring their options within the new reality. By sharing their experience with others including the researcher through networking, actors in this study were engaged in constructing their own new identity within the integrated organisation as well as validating the emerging identities. Sharing their emotional experience, according to the constructivists, denotes the process of making sense of their human experience which is otherwise very hard to recognise (Neimeyer et al, 2000). As a result of this experience sharing, professionals relocated their personal experiences into the larger social sphere hence aiding the construction of the new collective social identity (Habermas, 1984) to include the entire newly integrated organisation.

Neimeyer (2001) maintained that, reconstructing meanings in response to loss is a fundamental process in grieving. Attig (2001) argues that this meaning reconstruction approach provides an opportunity for the grieving persons to grow through relearning themselves and their relationship with the physical and social surrounding. This constructed meaning is idiosyncratic and context bound, yet this study showed that there was a mutual effect between the individual and the collective construction of meaning. In an attempt to make sense of the change, professionals were cognitively engaged in a wide range of networks trying to find some understanding of what integration was and to negotiate their new personal and social identity within the new organisation. As a consequence, professionals' identities were gradually transformed through shifting affiliations. This continuous affiliation shifting resulted in many networks dissolving and

new networks formation. This affiliation shifting was in response to the ever changing needs of the actors, networks and service users.

As a corollary to this emergence of distinctive and reworked individual and collective identities, there was a variation in the degree of professional engagement in the integration process. At one end of the continuum, research participants reported that some professionals appraised the integration and viewed it as an opportunity to grow professionally. While, at the other end of the continuum, other professionals were not only resisting the change but also trying to sabotage the outcome of change. Nevertheless, there was a strong consensus among the research participants that the majority of the professionals were actively engaged in the process of integration after a relatively short period of denial and discomfort hence, resistance became outside the norm.

This employee's perception of the change brought about formation of the networks. The function of those networks was to deal with the professionals perceptions of the change. To counteract the negative perception of the restructuring on themselves and the services, professionals utilised networking to harness the power of all the available actors human and nonhuman. Using this relational power, professionals were able to shape the service provision to match the service users' needs and to up-skill themselves and the service users not only in the clinical practice, but also in shared decision making guided by the professional, governmental and local governance (Parsons, 1967).

Indeed, these networks enabled professionals to negotiate opportunities and weigh risks within the policy process. As a result, professionals were selective in adapting and adopting the change. Health care professionals were able to adjust the integration process itself through selectiveness in knowledge sharing within and across network boundaries. This discerning knowledge

brokerage within and across networks resulted in new roles being created as well as the traditional roles.

Throughout the integration process actors claimed that they adapted their roles, practice and behaviours to accommodate the perceived service users needs. Networks were formed and dissolved guided by the service user care needs. Accordingly, it was the service user that appeared to be the core actor in all of the networks (NMC, 2015).

This integration through networking resulted in changes not only in the professionals' position within the policy implementation process but also in the professionals' clinical role and boundaries. Actors/networks crossed the traditional way of working and professionals boundaries to provide the care to the service users irrelevant of their geographical area. Network boundaries became permeable to actors hence, actors (human and materials) joined and left networks guided by the role they could play in serving the network/s core function in providing care to the service users and many actors were part of more than one network.

The fluidity in the networks composition resulted in the traditional boundaries including the one between acute and community care, to dissolve and the services to reconfigure into a single service. As a result, the care provision became a continuous trajectory parallel to the patient's health care journey. Professionals collaborated at the interface between the acute and community/primary care and complemented each other's role.

"*Yeah basically we now have GPs work with us every other day; there are lots of patients who would benefit of this. For example, yesterday, I have a virtual GP with me. We go out and visited a patient together and it makes the visits a lot more efficient. Because, if I was on my own, I would listen to her, she wanted to repeat prescription of certain things. So, I have to come back*

and ask one of the ambulatory care doctors to prescribe it. They might have some questions. So,

they might then say no we want her to come to the ambulatory care for medical review. Actually,

yesterday, I went with the GP. We sat there with a family. We discussed everything. The doctor

was able to see the prescription and I will be able to deliver the medication to the patient today.

It is lot more holistic and you got a nurse and a doctor all do a very different assessment there

together and its working out very very well and its definitely keeping the patient at home and

stopping readmission into the hospital". (Actor VM)

While, professions of well-defined boundaries at both ends of the health care trajectory at both

sides; the acute and the community care became more competence oriented and carried out tasks

that were traditionally performed by other professions.

"If a housebound patient has been referred for Spirometry, see them for Spirometry. Then I also

do pulmonary rehabilitation (PR). You know it is mainly the physio who will do the PR. I don't

do this all the time at the clinic, but they will give me a slot every now and then, and when they

are off or when they are not there, I step in to do PR." (Actor RN)

5.3 Emerging networks

Health care professionals were involved in a wide range of networks that enabled them to

understand and influence the ongoing change within the integrated organisation. These networks

emerged, expanded and dissolved out of necessity to enable professionals to cope with change as

well as the driving forces behind the change. These networks were functional as they addressed a

specific problem/s or need/s to build certain kinds of capabilities among network members. As a

result, four types of networks that emerged at different stages of the integration process were

observed in this study.

At the beginning, a resistance (grief) networks were established as a natural primary response to the change. Professionals saw change as a threat to their existence status quo as it has created some disturbance to their practice. Whilst having a huge impact on the change in the early stages, this type of network started fading as the other three types of networks emerged. Once health care professionals realise that change is a reality, a new type of networks that focused on understanding the professional's role in the integration process have emerged. The main goal of this type of networks was to understand what integration was and what the role of the professionals in the integration process could be. Professionals were trying to find out where they could fit in with the new change, what was expected from them in relation to the integration process as well as to what was expected from them in relation to the services the integrated organisation will provide to the customer users.

As a result of these understanding networks, professionals' enablement networks have emerged. This type of networks was concerned with enabling the professionals to cope with the emerging changes through knowledge production, manipulation and distribution within and across boundaries. This knowledge was about the service users, the future direction of the change, managing the change, managing the resources and managing the service. This type of networks was used as a professionals' coping strategy to up skill themselves in both clinical and management decision-making to establish the new services. This type of networks was the one which shaped the structure, the role and function of the 4th type of networks, the caring networks.

Caring networks focused on patients' care. The patient was the core value or function of these networks. This type of networks was the goal of the health care restructuring. Service user needs were meticulously used as a relational source of power in securing and mobilising the resources that enabled the professionals to function within the caring network. Patients' choice forced

health care professionals to seek new knowledge and to explore alternatives. This new knowledge became an important actor in the dynamics of the COPD patient care. Through these four types of networks and the generated knowledge, professionals had a greater role in shaping the services they provided.

5.4 Mobilising the professional's role

Despite the immense and important role that frontline health care professionals play in the health care system, they are infrequently regarded as equal partners in the health care policy process implementation. Consequently, the unique skills held by professionals are often underutilised across the health care service. This is even more significant with professions other than medicine such as nursing and physiotherapy. However, the DH (2006c) Modernising nursing careers - setting the direction , the NHS England New care models (2016-a) and Commissioning for Value – Integrated Care Pathways packs (NHS England, 2015) point out that nurses and other frontline health care professionals have a significant part to play in making the future health care. Nonetheless, for those health care professionals to fully contribute, it is crucial for them, particularly nurses, to practice to the full extent of their knowledge and training while modernizing the way health care services are provided.

In this case study, the cultural, social, financial and clinical changes within the integrated organisation resulted in changes in the way health care professionals practiced. Professionals working at the interface between the acute and primary/community services as well as those who span the two sides of services defined their role based on the clinical aspect of their role which was still evolving such as virtual ward and ambulatory care. This was clearly demonstrated through the inward journey interviews. Though it was about six month later since our last conversation, in some cases professionals substantiated that things has moved on in relation to the type of service, population, skill mix, scope of practice and even the settings and

expectations. These changes were happening in all care settings across the acute-community and primary care. This new ways of working narrative embraced complexity and become more sophisticated and far less boundary driven.

" Now w*e do sort of six weekly multidisciplinary virtual ward rounds with one of the consultants who have that integrated element to her. She has a community hospital consultant role. But in between times we can just ring up and say, we have got this patient, I think we need to get him to clinic sooner, and then we often go to clinic with the patient when they go and we help them (*the patients*) filling forms for social services and benefit especially those who cannot fill them. We talk with GPs on the phone or by fax say, we have asked the patient to make an appointment to see you because these are our concerns. So, there is a lot of steering care if you like."* (Actor Pz)

As a result, professional training expanded in response to the evolving services and was not a pre-requisite for the service to change.

"....We created a new integrated respiratory registrar training post. Doctor----- has done it and now she got a consultant post... " (Actor RC)

The inter-professional relationship and cooperation improved as members of the multidisciplinary teams gained experience and grew confident in relation to their role and practice. Professionals claimed that, though it was an ongoing process, developing protocols and care pathways elucidated expectations of their roles as well as other professionals and that change became the new institutional reality and status quo. Each actor of the networks including the smart technology played a vital role in developing these pathways.

Another important element in the integration as a special form of organisational restructuring was the ability to transform the professionals' positions within the health care policy process. Therefore, appointing health care professionals at the executive levels was not a cause for concern. Professionals were able to strike a balance between their professional role toward their service users and professional colleagues and their financial and target driven managerial role. Health care professionals at all levels were able to negotiate opportunities and risks associated with change. They were selective in adopting change, adapting the change and distributing the knowledge about change across boundaries. This way, actors became activists and advocated the integration yet manipulated the change as they passed it across boundaries. Simultaneously, these organisation changes transformed the professionals' roles within the organisation.

Actors were changing themselves as they were changing the service provision they worked in. Indeed, there was a reciprocal influence between the actors and their context. As a result, Professionals played a significant role not only in redesigning the services and their identity within the emerging services but also, influencing the intention for integration to some extent.

5.5 Mobilising the services

The networks mobilisation in this case study so far resulted in changes at all levels. Those changes could be grouped into three main categories. These categories represented changes that happened to professionals practice and the organisational functions over the last five years and are attributed to the health care integration process. Those categories include;

5.5.1 Mobilising technology

A main actor within these networks was the information and communication technologies (ICT). Technology increasingly blurred health care boundaries such as those between acute and community services. As convergence between technology and the health service progressed at a

rapid pace, the traditional way of delivering the health care service changed. Modern health care organisations including this integrated one exploited communication technology advances to provide alternatives to services that were otherwise provided on health care organisation sites or face to face. Smart technologies provided access to patients' data instantly and facilitated the exchange of information between the professionals as well as with the patients. This in turn aid not only decision making about the patient's care but also access to decisions made by other professionals, as well as to sharing the decision making with patients and other professionals through emails, texts and Skype conferencing.

"No matter where Mr ..... Everybody knows what is happening. .... We talk together... we know what is happening out there. We have one plan" (Actor Ph)

Technology played a huge role in transforming the services by enabling professionals to access patients health care documents, investigations as well as plans, implement and document care and share information with other professionals including patients' referral in a timely manner.

"We have I-Pad which enable us to access a system called RiO, through this system we can see patient blood result, X-rays, and many other things but most importantly we do not have to go back to the office to document our care anymore, we can do it on the I-Pad" (Actor Ph)

Consequently, care planning, care delivery and documentation were not attached to a geographical area any more. This in turn changed the human space relationship.

"In fact community matron attends our MDT meeting ..... Or over the phone....... intranet is great" (Actor CRN).

In this context, the DH (2004) placed a great importance on the ways in which telemedicine in general enables health care transformation by facilitating health care information exchange between professionals to provide quality care. In this case study, Telemedicine went a step further and provided health care professionals with the ability to interprofessional networking and learning hence up skilling themselves.

Moreover, as professionals felt a lack of guidance on what they were expected to do and how they were to achieve it at the early stages of integration process, they also saw networking with other professionals, directly or via technology, as an opportunity to cope with lack of knowledge about the change and how to fit within the new organisation. Considering the vast geographical area of the organisation and the large number of employees, the intranet and email played a major role in communicating the emerging changes between the organisation's management and the employees. However, professionals claimed that technology did not yet reach its full potential and was still dragging behind the clinical services transformation. As a consequence, in 2017, the organisation started to build a business case for a pan organisation IT system that will not only enable professionals access to the patient's documents, share information, request investigation and do referrals, but to also track patient through their health care journey trajectory irrelevant of the patient geographical area.

5.5.2 Mobilising the health care organisation function

At the organisational level, all the functions of the health care organisation were been modified. Culturally, there has been a shift in the focus form ailment treatment to prevention through educational programs such as smoking cessation service. Patients became partners in planning their care. Professionals' relationship across the community/primary and acute side of the organisation were revamped.

"Before, we were an acute hospital; we do not have much direct say or link to the community. Both, us and the community have a little bit of that ambivalent feeling towards each other. So, for example, patient were admitted, just treated and discharged as soon as it was safe to do so. While, since we became integrated care organisation we do. For example, With regard to COPD patients, from the day they are admitted, the matrons and the district nurses in the community communicate are with us more than they used to and establish a plan. Because the whole idea of having us an integrated organisation is to prevent patients from coming in if they can be managed in the community now" (Actor Bt).

This shift in the cultural role of the health care organisation resulted in changes in health care services commissioning hence the financial role of the health services.

"we realized that if we were moving services from hospital into community, there was a risk that we were reducing activity and that means that your money on a Payment by Result (PbR) basis would go down. Because PbR is the contractual mechanism where you get paid more the more activity you do. So, this year we have got a block with what we call sophistication. This block means you got a value that you get paid for whatever happens. Then, you have got a cap and a collar. The cap allows you to be funded for additional activity that may happen but also the commissioners get some security that you are not going to go above that cap. Then, you have a collar below the block where if you go below the collar, they get some payment back. Because we want to maximize our income our plan is hit the top. One more thing with this arrangement is that we do not get penalised for missing targets like C.Diff and MRSA. So for us, there is a bit of a degree of certainty about the amount of money we have within the block" (Actor SL).

As a consequence, the patient's care became a life journey irrelevant of their geographical location rather than sporadic care episodes. Health care services were mobilised in relation to

time and place to where the patients were guided by their care needs. Patients care pathways were modified and new care pathways emerged to meet the service users' growing needs along with fast-tracking patients through the system.

These changes in the health care organisation functions resulted in a new model of care at the interface between the acute and the primary/community care sides of the integrated organisation. This transitional model of care aims to facilitate the early discharges of the patient back to the community as well as to divert those whose care needs could be met as close to their natural environment as possible away from the acute side of the organisation. As a result, a shift in the competence, skill mix and composite of professionals working at the boundaries between both the acute and the community of the integrated organisation happened.

Therefore, the relationship between space and practice changed at the centre of the integration. Respiratory physician consultants, who traditionally saw patients in the acute setting moved out to see patents closer to their homes in the community and primary care. Within the integrated organisation General practitioners (GP) did not only see patients in the urgent care centre and GP practice but also, joined the virtual team in response to the patients' needs. Virtual matron which was a newly established nursing role alongside the virtual GPs were working across both sides of the service; the community and the acute. This flexibility in skills mobilisation across the boundaries aimed to facilitate the patient re-settling back in the community after a hospitalisation period as well as to supporting the patient in the community to keep them out of hospital (Naylor and Keating, 2008). Though some patients did visit the acute side of the service, yet a one stop shop ambulatory care meant that patient can have all the investigations required such as X-Ray, Scans, blood works and so on without having to be admitted to the hospital.

Space itself evolved overtime in response to the ongoing changes. Over five years, a new ambulatory care unit was established. This unit was originally based in a small room attached to the accident and emergency department. However, other contextual developments where this organisation operates impacted the process of establishing the ambulatory care and the virtual service and the way they functioned as a whole. The primary care trust (PCT) which later became the clinical commissioning group (CCG) serving the population from which most of the integrated organisation service users are, demanded that more and more of the patients' care should be delivered closer to home. Hence, ambulatory care unit was relocated into a state of art purposefully built unit to accommodate the increasing demands.

"We were in the little cupboard in Accident and Emergency (A&E) and as the population we served increased, we the team grow up and we moved to this state of art unit" (actor Am).

All of these cultural, social, financial and clinical changes within the integrated organisation were cumulative, progressive, multidisciplinary lead and patient focussed.

"it is a team effort, you know a charge nurse, a consultant, everyone who is sort of involved in the development of everything....nursing and medics, we have our regular consultant who set here......we set all together, we talk about how things has been, how they should be and how things should move forward.........it is kind of develop as it comes sort of, ooh, we get a lot of these patents ....alright ....yah, could we be doing this as well……we get question from other part of the hospital, other team members like, would it be possible to see these types of patients.............. obviously we are not meant to be replacement of other services...........no you are complementary service.............so if a service is doing something we obviously shouldn't be doing it" (Actor Am).

These cultural, social and financial changes in the health organisation function resulted in changes in the patient's access to health service in relation to time, place and skills available.

5.5.3 Emerging model of care and pathways.

Those new models of care are in line with the government's Vanguards' initiative in 2014(NHS England, 2016b). According to the NHS England, the "vanguards are a key element within the Five Year Forward View which is a partnership between NHS England, the Care Quality Commission, Health Education England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence" (NHS England -a, 2016). Those fifty vanguards would be the spearhead that will motivate the rest of the NHS organisations progress into the future through developing new care models (NHS England, 2015; NHS England-b, 2016).

Professionals achieved all of these changes by developing new ways of working and new roles as well as by working across both professional and geographical boundaries. This professional role spanning and extending resulted in a new model of care with more interprofessional working and learning. As a consequence of mobilisation process dynamics new care models have emerged (Diagram 5). Indeed, there has been a shift not only from the dichotomy of acute and primary care providers but also, a shift in the care-models form a single profession like the nursing care models such as the one mentioned in the literature review to a model based on multiprofessional approach.
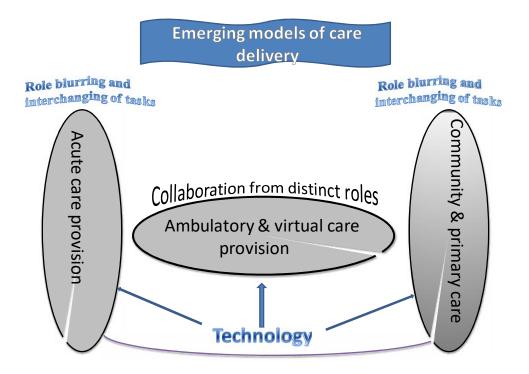
On one hand, the emerging service delivery provision at the acute/community boundaries in the virtual and ambulatory care service showed that traditionally distinct professional roles such as GPs and virtual ward matron collaborated in delivering a transient care package. This new service provision functioned as a gate keeper that facilitated early smooth discharge back to the

community and supported patients settling after discharge. Moreover, this service provision prevented admission or diverted patients from Accident and Emergency (A&E) back to the community and mobilised the right support to keep them out in the community. Yet, if patient's care needs could not be met in the community supported by the new ambulatory/virtual care, they facilitated admission. Furthermore, these emerging cross boundaries care provision reduced the communication barriers within the organisation, helped in establishing a valuable cooperation and interdependency among the staff and made a substantial effect on training and education. Henceforth, has improved the early recognition of deteriorating patients as well as improved the service users overall quality of care.

On the other hand, professions of well-defined boundaries at both the acute and the primary/community care were becoming more competence oriented and carried out tasks that were traditionally performed by other professions. This was clearly demonstrated in the role of the respiratory nurse within the COR team whose role became a hybrid between a physiotherapist and a nurse. This respiratory nurse has assumed lots of the care practice traditionally performed by physiotherapists alongside the traditional nursing role.

This fluidity in skills mobilisation across the boundaries and interprofessional working resulted in modifications in both professionals' individual and social identity. Indeed, professionals were changing themselves as they were changing the context they existed within. This was clearly seen in emerging services like the ambulatory and virtual services. It has been noticed that professionals in those provisions tended to associate themselves with the core function of the network such as ambulatory care practitioners or professionals.

Diagram 5: Emerging model of care delivery.

To summarise, as a consequence of professional uncertainty, a wide range of network mobilisation both formation and dissolution has happened. Outgrow of this networks mobilisation was a sequence of mobilisation dynamics that brought about mobilisation of both the professional role and care provision. The next chapter will explore the professional positionality within health care policy process. Based on these research findings and in the light of available literature on change theories a model of change through integration will be proposed. Chapter 6 as well, will conclude with a critical reflection on the research process before highlighting what this research adds to the available knowledge of health care professionals positionality within health care policy process and identifying possible area of further research.

Chapter 6

6.0 Discussion

Many studies have examined the impact of health care reform on a wide range of health care professions and professionals either as a collective or as an individual profession. Those studies looked at professionals' perception of practice and workload related issues, quality of care, importance of reform to professionals, safety issues and the implications of the reform (Corey-Lisle, 1999; Aiken et al , 2001; Ritter-Telitel, 2002; Rushmer and Dowling, 2000; Ryan-Nicholls, 2004; Doherty, 2009; SPICe, 2012; Stressing and Borthwick, 2014). Yet, very few studies aimed to understand the role of the health care professionals in health care restructuring. The change investigated in this study was major, mainly professionally-led, ongoing multi-organisational integration. It was drastic in that it involved physical relocation of both services and professionals, creation of new services, new care models and modification of the organisational culture and financial management.

Though this case study answered the research question " What are the implications of the services integration policy to the health care professionals in relation to their practice and on interrelationship", however, as the research progressed, it became apparent that the primary research question addressed by this study was "'what is the role of the health care professionals as policy actors in the health care policy process". Answering this research question has made a contribution to previously under-studied relationship between health care professionals and other non-human actors and factors in the health care policy process. This study traced the interactions between the frontline health care professionals and the available resources and how their proportionality to other policy actors influenced their ability and willingness to manipulate, adapt to and adopt the change.

This evaluation of the findings is developed by exploring professional positionality, power and control in the policy implementation process and how change has evolved. This is followed by locating the research findings in relation to theoretical concepts serving to develop and question contemporary debates concerning the notion of the health care professional's positionality in the health care policy process and the implication of policy processes to the professional practice. Building on this, a proposed model for change through integration as a particular form of change will be presented and the chapter will conclude with some critical reflections on the research, before highlighting what this work adds to our understanding of contemporary healthcare professional's role within health policy process, and identifying possible areas for further research.

6.1 Professionals' positionality in the policy process

Traditionally, Callons and Latour's ANT focal actor identifies other actor/s and attributes interest to those identified actors. In this case study, it seems there were many focal actors who identified other actors and attributed roles to them. Indeed, in this case study, the central government set the general direction as governance. In response to this general direction, the local health care organisation interpreted those directions according to the local needs and circumstances as well as the available options and resources. Within the local health organisations, a wide range of already formed micro-networks interpreted those local directions in different ways guided by their own local and global context. Henceforth, these multilevel networks resulted in a wide range of interpretations. Members of those micro-networks became activists for those local interpretations and got engaged in a wide range of relationships with a large number of actors; human and nonhuman such as technologies, artefact, places, policies and documents within their original and new networks. Those networks included heterogeneous actors of aligned and sometime conflicting interests. In traditional ANT, the obligatory passage point (OPP) is defined by the focal actor through which other actors must pass and by which the focal actor becomes

indispensable (Callon, 1986a) and actors accept the roles defined for them during interessement. Within this case study, actors in these emerging networks were fully involved, not only in deciding their position within the networks but also in designing their role within the services provided, the direction of the network as well as the linkage of these micro-network to each other within the organisation guided by each actor's interpretation of the policies and ability to interact, negotiate and manoeuvre.

Actors were conducting the interessement by themselves as well as enrolling themselves in the policy process. Due to the lack of preparation and fear of the unknown, professionals including innovators and early adopters, of certain/similar interesst came together to identify or clarify their roles in the integration process and how they would function within the new organisation. Actors joined these networks seeking information about the integration and how they could be part of the change. These emerging networks were functional and actors joined in across traditional geographical and professional boundaries. Sharing information between actors across the geographical and professional boundaries resulted in a new combination of knowledge that was not known in its entirety, to any of the actors before.

Furthermore, new networks emerged from central and auxiliary actors within established networks like rhizomes. Those emerging networks' intention was to adapt the original network function to the new local micro-context or to try and implement the core function of the original network into a completely different/new context or, to develop a completely new function and new context such as the ambulatory service. However, some of those network functions were to cope with the psychological implications of change on the professionals or to seek information as well as to share information. In this sense, actors could be seen not only as nodes in a network but also as buds that have the ability to engage in an entrepreneurial working by problematising

certain aspects of the work and providing a vision for improving the service hence, starting a new cycle of policy translation.

This way, those actors became advocates for the integration and helped not only shaping the service but also the diffusion of the change by motivating others to adopt and institutionalise the change (Battilana et al., 2009). Though, it could be a small divergence from the organisation's norm and institutions at the time yet, change was incremental and the service turned up to be entirely different form the original one.

Central actors of any given network might have more power and resources to their disposal. Those central actors enjoyed important financial or employment advantages of the integration and were the most adept at using persuasion according to the elite's theory (Higley, 2010). Yet, these power and recourses were used in general to respond to initiatives and concerns of peripheral actors within the network to warrant their alignment in the translation within and across networks. This power was sometimes in the form of knowledge, skills, connections, budgetary, hierarchal role or even negotiation skills. Nonetheless, it is worth noting that, this power and the resources were not inherent to the central actors (Foucault, 1980; Latour, 1986). The necessity for change created by the organisation's internal and external context provided the opportunity and openness for all actors to mobilise the resources into their direction, governed by their positionality in relation to policy processes as well as the caring processes. At a practical level, this resource mobilisation could have been in the form of promotion into one of the new posts, or even coincidental by only being there when things happened. Therefore, peripheral actors who might appear powerless were aware of their positional and relational power within the network and influenced change either directly by using the power of the network or indirectly through brokers who mobilised resources to support those peripheral actors accomplish their goals.

At the beginning, the opposition elites played a major role in shaping the policy process at both the micro and macro levels. Those opposition elites were able to influence the policy process either by mounting counter movement networks to the integration process and highlighting its futility (Gale, 1986) or, by using the resistance as a relational power negatively to gain favour within and across networks. This continuous interpretation and translation of the policy cascade from the DH, local health organisation, local micro- network and actors resulted in a continuous and ongoing translation that caused modification, transformation, emergence and disappearance of the networks and the services they provide.
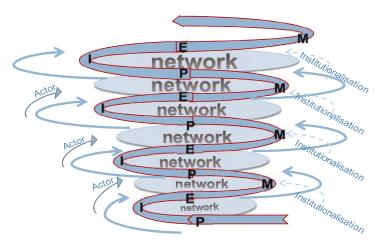
6.2 Interplay, power and control

In this case study, it is evident that, clashes of the framing of meaning were prominent in those areas where knowledge about changes had not yet diffused across the integrated organisation as well as in areas where roles and boundaries were still being negotiated. This was seen in areas where the patients' medical conditions were complex as well as where the services were thought to be distant from the centre of the integration processes such as in the intensive care setting. In these contexts, the traditional differential power privileges of certain professions, such as medicine or roles such as site management, over others resulted in threats to the emerging changes hence affecting the stability of the "*discourse institutionalisation"*(Diagram 6).

In these situations, actors drew multiple relational power recourses into the negotiation process to help them maintain a degree of control. In many cases, intrinsic professional and positional power managed to divert the discourse of the policy translation temporarily. Though, this inherent professional and positional power could be seen as another actor within that network. Robinson and Cottrell (2005) drew attention to this working status power that might result in inter-professional conflict. Notwithstanding, the concept of power in this case study was fluid and shifted across the professional and positional boundaries of the network as the changes

diffused through the organisation by means of negotiation and showcasing. The significance of this changes diffusion lies in the prospect of more actors "Interessement" and "Enrolment". This gave stronger momentum to the change process which resulted in more opportunities for the network/s to access and capitalise on relational power. However, it is of importance to recognise that, as more actors joined or left the network the dynamics of the network interplay were modified.

Nevertheless, it is worth mentioning that, networks were still emerging as this study drew to a close and whenever a new actor joined or left a network a new policy translation process started again (Diagram 6). Thus, it could be expected that, as long as the health care professionals and the rest of the stakeholders continue to strive for better and more efficient service, whenever a network/service reaches a relatively "*discourse institutionalisation*", this will be problematised again and a new policy process will start over and over again. This was seen in many policy networks. To explicate, once the virtual ward reached a "*discourse institutionalisation*", virtual ward matrons noticed that, they were not able to meet some of emerging and the unforeseen service users needs out in the community. Those emerging and unforeseen needs were not on the original virtual ward plan. As a result, these needs from the service users' side were problematised and used as a starting point for a new cycle of policy process that resulted in a GP joining the team.

Diagram 6: Development and diffusion of integrated care

P:Problematisation I: Interesment, E:Enrolement, M:Mobilisation

On the other hand, central actor's used of power within the network and across networks to address actors concerns and initiatives. As a result the concept of power has been moved beyond the professional action interpretations based on need for control as suggested by Abbott (1988). Abbotts' interpretation was based on the action of medical professionals who traditionally had better access to the resources in comparison to other allied health care professionals such as nurses who needed to constantly negotiate the rules and resources. Though, the power capacity associated with professional title has slightly shifted since Abbotts' study due to more inter-professional learning and working (Dent and Whitehead, 2002; Caldwell et al., 2006). This inter-professional dynamics understanding requires us to move beyond the traditional linear interpretation of power and control and to uncover the interplay between the actors in the formation of the "*discourse institutionalisation*" in such complex health care context.

6.3 Making things happen: Frontline professionals as entrepreneurs

The integrated organisation context, including current financial austerity and the lack of permanent senior management and leadership, required an innovative approach to meet the increasing expectations of both the service users and commissioners. These increasing

expectations obliged health care professionals to rethink the existing services and demands. In response to the disassembling of the strategic leadership, this study showed that health care professionals, who took on the role of entrepreneurs, were waiting for the opportunity to lead health care service transformation. Once they felt the sense of urgency to change from both the DH and the local management, health care professionals managed to lead a progressive and evolutionary vision for the health care organisation that met the service users' demand within the available resources. At the beginning, the desired end of the integration was not clear. As a result, innovative entrepreneurs had to capitalise on the wealth of other health care professionals' skills and knowledge of their service users' needs and available resources to clarify and refine the desired end result.

Embedded in this emerging vision was the notion of "users' wants" from the point of health care professionals' views which directly related to what service users were expecting from the services in the day to day interaction as well as in the long term (Giddens, 1993; National Voice, 2011). This way, health care professionals managed to empower other actors including the service users to act on this progressive combinatorial vision. The heath care professionals' knowledge of the organisation culture, norms and service users' needs was highlighted by Galpin (1996) as a major component of a successful organisation change.

Despite the fact that change was still emerging, health care professional entrepreneurs managed to convince and enrol a wide range of actors and to black box creative solutions. Using relational power, professional entrepreneurs manoeuvred through what appeared contradicting, conflicting and sometime complementary sets of institutions to create a new integrated service by focussing on the patients' needs. However, communicating achievement at both micro and meso-network levels in a timely manner gave change its momentum. Likewise, publicising the changes via

showcasing, open events, newsletters and face to face meetings not only drew attentions of other actors to join the movement but also helped consolidate these changes.

Traditionally, breaking with the existing norms of an organisation flares up resistance from those who believe in the current institutions (Levy and Scully, 2007) as well as those who might lose out by changing the present practice. The greater the divergence from the previously existent norms of the organisation has resulted in the greater the potential confrontation by prominent actors who benefited from that situation.

To avoid clashes with the "institutional defenders" (Levy and Scully, 2007), entrepreneurs spread the word about the impending change and its importance for the organisation's future long before the changes started. Furthermore, as there was no clear vision of the service future or for the structure of the organisation, entrepreneurs focused on the anomalies of the current system and encouraged other actors to get engaged in designing the future service whilst keeping in mind the users' needs. This way, the entrepreneurs managed to draw stakeholders' attention as well as to get people familiar with the idea of change. As a result, though change was led by the entrepreneurs, yet integration was a combinatorial construct by the whole stakeholders.

Communicating the imminent change in such manner facilitated the diffusion of change as professionals started seeking more information about the change and where they would fit within it. On the other hand, at the early stages of the integration, innovators implemented the change very locally in areas where health care professionals were recruited to the emerging roles or were promoted to take on those new responsibilities such as ambulatory care and virtual ward. Professionals in those areas were intrinsically pro-innovation or at least beneficiary of the change. As a result, innovation entrepreneurs were able to capitalise on the success of those

localised micro pilots and show case the potential attainments of the integration at the meso-level.

At the beginning of the integration process and as innovators navigated through against some of the organisation's norms and into the unknown, there was a risk of derailing the organisation's institutionalised practice. Yet, scepticism, hesitation and resistance from some actors alongside the resource limitations played a major role in maintaining the work of the organisation (Beckert, 1999; Hung and Whittington, 2011). To minimise or to avoid clashes with those sceptical actors, innovators were forced to weigh all advantages and disadvantages of any proposed change beforehand. However, those opposing actors swayed gradually and the resistance faded slowly as the organisation reached stability with institutionalising the new reality, though, this stability was still temporary and the change was still emerging.

The resistance networks contributed to curtailing the innovation in some areas and managed to have a say in the integration process as a whole through negotiations. Consequently, health care professionals' opponents and allies to change were negotiating their own identity simultaneously as they were changing the institutions throughout the course of the integration. Accordingly, this study demonstrates that the change through networking should not be ascribed to the social force or to the individual intention, interest and ability but rather to the interplay between all actors and factors involved (Hodgson, 2006). Though the study findings gave weight to the power of persuasion, it could be argued that, the findings contradict the suggestion of the National Leadership and Innovation Agency for Healthcare in a study undertaken in Wales (NLIAH, 2009) which gave more weight to role of individual actors in shaping the integrated health and social care outcomes. Health care commissioners were a major driving force for change in this case as recommended by the " *NHS five year forward view"* (Monitor, NHS England, 2014). Yet,

This study, notice that there was more commissioners say on what was needed and not on how to be done as that was left for the health care professionals to design.

6.4 Research findings in relation to theoretical concepts

Health care organisations are institutions which mix human and nonhuman actors and organise/control their relations. Those heterogeneous entities are inseparable from their context and overlap with each other. They function through a set of relations that are in a constant motion in relation to their position from each other and the intensity of their network connections and interdependence. Manipulating any of these actors, factors or their contexts is bound to influence other actors within the network hence affecting their identity. In such dynamic and interconnected networks even minor changes to any components might yield widely diverge outcomes for such a developing and dynamic system. Therefore, it was important to examine the implications of the organisation context and the dynamic of the change (diagram 3) in the light of Van de Ven basic theories.

This study demonstrates that, the integration of multi-organisations as a special form of change does not fit traditional models of change. Professionals' role reconfiguration and service expectations at both levels, the management and the health care professional levels, created complexity and resulted in all four Van de Ven (1992) basic paradigms of change to operate simultaneously (Stacey, 1992).

The change characteristics of this integrated organisation do not fit Van de Ven's life cycle nor teleology as it was not linear nor circular or deterministic. In this case study, integration was more of a life course as it never went back to the same point where it started. Indeed, change process always ended up with something new. Although the integration process had lots of the evolutionary characteristics, the emerging networks went a step further as it did not only adapt to

the change, but also adapted the change to its function as well like the way a river runs the course it takes. Actors in each micro-network were engaged in negotiating and implementing combinatorial vision within that micro-network guided by their local network function and in the light of both the meso and macro-networks function.

The change was unprecedented and nobody had a clear vision of neither how the final product should be nor how they should arrive at the final product. The change was more of a progressive yet unpredictable and indecisive trial and error process using all available recourses.

In the beginning, the integration process was initiated by the local management as a response to a government policy and was guided by local circumstances (Tushman & Romanelli, 1985) which resembled the punctuated equilibrium model of change characteristics. This local management proposed change clearly indicated that the integration process was not a completely bottom up change. Yet, the absence of the permanent management at the executive level opened the gate for the health care professionals to lead and construct the change without the coercive or directive management pressure (Dunphy and Stace, 1993, Waddell et al., 2000). The road map for the policy translation was assembled by the health care professionals. In the light of the uncertainty and lack of guidance due to the inadequacy of senior management and leadership, professionals revolted against the traditional status quo of up-down governing and led a change in the services they provided. As a result, the change at both, the micro and meso levels was orchestrated by the health care professionals guided by the consumers' needs/wants and the available resources rather than at a strategic level.

Although the integration process was an incremental change that occurred over time and was led by the health care professionals, it was not done in orderly steps in which participants knew what to expect next nor what the end result would be (Beer, 1980; Gersick, 1994).The integration

process substantiated radical changes to the original organisations' practice and identity (Greenwood and Hinings, 1996; Hernandez et al., 2000, Chreim et al., 2012, RCN, 2014). However, in contrary to the norms of radical change model, the top management was dragging behind and had to tailor the organisation's vision, identity, strategies and values in line with the frontline actions and negotiations (Ho et al., 1999; Ingersoll et al., 2000). Yet, once permanent management were appointed they played a major role in institutionalising the discourse through governance.

In the literature, many models have been presented to provide explanations of the organisational change stages (Judson, 1991; Kotter, 1995; Galpin, 1996; Armenakis and Bedeian, 1999). Judson's (1991) model of implementing change contains five Stages: a) analyzing and planning the change, b) communicating the change, c) gaining acceptance of new behaviours, d) changing from the status quo to a desired state and, e) consolidating and institutionalizing the new state. In this model Judson suggested negotiation and reward as a way to deal with resistance at any stage of the change process.

In comparison, after establishing the need for change Galpin (1996) argued that change agents need to analyse the current situation, generate a detailed recommendation and then develop and disseminate a vision for the change. Furthermore, Galpin recommended pilot testing the recommendations before rolling them out. Finally, according to Galpin change agents need to measure, reinforce, and refine the change as they go. In Galpin's model, understanding the organisation institutions is a pivotal tool to the change agent.

Kotter's (1995) model of change on the other hand, shares the importance of establishing the urgency of change and of creating a vision for the required end result from change as well as communicating this change vision through a wide range of communication channels. Yet, Kotter

promote empowerment of others to act on the vision by adapting the organisation's structure and developing policies and procedures that aid the change implementation. To maintain the momentum of the change, Kotter recommends celebrating every small win and appraising the effort of change by connecting the organisation's success to those efforts of change. However, at the heart of this case study was the emergence of both the vision for the change and the change process. Therefore, it could be argued that none of those models could accommodate the integration implementation process.

Building on Bandura's (1986) social learning theory Armenakis et al. (2001) argued that for a change to be successful, change agents need to create a readiness for change in the organisation. This readiness for change, could be achieved by 1) highlighting the need for change 2), the employee's enablement, 3) making sure that change is in the best interest of those involved in it, and that, 4) the change is right for the organisation. Furthermore, Armenakis et al. identifies influential strategies in order for organisational change to succeed. Those strategies revolve around information management, training and employee development and communicating the change throughout the process.

Nevertheless, in this study setting, the absence of management guidance at the top level negated the experience of the professionals. Professionals were left to navigate the integration process alone due to the lack of support. As a result, grievance was observed not only at the personal emotional level at the beginning of the integration, but resentment at the organisational level was also observed. Unfortunately, none of the existing models account for the implications of the change process on the employees' behaviours during the change process nor the implications of the employees' behaviours and psychological responses to both the change process and the end result. As a result, it could be argued that, the integration as a special form of change in this case study does not fit any of the currently available change models. Therefore, a new model of

change that accommodates integration led by professional entrepreneur in the absence of a stable management is needed. The next section will present a model that suits such emerging change.

6.5 A model for multiple organisations emergent change through integration

Emergent Integration as a special form of change is multifaceted, progressive, evolutionary and responsive to the users and purchasers' needs/demands and is governed by the available resources. Embedded in the emerging vision and change is the notion of the growing service users' wants/needs/expectations from the service providers. In the light of this study's findings, a model for emerging change through integration in vacuity of strategic leadership as a special form of change was suggested. This model is an attempt to integrate existing empirically based ideas found in related fields.

This proposed model describes the stages of change implementation. Entrenched in this model is the need to deal with the employees' interpretation of the unfolding events and its implication to their behaviours (Isabella, 1990; Jaffe et al., 1994; Neimeyer, 2000). This model is built on seven components of emerging integration change life course (figure 3).

Integration legitimisation rhetoric across the whole organisation throughout all the change process has played a major role in the diffusion of the change. However, of vital importance was the aligned move in the NHS from governing to governance which gave the local organisation and employees the opportunity to manoeuvre while constructing the new integrated service. Moreover, once appointed a responsive management enabled the change *"discourse institutionalisation"* hence consolidating the integration.

Figure 3 : A model for emerging organisation integration life course

Integration   Legitimisation   Rhetoric   across   the   Organisation

Diagnosis and problematisation

- Establish the need for change focusing on the anomalies of the current system.
- Communicating the need for the change (Judson, 1991; Kotter, 1995).
- Advertise the impending change before it happens and deal with the psychological consequence on employees in timely manner (Isabella, 1990; Jaffe et al, 1994; Neimeyer, 2000).

Prognostic framing

- Find a unifying issue that makes change everybody's business.
- Empower actors including the service users to build a combinational vision for the proposed change (Fisher et al, 2007).
- Advertise the proposed change as superior to the existing status quo (Armenakis et al., 1999).
- Communicate the emerging combinational vision through wide range of communication channels.

Building capacity

- Identify change protagonists and antagonists and address their concerns early (Judson, 1991; Kotter, 1995).
- Make change
- Recruit those benefiting from the change.
- Encourage inter-professional working and learning (Fisher et al, 2007).
- Empower actors to identify areas for improvement.
- Empower actors involved in developing the shared vision to communicate it and act upon it by adapting the system.
- Adapt infrastructure including communication tools to enable inter-professional networking and practice.

Motivation

- Communicate formal activity that support change (Judson, 1991; Kotter, 1995).
- Make change appear in congruence with actors ambition (Armenakis et al., 1999).
- Attribute the vision and the achievement to the actors involved in the development and implementation (Kotter, 1995).
- Financial (promotion) psychosocial (title) and professional incentives (role autonomy) (Judson, 1991).

Implementation

- Pilot changes locally in areas where you have pro-change activists (Galpin, 1996).
- Empower professional integration.
- Communicate, celebrate and capitalise on change achieved through all available channels in a timely manner and appraise those involved in implementation (Kotter, 1995).
- Address the psychological consequences of the change on all involved actors and at all levels.
- Move resources and change policies to accommodate emerging changes (Isabella, 1990; Jaffe et al., 1994; Neimeyer, 2000).
- Empower employees to adapt the change to their micro level and to adopt the change gradually.
- Let change snowball through professional networking.

Consolidating the change

- Be responsive to the change on the ground and adapt the overall strategic intent accordingly.
- Publicise the changes by show-casing, and other means of communications (Kotter, 1995).
- Connect the success of the organisation to the new changes (Kotter, 1995).
- Institutionalise changes by creation of new policies, procedures, protocol, revising jobs titles and job descriptions, and organisation's mission, and strategies (Armenakis et al., 1999).

Evaluation

- Measure change.
- Refine unintended changes (Baumgartner and Jones, 2009).

Note: This study contributions to the model are written in bold

6.6 Reflection on the adoption of the ANT as a theoretical framework

Organisations are built on stability and routine and therefore change can be very slow and often occurs over a long period of time (Sotarauta, 2016). This established routine gives the employees a degree of certainty in relation to role expectations and rewards for performance (Rafiqui, 2009). Yet, this stability and routine might hinder the ability of the employees to respond when there is a requirement either internally or externally driven to institute large-scale change within a very short time frame. On the other hand should the employee want to improve and innovate, Battilana (2006) and Battilana et al. (2009) argue that a sudden and immense deviation from the routine and norms by employee/s might cause huge disturbance in the organisation practice hence could result in disciplining those employees. As a result, organisations themselves could obstruct or stimulate their own transformation.

 In this case study, the established health care professional practice have fairly well-defined boundaries between the different professional groups, disciplines, departments as well as between acute and community/primary care. This may make it difficult to introduce changes that challenge these boundaries and can make collaboration difficult. Moreover, this organizational boundaries limit access to established resources.

Generally, there is a tendency to view organisation change and innovation as top down directives that dictate the actors' participation rather than examine what is really happening. Accordingly, this top down approach presumes that change and innovation is built on new knowledge that is external to the current practice with fairly clear "rules of the game" (Sotarauta, 2016). This view overlooks the role of both the internal and external agencies in organisational change. Furthermore, this up-down approach ignores the role of the interplay between the actors and the recombination of the existing knowledge in developing a vision for change and convincing other actors to diverge from the institutionalised practice (Dtling and Grillitsch, 2015). In this case

study, the health care professionals' existing knowledge of the current practice and the dynamics of the organisation played a major role in both actors' acceptance and adoption of the changes and the diffusion of the innovations within the organisation. Drawing upon ANT notion of networks boundary organising emphasized the importance of actors spanning (Fennel and Alexander, 1987) and brokerage across boundaries (Wenger, 2000) in service innovation and diffusion of change.

Adopting the ANT theoretical framework to this study made it possible to understand how the health care organisational context influences the way actors collaborate across the organisational and professional boundaries to generate, share, diffuse and validate the existent and recombinant knowledge. Simultaneously, it enabled us to view health care integration as a multifaceted, emergent and dynamic phenomenon that evolved within a complex ecology rather than in isolation of its internal and external context (Jessop, 2001). At the same time, adopting ANT avoided the trap of the human actor-centric bottom up view which attributes innovations to frontline health care professional with minimal consideration to the overarching governance, institutions and global context as other policy drivers. As a result, this gave us a more refined mixture of both bottom-up and top-down approaches to understand change by embedding the four parts of change namely; the context, the institutions, the actors and a responsive management.

The responsive management in this case study was represented by the overarching governance framework to understanding health care integration as a special form of organisation innovation and change. While, institutions represent the rules, norms, values, regulations, recurrent patterns, behaviours and attributes needed for the organisation to function. These institutions are embedded in the social context and can only be seen in social exchanges. These research findings suggest that, there is a reciprocal effect between those institutions and the actors

functioning within them. Jessop (2001) convincingly argued that, those institutions are socially constructed and are interwoven with the way actors interpret and operationalise them. Therefore, this study gave a serious attention to the actors' intentions and interests in order to understand the selectiveness of the actors networking, thus the combinatorial knowledge generation and dissemination within and across networks boundaries (Halse and Bjarnar, 2014). Furthermore, unlike other diffusion innovation accounts, adopting the ANT framework enabled us to map actors' moves and the counter moves in pursuing their interests rather than attributing properties to actors retrospectively.

6.7 The NHS and the Actor Network

Non-human actors such as materials do not perceive the world like human hence they do not respond similarly (Bruun and Langlais, 2003). Yet, the material elements are fundamental components of networks such as the NHS that relies heavily on the nonhuman infrastructure in delivering the services. Hence, analytically, both human and non-human elements should be treated similarly (Law, 1992). Latour (1996) argued that non-humans' entities are critical to social interaction and it is impossible to isolate those interactions from their context in complex organisations such as the NHS.

This study drew upon ANT insight of assigning equal agency to all involved actors to explore the complex interconnections between diverse entities such as human beings, technology, institutions, geographical and political entities, and consumers. The available literature does not include any studies conducted on health care organisations' integration in the United Kingdom. The extensive fieldwork carried out during this study helped to identify a huge number of actors involved in this complex multi-health care organisation integration.

The resulting integrated organisation is the product of actors both human and non-human interactions and collaborations within the network/s. Although health care professionals were the major actors with the network/s, other actors like the consumers, and the public's standpoint and expectations, the available technology, the space and the geography, the available resources, the political and economic contexts of the network/s and the management played a huge role in shaping the network/s hence the integration process. However, further studies on health care integration may also be able to shed further light on as yet unidentified actors, which can then be included in the network/s to complete the picture.

Although Latour (1993b) stresses on the importance of following the network wherever it leads, it should be noted that in this study the network/s were not completed and were still emerging when the field work was completed. Moreover, as highlighted in the literature, heath service restructuring has been in progress since the inception of NHS and the health care service will always undergo adjustments in response to the changes in resources available, the users changing needs, the professionals and management's expectation and the development in both technology and medical science. Hence, networks and services will always be shifting. For that reason, this case study was bounded in terms of context, time and space. Due to the limited resources, this study investigated a cross section in relation to time and space of the integration process as described earlier in the research methodology chapter.

6.8 ANT as innovation diffusion approach

Introducing changes could result in disturbance to the status quo of practice which might make people less willing to take risk and adopt these changes. In literature, there are three main approaches to understanding the diffusion and adoption of innovation (Slappendel, 1996). Two of them, the structuralism and the individualist approaches rely heavily on the intrinsic characteristics of either the individuals or the organisation in relation to accepting and

implementing innovations (Rogers, 2010). This is why, it is common for few individuals to accept the risk of adopting a new idea, product or behaviour before anyone else while the rest wait until changes have been tried by others. However, individuals and organisations are not isolated from their environment as they interact with their context which includes both human and nonhuman, and are governed by rules and regulations. As a result, a third interactive approach offers better view to understanding innovation diffusion as it recognises the individuals' characteristics as well as the way they interact within a context (Sarosa, 2012).

This third approach is in line with ANT as individual innovators enable the diffusion of the innovation by building networks of alliances with both human and nonhuman actors using translation process (Callon, 1986b). This network formation correlates with Rogers (2010) diffusion of innovation theory. Rogers argues that, the success of innovation adoption is dependent on the actors' choice to adopt or reject new ideas. Rogers's theory provides a mechanism for both the diffusion and adoption of innovation. As the new change is introduces to a social system, actors go through five steps " 1) knowledge, 2) persuasion, 3) decision, 4) implementation, and 5) confirmation" (Rogers, 2010, p.36). However, Rogers's theory presumes change as an external force and that the only role actors play is either accepting or refusing the innovations. Therefore, ANT could provide an alternative to understanding the process of innovation adoption and diffusion for change from within. Tatnall and Lepa (2003) and Tatnall and Burgess (2004) employed ANT to understand the adoption of innovation in electronic commerce. They argue that ANT acknowledges actors interactions as a determinant factor in adopting innovation in addition to the individual characteristics and organisational structure.

Adopting the ANT as a theoretical approach in this case study took us beyond Rogers's five steps of innovation adoption and diffusion as it demonstrated how professionals were able to move between these steps. During the problematisation stage, individuals were uncertain about

the integration as a new innovative change due to the lack of knowledge in relation to what integration was, how it was going to be implemented and what the consequences of integration to their practice were. This uncertainty resulted in formation of resistance (grief) networks. At the interessement stage innovative focal actors persuaded other actors through addressing their concerns about the integration's expected consequences to their practice in terms of both their professional role and patient care. This interssement has strengthened the network between the actors (Sovacool and Hess, 2017). Once these concerns were addressed, health care professionals were able to make a decision to enrol or decline. As other actors got aligned with the interests defined to them by the network and adopted the integration, network/s mobilised all the available resources to enable actors to cope with the emerging change and demonstrate the usefulness of the integration. So, the change was diffusing as a result of this network formation. To secure the actors commitments and to guarantee a successful implementation as well as to prevent betrayal, a confirmation of the agreed decisions was inscribed, black boxed and publicised,

According to Rogers (2010) human beings are the only actors who can influence the diffusion of innovation by choosing to adopt or reject. On the contrary, ANT treats both human and nonhuman actors equally in the process of translation. In this case study nonhuman actors like communication technology have played a major role in spreading the integration idea across the organisation as well as enabling the change implementation. Moreover, ANT acknowledges innovation diffusion and adoption as a *"political game"* (Sarosa, 2012, P. 247) in which all actors including the innovators were involved in negotiating the process as well as the products. In this case study, actors adapted the change as well as their practice as they got themselves interested and enrolled in the networks. ANT was able to show how actors used the relational power to reach a combinatorial agreed innovation within and across networks before adopting the interssements assigned to them. This actor's negotiation ability within a network explains why we have seen different categories of health care professionals adoption of integration in

relation to time. Furthermore, the negotiation across networks provided multiple entry points for actors to join the networks in the favour for adoption, yet this multiple entry made convergence complicated. Rogers (2010, p.22) argue that, there are ''five categories of innovation adopter 1) innovators, (2) early adopters, (3) early majority, (4) late majority, and (5) laggards''. In this Case study, ANT approach was able to demonstrate the reasons why actors belonged to each one of these categories, as we have seen in chapter 4, and how they moved between those categories as the innovation diffusion and adoption got momentum. Indeed, emerging networks have supported actors adopting the change as both the change and the networks coevolved over time.

6.9 Reflection on being an insider researcher

Researchers utilise a wide range of research methodologies and research methods to address problems and provide explanations and develop better understanding for issues of concern (Creswell, 2014). Besides choosing the right methodology and research methods the researcher's ability and suitability to do the research is a crucial factor to conducting a credible research. This became very important in qualitative research as to some extent the researcher ontology and epistemology as well as his previous knowledge and assumption of the research context and phenomenon are decisive to the accuracy of the generated data and the trustworthiness of the research findings. As a result the researcher role and connections to the researched should be clarified.

Adler and Adler (1994) argue that researchers role in research could be anywhere between being a complete stranger to the research topic, settings and the group to a full member of the research group and the phenomenon being studied (Griffith, 1998). In literature, the later one who shares the same characteristics (e.g. sex, race, profession, class and so on) and affiliation with group being studied is referred to as insider researcher (Breen, 2007). However, this idea of a clear distinction between insider outsider has been refuted by many scholars (Carter, 2004; Kelleher

and Hillier, 1996 and Labaree, 2002) who claimed that the researchers- researched relationship could be anywhere on a continuum of being a full member to a completely stranger. Griffith (1998) and Merton (1972) went even further by calming that, as the research evolves the boundaries between the researcher and the researched shift and the lines of separations become more permeable. Personally, the insider outsider aspect of the research was dependent on the person I was interviewing and the topic we were discussing. Indeed I felt that, whenever I interviewed health care professional I was more of an insider than when I interviewed managers, although I never met some of those professional participants face to face before. Moreover, within the same interview, whenever I played the devil's advocate and tried to challenge the participant's beliefs or perceptions I was made to feel an outsider. Conversely, sympathising with the participants adopted stance appeared to stimulate greater insiderness.

As a frontline health care professional and researcher in this study, I brought my previous knowledge, assumptions and experience of both the research topic and research context to this research. I have been working as a health care professional for the last 23 years of which the last10 years were at the same organisation where this study was conducted.

Most of the research participants interviewed were my colleagues whom I do work with. As a result of this friendly and working relationship with the participants, all invitations to contribute to the research were accepted. Although some participants were hesitant to contribute due to the ongoing consultation on the senior jobs at the beginning of the study, all of them were at ease during the interviews. Participants explained that their worries were not to do with me as a researcher but rather as one of the participants said were due to *"the turmoil situation of the orgsnisation"*.

However, it is of importance to point out that I had no administrative power or authority over any of the participants that could defect the quality of the data collected (Smyth & Holian, 2008). Yet, I made good use of all advantages of being an insider researcher. I was able to move freely within the organisation sites and to collect data any time of day and any day of the week without any restrictions. Managers and colleagues were very positive and were happy for me to conduct the interviews with them in their working places and sometime held informal conversation down the organisation corridors and the staff cafeteria. They gave importance to the study and volunteered their time to conduct the interviews. In many occasions, health care professional colleagues provided information and documents during casual conversations and sometime without even being approached or asked to do so. I was able to go back to participants and ask them for clarification should I have unclear point in the interviews, informal conversations or missing data. Very often, participants were able to approach me between the time I provided them with the invitation letter and the time of the interviews and to talk about the research as well as to negotiate the suitable time for the interview. Sometimes, participants were able to reach me and clarify things even after the interviews were conducted. Participant sometimes sought me to tell me about incident or events they thought could help the study.

Being an insider researcher minimised the potential disruption to the social interaction as participants saw me as part of the phenomena rather than someone who intruded upon their territories. As a result, nearly all interviews were more of a friendly conversation and in many occasions participants talked about their personnel issues of concerns that I did not even ask about as they felt that I could be a vehicle for their voice to be heard. Moreover, some participants including myself used the interviews to explore their own feelings and experience as well as to get better insight of the change.

Being an insider, was of great advantage in relation to getting access to local documents, interviewing participants and support of both colleagues the management. As participants felt that I was one of them, they were very helpful in directing and introducing me to other potential participants and documents that could enrich the research collected data. Yet, this overload of detailed research data could have diverted my attention from the macro picture of the integration process to the micro elements of the change process. Having a clear research protocol and a theoretical framework to guide the research process kept the research focussed.

On the down side, this researcher's positionality and acceptance within the research context sometime blurred the distinction between my roles as a health care professional and as a colleague and a researcher (Fox et al, 2007; Garton and Copland, 2010). This could bear ethical consequences in relation to accessing confidential information either intentionally or coincidentally due to my employment status (Labaree, 2002). These concerns were addressed earlier in the research methodology in negotiating overlapping roles section. Throughout the study, I was able to express my role as a researcher and to verbally consent the participants to use the information they provided in the study. On the other hand, although all information I accessed has influenced my understanding of the phenomena in some way, the only data I used directly in this study were the information available to the public.

One more thing, some participants presumed that I knew about things they were talking about, which without further questioning and indirect exploration could have resulted in missing or misunderstanding valuable information. Moreover, the over familiarity with the research context bore a high risk of prejudging the research data or overlooking some aspects of the social interactions (Smyth & Holian, 2008). To counter balance the insider disadvantages, these issues were addressed early in the research process by the choice of the research methodology and approach, highlighting my role in the research process as well as my presumptions and

understanding of the research context and the phenomena. Moreover, my academic supervisors who both are expert researchers and outsiders to the research settings monitored not only the research process but also the data generated.

To conclude, although being and insider researcher bore great ethical and practical challenges, the easy access to the data and the ability to clarify information enhanced the trustworthiness of the research. Knowing the participants work and background and having a shared experience facilitated the interview as I was able to relate questions to their own and my experience and to use real examples from our own work. Having an in depth understanding of the researched context and sharing a similar experience to that of the participants helped me to understand the participants experience and challenges that we faced during the change process.

6.10 Theoretical implication

The fact that, ANT is semiotic in nature hence meanings and significance are relational (Law, 1992) left it open to the criticism that it cannot provide more than a descriptive account (Cresswell et al., 2010). However, using the ANT to understand how humans and non-human actors including materials, ideas and so forth interacted, revealed three distinctive contributions to the policy process studies. First, it expands the field of study to a broader field of interaction (Levinson et al. 2009) to capture the enormous complexity of the integration process in relation to space, meanings and professional and organisational identity reconstruction. The ANT as a theoretical framework can have practical relevance for investigating a multi-organisation integration and other major restructuring in healthcare services. Deploying ANT to study this multi-sited organisation enabled us to gain insight into both the local context and the wider social system wherein those local contexts are situated. This allowed us to understand the integration process through tracing the deconstruction and reconstruction of networks between wide ranges of heterogeneous actors.

It could be argued that, using the ANT shows the role of the material actors in mediating the policy process. Moreover, ANT made it possible to explore the interwoven relationships between all the actors including the local and global contexts involved in the policy process and how they shaped each other through building alliances and interests. Focussing on the interplay between the actors made it possible to trace the emerging changes and to link these changes to the social interaction that were occurring. This contextual approach enabled us to appreciate the role of the social interaction and actor's interest in shaping the policy process. This became very important in situations where actors had affiliations outside the organisation such as professional bodies and unions. In this case study, the extended scope of practice for example opened the door for nurses to engage in activities that were beyond their traditional scope of practice.

Finally, dismantling the matrix of interwoven and competing power relations (Levinson et al. 2009) enabled us to see the distribution of policy process influence across the macro networks between the management, the DH and professionals and the role of the service users in the direction of the policy process. This way, we were able to see how the health care professionals lead the change in the void of management at the executive level at the beginning of the integration process.

ANT has traditionally been used in the field of technology and design implementation in organisations (Shim and Shin, 2015). This study extends the ANT literature further to the field of multiple health care organisation integration and major health care service restructuring. Furthermore, this study substantiates that, combined with the right research methodology and research method, ANT is a capable theoretical framework that offers researches with a tool to understand the interplay dynamics between human and nonhuman actors at a deeper level. In particular, ANT has helped in focusing the sampling technique by directing attention to actors involved in the care of the COPD patients on various sites of the organisation. In a similar vein,

once those actors were identified, ANT played a foremost part in tracing and elucidating the interplay between those actors over time within and across networks.

ANT has been criticised for focusing on the privileged actors within a network and ignoring those marginalised or those who live across the boundaries of the networks. This study demonstrated that peripheral actors played a major role in the way the networks developed by capitalising on the accumulative relational power available to the whole network. Even more, in this study it seems that the plot of the integration story was constructed mainly by those who work across networks boundaries.

Though this study carefully relied on ANT to understand the implications of the health care integration as a special form of change on health care professionals and to understand the role of those professionals in policy process, it also bears some limitations. Due to the limited time and resources available, this study focussed on a cross section of the organisation and was not able to account for changes other than those connected with the virtual COPD patient's journey. In addition, the organisation integration is still an ongoing process and changes are still emerging which meant that, the story line of the research has been left open ended and further studies at later stages of the organisation integration are needed.

6.11 Implications for health care professionals educational

The current integration process produced a health care practice that is largely patient-centred rather than setting-defined. So, coordinating care and managing transition across settings is becoming an integral part of health care professionals' roles. This paradigm shift required the education sector to produce well prepared professionals who could deliver a wide range of care in those emerging areas such as the transitional care rather than in discrete settings and as team members rather than individual clinical providers. Indeed, the educational system needs to adapt

to the new changes in which the learner needs to follow patients and families care trajectory rather than being fixated at settings or level of care. Thereupon, student's clinical experience should focus on health and ill care of patient and family along their life continuum rather than on episodic care. Furthermore, the new team approach requires a substantial shift form discrete professionals to a multidisciplinary intrprofessional education at both clinical practice and classroom levels.

Transitional care such as the ambulatory care and virtual ward that facilitate patient's early discharge to their normal place of living, prevent readmission and divert patient form hospital was a major component of the organisation's restructuring. This transitional care is infrequently specifically taught within professional education programmes; hence, educational centres need to pay more attention to equipping the professionals with the skills and knowledge to practice in those across settings emerging care models (Sochalski and Weiner, 2011) and to focus at delivering care to patients across setting rather within settings.

In this new era of health care professionals, particularly nurses, are expected to work at the top of their license and to demonstrate higher levels of decision making not only in relation to clinical practice but also to management and leadership (CC3N, 2015). This was clearly highlighted in the NMC standards for pre-registration nursing education currently being consulted in (NMC, 2017). Those pre-registration education standards aim to equip future nurses with the skills that would not only improve the health and wellbeing of the service users but also would drive up the quality and standards of health care using the best available evidence and technology. The NMC expects nurses to lead, delegate, supervise and challenge substandard practice. Considering that newly graduates are not expected to have all of the practical skills of these competencies, the NMC and the DH put the onus on the employers to provide opportunities to nurture this highly skilled graduate in developing advanced expertise (DH, 2010e; NMC, 2010).

This became significant during the course of the study, as research setting happened to be one of 11 networks of health, social care and educational providers selected in England to deliver the new Nursing Associate Programme from January 2017. Though it is not clear yet, once the new nursing associates graduate they will be expected to carry out a range of clinical functions under the supervision of the registered nurse. This will free registered nurses time to practice at the top of their license. Though it is not fully understood yet, introducing these nursing associates will have considerable implications for the role of the registered nurse in the future.

6.12 Implications for practice

This research adds to the growing evidence which donates that, promoting service transformation such as health care integration necessitate a bigger role for the employees closest to the service users. Organisations need to attend to front line workers as key contributors to change and development that is meaningful for service users. Therefore, a possible implication for this study is how to build capacities in front line workers and how to harness their creativities within the change processes to develop from a patient cantered care journeys perspective new care pathways. As experts in service users' needs, these professionals will be able to innovate in both service delivery and service restructuring.

Secondly, professional integration is a precursor to service integration. This professional integration could be promoted by encouraging interprofessional education and practice to foster collaboration and role familiarity between health care professionals. Thirdly, managers and policy makers should address employee's concerns in timely manner and governance should be flexible and responsive to accommodate the emerging changes. Finally, this study shows that there is a trend to move away from a uni-profession health care model like nursing or medical models to a model that is based on an inter-professional approach.

6.13 Limitations

In line with the constructivist approach, there is multiplicity and fluidity in any social reality. This in turn makes it quite difficult for researchers to find the balance between focussing the research and addressing those multiple realities. The huge number of involved actors and the never-ending episodes of negotiation between those actors and the infinite number of micro-network perplexed the task of capturing those multiple realities. This left us with the choice of not only pondering which part of the research context to focus on but also which reality to capture without neglecting the global picture. Yet, the choice of the case study approach mediated to a certain degree against this by delineating both the internal and external boundaries.

A core component of qualitative research in general is the centrality of the researcher and the notion of eventuality. The centrality of the researcher is represented very early in the research process in choosing the research topic, the research question, methodology and method and in interpretation. Eventuality on the other hand, is governed by practical constrains such as being there on the right time, availability of resources and time. Although thick descriptions from the field, a poly-narratives and an autoethnography helped elucidating the researcher's role in the story line yet, the limited and sporadic time the researcher spent in various field site resulted in a challenge in relation to capturing all the temporal components of the case studies. There was an attempt to augment this shortcoming with field observations and analysis of local organisation's and published documents. Furthermore, despite the lack of transcripts checking by all participants affected the overall rigour of the study; data triangulations from more than one source reconciled this shortcoming. Verifying and validating the findings of each interview with the consecutive interviews allowed us not only to build on those findings but also, to interweave each of the interviews into the final story line. Moreover, data generated by the interviews, document analysis, field note and autoethnography were cross referenced to enhance the rigour of the study. However, keeping in mind the multiple realities and the fluidity of the social

phenomena, it is worth acknowledging that this story line is one account of potentially many versions of this story that could be told (Gad and Jensen, 2010).

6.14 Areas for future research

This study has raised issues that warranty further investigation. Firstly, exploring the frontline health care professionals' positionality in policy process in the presence of a stable management at the executive level may well generate knowledge that would enable the identification of core requirements within executives to empower positive change. Secondly, over time it would be of particular interest is to explore the implications of health care integration on health care education. Thirdly, attention needs to be directed towards strategies for shifting the focus of health care services from the professionals to the patients and the implications of this focus shift to both professional identities and professional boundaries. Additional attention is needed to expose and articulate the shared components of healthcare professionals work. This could promote greater inter-professional learning and working. Furthermore, it is worth giving more attention in future studies to the service users' role within current and future healthcare services policy process. Finally, more studies to identify other actors involved in health care integration policy process are needed as this work findings are based only on one case study.

6.15 Originality and value

To my knowledge, there is no other paper that offers a generalised framework to conceptualise a multiple health care organisational integration and its implication to frontline health care professionals and the positionality of those professionals in the policy implementation process. This case study used ANT as a theoretical framework to understand the frontline health care professionals interpretation of change through integration as a special form of change. This research integrates components from the existing organisational change models with some modifications to describe the stages of change

through integration. Entrenched in this model is the way to deal with the employees'
interpretation of the unfolding events and its implications to their psychological and behavioural
responses.

6.16 Conclusion

This study contributed to the understanding of frontline health care professionals' role and
position in the contemporary health care. By focussing on the health care professionals this study
amplified the voice of a very often overlooked and taken for granted major part of the health
service policy process.

The objectives of this study were to understand the implications of health care organisation
integration on health care professionals' practice and the role that frontline health care
professionals play in health care policy process through a contextual account of their
perceptions. As it is difficult to follow change in large organisations such as the NHS in relation
to time and data management, a constructive case study approach was used to delineate the
boundaries of the case. A novel approach was deployed to collect the data in that across section
of the organisation transformation was taken by following a virtual COPD patient's journey
through the health- ill-health care continuum. Actors involved in the care of this patient directly
or indirectly were identified and interviewed. Local and global documents that dealt with the
integration were collected and analysed. Autoethnographic approach was used to invite readers
to enter my world as an insider practitioner's researcher whose individual experience is being
written as part of a shared social experience and to uncover discourses that contribute to the
integration policy implementation in the trust. Integrating my autoethnography in the case study
has broadened our understanding of the phenomenon at both personal and social level. ANT
framework was utilised as a theoretical perspective to guide the data collection and analysis.

The change in this study was divergent, hence, it worth mentioning that, not all actors shared a common understanding of the intermediaries circulating the network/s. Undeniably, many actors failed to recognise the legitimacy of an actor regarded by others as an obligatory passage point or centre of control. Therefore, they resisted the roles the network assigned to them and responded to instructions unpredictably. As a result, key actors began to pursue their interests elsewhere at the beginning of the integration process. Those unpredictable responses became actors within the network/s and influenced the speed and direction of the change. A wide range of networks emerged and dissolved in response to integration with a wide range of functions to deal with the consequences of the integration. Yet, those networks, both supporting and opposing the integration, proved to be valuable and continued to modify their emerging vision to accommodate wide range of actors' interests and concerns to prevent the network collapsing. Patient's needs were used meticulously as a relational power to hold the network stable together as well as to gain influence within the networks throughout all stages of policy translation.

A main characteristic of this case study was that it did not have a clear consistent and stable vision from the outset. Visions were continuously emerging over time, yet the emerging visions were not allowed to fragment into competing versions of what the integration is about. Though, throughout the integration process, there was never complete agreement on the emerging vision, so far, the emerging integration vision provided a relatively stable narrative that framed how these competing demands and interests were ordered in terms of priority.

In line with the social constructivist branch of the social movement theory, this case study demonstrates that professionals agreed that, the context's necessity for change represented a problem within the integrated organisation. In the absence of a permanent management at the executive level, this necessity for change was antecedent to the health care professionals taking lead in policy translation. Once permanent management was in post it tried to reign in the

integration process through governance. Furthermore, to bridge the gap between the management and the shop floor, frontline health care professionals were appointed at the executive levels.

Data collected in this study showed that there was a reciprocal effect between the acute and the primary/community health care service integration and the way health care professionals practice. This observation is in line with choice of the ANT which suggests that actors and context mutually create each other. Professionals were changing themselves as they were changing the service provision they worked in. Indeed, Professionals played a significant role not only in redesigning the services and their identity within the emerging services through negotiations but also, influenced the intention for integration to some extent. Undeniably, these study findings demonstrated that not only did the frontline health care professionals' positionality within policy process change but so also did the service users' needs from the point of view of those professionals. These service users' needs were used meticulously as a relational power in negotiation within and across networks.

Methodologically, this research is located within a social constructivist paradigm where identities are perceived to be dynamic, relational and discursively constructed. Additionally, the roles are derived from individual and collective agency, performed through social interaction, mediated by organisational structure and communicated through language and discourse.

This study provided an example for the use of ANT in social research specifically in a health care context. Of particular interest is ANT use regarding the human and non-human inseparability and equal agency within a hybrid network. ANT offered a distinctive way of viewing human, text and artefact as relational actants entrenched in a network rather than being divided into isolated domains. This hybrid network concept provides useful in this study as it focuses on the effectiveness of the interaction taking place between actors of diverse interest

around a goal. Following form this; ANT was able not only to help us identify actors involved in the policy translation but also facilitated the exploration of the dynamic interrelationship between those actors in a given context. Using the ANT to understand the integration process provided us with new perspective to understand the trajectory of change process. This case study demonstrated that, the failure and success of change is reliant on the resilience and extents of the networks created and the ability of those networks to black box the new reality rather than the presumed value of the change itself. This case study suggest that for changes to succeed, organisations need to harness the capacity and creativity of frontline professionals to improvise a patient centred care journey using the available resources to solve the shortcoming of the NHS rather than presuming structural solutions. This can only be achieved by the frontline professionals through translating both human and materials actors interests, identity and role into a durable aliened structure in which the new reality became no longer questionable. Hence, the research strategy of incorporating ANT and case study methodology provided an opportunity to narrate the story of multiple health care organisation integration and to emphasise the role of social interaction in the changing process.

References

Abbott, A. (1988). <u>The System of professions: an essay on the division of expert labour</u>. : Chicago, USA: The University of Chicago Press Ltd.

Abbott, S., Shaw S and Elston, j. (2004). Comparative analysis of health policy implementation: the use of documentary analysis. <u>Policy Study</u>. 25(4): 259-266.

Abel-Smith, B. (1975). <u>History of the nursing profession</u>. London: Heinmann.

Addicott, R., Maguire, D., Honeyman, M. & Jabbal, J. (2015). <u>Workforce planning in the NHS</u>. Kings Fund: UK.

Adler, P. and Adler, P. (1994). Observational techniques. In N. Denzin and Y Lincoln (Eds.). <u>Handbook of qualitative research</u> (pp. 377–392). Thousand Oaks, CA: Sage.

Afarikumah, E., Yunkap, K. & wankam, S. (2013).' Deploying Actor -Network Theory to Analyse Telemedicine Implementation in Ghana'. <u>Science Journal of Public Health</u>.1(2): 69-76.

Age Concern. (2009). <u>One Voice: Shaping the society</u>. Age UK.

Ajjawi, R. & Higgs, J. (2007). 'Using Hermeneutic Phenomenology to Investigate How Experienced Practitioners Learn to Communicate Clinical Reasoning'. <u>The Qualitative Report</u>. 12(4): 612-638.

Aiken, L., Clarke, S. & Sloane, D. (2000). 'hospital restructuring dose it adversely affect care and outcomes?'. <u>Journal of Nursing Administration</u>. 30(10):457-465.

Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., Giovannetti, J., Rafferty, A. & Shamian, J. (2001).' Nurses report on hospital care in five countries'. <u>Health Affairs</u> 20(3): 43-53.

Aiken, L., Sloane, D. &Sochalski, J. (1998).' Hospital organisation and outcomes'. Quality in Health Care.7, 222-227.

Alaszewski, A. (1995). 'Rrestructuring heal and welfare professions in the United Kingdom: the impact of internal market on the medical, nursing and social work professions'. in T. Johnson, G. Larkin & M. Saks. (eds.). Health professions and the state in Europe. (Edi). London : Rutledge, p31-42.

Alcouffe, S., Berland, N. & Levant, Y. (2008).' Actor-networks and the diffusion of management accounting innovations: A comparative study'. Management Accounting Research. 19: 1–17.

Alford, R. (1975). Health care politics: Ideological and interest group barriers to reform. University of Chicago Press: Chicago.

Allan, P. & Jolley, M. (1982) Nursing, Midwifery and Health visiting since 1900. 2nd edn. London: Faber and Faber.

Allsop, J. (1995) Health policy and the NHS: Towards 2000. London: Longman.

Amiot, C., Terry D., Jimmieson, N. & Callan, V. (2006) .'A longitudinal investigation of coping processes during a merger: Implications for job satisfaction and organisational identification'. Journal of Management. 32: 552 - 574.

 Anderson, L. (2006) .'Analytic Autoethnography'. Journal of Contemporary Ethnography. 35 (4): 373-395.

Appel, A. & Malcolm, P. (2002).'The triumph and continuing struggle of nurse practitioners in New South Wales, Australia'. Clinical Nurse Specialist. 16(4) 203–10.

Armenakis, A. & Bedeian, A. (1999).' Organisational change: a review of theory and research in the 1990s'. Journal of Management. 25 (3): 293-315.

Armenakis, A., Harris, S., & Feild, H. (2001). Paradigms in organizational change: Change agent and change target perspectives. In R. Golembiewski. (Ed.). <u>Handbook of organizational behaviour</u>. Marcel Dekker: New York, p631-654.

Ashworth, P. (2000).'Editorial: Nurse consultant- a role whose time has come'. <u>Intensive and Critical care Nursing</u>. 16(2): 61-62.

Ashford, S. (1988).' Individual strategies for coping with stress during organizational transitions'. <u>The Journal of Applied Behavioral Science</u>. (24):19-36.

Asthana ,S. (2011).' Liberating the NHS? A commentary on the Lansley White Paper, "equity and Excellence". <u>Social Science and Medicine</u>. 72 (6):815-820.

Athié, K., Menezes, A., da Silva, A., Campos, M., Delgado, P., Fortes, S. & Dowrick, C. (2016).' Perceptions of health managers and professionals about mental health and primary care integration in Rio de Janeiro: a mixed methods study'. <u>BMC Health Services Research</u>. 16 .532 :1740-8

Atkinson, P. & Coffey, A. (1997). 'Analysing Documentary Realities'. in D. Silverman. <u>Qualitative Research: Theory, Method and Practice</u>. ed. London: Sage.

Attig, T. (2001). 'Relearning the world: Making and finding meanings'. In R. Neimeyer (Ed.). <u>Meaning reconstruction and the experience of loss</u>, Washington, DC: American Psychological Association, pp. 33-53.

Audit Commission. (1999). <u>Critical to Success: The place of efficient and effective Critical Case Services with the Acute Hospital</u>. London: Audit Commission.

Baer, E. (1997). Women the politics of career development: the case for nursing. In A. Raferty, J. Robinson & R. Elkan. (eds.). <u>Nursing History and the politics welfares</u>: London. Rutledge. p242-258.

Baker, M. (2000). <u>Making sense of the NHS White Papers</u>. (2nd eds.). Oxon: Radcliffe Medical Press.

Bandura, A. (1986). <u>Social foundations of thought and action: A social cognitive theory</u>. Englewood Cliffs. NJ: Prentice-Hall.

Barton, L. (1996). <u>Disability and society: Emerging issues and insights. </u>(Eds). London: Longman.

Barrett, S. (2004).' Implementation studies: time for a revival? Personal reflections on 20 years of implementation studies'. <u>Public Administration.</u> 82 (2) :249–262.

Barrett, S. & Fudge, C. (1981). <u>Policy and action: Essays on the implementation of public policy</u>. Routledge.

Bartunek, J., Rousseau, D., Rudolph J., & DePalma, J. (2006). 'On the receiving end: Sensemaking, emotion, and assessments of an organizational change initiated by others'. <u>The Journal of Applied Behavioral Science</u>. 42(2):182-206

Barzelay, M. & Gallego, R. (2006) .'From ''New Institutionalism'' to ''Institutional Processualism'': Advancing knowledge about public management policy change'. <u>Governance</u>. 19 (4): 531–57.

Battilana, J. (2006).' Agency and institutions: The enabling role of individuals' social position'. <u>Organization</u>. 13(5): 653–676.

Battilana, J., Leca B. & Boxenbaum, E. (2009).' How Actors Change Institutions: Towards a Theory of Institutional Entrepreneurship'. <u>The Academy of Management Annals</u>. 3(1) :65–107.

Baxter, S. & Brumfitt, S. (2008).' Professional differences in interprofessional working'. <u>Journal of Interprofessional Care</u>. 22 (3): 239-251.

Baumgartner F. & Jones B. (2002). <u>Policy Dynamics</u>. Chicago: University of Chicago Press.

Baumgartner, F. & Jones, B. (2009). <u>Agendas and Instability in American Politics</u>. *(2nd eds)*. Chicago, IL: University of Chicago Press.

Bazeley, P. (2007). <u>Qualitative data analysis with NVivo</u>. London: Sage.

Beckert, J. (1999).' Agency, entrepreneurs, and institutional change: The role of strategic choice and institutionalized practices in organizations'. <u>Organization Studies</u>. 20: 777–799.

Beech, M. (2015). The Ideology of the Coalition: More Liberal than Conservative. In. M. Beech & S. Lee. The Conservative-Liberal Coalition: Examining the Cameron-Clegg Government. (eds.). Hampshire. UK: Palgrave Macmillan, p. 1-15.

Beer, M. (1980). <u>Organisation change and development: A systems view</u>. Scott Foresman and Company. Glenview.

Benner, P. (1994) <u>the introduction</u>. xiii-xxvii in Benner P. <u>Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness</u>. (eds.). London: SAGE Publications.

Benner, P. (1991).' The role of the experience, narrative, and community in skilled ethical comportment'. <u>Advances in Nursing Science</u>. 14(2)1-21.

Bergen, A. & While, A. (2005).' Implementation deficit and street-level bureaucracy: policy, practice and change in the development of community nursing issues'. <u>Health and Social Care in the Community</u>.13 (1):1-10.

Bingham, S. (1979), <u>Ministering Angels</u>. Oradell. NJ: Medical Economics Co.

Black, N. (2010). 'Liberating the NHS: Another attempt to implement the market forces in English health care'. <u>The New England Journal of Medicine</u>. 363:1103-1105.

Boden, R., Cox, D. & Nedena, M. (2006).' The Appliance of Science? New Public Management and Strategic Change'. <u>Technology Analysis & Strategic Management.</u> 18(2): 125-41.

Boss, S. (2002). 'Expanding the perioperative role: The surgeon's assistant'. <u>British Journal of Perioperative Nursing</u>. 12(3):105-113.

Bowen, G. (2009). 'Document analysis as a qualitative research method.. <u>Qualitative Research Journal</u>. 9(2): 27-40.

Bowling, A. (1997). <u>Research methods in health :investigating health and health services</u>. Buckingham. Philadelphia: Open University Press.

Breen, L. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. <u>The Australian Community Psychologist.</u> *19*(1): 163-174.

Bringer ,J., Johnston, L. & Brackenridge, C. (2004).' About the Use of QSR*NVIVO within a Grounded Theory Study Maximizing Transparency in a Doctoral Thesis1- The Complexities of Writing. <u>Qualitative Research</u>'. 4(2): 247-265.

British Association of Critical Care Nurses (BACCN). (2003). 'Position statement on the role of HCA who are involved in direct patient care activities within critical care area. <u>Nursing in Critical Care</u>'. 8(1): 3-12.

Brown, D. (2002). Michel Serres: Science, translation and the logic of the parasite. <u>Theory Culture and Society</u>. 19 (3): 1–27.

Brunner, S. (2008).'Understanding policy change: Multiple streams and emissions trading in Germany. Steffen'. <u>Global Environmental Change</u>. 18: 501– 507.

Bruun, H. & Langlais, R. (2003). 'On the embodied nature of action'. <u>Acta Sociologica</u>, 46, 31-49. Accessed on 17/1/ 2015 @ http://journals.sagepub.com/doi/pdf/10.1177/0001699303046001003

Burnum, S. (1994).' Realities in nursing practice: A strategic view'. <u>Nursing and Health Care</u>.15 (8): 400-450.

Buse, K., Mays, N. & Walt, G. (2005). Making health policy. Milton Keynes., UK: Open University Press.

Caldwell, K., Atwal, A., Copp, G., Brett-Richards, M. & Coleman, K. (2006),' Preparing for practice: how well are practitioners are prepared for teamwork'. British Journal of Nursing. 15(22):1250-1254.

Calkin, S., Ford, S. & Middleton, J. (2011).' Chief nursing officer to extend tenure'. Nursing Time. Accessed on 30 September2011. @ http://www.nursingtimes.net/nursing-practice/clinical-specialisms/management/chief-nursing-officer-to-extend-tenure/5026652.article.

Callon, M. (1986a). 'The sociology of an actor network: The case of the electric vehicle'. In M. Callon, J. Law & A. Rips. (Eds.). Mapping the dynamics of science and technology (pp. 19–34). Basingstoke, UK: Macmillan.

Callon, M. (1986b) .'Some elements of a sociology of translation: Domestication of the scallops and the fishermen of St Brieuc Bay'. In J. Law. (eds.). Power, Action and Belief: A New Sociology of Knowledge. London. Routledge and Kegan Paul, p.196-229.

Callon, M. & Latour, B. (1981).' Unscrewing the Big Leviathan: how actors macrostructure reality and how sociologists help them to do so. in K. Knorr Cetina & A. Cicourel .(eds.). Advances in Social Theory and Methodology: Toward an Integration of Micro and Macro-Sociologies. London: Routledge & Kegan Paul.

Callon, M. & Law, J. (1997).'After the Individual in Society: Lessons on collectivity from science, technology and society'. Canadian Journal of Sociology. 22 (2): 165-182.

Cameron, A. (2000).' New role development in context. In D. Hamphris & A. Mmasterson. (eds.). Developing New Clinical Roles. Edinburgh: Churchill Livingstone.

Campbell, M. (1992). 'Nurses' professionalism in Canada: a labour process analysis'. International Journal of Health Sciences. 22, 751-765.

Carper, B. (1978).' Fundamental patterns of knowing in nursing'. <u>Advances in Nursing Science</u>. 1(1); 13-24.

Carter, D. (2000).' Quantitative Research'. in D. Cormack. <u>The research process in Nursing</u>.(4th eds.). United Kingdom: Blackwell Science.

Carter, J. (2004). Research notes: reflections on interviewing across the ethnic divide, <u>International Journal of Social Research Methodology</u>.7(4):345–353.

Castledine , G. (1999).' Nursing consultants heralds new era for clinical nursing'. <u>British Journal of Nursing</u>. 8(8): 1258.

Castree, N. (2002). False antitheses? Marxism, nature and actor-networks. <u>Antipode</u>. 34(1): 111–116.

Cavendish, C. (2013). <u>An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings</u>. The Cavendish Review. Accessed on 11/12/2014@
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

CC3N. (2015). <u>National Competency Framework for Registered Nurses in Adult Critical Care</u>. Critical Care Networks-National Nurse Leads (CC3N).

Charlton, B. and Andras, P. (2005).' Modernising UK health service: 'short-sharp- shock' reform, the NHS subsistence economy, and the spectre of health care famine'. <u>Journal of Evaluation in Clinical Practice.</u> 11(2): 111-119.

Charmaz, K. (2000).' Grounded Theory: Objectivist and Constructivist Methods. In (2end eds.). N. Denzin & Y. Lincoln. <u>Handbook of Qualitative Research</u>... London: Sage Publications, Inc.

Charmaz, K. (2003).' Grounded theory. In (ed.). J.Smith <u>Qualitative psychology: A practical guide to research methods.</u> London: Sage, p. 81-110.

Charmaz, K. (2006). Constructing Grounded Theory: A practical guide through qualitative analysis. London: Sage Publications.

Chreim, S., Williams, E. & Coller, E. (2012).' Radical change in healthcare organization: Mapping transition between templates, enabling factors, and implementation processes'. Journal of Health Organization and Management. 26 (2): 215-236.

Clark, D. (2013).' The united kingdom health care system: Myth and realities'. In D. Mason, J. Leavitt & M. Chaffee (6th Eds.) Policy and politics in nursing and healthcare - Revised reprint. USA: Elsevier, p300-305.

Clark, E., Litt, M., & McCann, T. (2005).' Research students: An ethical dilemma'. Nursing Researcher.2 (3): 43-51.

Clarke, J. & Newman, J. (1997).The Managerial State: Power, politics and ideology in the remaking of social welfare. London. UK: Sage Publications.

Coffey, A. (1999). The Ethnographic Self: fieldwork and the representation of Identity. London: Sage.

Colebatch, H. (2002). Concepts in the Social Sciences Policy. (2nd eds). Buckingham: Open University Press.

Commission for Healthcare Audit and Inspection. (2007). Caring for dignity A national report on dignity in care for older people while in hospital. Finsbury Tower. p103-105 Bunhill Row. London. Accessed in 11/08/2011 at http://i.telegraph.co.uk/telegraph/multimedia/archive/00669/nwards127_pdf_669224a.pdf

Commissioning Board (2012) The importance of nurse leadership in securing quality, safety and patient experience in CCGs: Briefing note. National Health Service.

Committee on Nursing. (1972). Report of the Committee of Nursing. (Briggs Report) London, HMSO.

Connelly, L. *(*2016).'Trustworthiness in Qualitative Research'. Medical Surgical Nursing. 25(6):435-36.

Conway, J. (2007).' The changing skill mix and scope of practice of health care workers in New South Wales: Implications of education and training reforms for registered nurse practice, performance and education'. Contemporary Nurse. 26: 221–224.

Corbin, J. and Strauss, A. (2008). Basics of qualitative research: Techniques and procedures for developing grounded theory. (3ed eds.). London: Sage.

Corey-Lisle, P., Tarzian, A., Cohen, M. & Ttrinkoff, A. (1999).' Health care reform: Its effects on nurses'. The Journal of Nursing Administration. 29(3)30-37.

Covin, T. & Kilmann, R. (1990).' Participant perceptions of positive and negative influences on large-scale change'. Group and Organization Studies. 15 (2): 233-248.

Cox, J. and Hassard, J. (2007). 'Ties to the past in organization research: A comparative analysis of retrospective methods'. Organization. 14(4), 475–494.

Creswel, J. (2014). Educational research: Planning, conducting, and evaluating quantitative and qualitative research. (7th ed.). Harlow: Pearson Education. USA.

Cresswell, K., Worth, A. & Sheikh, A. (2010). Actor network theory and its role in understanding the implementation of information technology developments in healthcare. BMC Medical Informatics Decision Making. (1):1–11. Accessed on 22/10/15 at http://www.biomedcentral.com/1472-6947/10/67

Creswell, W. (1998). Qualitative inquiry and research design: Choosing among five traditions. CA. Thousand Oaks: Sage.

Crowley-Henry, M. (2009) .'Ethnography: Vision s and versions/. In J. Hogan, P. Dolan & P. Donnelly. (eds.). Approaches to Qualitative Research: Theory & its practical applications, A guide for dissertation students. Cork, Ireland: Oak Tree Press, 37-63.

Currie, G. & Procter, S. (2005).'The antecedents of middle managers strategic contribution: the case of professional bureaucracy'. <u>Journal of Management Studies</u>. 42(7)1325-1356.

Cutcliffe, J. & McKenna, H. (1999).'Eestablishing the credibility of qualitative research findings: the plot thickens'. <u>Journal of Advanced Nursing</u>. 30(2): 374-380.

Darzi, A. (2007). <u>Our NHS, our future: NHS next stage review, interim report</u>. Accessed 13 August 2008 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077.

Davies, C. (2008). <u>Reflexive Ethnography: A guide researching selves and others</u>. (2end eds). Oxon: Routlrdge.

Dealey, C., Moss, H., Marshal,l J., Elcoat, C. & Dbe, M. (2007).'Auditing the impact of implementing the Modern Matron role in an acute teaching trust'. <u>Journal of Nursing Management</u>. 15(1):22-33.

Dean, M. & Bolton, J. (1980). The administration of poverty and the development of nursing in nineteenth-century England. In C. Davies. (eds<u>). Rewriting nursing history</u>. London: Croom Helm, p.76-101.

Deegan, M. (2001). <u>The Chicago school of ethnography</u>. In P.Atkinson, A.Coffey, S. Delamont, J. Lofland, & L. Lofland. (eds.). Handbook of ethnography. CA: Thousand Oaks. Sage, p.11-25.

Dent, E. & Goldberg, S. (1999).' Challenging resistance to change'. <u>Journal of Applied Behavioral Science</u>, 35(1): 25-41.

Dent, M. (2003). <u>Remodelling hospitals and health professionals in Europe</u>. Basingstoke: Palgrave Macmillan.

Dent, M. & Burtney, E. (1996).' Managerialism and professionalism in general practice: teamwork and the art of pulling together'. <u>Health Manpower Management</u>. 22 (5): 13-23.

Dent, M. & Whitehead, S. (2002). Configuring the 'new' professional. In M. Dent & Whitehead, S. (eds.). Managing Professional identities. knowledge, performativity and the 'new' professional. London: Routledge.

Denzin, N. (2006).' Pedagogy, Performance, and Autoethnography'. Text and Performance Quarterly. 26(4): 333-338.

Denzin, N. (1997). Interpretive ethnography: Ethnographic practices for the 21st century. Sage.

Denzin, N. & Lincoln, Y. (1994). Handbook of Qualitative Research(eds.). Thousand Oaks: Sage Publications.

Denzin, N. & Lincoln, Y. (2000). Introduction: The discipline and practice of qualitative research. In N. Denzin &Y. Lincoln. (Eds.). Handbook of qualitative research (2nd eds). CA: Thousand Oaks. Sage, pp. 1-29.

Department of Health. (1989a). Working for Patients. London. HMSO.

Department of Health. (1989b). Working for Patients. Working Paper 10: Education and training. London. HMSO.

Department of Health. (1989c). Medical Audit.NHS Review. Working paper 6. London. HMSO.

Department of Health. (1991). The Patient's Charter. London. HMSO.

Department of Health. (1997) The New NHS: Modern, dependable. The Stationery Office. London.

Department of Health. (1998).A First Class Service, Quality in the New NHS. Department of Health. London.

Department of Health (1999a). <u>Saving Lives: our healthier nation</u>. The Stationery Office. London.

Department of Health. (1999b). <u>Making Differences: Strengthening the Nursing, midwifery and Health Visiting contribution to health and health care</u>. London. HSMO.

Department of Health. (2000a). <u>The NHS Plan</u>. The Stationery Office. London.

Department of Health. (2000b). <u>Comprehensive Critical Care: A Review of Adult Critical Care Services.</u> London. DH.

Department of Health. (2000c). <u>Meeting the Challenge: A Strategy for the Allied Health Professions</u>. London .UK.   accessed on 11/3/2015 @ http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/assetRoot/04/05/51/80/04055 180.pdf

Department of Health. (2001a). <u>The nursing Contribution to the provision of Comprehensive Critical Care for Adults: A Strategic Programme for Action</u>. London: DH.

Department of Health. (2001b). <u>Shifting the Balance Power in the NHS: Securing delivery.</u> The Stationery Office. London.

Department of Health. (2002). <u>Census Figures</u>. London: DH. Accessed on 9/7/20012@ http://webarchive.nationalarchives.gov.uk/search/result/?q=2002++Census+Figures++++& include=CRITICAL+CARE+HOSPITAL+BED&exclude=&site=&year=2002

Department of Health. (2003a). Agenda for Change Agreement. Stationary Office, London.

Department of Health. (2003b). <u>The NHS Knowledge and Skills Framework and related development review: summary</u>. Accessed 12/7/2012. Available from: <http://www.dh.gov.uk>.

Department of Health. (2004). <u>The NHS Improvement Plan – Putting People at the Heart of Public Services</u>. The Stationery Office. London.

Department of Health. (2005a). <u>Quality Critical Care- Beyond 'Comprehensive Critical Care'</u>. London: DH.

Department of Health. (2005b). <u>Research governance framework for health and social care: Second edition.</u> Accessed on 10/11/2010 at ttp://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/ digitalasset/dh_4122427.pdf

Department of Health. (2006a). <u>Our health, our care, our say: A new direction for community services.</u> London. The stationary office Ltd. Great Britain.

Department of Health. (2006b). <u>Health Challenge England- next steps for Choosing Health</u>. London. UK.

Department of Health. (2006c). <u>Modernising nursing careers - setting the direction</u>. London. DH.

Department of Health. (2007). <u>NHS Next Stage Review interim report: our NHS our future</u>. The Stationery Office.

Department of Health. (2008a). <u>NHS Next Stage Review: A High Quality Workforce</u>. The Stationery Office.

Department of Health. (2008b). <u>Towards a Framework for post-registration Nursing Careers: Consultation Response Report.</u> London. DH.

Department of Health, (2009). <u>Understanding what matters: A guide to using patient feedback to transform services</u>. Accessed in 13/7/2010 @ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh _099779.pdf

Department of Health. (2010a). the White Paper, Liberating the NHS: Equity and Excellence. The Stationery Office Limited. London. UK.

Department of Health. (2010b). Liberating the NHS: Developing the Healthcare Workforce. DoH. London.

Department of Health. (2010c). Equity and Excellence: Liberating the NHS- Transition and the 2011/12 operating framework. DoH. London.

Department of Health. (2010d). Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I and II , Chaired by Robert Francis QC. London: The Stationery Office. Accessed on 9/9/2013 @ Volume I http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf Volume II http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol2.pdf

Department of Health. (2010e). Preceptorship framework for nursing. London: DH.

Department of Health. (2012a). Critical Care Beds Time series 1999-2011. Accessed on the 15/09/2012 @ http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ Beds/DH_077451

Department of Health. (2012b). The case for change – The Health and Social Care Act 2012. Accessed in 15/02/2013 @ http://www.dh.gov.uk/health/files/2012/06/A2.- Factsheet-Case-for-change-240412.pdf

Department of Health and Ageing. (2013). Partners In Recovery (PIR) Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative: Operational Guidelines for PIR Organisations Australian Government. Accessed on13th December 2016 @ http://www.partnersinrecovery.net.au/wp-content/uploads/2013/07/PIR-Operational- Guidelines.pdf.

Department of Health and social security. (1983.) NHS <u>Management inquiry- Griffiths'</u> <u>Report</u>. London. HSMO. Accessed in the 11/4/2012 @ http://www.sochealth.co.uk/national-health-service/griffiths-report-october-1983/

Diani, M. (1996). 'Linking mobilization frames and political opportunities in Italy'. <u>American Sociological Review</u>. 61: 1053-1069. Access on 12/12/ 2016 @ https://www.researchgate.net/publication/271685638_Linking_Mobilization_Frames_and_ Political_Opportunities_Insights_from_Regional_Populism_in_Italy

Dinesen, B., Gustafsson, J., Nohr C., Andersen, S., Sejersen, H. & Toft, E. (2007).' Telehomcare technology across ‚Sectors: Claims of jurisdiction and emerging controversies'. <u>International Journal of Integrated Care</u>. 7(21).

Dingwall R., Rafferty A. and Webster C. (1988). <u>An Introduction to the Social History of</u> <u>Nursing London</u>. London: Routledge.

Doetter ,L. & Götze, R. (2011).' Health care policy for better or for Wworse? Examining NHS reforms during times of economic crisis versus relative stability'. <u>Social Policy &</u> <u>Administration</u>. 45 (4) 488–505.

Doherty, C. (2009).' A qualitative study of health service reform on nurses' working lives: Learning from the UK National Health Service (NHS)'. <u>International of Nursing</u> <u>Studies</u>.46, 1134-1142.

Dopson, S. (2009).' Changing forms of managerialism in the NHS: hierarchies, markets and networks. in J. Gabe & M. Calnan. (Eds.) <u>New Sociology of the Health Service</u>. Oxon: Routledge, p.37-55.

Dtling, F. & Grillitsch, M. (2015).' Does Combinatorial knowledge lead to a better innovation performance of firms?'.<u>European Planning Studies</u>. 23 (9): 1741–1758.

Dunphy, D. & Stace, D. (1993).' The strategic management of corporate change'. <u>Human</u> <u>Relations.</u> 46(8): 16-1.

Dyer, C. (1995). <u>Beginning Research in Psychology: A practical guide to research methods and statistics</u>. Oxford. UK: Blackwell Publisher.

Dye, T. (2001). <u>Top down policy making</u>. New York and London: Chatham House.

Ehrenreich, B. & English, D. (1973). <u>Witches, midwifes and nurses: A history of women healers</u>. Old Westbury: The Feminist Press.

Ellis, C. Bochner, A. (2000).' Autoethnography, personal narrative, reflexivity'. In N. Denzin & Lincoln Y. (Eds.). <u>Handbook of qualitative research</u> ((2nd eds.). CA: Thousand Oaks, Sage, p.733-768.

Engwall, M. (2003).' No project is an island: Linking projects to history and context'. <u>Research Policy</u>. 32: 789–808.

Edwards, B. (2007). <u>An Independent NHS: A review of the options</u>. London: Nuffield Trust.

Esmonde, L., McDonnell, A., Ball, C., Waskett, C., Morgan, R., Rashidian, A., Bray, K., Adam, S. & Harvey, S. (2006).' Investigating the effectiveness of critical care outreach services: a systematic review'. <u>Intensive Care Medicine</u>. 32:1713-21.

Finkelman, A. & Kenner, C. (2013). <u>professional nursing competences for quality leadership</u>. (2end eds.). Jones and Bartlett Learning.

Fennel, M. & Alexander, J. (1987).' Organizational boundary spanning in institutionalised environments'. <u>Academy of Management Journal.</u> 30(3): 456–476.

Fischer, f., Miller, G. & Sidney, M. (2007). <u>Handbook of Public Policy Analysis: Theory, Politics, and Methods</u>. (eds.). USA: CRC Press. Taylor and Francis Group.

Fisher, J., Steggall, M. & Cox, C. (2006).' Developing the A&E nurse practitioner role'. <u>Emergency Nurse</u>. 13 (10):26–31.

Fox, M., Martin, P. & Green, G. (2007). Doing practitioner research. London: Sage Publications Ltd.

Foucault , M. (1980). Power/Knowledge: Selected Interviews and Other Writings. 1972-1977. New York: Pantheon Books. Random House.

Frances, B. & Humphreys, J. (1998).' The commissioning of nursing education by consortia in England: A quasi- market analysis'. Journal of Advanced Nursing. 28 (3):517-23.

Francis, R. (2013). The Mid Staffordshire- NHS Foundation TrustPublic Inquiry: Executive summary. The Stationery Office Limited. London. Accessed in 15/02/2013 @ http://cdn.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Freidson, E. (1975).' Dilemmas in the doctors/ patient relationship. In A. Cox & A. Mead (eds.). A sociology of the Medical Practice. London: Collier -Macmillan.

Funk, G., Anders, S., Breyer, M., Burghuber, O., Edelmann, G., Heindl, W., Hinterholzer, G., Kohansal, R., Schuster, R., Schwarzmaier-D'Assie, A., Valentin, A., & Hartl, S. (2010) .' Incidence and outcome of weaning from mechanical ventilation according to new categories'. European Respiratory Journal. 35: 88-94.

Future Hospital Commission. (2013). Future hospital: caring for medical patients, A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians.

Gad, C. & Jensen, C. (2010).' On the consequences of post-ANT'. Science Technology and Human Values. 35(1): 55–80.

Gale, R. (1986).' Social Movements and the State: The Environmental Movement, Countermovement, and Government Agencies'. Sociological Perspectives. 29 (2): 202-240.

Galpin, T. (1996). <u>The human side of change: A practical guide to organization redesign</u>. San Francisco: Jossey-Bass.

Gamarnikow, E. (1970). <u>Sexual division of labour. The case for nursing.</u> in A. Kuhn & A.Wolpe. <u>Feminism and materialism</u>. (eds.). London: Routledge and Kegan Paul.

Garton, S. &Copland F. (2010).' I like this interview; I get cakes and cats!: the effect of prior relationships on interview talk'. <u>Qualitative Research</u>. 10(5): 533–551.

Geege, M. (1995),' Re-engineering of Health Care: Opportunity or threat for the occupational therapist?'. <u>Canadian Journal of Occupational Therapy</u>. 62(4):197-207.

Graneheim, U. & Lundman, B. (2004).' Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness'. <u>Nurse Education Today</u>. 24: 105-112.

Greenwood, R. and Hinings, C. (1996).' Understanding radical organisational change: Bringing together the old and the new institutionalism'. <u>Academy of Management Review</u>. 21(4):1022-1054.

Gersick, C. (1994) . 'Pacing Strategic Change: The case of a new venture'. <u>The Academy of Management Journal</u>. 37 (1): 9-45.

Gerstl-Pepin, C. & Patrizio, K. (2009'). Learning from Dumbledore's Pensieve: metaphor as an aid in teaching reflexivity in qualitative research'. <u>Qualitative Research</u>. 9(3):299-308.

Gherardi, S & Nicolini, D. (2000).' To transfer is to transform: The circulation of safety knowledge'. <u>Organization</u>. 7 (2): 329-348.

Giddens, A. (1993). <u>New rules of sociological method: a positive critique of interpretative sociologies</u>. (2nd eds). Cambridge: Polity.

Gibbs, G. (2002). <u>Qualitative data analysis: Explorations with NVivo</u>. Berkshire. UK: Open University Press.

Gilson, L., & Raphaely, N. (2008).'The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007'. <u>Health Policy Plan</u>. 23(5): 294–307.

Glasby, J. (2017) .'The holy grail of health and social care integration: Cost savings may be hard to identify but the real benefits are human'. <u>British Medical Journal</u> .356. 801.

Glaser, B. (1992<u>). Basics of grounded theory analysis: Emergence versus forcing</u>. Mill Valley. CA: Sociology Press.

Glaser, B. & Strauss, A. (1967). <u>The discovery of grounded theory. Strategies for qualitative research.</u> New York: Aldine de Gruyter.

Glen, S. (2004).' Healthcare reform: Implication for the education and training of acute and critical care nurses'. <u>Postgraduate medical Journal</u>. 80, 706-710.

Goodman, B. (2016).' The missing two Cs-commodity and critique: Obscuring the political economy of the gift of nursing'. <u>Journal of Research in Nursing</u>. 21(4): 25–335.

Green, J. & Thorogood, N. (2009). <u>Qualitative methods for health research</u>.(2end eds). London: Sage Publications.

Griffith, A. (1998). Insider/outsider: Epistemological privilege and mothering work. <u>Human Studies.</u> 21, 361–376.

Group, T. & Roberts, J.(2001<u>). Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights, and Range of Practice</u>. USA: Indiana University Press.

Guba, E. &Lincoln, Y. (1989). <u>Fourth Generation Evaluation</u>. Newbury Park: Sage Publications.

Guba, E. & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln. Handbook of qualitative research (eds.). CA: Thousand Oaks, Sage, p. 105-117.

Guillebaud Committee. (1956). Report of the committee of enquiry into the cost of the National Health Service London. HMSO Accessed on 11/3/2017 @ https://www.sochealth.co.uk/1956/01/10/guillebaud-report

Habermas, J. (1984). 'The public sphere: an encyclopedia article (1964)'. New German critique. 49–55. Accessed on 25/09/2017 @https://unige.ch/sciences-societe/socio/files/2914/0533/6073/Habermas_1974.pdf

Hajer, M. (2005). Coalitions, practices, and meaning in environmental politics: From acid rain to BSE. In J. Torfing & D. Howarth. Discourse Theory in European Politics. (eds.). Basingstoke: Palgrave Macmillan, p 297–315.

Hajer, M. (2006). Doing Discourse Analysis: Coalitions, Practices, Meaning. In words matter in policy and planning : Discourse theory and methods in the social sciences. In M. Brink & T. Metze. Netherlands Geographical Studies 344. (eds.). Utrecht. KNAG/Nethur. 65–74

Ham, C. & Curry, N. (2011). Integrated care :What is it? Does it work? What does it mean for the NHS?. UK: Kings' Fund.

Ham, C. & Alderwick, H. (2014).The King's Fund perspective. In Clinical strategy: the next five years. UK: King's Fund. *

Hammersley, M. (2008) .Questioning Qualitative Inquiry. London: Sage Publication.

Halse, L. & Bjarnar, O. (2014). Social fields of knowledge flows: A regional cluster in a global context. In: R. Rutten, P. Benneworth, D. Irawati et al. The Social Dynamics of Innovation Networks. (eds). Abingdon: Routledge, p. 157–176.

Hays, D. & Singh, A. (2012). Qualitative Inquiry: in Clinical and educational settings. The Guilford Press. London.

Health and Social Care Act 2012. (2012). The stationery Office. UK. Accessed in 15/02/2013 @ http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

Heckman, J. (1998). Let's keep our eye on the sparrow: First vice presidential address american academy of orthopaedic surgeons, Academy News. The annual meeting edition of the AAOS Bulletin, accessed on 10 January 2015 @ http://www2.aaos.org/acadnews/98news/vpaddr3.htm

Hernandez, S., Kaluzny, A. & Haddock, C. (2000).Organizational innovation, change, and learning. In S. Shortell & A. Kaluzny. (eds.) Health-care management organisation design and behaviour. New York: Delmar Publishers, p. 330-355.

Higley, J. (2010). Elite theory in political sociology). In T. Kevin, J. Leicht, C. Jenkins. Handbook of Politics: State and Society in Global Perspective (eds.). London: Springer, p161-176.

Ho, S., Chan, I. & Kidwell, R. (1999).' The implementation of business process reengineering in American and Canadian hospitals'. Health Care Management Review. 24: 19-31.

Hodgson, G. (2006).' What are institutions'. Journal of Economic Issues. XL(1): 1–25.

Holloway, I. & Wheeler, S. (2010). Qualitative Research in Nursing and Health care. (3ed eds.). Chichester: WileyBlackwell.

Holt, N. & Dunn, J. (2004).' Toward a Grounded Theory of the Psychosocial Competencies and Environmental Conditions Associated with Soccer Success'. Journal of Applied Sport Psychology. 16(3):199-219.

House of parliament. (1913). National Insurance Act. Eyre and Spottiswoode, Ltd.

Accessed on 15/3/2016 @

http://www.legislation.gov.uk/ukpga/1913/37/pdfs/ukpga_19130037_en.pdf

Huberman A. and Miles M. (2002) The Qualitative Researcher Companion. London: Sage
Publications.

Hughes, E. (1958). Men and their Work. Toronto: Free Press of Glencoe.

Hung S-C. & Whittington, R. (2011). 'Agency in national innovation systems: Institutional
entrepreneurship and the professionalization of Taiwanese IT'. Research Policy. 40(4):
526–538.

Hunter, D. (1993). The Mysteries of Health Gain. in Harrison A. Health Care UK. (eds.).
London: King's Fund Publishing.

Hutchinson, S. and Wilson, H.(2001). Grounded theory: THE method. In P. Munhall.
Nursing research; A qualitative prespective.(3th Edns). Sudbury: Jones and Bartlett
Publisher.

Hutt, R. & Buchan, J. (2005). Trends in London's NHS Workforce: An updated analysis of
key data. Cavendish Square. London: Kings Fund.

Ingersoll, G., Kirsch, J., Merk, S. & Lightfoot, J. (2000).' Relationship of organisational
culture and readiness for change to employee commitment to the organisation'. Journal of
Nursing Administration.30: 11-20.

Isabella, L. (1990).' Evolving interpretations as a change unfolds: How managers construe
key organizational events'. Academy of Management Journal. 33: 7–41.

Jaffe, D., Scott C., and Tobe, G. (1994). Rekindling commitment: How to revitalize
yourself, your work, and your organization. San Francisco: Jossey-Bass.

Jessop, B. (2001).' Institutional re(turns) and the strategic-relational approach'.
Environment and Planning. 33: 1213–1235.

Jewson, N. (1976). The disappearance of the sick man from the medical sociology'. Sociology. 10 (2): 225-44.

Jones, K., Jennings, B., Moritz, P., & Moss, M. (1997).' Policy issues associated with analysing outcome of care'. Image. 29(3): 261-268.

Jones, L. (1994). The Social Context of Health and Health Work. London: Macmillan.

Judson, A. (1991). Changing behaviour in organizations: Minimizing resistance to change. Cambridge: MA. Basil. Blackwell.

Kelleher, D. and Hillier S. (1996). Researching cultural differences in health (Eds). London, Routledge.

Kelly, R. & Palumbo, D. (1992). Theories of Policy Making. in. M. Hawkeworth & M. Kogan. (eds.). Encyclopedia of Government and Politics. (Vol. 2). London: Routledge.

King's Fund Centre. (1989).' Intensive Care in the United Kingdom: report from the King's Fund Panel'. Anaesthesia. 44: 428-431.

Kingdon , J. (1984).Agendas, Alternatives and Public Policies. Boston: Little Brown.

Klandermans, B (1984).' Mobilization and participation: Social-psychological expansions of resource mobilization theory'. American Sociological Review. 49(5): 583–600.

Klein, R. (2006). The New Politics of the NHS,(5th eds.). London: Longman.

Koch, T. (2006).' Establishing rigour in qualitative research: the decision trail'. Journal of Advanced Nursing. 53(1): 91–103.

Koch, T& Harrington, A. (1998).' Reconceptualising rigour: the case for reflexivity'. Journal of Advanced Nursing. 28(4): 882-890.

Kotter, J. (1995).' Leading change: Why transformation efforts fail'. <u>Harvard Business Review</u>. 73 (2): 59–67.

Labaree, R (2002).The risk of going observationalist: negotiating the hidden dilemmas of being an insider participant observer. <u>Qualitiative Research</u>. 2(1): 97–122.

Latour, B. & Woolgar, S. (1986). <u>Laboratory life: The construction of scientific facts</u>. Chichester: Princeton University Press.

Latour, B. (1986). The Power of Associations. In J. Law. <u>Power, Action and Belief: a New Sociology of Knowledge</u>?. (eds.). London: Routledge, p264–280.

Latour, B. (1993a). An Interview with Bruno Latour. Edited by T. Hugh Crawford.

<u>Configurations</u>. 1 (2): 247–268.

Latour, B. (1993b). <u>We Have Never Been Modern</u>. Hemel Hempstead: Harvester Wheatsheaf.

Latour, B. (1999). <u>On recalling ANT</u> in: J. Law and J. Hassard (Eds) Actor Network Theory and After. pp. 15–25. Oxford: Blackwell.

Latour, B. (2005). <u>Reassembling the Social: An Introduction to Actor-Network-Theory</u>. Oxford: University Press.

Latour, B. (1996). On Actor-Network Theory: A few clarifications. <u>Soziale Welt</u>. 47, 369-381. Accessed on17/3/2014 @ https://www.jstor.org/stable/40878163

Law, J. (1987). 'Technology and Heterogeneous Engineering: The Case of portuguese expansion'. in W. Bijker, T. Hughes & T. Pinch. <u>The social construction of technological systems: New directions in the sociology and history of technology</u>. Eds). Cambridge, Ma, MIT Press, p111-134.

Law, J. (1992). 'Notes on the theory of the actor network: Ordering, strategy and heterogeneity'. <u>Systems Practice</u>. *5*, 379-393.

Law, J. (2004). <u>After method: mess in social science research</u>. Abingdon and New York: Routledge

Leary, T. & Ridley, S. (2003).' Impact of an outreach on re-admissions to a critical care unit'. <u>Anaesthesia</u>. 58 (40):328-332.

Leathard, A. (1990). <u>Health Care Provision: Past, Present and Future</u>. London: Chapman and Hall.

Leatt, P. Baker, G. Halverson, P. & Aird, C. (1997).' Downsizing, reengineering and restructuring: a long term implication for health care organisation'. <u>Frontiers of Health Services Management</u>. 13(4):3-37.

Lee, K. (2006). 'A fugue about grief'. <u>Qualitative Inquiry</u>**.** 12(6): 1154-1159.

Lee, K. (2010),' An autoethnography: Music therapy after laser eye surgery'**.** <u>Qualitative Inquiry</u>**.** 16(4): 244-248.

Lee, N. and Hassard, J. (1999).'Organization unbound: Actor network theory, research strategy and institutional flexibility'. <u>Organization</u>. 6(3) :391–404.

Levinson, B., Sutton, M. & Winstead, T. (2009).' Education Policy as a Practice of Power: Theoretical Tools, Ethnographic Methods, Democratic Options'. <u>Educational Policy</u>. 23(6):767–795.

Levy, D. & Scully, M. (2007).' The institutional entrepreneur as modern prince: The strategic face of power in contested fields'. <u>Organization Studies</u>. 28(7): 971–991.

Lewis, L. (2000).' Blindsided by that one" and "I saw that one coming": The relative anticipation and occurrence of communication problems and other problems in implementer' hindsight". <u>Journal of Applied Communication Research</u>. 28 (1):44-67.

Liamputtong, P. & Ezzy, D. (2005). Qualitative research methods. *(*2nd edn.). South Melbourne: Oxford University Press.

Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. Newbury Park CA: sage Publications.

Lincoln. Y. & Guba, E. (2000). 'Paradigmatic controversies, contradictions, and emerging confluences'. In N. Denzin & Y. Lincoln. Handbook of qualitative research (2nd eds.),. CA: Thousand Oaks, Sage, pp. 163-188

Lindseth, A. & Norberg, A. (2004),' A phenomenological hermeneutical method for researching lived experience'. Scandinavian Journal of Caring Sciences.18: 145–153.

Lipsky, M. (1980). Street-Level Bureaucrats: Dilemmas of the individual in public services. New York: Russell Sage Foundation.

Lipsky, M. (2010). Street-Level Bureaucracy. Dilemmas of the individual in public services. New York: Russell Sage Foundation

Localism Act 2011. (chapter. 20) (2011). Information and publishing solution (TSO). The Stationery Office. Accessed on 17th November 2015 @ http://www.legislation.gov.uk/ukpga/2011/20/pdfs/ukpga_20110020_en.pdf

Longley, M. Shaw, C., Dolan G. & Stackhouse R. (2007). Nursing- Towards 2015: Alternative Scenarios for Healthcare, Nursing and Nurse Education in the UK in 2015. Accessed in 21 June 2011 @ http://www.nmc-uk.org/Documents/ResearchPapers/Nursing%20towards%202015%20full%20report%20.pdf

Long, T. & Johnson, M. (2000).' Rigour, reliability and validity in qualitative research. Clinical effectiveness in nursing'. 4(1): 30-37.

Luck, L., Jackson, D. & Usher, K. (2006).' Survival of the fittest, of socially constructed phenomena? Theoretical understandings of aggression and violence towards nurses'. Contemporary Nurse. 21(2): 261–263.

Maas, L., Specht, P. & Ramler, L. (1997). 'Shared Governance Models in Nursing: What is Shared, Who Governs, and Who Benefits?'. In C. McCloskey & K. Grace. <u>Current Issues In Nursing</u>. (5th eds.). St. Lois, Mo. Mosby, p 388-396.

MacDonald, C. (2002) .'Nurse autonomy as relational'. <u>Nursing Ethics</u>. 9 (2): 194-202.

Maciejewski, P., Zhang, B., Block, S. & Prigerson, H. (2007). 'An Empirical Examination of the Stage Theory of Grief'. <u>Journal of American Medical Association</u>. 297(7):716-723.

Majchrzak, A. (1984). <u>Methods for policy research.</u> London: Sage Publications.
Mandal, S., Suh, E., Davies, M., Smith, I., Maher. T., Elliott, M., Davidson, A. & Hart, N. (2013) .'Provision of home mechanical ventilation and sleep services for England survey'. <u>Thorax</u>. 68 (9):880-881.

Marshall, H. & Bottomore, B. (1992). <u>Citizenship and Social Class</u>. London: Pluto Press.

Marsland, D. (1996). <u>Welfare or Welfare State</u>? Basingstoke: Macmillan.

Mays, N. & Pope, C. (1995).' Rigour and qualitative research'. <u>British Medical Journal</u>. 311, 109.

Mays, N. & Pope, C. (2000). 'Qualitative research in health care: Assessing quality in qualitative research'. <u>British Medical Journal,</u> 320 (7226): 50.

McKee, M. & Lessof, L. (1992). <u>Nurse and doctor: whose task is it anyway. Robinson J, Gray A and Hee RE Policy Issues in Nursing</u>. Buckingham: Open University Press.

McLean, C. & Hassard, J. (2004).' Symmetrical Absence-Symmetrical Absurdity: Critical Notes on the production of Actor Network Theory'. <u>Journal of Management Studies.</u> 41:493-519.

McMurray, R. (2010).'The struggle to professionalize: an ethnographic account of the occupational position of Advanced Nurse Practitioners'. <u>Human Relations</u>. 64 (6): 801-822.

Merriam, B. (1998). <u>Qualitative research and case study applications in education</u>. San Francisco. CA: Jossey-Bass Publishers.

Merriam, S. (1995).' Theory to practice- what can you tell from an N of 1? Issues of validity and reliability in qualitative research'. <u>Pennsylvania Association for Adult continuing Education Journal of Life Long Learning</u>. 4:51-60.

Merton, R. (1972). Insiders and outsiders; a chapter in the sociology of knowledge, <u>American Journal of Sociology.</u> 78, 9–47.

Michael. M. (2000). <u>Reconnecting Culture, Technology and Nature: From Society to Heterogeneity</u>. London: Routledge.

Mills, J., Bonner, A., & Francis, K. (2006). 'Adopting a constructivist approach to grounded theory: Implications for research design'. <u>International Journal of Nursing Practice</u>, 12(1): 8-13.

Miles, M. & Huberman, A. (1994). <u>Qualitative data analyses: An expanded sourcedbook</u>.(2nd edn). California: Thousand Oaks.

Millward, L. Bryan, K. (2005).' Clinical leadership in health care: a position statement'. <u>Leadership in Health Services</u>. 18 (2): 13 – 25.

Mitchell, J. (1984).' Is nursing any business of doctors? A simple guide to the nursing process'. <u>British Medical Journal</u>. 288, 216-219.

Mitra, R. (2010).' Doing ethnography, being an ethnographer: The autoethnographic research process and I'. <u>Journal of Research Practice</u>**.** 6(1). Article M4. Accessed on 11/7/2017 @ http://jrp.icaap.org/index.php/jrp/article/view/184/182/

Mole, K. (2002).' Street-level technocracy in UK small business support: Business Links, personal business advisers, and the Small Business Service" <u>Environment and Planning '.</u> <u>Government and Policy</u> 20(2): 179 – 194.

Monitor, NHS England. (2014) Reforming the payment system for NHS services: supporting the five year forward view. London: Monitor. Accessed on 11 January 2016@: www.gov.uk/government/publications/reformingthe-payment-system-for-nhs-services-supporting-the-five-year-forward-view.

Morgan, G. & Smirich, L. (1980).' The case for qualitative research'. Academy of Management Review. 5(4):491-500.

Morse, J. & Field P. (1996). Nursing research: The Application of Qualitative Approaches. (2nd edn). United Kingdom: Chapman& Hall.

Mullally, S. (2003).Keynote address CNO. Accessed in 12/05/2010 @ www.dh.gov.uk
Munhall, P. (2006). Nursing research; A Qualitative Perspective. (4th Edn). Sudbury. MA. Jones and Bartlett Publisher.

Munhall, P. (2001). Nursing research; A Qualitative Perspective. (3ed Edn). Sudbury. MA. Jones and Bartlett Publisher.

Murphy, E. & Dingwall, R. (2003). Qualitative Methods and Health Policy Research. New York@ Walter de Gruyter.

Murphy, R. (1990). The different world of the disabled. The body silent. London: Norton and Company Ltd.

National Audit Office. (2017). Health and social care integration. Accessed on march 2017 at https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

Nakamura. R. (1987).' Textbook policy process and implementation research'. Policy Studies Review. 7(1): 142-154.
Nancarrow, S. & Borthwick, A. (2005).' Dynamic professional boundaries in the healthcare workforce'. Sociology of Health & Illness. 27(7):897-919.

National Health Service and Community Care Act. (1990). Accessed on 12/3/2014 @ https://www.legislation.gov.uk/ukpga/1990/19/contents

National Voice. (2011). Integrated care: what do patients, service users and carers want form integration?. Accessed on 15/11/14 at http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf

Naylor, D. (2012). 'Advancing high value transitional care the central role of nursing and its leadership'. Nursing Administration Quarterly. 36(2): 115–126.

Naylor, D., Brooten, D., Campbell, R., Jacobsen, S., Mezey, D., Pauly, D., & Swartz, J. (2010).' Comprehensive discharge planning and follow-up of hospitalized elders: A randomized clinical trial'. Journal of the American Medical Association. 281(7): 613–620.

Naylor, M. & Keating. S. (2008).'Transitional Care: Moving patients from one care setting to another'. American Journal of Nursing.108(9):58-63.

Neimeyer, R. (2000). 'Searching for the meaning of meaning: Grief therapy and the process of reconstruction'. Death Studies. 24(6):541–558.

Neimeyer, R. (2001).' Reauthoring life: Grief therapy as meaning reconstruction'. Israel Journal of Psychiatry and Related Science Journal. 38(3-4):171-183.

Ngunjiri, F., Hernandez, K. & Chang, H. (2010).' Living autoethnography: Connecting life and research'. [Editorial]. Journal of Research Practice. 6(1). Article E1. Accessed on 17/8/2016 @ http://jrp.icaap.org/index.php/jrp/article/view/241/186

NHS Executive. (1998). Information for health: an Information strategy for the modern NHS 1998–2005. A national strategy for local implementation. London: Department of Health.

NHS Management Executive. (1991). NHS Management Executive. Junior doctors. The new deal. London. Accessed on 12/10/11 at http://www.dhsspsni.gov.uk/scujuniordoc-2

NHS England (2016-a) New care models: Vanguards - developing a blueprint for the future of NHS and care services. accessed on 11/1/2017 @ https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

NHS England. (2016-b). New care models. Accessed on 15/11/2016 @ www.england.nhs.uk/vanguards #futureNHS

NHS England. (2015). Commissioning for value – integrated care pathways packs. Accessed on 10/10/2016 @ https://www.england.nhs.uk/2015/03/integrated-pathways/

NLIAH. (2009). Getting Collaboration to Work: Lessons from the NHS and Partners. Cardiff. NLIAH.

NMC. (2010). Standards for pre-registration nursing education. UK: Nursing and Midwifery Council.

NMC. (2015). The Code: Professional standards of practice and behaviour for nurses and midwives. UK: Nursing and Midwifery Council.

NMC. (2017). Future nurse standards and education framework: consultation. UK: Nursing and Midwifery Council. Accessed on 17July 2017@ https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2017/council-item-7-may-2017.pdf

Norman, S. (2000).' Making sense of higher level of practice'. Nursing Standard. 14(35): 49-51.

Nurses, Midwives and Health Visitors Act. (1979). Accessed in the 11/4/2012 @ http://www.legislation.gov.uk/ukpga/1979/36/pdfs/ukpga_19790036_en.pdf

O'Leary, Z. (2014). The essential guide to doing your research project (2nd edn.). CA: Thousand Oaks. Sage Publications.

Olson, T. (1997). 'Ordered to care?: Professionalization, gender and the language of training'. In A. Rafferty, J. Robinson & R. Elkan. <u>Nursing History and the Politics of welfare</u>. London: Rutledge, p 1915-37.

Oppenheim, A. (1992). <u>Questionnaire design, interviewing and attitude measurement</u>. London: Pinter Publishers.

Oreszczyn, S. @ Carr, S. (2008),' Improving the link between policy research and practice: using a scenario Workshop as a qualitative research tool in the case of genetically modified crops'. <u>Qualitative Research</u>. 8(4): 473-498.

Ostrom, E.(2007).' A diagnostic approach forgoing beyond panaceas'. <u>Proceedings of the National Academy of Sciences</u>. 104(39): 15181– 15187.

Paley, J. (2002).' Caring as a slave morality: Nietzschean themes in nursing ethics'<u>. Journal of Advanced Nursing</u>. 40(1): 25-35.

Papadopoulos, T., Radnor and, Z., Merali, Y. (2011). 'The role of actor associations in understanding the implementation of lean thinking in health care'. <u>International Journal of Operations and Production Management</u>. 31 (2): 167-191.

Parsons, T. (1967). <u>On the Concept of Political Power: Sociological theory and modern society</u>. London: Free Press.

Pater, J. (1981). <u>The Making of the National Health Service London</u> :King's Fund Historical Series. King Edward's Hospital Fund for London.

Patton, M. (2002). <u>qualitative research and evaluation methods</u>. (3ed Edn). Lndon.UK: Sage Publications.

Paulsen, N., Callan, V., Grice, T., Rooney, D., Gallois, C., Jones, E., Bordia, P. & Jimmesion, N. (2005).' Job uncertainty and personal control during downsizing: A comparison of survivors and victims'. <u>Human Relations</u>. 58 (4):463-496.

Pittard, A. (2003).' Out of our reach? Assisting the impact of a critical care outreach service'. Anaesthesia. 58 (9)882-885.

Polit, D. & Beck, C. (2012). Nursing research: Generating and assessing evidence for nursing practice. Philadelphia, PA: Lippincott Williams and Wilkins.

Polit, D. & Beck, C. (2014). Essentials of nursing research: Appraising evidence for nursing practice (8th edn.). Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Ponterotto, J. (2005).' Qualitative Research in counselling psychology: A primer on research paradigms and philosophy of Science'. Journal of Counselling Psychology. 52 (2): 126–136.

Pope, C. & Mays, N. (1995).' Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research'. British Medical Journal.311: 42-45.

Porter, S. (2000). qualitative research. in D. Cormack. The research process in Nursing. (4th edn). United Kingdom: Blackwell Science.

Porter, R. (1996). The Cambridge Illustrated History of Medicine.(edi). UK: Cambridge Press.

Price, D., Pollock, A., & Shaoul, J. (1999).' How the World Trade Organization is shaping domestic policies in health care, Lancet', 354(9193): 1889–92.

Pyne, H. (1998). Professional Discipline in nursing, midwifery and health visiting. (3edn). Oxford: Blackwell Science.

Quinn I. (21 May 2010) Lansley orders halt to all Darzi plans nationwide. Pulse, Accessed on 11/2/2016@ http://www.pulsetoday.co.uk/lansley-orders-halt-to-all-darzi-plans-nationwide/11032700.article

Rafferty, A. & Griffin, M. (2006). 'Perceptions of organizational change: A stress and coping perspective'. <u>Journal of Applied Psychology</u>. 91(5):1154–1162.

Rafiqui, P. (2009).' Evolving economic landscapes: Why new institutional economics matters for economic geography'. <u>Journal of Economic Geography</u>. 9(3): 329–353.

Ramsey, E. & Miller J. (2003). <u>Experiences between philosophy and communication: engaging the philosophical contribution of Calvin O Schrage</u>. USA: State University of New York Press.

RCN. (2014). <u>The nursing role in integrated care models: Reflecting on the United States' experience</u>. UK. Royal College of Nursing. Accessed on 26/2/2015@ https://www.rcn.org.uk/about-us/policy-briefings/pol-0214

Redwood, S., Lloyd, H., Carr, E., Hancock, H., McSherry, R., Campbell, S. & Graham, I. (2007).' Evaluating nurse consultants' work through key informant perceptions'. <u>Nursing Standard</u>. 21(17): 35-40.
Reed-Danahay, D. (1997). Auto/ethnography : rewriting the self and the social. edn. Oxford: Berg Publishers.

Rhodes, W. (1997).' From marketisation to diplomacy: It's the mix that matters'. <u>Public Policy and Administration</u>. 12:.31-49.

Richards, A., Carley, J., Jenkins-Clarke, S.& Richards, D. (2000).' Skill mix between nurses and doctors working in primary-care delegation or allocation: a review of the literature'. <u>International Journal of Nursing Studies</u>. 37 (3):185–97.

Richardson, G. (1999).' Identifying, evaluating and implementing cost-effective skill mix'. <u>Journal of Nursing Management</u>. 7, 265–70.

Ritter, J. & Tonges, M. (1991). 'Work redesign in a high intensity environments. Pro act for critical care'. <u>Journal of nursing Administration</u>. 21(12):26-35.

Ritter-Telitel, J. (2002).' The impact of restructuring on professional nursing practice'. <u>The Journal of Nursing Administration</u>. 32(1):31-41.

Rivett, G. (1998). <u>From cradle to Grave: fifty years on the NHS</u>. London. King's Fund.

Rivett, C. (2007). <u>National Health Service History. Nursing</u> : Accessed on 11th February 2011 at http://www.nhshistory.net/cvrivett.htm.

Rogers, E. (2010.) <u>Diffusion of Innovations</u>. (3rd edn.). London: Collier Macmillan Publishers.

Robinson, M. and Cottrell, D.(2005). 'Health professionals in multidisciplinary and multi-agency teams: Changing professional practice'. <u>Journal of Interprofessional Care</u>. 19 (6): 547-560.

Ronai, C. (1992).' The reflexive self through narrative: A night in the life of an erotic dancer/researcher'. In C. Ellis & Michael G. Flaherty (eds.). <u>Investigating subjectivity: Research on lived experience.</u> Newbury Park, CA. Sage Publications, p.102-124.

Royal College of Nursing. (RCN.) (2004). <u>What a difference a nurse can makes: An RCN report on the benefits of expert nursing to the clinical outcomes in the continuing care of older people</u>. London. The Royal College of Nursing.

Royal College of Nursing. (RCN.) (2005). <u>NHS Knowledge and Skills Framework outlines for nursing posts: RCN guidance for nurses and managers in creating KSF outlines in the NHS</u>. London.

Rushmer, R. and Dowling, M. (2000).' Changing NHS structure: Implication for nursing careers'. <u>British Journal of Nursing</u>. 9(22):2297-2302.

Rubenstein, L., Lammers, J., Yano, E., Tabbarah, M. & Robbins, A. (1996).' Evaluation of the VA's pilot program in institutional reorganization toward primary and ambulatory care: Part II, a study of organizational stresses and dynamics". <u>Academic Medicine</u>. 71(7): 784-792.

Rubin, A. & Babbie, E. (1997). <u>Research methods for social work</u> (3rd ed.). Pacific Grove, CA. Brooks/Cole.

Rutland, T and Aylett, A. (2008). The work of policy: Actor networks, governmentality, and local action on climate change in Portland, Oregon. Environment and Planning D: Society and Space. 26 (4): 627–646.

Ryan, F., Coughlan, M. & Cronin, P. (2007).' Step-by –step guide to critiquing research part 2: qualitative research'. <u>British Journal of Nursing</u>. 16(12): 738-744.

Ryan-Nicholls, K. (2004).' Impact of health reform on registered psychiatric nursing practice'. <u>Journal of Psychiatric and Mental Health Nursing</u>. 11: 644–653.

Sabatier, P(1999). <u>Theories of the policy process</u>. Boulder Colo. Westview Press

Sandelowski, M (1993).' rigor or rigor mortis: the problem of rigor in qualitative research revisited'. <u>Advances in Nursing Science</u>.16(2): 1-8.

Sarosa, S. (2012).' Adoption of social media networks by Indonesian SME: A case study'. <u>Procedia Economics and Finance</u> .4:244 – 254. Accessed on 5/12/2015@ file:///C:/Users/A.%20Altabaibeh/Desktop/kingston%2011-7-17/for%20reference/Sarosa,%20S.%20(2012).'%20Adoption%20of%20social%20media%20networks%20by%20indonesian%20SME-%20A%20case%20study'.%20Procedia%20Economics%20and%20Finance%20.4-244%20–%20254..pdf

Savage, J. (1987). <u>Nurses and gender</u>. Milton Keynes: Open University Press.

Schmidt, V. (1995). 'The new world order, incorporated: The rise of business and the decline of the nation-state'. <u>Daedalus</u>. 124:75-106. Accessed on 23/3/2011@ https://ir.lib.uwo.ca/cgi/viewcontent.cgi?referer=https://www.google.co.uk/&httpsredir=1&article=1062&context=economicsperg_ppe

Schreiber, R. & Stern, P. (2001). <u>Using Grounded Theory in Nursing</u>. (eds). NewYork: Springer.

Schwandt, T. (2000). 'Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism'. In N. Denzin & Y. Lincoln. <u>Handbook of qualitative research</u>. (2nd edn.). Thousand Oaks. CA. Sage , pp. 189–213.

Schweiger, D., Ivancevich, J. & Power, F. (1987).' Executive Actions for Managing Human Resources before and after Acquisition'. <u>The Academy of Management Executive.</u> 1(2): 127-138.

Scott, C. & West, E. (2001).' Nursing in the public sphere: health policy research in a changing world'. <u>Journal of Advanced Nursing</u>. 33(3): 387-395.

Serres, M. (1982). <u>Hermes: Literature, science, philosophy</u>. J. Harari and DBell (eds.). Baltimore. Johns Hopkins.

Shim, Y. Shin, D. (2015).'Analyzing the development of 4th generation mobile network in China: actor network theory perspective' <u>. Info</u>.17 (1): 22 - 38. Accessed on 22/ 12/ 2016 @ http://dx.doi.org/10.1108/info-09-2014-0041

Shindul-Rothschild, J., Brry, D.& Long-Middlrton, E. (1996).' Where all nurses have gone? The result of our patient survey'. <u>American Journal of Nurses</u>. 96(11): 25-40.

Sibbald, B., Petchey, R., Gosden, T., Leese, B. & Williams, J. (2002). Salaried GPs in PMS pilots: Impact on GP recruitment, retention, workload, quality of care and costs' in national evaluation of first wave NHS personal medical services pilots: summaries of findings from four research projects. ed. The PMS National Evaluation Team. Manchester: National Centre for Primary Care Research and Development.

Sibbald, B., Shen, J. & McBride, A(2004).' Changing the skill-mix of the health care workforce'. <u>Journal of Health Service Research and Policy</u>. 9(1):28-38.

Simmons, O. (2010) .'Is That a Real Theory or Did You Just Make It Up? Teaching Classic Grounded Theory'. <u>The Grounded Theory Review</u>. 9 (2): 15-38.

Sinkovics, R., Penz, E & Ghauri, P. (2008).' Enhancing the Trustworthiness of Qualitative Research in International Business'. <u>Management International Review</u>. 6:689-714.

Slappendel, C. (1996).' Perspectives on Innovation in Organizations'. <u>Organization Studies</u>.17 (1): 107-129.

Smith, M. (1993). <u>Pressure, power and policy</u>. Hemel Hempstead. Harvester Wheat sheaf.

Smith, M. (1998).' Prime ministers, ministers and civil servants'. in <u>The core executive</u>. ESRC. <u>Whitehall programme: End of programme conference paper.</u> 17-19 December.

Smith, M. (1999) <u>The core executive in Britain. Basingstoke</u>. Macmillan.

Smith, S., Roberts, P. & Balmer, S. (2000).' Role overlap and Professional boundaries: Future implications for Physiotherapy and Occupational Therapy in the NHS'. <u>Physiotherapy</u>. 86 (8): 397-400.

Smyth, A. and Holian, R. (2008). Credibility issues in research from within Organisations. In P. Sikes and A. Potts (Eds.). <u>Researching education from the inside</u> (pp. 33–47). New York. NY: Taylor & Francis.

Sochalski, J. &Weiner, J.(2011). <u>Health care system reform and the nursing workforce: matching nursing practice and skills to future needs, not past demands</u>. in Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine (2011) The future of nursing: Leading change, advancing health. Institute of Medicine of the National Academies. The National Academies Press. Washington, D.C. Accessed on 12 June 2014 @ https://www.ic4n.org/wp-content/uploads/2012/01/Future-of-Nursing-Leading-Change-Advancing-Health.pdf

Sole, M., Klein, D., Moseley, M. (2009). <u>Introduction to critical care nursing.</u> (5th edn.). Philadelphia: Saunders/Elsevier

Sotarauta, M. (2016).' Combinatorial knowledge dynamics through the eyes of institutional entrepreneurs and institutional navigators'. Environment and Planning C. Government and Policy. 0(0):1-16.

Sovacool B. & Hess D. (2017) Ordering theories: Typologies and conceptual frameworks for sociotechnical change. Social Studies of Science. 1–48.

SPICe. (2012). SPICe briefing integration of health and social care: International comparisons. The Scottish Parliament. The Scottish Parliament. The Information Centre. Accessed on May 2014 @ www.scottish.parliament.uk

Stacey, R. (1992). Managing the unknowable: strategic boundaries between order and chaos in organizations. San Francisco. California: Jossey-Bass.

Staeheli, L. & Lawson, V. (1995).' Feminism, praxis and human geography'. Geographical Analysis 27: 321–8.

Stake, R. (1995). The Art of Case Study Research. London:Sage Publication. Thousand Oaks.

Stake, R. (2000) . Case Studies. In Denzin N. and Lincoln Y. Handbook of qualitative research. (2nd edn). London: Sage Publication. Thousand Oak.

Stake, R. (2006) Multiple case study analysis. New York: Guilford Press.

Starks, H. & Trinidad, S. (2007).' Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory'. Qualitative Health Research. 17 (10): 1372-1380.

Stein, L. (1967).' The doctor–nurse game'. Archives of General Psychiatry. 16(6): 699–703.

Stewart, I. (1991). 'Inquiry, insights, and history: The spirit of nursing'. The Journal of Professional Nursing .7(3)149.

Stieglitz. S., George, S., Priegnitz, C., Hagmeyer, L. & Randerath, W. (2013).' Frequency and management of respiratory incidents in invasive home ventilation'. Chronic Respiratory Disease. 10(3) :135–140.

St John, W. & Johnson, P. (2000).' The pros and cons of data analysis software for qualitative research'. Journal of Nursing Scholarship. 32(4): 393-397.

Strauss, A. & Corbin, J. (1998). Basics of qualitative research: Grounded theory procedures and techniques. (2end edn). London: Sage.

Strauss, A.(1987) Qualitative research for social scientist. Cambridge. UK: Cambridge University Press.

Stressing, S.& Borthwick, A. (2014).' The impact of workforce redesign policies on role boundaries in "generalist" podiatry practice: expert views within the professional body'. Journal of Foot and Ankle Research. 7(1), 52. Accessed on 03/04/2015 @ http://doi.org/10.1186/s13047-014-0052-7

Suddaby, R., & Greenwood, R. (2005).' Rhetorical strategies of legitimacy'. Administrative Science Quarterly. 50(1): 35–67.

Sutherland, K., & Leatherman, S. (2006). Regulation and quality improvement: A review of the evidence. London. The Health Foundation.

Tatnall ,A. & Lepa, J. (2003). 'The Internet, E-Commerce, and older people: An Actor Network approach to researching reasons for adoption and ase'. Logistics Information Management. 16 (1): 56-63.

Tatnall, A. & Burgess, S. (2004). Using Actor-Network Theory to iIdentify factors affecting the adoption of E-commerce in SMEs', in M. Singh. (ed.) E-Business innovation and change Management, IDEA Group Publishing, Hershey, p. 152-169.

Tedlock, B. (2000).' Ethnography and ethnographic representation'. In N. Denzin & Y. Lincoln. Handbook of qualitative research (2nd edn.). Thousand Oaks. CA. Sage , p. 455-486).

Terry, D., Carey, C. & Callan, V. (2001).' Employee adjustment to an organisational merger: An intergroup perspective'. Personality and Social Psychology Bulletin. 27: 267-280.

Terry, D. & Jimmieson, N. (2003) .'A stress and coping approach to organizational change: Evidence from three field studies'. Australian Psychologist. (38): 92-101.

Thatcher, M. (1998).' The development of policy network analyses'. Journal of Theoretical Politics. 10 (4): 389–416.

The Intensive Care National Audit and Research Centre. (2007). Evaluation of outreach service in critical care. Accessed in 7th July 2011@ http://www.sdo.nihr.ac.uk/files/project/74-final-report.pdf

The International Association for Human Caring. (IAHC.) (2013). Caring: The essence of nursing. Accessed on 11/04/2012 at http://www.humancaring.org/aboutus/

The labour party manifesto. (2017). A manifesto for a better, fairer Britain: For the Many not for the few. Labour Party.UK. Accessed on 5th June 2017at ttp://www.labour.org.uk/index.php/manifesto2017

The Royal College of Surgeon in England. (1999). Assistants in surgical practice. A discussion document. London. RCS.

Thompson, M. (1989).' Hypothesis: old people would benefit from a patient-held standardized primary health care record'. Age and Ageing. 18:64-6.

Tracy, S. (2010).' Qualitative quality: Eight "big-tent" criteria for excellent qualitative research'. Qualitative inquiry. 16 (10): 837-851.

Tsoukas, H. (2000).' False dilemmas in organization theory: Realism or social. constructivism?'. <u>Organization</u>. 7 (3): 531-535.

Tushman, M., & Romanelli, E. (1985).' Organisational evolution: A metamorphosis model of convergence and reorientation. In L. Cummings & B. Staw. (Eds.). <u>Research in Organizational Behavior</u>. (7): 171-222. Greenwich**:** JAI Press.

United Central Council for Nursing, Midwifery and Health Visiting. (UKCC.) (1999). <u>Fitness for practice: The UKCC Commissioning for Nursing and Midwifery Education.</u> London. UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health visiting. (1999a). <u>A higher level of practice: Draft Description and Standard</u>. UKCC. London.

United Kingdom Central Council for Nursing, Midwifery and Health visiting. (1992). <u>The scope of professional practice</u>. UKCC. London.

United Kingdom Central Council for Nursing, Midwifery and Health visiting. (1994). <u>The future of professional practice- the council standards for education and practice following registration</u>. UKCC. London.

Unite's community. (undated). <u>Factsheet down banding</u> . Unite the Union. London. UK. Accessed on 12/8/2016@ http://www.unitetheunion.org/uploaded/documents/Unite%20in%20health%20-%20down%20banding%20factsheet11-22355.pdf

Van de Ven, A. (1992).' Suggestions for study strategy process'. <u>Strategic Management Journal</u>. 13:169-91.

Van de Ven, A. & Poole, M. (1995).' Explaining development and change in organizations'. <u>Academy of Management Review</u>. 20 (3): 510-540.

Van Maanen, J. (1988). Tales of the field: On writing ethnography. Chicago: University of Chicago Press.

Vickers, D. & Fox, S. (2005). Powers in a factory. In B. Czarniawska & T. Hernes (eds.). Actor network theory and organizing. Copenhagen. Malmo. Liber, p. 129–144).

Vishnevsky, T. & Beanlands, H. (2004).' Qualitative research'. Nephrology Nursing, 31: 234–238.

Wade, G. (1999).' Professional nurse autonomy: Concept analysis and application to nursing education'. Journal of Advanced Nursing. 30(2): 310-318.

Waddell, D., Cummings, T. & Worley, C. (2000). Organisation development and change. South Melbourne. Nelson Thomas Learning.

Wainwright, P. (1996). Professionalism and the concept of role extension. In G. hunt & P. Wainwright. Expanding the role of the Nurse (eds.). London: Blackwell Science.

Walters, A. (1994). 'The comforting role in critical care nursing practice: A phenomenological interpretation'. International Journal of Nursing Studies. 31(6):607-616.

Walt, G. & Gilson, L. (1994).' Reforming the health sector in developing countries: the central role of policy analysis'. Health Policy and Planning. 9(4): 353–70.

Walt, G., Shiffman, J., Schneider, H., Murray, S., Brugha, R. & Gilson, L. (2008). 'Doing' health policy analysis: methodological and conceptual reflections and challenges'. Health Policy Plan. 23 (5): 308-317.

Weir, M., & Skocpol, T. (1985).' State Structures and the Possibilities for "Keynesian" Responses to the Great Depression in Sweden, Britain, and the United States'. In P. Evans, D. Rueschemeyer, & T. Skocpol. (eds.). Bringing the State Back In. Cambridge. Cambridge University, p. 107-164.

Wells, J. & Cunningham, J. (2017).' Political and policy influences on nursing health care'. in P. Luanaigh (eds.). Nurses and Nursing : The person and the profession. UK: Taylor and Francis Routledge, p. 185-199.

Wenger, E. (2000).' Communities of practice and social learning systems'. <u>Organization.</u> 7(2): 225–246.

Wengraf, T. (2001). <u>qualitative research interviewing</u>. London: Sage Publication.

Wicks, D. (1998), <u>Nurses and doctors at work: Rethinking professional boundaries</u>. Buchingham: Open University Press.

Williamson, G., Jenkinson, T. & Proctor-Childs, T. (2008). Nursing in contemporary health care practice: Transforming nursing practice..Exter. UK: Learning Matters

Winters, B., Pham, C., Hunt, A., Guallar, E., Berenholtz, S. & Pronovost, J. (2007).' Rapid response systems: a systematic review'. <u>Critical Care Medicine</u>. 35: 1238–43.

White, R. (1985). <u>The effect of the NHS on the nursing profession1948-1961</u>. King's Fund. London: Oxford University Press.

Wolcott, H. (2004). The ethnographic autobiography. Auto/Biography, 12, 93-106

Wong, F. (1998).' Health care reform and transformation of nursing in Hong Kong<u>'. Journal of Advanced Nursing</u>. 28(3): 473-482.

Wunsch, H., Linde-Zwirble, W., Harrison, D., Barnato, A., Rowan, K. & Angus, D. (2009).' Use of intensive care services during terminal hospitalizations in England and the United States'. <u>American Journal of Respiratory Critical Care Medicine</u>. 180: 875–80.

Yin, R. (1984)/ <u>Case study research: Design and methods</u>. (2end eds.). London: Sage Publications.

Yin, R. (2003.) <u>case Study research design and methods</u>, (3rd edn). London. Sage Publications Ltd.

Zhou, J. & George, J. (2001).' When Job dissatisfaction leads to creativity: Encouraging the Expression of Voice'. <u>Academic Management</u>. 44 (4): 682-696.

ppendix A

Trust's Research and Ethical Committee and The insurance letter from the Middlesex University and the trust ethical approval

Whittington Health **NHS**

Research Management and
Governance Department
Undergraduate Centre
Whittington Health
Magdala Avenue
London
N19 5NF

Tel: 020 7288 3405

FINAL R&D APPROVAL

19th April 2012

Mr Abdelhakim Altabaibeh
Critical Care Unit
Whittington Health
Magdala Avenue
London
N19 5NF

Dear Mr Altabaibeh,

R&D Ref: 2012/19   (Please quote in all correspondence)
Title: United Kingdom Care Reform – Implication for critical care
                  nursing in an integrated health

Thank you for registering the above study with the Whittington Health. I am pleased to inform you that your study now has local R&D approval to proceed and recruit participants at the Whittington Health.

As Principal Investigator you are required to ensure that your study is conducted in accordance with the Department of Health's Research Governance Framework for Health and Social Care (2nd edition 2005) and that all members of the research team are aware of their responsibilities under the Framework.

Please find attached the conditions of the R&D approval and a reminder of your responsibilities as a researcher and ensure that both yourself and the research team are familiar with and understand the roles and responsibilities both as a team and individually.

Please do not hesitate to contact a member of the team with regards to assistance and guidance for your research.

Yours sincerely

Anna Jones
Research Network Coordinator
Research and Development Department
Whittington Health

Cc: L.Ghali@mdx.ac.uk
       M.Volante@mdx.ac.uk

UCL MEDICAL SCHOOL   UCLPartners

.... caring for you W

Established as The Whittington Hospital NHS Trust

Chairman : Mr Joe Liddane   Chief Executive: Dr Yi Mien Koh

Date: 19th March 2012

Our ref:AA/190312/

TO WHOM IT MAY CONCERN

Re: *(Abdelhakim Altabaibeh), Student Number: 2138543*

This is to confirm that Middlesex University has declared itself as a sponsoring organisation for research projects that involve NHS patients, staff and other resources as described in the *Research Governance Framework for Health and Social Care* (DoH 2000). Middlesex University confirms that it accepts the responsibility of Sponsor Organisation, and has structures in place, to ensure that:

- The research proposal respects the dignity, rights, safety and well being of participants and the relationship with care professionals.
- The research proposal is worthwhile, of high scientific quality and represents good value for money.
- The research proposal has been approved by an appropriate research ethics committee.
- *Appropriate arrangements are in place for registration of trials.
- The principal investigator, and other key researchers, have the necessary expertise and experience and have access to the resources needed to conduct the proposed research successfully.
- The arrangements and resources proposed will allow the collection of high quality, accurate data and the systems and resources proposed are those required to allow appropriate data analysis and data protection.
- Intellectual property rights and their management are appropriately addressed in research contracts or terms of grant awards.
- Arrangements proposed for the work are consistent with the Dept of Health research governance framework.
- Organisations and individuals involved in the research all agree the division of responsibilities between them.
- There is a clear written agreement identifying the organisation responsible for the ongoing management and monitoring of the study, whether this is the organisation employing the researchers, the sponsor, or another organisation.
- *Arrangements are in place for the sponsor and other stakeholder organisations to be alerted if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
- An agreement has been reached about the provision of compensation in the event of non-negligent harm and any organisation, including the sponsor itself, offering such compensation has made the necessary financial arrangements.

- Arrangements are proposed for disseminating the findings.
- All scientific judgements made by the sponsor in relation to responsibilities set out here are based on independent and expert advice.
- Assistance is provided to any enquiry, audit or investigation related to the funded work.

Working towards establishing the structures to achieve these indicators.

I therefore confirm that Middlesex University will be the sponsor for the research being undertaken by **Abdelhakim Altabaibeh**, project title, **Critical Care Nursing in an Integrated Health Care** as part of his **PhD in Nursing.**

Signed on behalf of Middlesex University

K. Rawlings

Kirsty Rawlings
HSSc School Administrator
Middlesex University
School of Health and Social Sciences

Date: 19 March 2012

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: ....

Print Name: Dr Lucy Ghali

Post: Chair of the School of Health and Social Sciences Ethical Committee

Organisation: middlesex University

Date: 19/03/2012   *(dd/mm/yyyy)*

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature:

Print Name: Dr Lucy Ghali

Post: Chair of the School of Health and Social Sciences   Ethical Committee

Organisation: middlesex University

Date: 19/03/2012   (dd/mm/yyyy)

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature:	*Kay Caldwell*
Print Name:	Dr Kay Caldwell
Post:	Head of the Istitute of Nursing and Midwifery
Organisation:	Middlesex University
Date:	19/03/2012 *(dd/mm/yyyy)*

Academic supervisor 2

Signature:	
Print Name:	Dr Margaret Volante
Post:	Senior Lecturer
Organisation:	Middlesex University
Date:	19/03/2012 *(dd/mm/yyyy)*

28