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Organisational Development to support integrated care in East London: the perspective of clinicians and social workers on the ground

Sonia Bussu and Martin Marshall

Introduction

Health systems across advanced economies all over the world face increasing challenges, as they try to improve population health and enhance patient care experience, while ensuring cost-effectiveness, and all this often in a context of financial austerity. That greater integration and coordination across acute, community and social care has the potential to produce better value than fragmented care systems would seem common sense; however, to date the evidence that integrated care (IC) interventions work is mixed (Fulop, et al., 2005). The perceived benefits are usually hypothesised or advocated by policymakers rather than confirmed by rigorous empirical evaluations (Goodwin and Smith, 2011; Roland et al., 2012; Nolte and Pitchforth, 2014). While there is some evidence of improvement in clinical outcomes (Mason et al., 2015), improved patient experience is more difficult to achieve (RAND Europe and Ernst & Young LLP, 2012; Powell et al., 2009).

Our own work (Bussu and Marshall, 2018; Lalani et al. 2019) and that of others in the IC field (Fulop et al 2005; 2011) have demonstrated the importance of the gap between policy and practice as a major explanation for the failure of IC initiatives. This is often the result of poorly aligned policies (e.g. piecemeal payments); limited attention to unintended consequences of policies (e.g. competition; targets); a pace of change that is too fast and does not always take account of capacity on the ground; the persistent inability to integrate across all sectors (e.g. education, housing); and failure to invest in building capacity and capability (e.g. new roles, training, curricular change). Within a fragmented system such as England's health service, where the split between commissioners and providers has led to organisations competing over contracts, organisational, cultural and professional divides continue to widen. In fact, health and social care systems are often organised with a seeming disregard for an overall alignment of activities. The rhetoric on coordination and integrated systems appears to be at odds with the reality on the ground.

Organisational development (OD) is often advocated as a solution to the challenge of driving organisational change within complex systems; it claims to help adapt existing knowledge and processes and foster continuous learning. OD is based on behavioural science knowledge and practice (e.g. leadership, group dynamics, and work design), where the aim is to help members of an organisation gain relevant skills to address the challenges entailed by a change process through involving them directly and transferring knowledge across the system (Beer 1980; Burke 2017). While this understanding of OD entails a series of initiatives to drive organisation change, some have argued that the overarching aim of OD is rather to foster a continually reflexive and learning organisation (Peck 2005), or an adaptive organisation (Bushe 2017). In the 1990s and 2000s, a new generation of scholars started to look back at the work of Kurt Lewin on action research (Burnes, 2004; Burnes and Cooke, 2012). The idea of dialogue

became central to the change process, leading to the development of dialogic OD (Dixon, 1998; Oswick, 2009). Both diagnostic and dialogic OD are informed by the same tenets of humanistic and democratic values, a concern for capacity building, and an awareness of organisational members (Bushe and Marshak 2009). Whereas in diagnostic OD there is an attempt to identify a "truth", dialogic OD assumes that there will be multiple, competing "truths" (Bushe and Marshak 2014: 27). Classical diagnostic OD is interpretative in nature and understands change as episodic, resulting from a planned and managed process of unfreezing, movement and refreezing (Bushe and Marshak 2014); dialogic OD draws on the idea that reality is socially constructed and negotiated, whereby organisations are understood as meaning-making systems (Bushe 2006; Bushe and Marshak, 2009; Burnes and Cooke 2012; Marshak 2009; Weick, 1995; Weick et al 2005). Weick's concept of sensemaking is helpful to explain how collective storytelling informs interpretation of a problem and decisions about how to address it based on previous experiences; and these interpretations will generate subsequent behaviours (Warwick-Giles and Checkland, 2018).

The appeal of OD to managers implementing IC programmes often lies in its promise to strengthen learning through experimenting, balance power differences, and manage cultural differences across professions. Is this promise being realised? This paper contributes to the literature on OD interventions in health and social care and our findings challenge assumptions that, in their current form, they are making a genuine difference. As noted by several commentators, not enough attention is paid to the evaluation stage of any OD programmes, and rigorous evidence of their effectiveness, or lack thereof, is weak (Church, 2003; Cummings and Worley, 2015; Burke, 2017).

The findings presented here are part of a larger qualitative and participatory evaluation in three East London municipalities looking at how health and social care professionals coordinate delivery of care across acute, community and social care. This paper examines activities, often labelled by proponents as 'OD', aimed at strengthening partnership working; it looks at the impact of these activities on the ground, based on the experience of clinicians and other professionals working at the point of delivery. The purpose is to evidence whether and to which degree the current approach to OD is enabling staff to change their working practices towards greater coordination. The next section briefly reviews the literature on OD within health settings; we then describe our methodological approach and present and discuss our findings.

OD in health and social care

The literature tells us that change within complex and highly regulated public sector organisations should be understood as an emergent learning process and often happens in a developmental and continuous fashion (Kanter 1983; Todnem 2005). Any change will take a long time to embed, suggesting a strategy of incremental change within a consistent and widely shared broader transformation vision (Carlstrom and Ekman 2012).

Pollitt (1993) and Dawson (1999) argue that health systems are characterised by three defining features: the range and diversity of stakeholders; the complex ownership and resourcing arrangements; and the professional autonomy of staff. Relationships of cause and effect may not be easily apparent, but an intervention in any part of a health or social care system is likely to have outcomes in many others, often

unintended and not always desirable (see Smith 1995). There is a high degree of interdependence between practitioners, and between practitioners and processes. Therefore, successful implementation will not only depend on the approach to change, but on sensitivity to different points of view (Iles and Sunderland 2001). Any new change programme or initiative will need to be clear about the benefits for staff on the ground, in order for them to commit to its implementation. Organisational theorists have emphasised the importance of being aware of the culture in an organisation in order for a change process to be successful (Peters and Waterman, 1982; Wilkins and Ouchi, 1983; Denison, 1996; Hemmelgarn et al., 2006). Carlstrom and Ekman (2012: 185) find that when managers are aware of organisational culture they can use the correct instruments to plan change processes.

In their literature review, Busetto et al. (2016) summarised the workforce changes taking place during the implementation of IC care models. These included new leadership and management roles, new professional roles and working environments (i.e. inter-disciplinary team meetings or multi-disciplinary pathways). IC very often challenges the way frontline staff have been taught to deliver care, as roles and responsibilities are redefined, new tools and processes implemented, and cross-professional and cross-sectoral collaboration formalised, which can often lead to resistance, resignation or disregard. Existing literature also suggests that both trust-based (relationship dynamics) and control-based (organisational dynamics) governance mechanisms play a crucial role in partnership development (Valentijn et al., 2015). There is widespread agreement among scholars and practitioners that a bottom-up approach is required, whereby the purpose and benefits of the change should not only be understood and embraced by staff on the ground but also co-produced with them, through incremental changes and by fostering distributed leadership (Willis et al., 2016; Erlingsdottir et al., 2018). OD programmes approach organisations as both living and meaning-making systems, as they promise to develop both organisational cultures and individual behaviours (Ramos and Rees 2008; Burnes and Cooke 2012). They are most suited to address adaptive challenges or complex issues, which do not entail a single right answer and which will never be completely "solved" (Bushe 2017). Attempts to integrate care represent a good example of adaptive challenge, as they require the engagement of those with a stake in the change and can only be managed through inquiry, experimentation and learning (Bushe 2017).

Thus, OD would aim both to support health and social care staff as they learn to work in an inter-disciplinary environment, and to foster a style of management that can embrace failure as a way to encourage a continuous learning cycle, with staff at all levels expected to share responsibilities. Yet, even under the label of OD, change continues to happen through more traditional and hierarchical channels, by having leaders decide on specific change initiatives and then delegating the management of the process to middle managers or external consultants (Bushe 2017). The following sections describe our findings and highlight how the OD principles underpinning IC programmes, such as an emphasis on bottom-up input, partnership working, continuous learning, and distributed leadership, failed to translate into effective OD activities to support staff. The principle of learning from failure is hard to embrace in a context of competing organisations and an internal market fuelling a blame game among staff; the understanding of good leadership as having a "vision" and managing top-down implementation of this vision is also difficult to challenge in real life (Bushe and Marshak, 2009).

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Description of the cases

The emphasis on working in partnership and collaboratively within the NHS (National Health Service) is not a new phenomenon (Warwick-Giles and Checkland 2018). The Conservative-Liberal Democrat coalition (2010-2015) renewed the emphasis on integration and partnerships as a way of providing better person-centred care at a time when punitive austerity measures were being implemented, which affected social care, following deep cuts to local government (National Collaboration for Integrated Care and Support, 2013). Through the Better Care Fund (BCF) (National Audit Office, 2014) the government pledged that £3.8 billion would be released by 2015/2016 to support IC; however, this was not new money, but local commissioners and local authorities were tasked with identifying areas where their existing budgets on health and social care respectively could be pooled together. The emphasis was mainly on reducing non-elective admissions and delayed transfers of care (Warwick-Giles and Checkland, 2018). In 2013, the "Integration Pioneers scheme" was announced, and the areas designated as pioneers by the new body leading the NHS in England (NHS England) were expected to develop innovative ways to address local and national barriers to IC delivery. Initiatives introduced under this programme included: multidisciplinary team working; raising awareness of local community support organisations; and the employment of "care navigators" to help complex patients with co-morbidities navigate the health system and access the help they need. Reports so far have provided limited evidence of any changes to service delivery, as the focus, which reflected national policy direction, was on quick wins rather broader strategic change (Erens et al., 2016).

Our study compares three municipalities in East London, which together achieved 'pioneer' status for IC in 2013. The three municipalities brought together healthcare commissioners and providers and the local authorities, covering the area served by one of the largest hospital groups in the UK, with a population of almost a million people. Their IC programme aimed to reduce non-elective admissions, by developing risk-stratification tools to identify high-risk patients and introducing multiprofessional intermediate care services that could treat patients in their home. Successive programmes in each municipality supported service reconfiguration based on a multiagency approach and colocation of health and social care professionals. There was investment in programmes to support organisation change across all three boroughs, whose rhetoric was inspired by the principles of OD, highlighted above. The focus of this paper is specifically on staff's perceptions of the impact of the OD activities, which interpreted (or tried to) such principles, and their suggestions to identify sustainable OD strategies.

Box 1 and 2 summarise the main OD activities in Borough A and B. Borough C did not implement any specific OD programme, but regular staff engagement events were organised, and there were bottom-up efforts at improving cross-organisational coordination.

BOX 1: OD programmes in Borough A

This OD plan was informed by the Burke-Litwin's (1992) model of organisational change and performance and Barry Oshry's system thinking (1995), which underpinned workshops for system leadership development. The plan covered culture change, systems learning and development and service transformation through a range of *ad hoc* workshops and development sessions, away days and staff engagement events. A Workforce was set up to deliver the plan. At senior level, developments on OD work were delivered through three life-course workstreams to facilitate a multiagency approach: Born Well; Growing Well; and Promoting Independence (focusing on Complex Adults). Each workstream involved a mix of actors from different organisations, but attendance from clinicians and social workers was consistently low.

The OD plan included a two-day coaching skill programme for multidisciplinary teams with the aim to develop a coaching culture – e.g. enabling partnership and collaborative working to co-design services; training to upskill non mental health staff with mental health and dementia awareness and assessment.

BOX 2: OD programmes in Borough B

In borough B, the transformation programmes involved commissioners, Community Health and Hospital Trusts and the local authority, as well as the voluntary sector. Although this work was not labelled as OD, the intent was to drive transformation, strengthen integrated care and support plans for all service users. The programme was divided into three workstreams: Wellbeing; Coordinated pathways; and Strategic enablers. Borough C developed a new 'system model' known as the Managed Network of Care & Support. The aim of this model was to improve connections between services and manage transfers of care in a more 'seamless' way. The programme included several developments that focused on joint assessments and integrated care planning, following the establishment of a multi-stakeholder planning forum that also included partners from the voluntary sector.

Methodology

The qualitative and participatory evaluation was commissioned by the three municipalities to assess the impact of recent IC programmes on the ground. The study focused on specific pathways to understand collaboration patterns within and across multiprofessional teams from acute, community services and social care. One of the aims of the evaluation was to assess the impact of existing OD activities. To carry out the evaluation a participatory approach was employed, the Researcher-in-Residence model (Marshall et al., 2014; Vindrola-Padros, et al., 2016; Lalani et al. 2019). The Researcher-in-Residence was embedded in the organisations under evaluation, working alongside managers and clinicians, who contributed to developing the research protocol and were involved in all stages of the research process; the rationale was to mobilise and co-create knowledge with a focus on problem-solving (Marshall et al.,

2014). The researcher spent several weeks with each of the teams involved and workshops were organised throughout the project to agree data-gathering methods, interpret and refine findings and coproduce recommendations on future OD strategies.

The project was approved by the UCL research ethics committee in August 2017 and gained NHS Health Research Approval in October 2017. The initial phase of the study (i.e. scoping) required a series of unconstructed observations of stakeholder organisations (May-September 2017) to build rapport and trust with programme managers and service leads and agree which teams would be involved. Complementary qualitative methods of data generation were used including documentary analysis, participant observations, semi-structured interviews, and coproduction meetings with participating staff. Analysis of relevant documents (e.g. IC programmes specifications; documents relating to OD programmes; any relevant audit/ evaluation work) allowed the researcher to assess the approach to OD and compare outcomes on the ground ("care as done") with the high-level vision ("care as imagined") (Hannigan et al 2018). The researcher attended senior level meetings and integrated services team meetings, spending several days with each team in the three localities under study over several months (September 2017- February 2018). Over 200 hours of participant observations and 81 semi-structured interviews were conducted (of which five group interviews involving two or three participants): 36 in Borough A, which was the most invested in the evaluation and where it was easier to gain access to different stakeholders; 23 in Borough B; and 22 in Borough C (see table in Appendix). Interviews lasted between 45 minutes and one hour and 30 minutes and were carried out at the interviewee's place of work ensuring a balanced mix of different roles from acute, community and social care – e.g. nurses, therapists, consultants and social workers. All interviewees signed consent forms prior to the interview; however, we felt that the requirement of one signed individual consent form did not always ensure protection of participants throughout the study. The participatory approach raised new ethical issues, while problematising traditional ones, particularly with regard to consent, as participants were involved in the research at different points and with different hats, or to guaranteeing anonymity in a context where participants knew each other. We took a reflexive approach, regularly sense-checking with participants and ensuring a safe space for open dialogue throughout the project. We reflect in detail on these ethical issues elsewhere (see Bussu et al., forthcoming). Participants from intermediate care and community care multidisciplinary services, which were reorganised as part of the IC programmes, were also involved in the participatory observations and coproduction workshops. The latter served to interpret findings with staff; assess whether initial results resonated with their experience; allow participants to provide clarifications and updates on recent developments; and coproduce suggestions and recommendations to address the challenges identified.

Data were analysed thematically after being transcribed by a professional transcription agency. Observational and conversational notes were transcribed at the end of every fieldwork day. Codes were developed to identify patterns within the data and incorporated into themes. Thematic maps aided the generation of themes and helped the researchers consider the links and relationships between different themes. Thematic analysis resulted in three key dimensions: the impact of existing OD activities on IC; the gap between the vision of change at the top (informed by OD principles) and the capacity for change on the ground; and bottom-up efforts to foster more coordinate care (see tables 1-3). Below we present

findings on each main dimensions and related subthemes. After identifying the main empirical concepts, we made analytical inferences and developed provisional explanatory accounts, which we discussed and interpreted with participants in the study.

Results

Key dimension 1: Impact of existing OD programmes - change strategy continues to be top down

Documentary analysis and participant observations at OD events, mainly attended by senior management, highlighted how a top-down approach informed OD work in all three boroughs (Box 1 and 2). It mostly aimed at influencing senior level staff rather than the delivery level, where it could arguably have more tangible impact. Only a few *ad hoc* activities were specifically targeted at frontline professionals. The national programme "Making Every Contact Count" for instance was a capacity building programme, but it was only rolled out in some areas. It entailed a half-day training delivered by an external coach and based on the recognition of the potential of the wider workforce in promoting health and wellbeing; it aimed to develop awareness of how to approach conversations with patients and service users. One of the boroughs partnered with a university to develop a Wheel of Partnership (see Figure 1) drawing on available literature on the skills, knowledge and behaviours required to deliver person-centred care. A team of facilitators involved 400 staff across the municipality to hear their experience of successful person-centred care. The analysis of these stories highlighted key drivers of success, such as creativity and innovation; resilience, can-do (pro-active) attitude; and positive risk taking. Exercises such as the Wheel of Partnership can potentially help promote stronger partnership working; however, they are often lost in a plethora of small-scale initiatives. Since these are not piloted and rolled out systematically, they tend to have limited sustainable impact on working routines on the ground.

The staff engagement events format was a popular way to increase knowledge about, and understanding of, different services in a locality. These were generally one-day events organised by external consultants, with market stalls run by staff to promote their own service. In some cases, action research methods such as storytelling were employed to help increase awareness of different roles and experiences of health and social care systems.

While participants acknowledged the merits of these events as they attempt to create synergies between different services, interviews unveiled frustration at the lack of genuine bottom-up involvement in shaping the agenda. Several interviewees shared their disappointment at the lack of follow-up on their suggestions after attending several meetings and putting forward proposals. Many experienced meeting fatigue, particularly as the goal of these events was not always clear to them (Table 1).

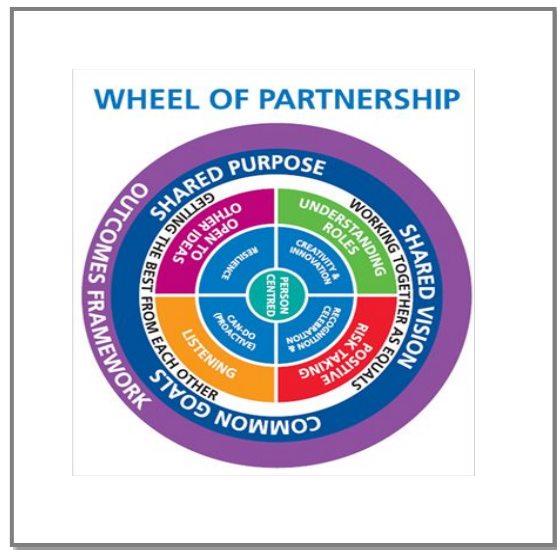Some areas planned coaching skill programmes to strengthen multidisciplinary teams and develop a coaching culture (e.g. enabling partnership and collaborative working to co-design services); however, these were often *ad hoc* initiatives with limited reach and scope. While some of this work has clear dialogic OD elements and participants generally shared positive feedback, interviewees also highlighted

the limitations of initiatives based on short-term training programmes and one-day events. In a context of limited capacity and high turnover, relying on a few members of staff attending occasional coaching sessions and events to transfer knowledge to the rest of the team in a sustainable way was perceived as optimistic. Overall, several participants felt the rhetoric of integration struggled to translate into practice.

Key dimension 2: The gap between the high-level vision and capacity of the ground

Our findings highlighted a growing barrier between acute and community care, often exacerbated by the internal market with different organisations (i.e. Health Trusts) increasingly focusing on different parts of the care system. This limited opportunities for staff to rotate, leading to increasingly separate acute/community careers; several participants mentioned how this contributed to reinforcing silo working. Interviews highlighted a perceived need for more direct channels of communication between teams working regularly together, in order to enable staff to build mutual trust. Instead, health and social care staff continue to have different professional and organisational cultures and opportunities to genuinely understand each other's roles are rare, in a context where capacity is limited and staff felt forced into task-orientated care. Cooperation was constrained by staff having to respond to different organisational pressures (Table 2).

Figure 1 – The Wheel of Partnership

Whereas the ethos of multidisciplinary work has been embraced widely, at least in rhetoric, a genuine multidisciplinary approach was often difficult to deliver in practice and participants pointed out how current OD work was falling short of genuinely addressing these gaps. Co-location of professionals in different roles and from different organisations in the same office space was one example of the rise of "team-based" organisations, whose rationale is that putting people in the same group will increase their capacity to collaborate (Liberati et al. 2016). However, in our three cases co-location by itself did not necessarily make staff more collaborative or accountable to each other. In the absence of shared professional and organisational visions and goals – and one management line - people often continued to work in silos, even as they sat next to each other.

As noted by other literature "most of what is called OD focuses on creating collaborative relations within facilitated containers", without much thought on how to create sustainable collaborative organisations (Bushe 2017:17). This inevitably raises much frustration among staff, who feel vulnerable, as expectations are placed on them, which too often feel unrealistic.

Key dimension 3: Bottom-up OD activities can help staff adapt their working routines

Some of the most interesting and effective examples of partnership working and capacity building were often not labelled as OD; they were beyond the remit of top-down programmes and were

led by frontline staff. These initiatives were often a good example of both diagnostic and dialogic OD, whereby staff recognised a problem and tried to change both behaviours and thinking through cross-disciplinary and ongoing dialogue. However, these were often isolated cases relying on the initiative of individual members of staff with limited support at organisational level.

In one of the three boroughs, *Discharge Forums* were held to discuss complex discharge cases. Three-hour sessions took place monthly at the local hospital and involved staff from acute care, community services, social care, GPs (General Practitioners) and the voluntary sector. Each session was centred around live cases of complex discharges and offered opportunities to discuss the challenges encountered, what worked and what needed improving. By involving staff from different care settings and organisations, this forum encouraged participants to take a whole-pathway focus. Cases were often described as patient journeys and served to develop an understanding of the difficulties encountered by different roles at different points of the journey, and how both staff and patients were affected. The sessions we attended had a clear focus, and several practical suggestions were shared on ways to increase mutual support and improve communication. As pointed out by some participants, unlike top-down and *ad hoc* learning events, the lessons that emerged from the Discharge Forum meetings were more likely to have meaningful impact on staff's working routines.

In another borough, a collaborative of senior Occupational Therapists (OTs) working in either acute, community or social services met every three months, and the minutes of the meetings were distributed to all Occupational Therapists in the area. Peer Learning for OTs (PLOT) meetings used to take place regularly in the same area and were open to all OTs irrespective of seniority; however, a lack of organisational support meant staff no longer had capacity to organise and attend them.

In yet another instance, palliative champions meetings were organised by lead community nurses in different localities to raise awareness about palliative care and end of life pathways and to strengthen joined-up working. Designated district nurses acted as palliative champions in each team and took responsibility over training colleagues; regular meetings were carried out across localities to share learning and develop good and consistent practice. Whereas these meetings were recognised by staff as important and useful, many complained that much of this work depended on individuals' goodwill and felt there was limited support from senior management. Furthermore, without senior-level support few felt authorised to make decisions and carry out actions (Table 3).

Table 1 – Key dimensions 1: Impact of existing programmes

Theme: Top down approach	
Staff's voice is not heard	I repeat myself every couple of months but no lessons learnt or anything. [Nurse]
	We should be a lot more involved. And the fact is it doesn't matter what we say. You know? They'll do what they want to do. If they want to take away a service, they'll do that. If they want to set up a new service, they'll do that. [Occupational therapist]

Meeting fatigue	There's too many meetings and the actions that come of it tend to be more work for us. [Physiotherapist]
	Some of the time there are too many meetings when really there are live people in the bed that you need to be working with. I really haven't got much time for paper. […]Training, I'm up for that because I know it benefits me, it benefits the patients, you can see the… But some of the meeting you just think, oh god! [Nurse]
Theme: Service change	
Change is fast-paced or perceived as unnecessary	It's like an oil-tanker that takes six miles to stop. That's how big the NHS is, so if you change something you've got to give it time to happen. [Nurse]
	In the NHS, if you stand still long enough things will go round and you come back to the same spot. [Lead therapist]
Poor communication	You know, it could be months into a change before you actually hear about it, and that's one of the things with the community… because when things change you don't always know. It's just by chance that you're… you know, you may have phoned somebody for information and they go, 'Oh, that's not us anymore, that's so and so'. [Nurse]
	[O]ften I'll be speaking to [name] and she'd say, 'Oh look, this has changed,' and I haven't known anything about it. No one's told me anything, it's just kind of word of mouth almost. So I'm then telling my team something different to what I told them last week, and they're getting confused. [Physiotherapist]

Table 2 – Key dimension 2: Gap between high-level vision and capacity on the ground

Theme: Barriers on the ground	
The internal market reinforces working silos	I strongly believe that because there's no vertical [between acute and community care] integration. [It's like] knee jerk approach, rather than systematic problem solving. [Nurse]
	We do also have a problem since the split between the Acute and the Community. Physios coming out used to have… go through the rotations in the NHS, get a broad base experience in all the different functions and then go through the layers: Band 5, Band 6, getting their broad base of experience before they then specialised. Now that doesn't happen […] So physios studying come out into the big wide world, they either go Acute or the go Community. Neither is really good because from an Acute perspective they've got no idea of what goes on in the community, and from a Community perspective you need the broad base… you know, they need a wide breadth of experience to deal with the patients that you get in the community. As they become elderly, you don't just have one

	problem, you've got multi-faceted problems and if you don't have that broad base of experience you can't… you can only deal with a part of a human being. [Lead Therapist]
Professional and organisational barriers	[T]he health team, they will prescribe. They don't know that you, as a social worker, you want to find out […] why that big huge amount of package is needed. If there's no justification we will try and see if you can reduce it, because the health people, they want to prescribe 'Oh this person needs 24 hours' but you as a social worker, you have to make sure that really that's the right care package to put in for that person. [Social Worker] I don't think we've got a shared vision or a set agenda really. Social care have got this financial envelope, they need to deliver this, they're going to deliver it to what they can afford to deliver it to, and actually I think health are just expected to pick up the rest. [Community Nurse]
Theme: Unrealistic expectations	
Staff feeling vulnerable	I mean, I think the Trust (hospital) tries to motivate by doing certain things but I don't think it's worked. […] Like there's employee of the month type of thing, but I don't think that hits people on the ground. It's like the managers who get the awards, and they're the only people that probably have the time to nominate each other. And then they wonder why the quality improvement programmes don't seem to hit the ground. […] We're asked to do a lot of things but then the training doesn't seem to respond to our needs, yeah. And so we find ourselves constantly in places where we're feeling a little bit vulnerable, and could do with a bit more backup, but you're sort of looking for your backup and it's like [Laughs], where is it?! [Physiotherapist]
Struggling to deliver expectations in a context of limited capacity	And then we also have to consider resources, is it a wonder that, maybe it is only two district nurses to work and then no one is able to physically attend a meeting because they've probably had to just get bank or agency to cover. […] So it is those kinds of things that we need to consider and put into mind. [Specialist palliative nurse] In the last five years Social Care has shrunk at least in half in terms of staffing, there is no money to employ more staff, I'm fully aware of it. [Social Worker]

Table 3. Key dimension 3: Bottom up OD activities

Problem-driven initiatives	That [Discharge Forum] is a place where you could actually talk about live cases, situations, and people are there who can actually make a difference. [Community nurse]

	And as a Palliative Care team we do have teaching and audit. Every six weeks all the teams meet together. [Specialist nurse]
Distributed leadership	Designated palliative champions in each team take responsibility over training colleagues. […] Distributed leadership felt as instrumental in embedding new practices, though peer-support [field notes - participatory observations at meetings]
Not enough understanding and support from senior management	Senior management often not aware of these activities; no support for staff to participate/ attend at organisational level [field notes - participatory observations at meetings]

Discussion

Our findings contribute to highlighting the gap between the rhetorical commitment to OD work and its impact where it most counts, at the point of delivery of care. While new governance mechanisms with dedicated "task and finish groups" involving cross-organisational partnerships were set up across all the boroughs under study, on the ground there was limited focus engaging staff and supporting them to change their working routines. OD initiatives were often designed to get staff to buy into a given vision based on senior management's experience, instead of helping develop new understanding based on the experience of those professionals that deliver care. In a study of IC in England, Warwick-Giles and Checkland (2018: 98) find that sensegiving by senior leaders was powerful but also "problematic, as the need to project a narrative of success may act to minimise or deflect attention from any difficulties".

The key dimensions presented in the previous section capture three overarching findings that can help further understanding of OD in IC. Firstly, when translating OD principles into activities, although the rhetoric was grounded in systems thinking, the underlying approach to change was as a top-down and transitional, or episodic and planned, process (Ackerman 1997). There was limited reflection on how to drive a genuinely bottom-up change process and enable a learning organisation (Bushe 2017). Whereas people can benefit from learning events about new ways of thinking and working, without system-wide culture change to support them they will be unlikely to successfully transfer these skills to their day-to-day working environment (Bushe 2017). Our observations and interviews highlighted a general consultation fatigue, with too many meetings and workshops with unclear goals and outcomes, which mostly failed to equip staff with the required skills to address their day-to-day challenges in moving towards more IC (Table 1). Recruitment and retention of staff continue to be huge challenges across all care settings; this also means that organisations are more cautious about releasing staff to support service improvements and OD activities.

Secondly, the knowledge gap about community provision emerged as a persisting problem that continues to affect referral pathways, potentially leading to duplication, overlaps and patients falling through the cracks (Table 2). Several participants felt that enabling staff to gain in-depth knowledge of both acute and community provision and develop relationships of trust across organisations focusing on different parts of the care system, for instance through regular rotations, would prove to be more effective long-term strategies than occasional staff engagement events and market stalls to promote

different services. Staff were keen to develop or strengthen (where existing) collaboratives as a way to address the distance between organisations and roles. These suggestions bring to mind Bushe's (2017:22) proposals to foster sustainable collaborative organisations through "networks of micro-relationships of partnership, where each person in the partnership feels responsible for the success of their common purpose". Whereas there is support in rhetoric for enabling staff from health and social care to carry out joint assessments and encouraging trusted assessment across different roles and teams, in practice until organisations align their guidelines and priorities, staff's efforts will continue to clash against too many administrative as well as well as cultural barriers.

Thirdly, the most effective OD initiatives, although outside the remit of official OD programmes, were those cases of distributed leadership, whereby frontline staff successfully addressed tangible needs, through developing ongoing dialogue across teams, but they lacked the necessary support at the organisational level to engender a culture where people felt authorised to make decisions and take actions (Table 3). Within a collaborative organisation, authority should be only partly tied to a given position or role and partly worked out based on a given issue and continuously shifting, as partners agree on the best way to address a specific problem and reach a common goal (Bushe 2017). However, the highly hierarchical system of health and social care organisations represents a crucial barrier.

The ensuing implications for practice are that an effective OD programme is tailored to the different teams and services and developed with frontline professionals, with a context-sensitive approach that considers local assets, needs and capacity. This requires in-depth understanding of staff's working routines and how the latter might be affected by service reorganisation. Support for existing forums, collaboratives and peer-learning activities led by frontline professionals might prove to be more effective than *ad hoc* meetings and events at encouraging constructive dialogue and building relationships of trust, by supporting more stable channels of communication based on actual needs. Rotations across acute and community care were often mentioned by participants as one way to help staff gain a better understanding of the whole pathway and address the issue of silo-working.

Conclusion

After years of rhetoric and much investment in IC programmes, on the ground the organisational fragmentation engendered by the internal market is exacerbating gaps in information exchange and coordination. The literature emphasises that to enable professionals to work in teams across sectors, they need to acquire a different set of knowledge, skills and attitudes from what they have traditionally been trained to use. In this respect, OD is often advocated as the favourite approach to build relationships of trust. However, our evaluation shows that, whereas off-the-shelf OD programmes have captured the imagination of senior management, they are not working for staff delivering care. A top-down approach to OD based on *ad hoc* events and training that aim to sell senior management's vision to staff is often perceived as disingenuous and has limited impact. The rhetoric of partnership working that informs these programmes continues to clash with the reality of misaligned organisational priorities and guidelines that often generate confusion at the point of delivery, as staff continuously negotiate between endorsing a multidisciplinary ethos in rhetoric and allegiance to the organisation that employs them in practice. Staff tried to develop spaces of ongoing dialogue on their own initiatives. These spaces

were often based on pathways (i.e. discharges; palliative care) and focused on patient journeys; they were tailored to address tangible problems that staff experienced in their working routines. It is this bottom-up approach to OD that demands better understanding and support at organisational level.

Our findings contribute to the literature on OD in public services and highlight the benefits of a context-sensitive, pragmatic, and long-term approach to OD to help create sustainable collaborative organisations. Future research should focus on ways to encourage distributed leadership and limit risk-aversion, ensuring staff have the required support to develop stable rather than *ad hoc* opportunities for dialogue and learning.

We recognise several limitations of this study, including the difficulty to generalise findings because of the relatively small geography of the cases evaluated. However, several of our results have strong international relevance given the growing emphasis on joined-up and patient-centred care. The literature on OD within healthcare continues to focus on new (or rebranded) models without paying enough attention to evaluation, and our study talks to many international scholars and policymakers trying to understand what works, where and why. The fast pace of change within the NHS in England in recent years (Ham et al., 2015) has created a very crowded policy context and generated confusion among staff between different programmes under evaluation and their impact (or lack thereof). We tried to address some of these challenges by including a wide range of different roles and organisations, as well as carrying out several hours of participatory observations with different teams. The participatory approach meant that staff on the ground and senior management were involved at each stage of the research process, from design to interpretation of the findings; this ensured greater accuracy and relevance of our results.

Based on our evidence, we argue that OD can have impact if embedded in those working routines that it aims to change and based on the needs of those it aims to support, and therefore any OD approach might be more effective if shaped by frontline staff.

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Appendix

Services under study and interviewees

Locality	Rapid response (Intermediate Care)	Discharge to assess (Intermediate Care)	Community services teams (Community Care)	Other professionals (Acute Care)
Borough A **36 interviews (including 1 group interview with two participants)**	3 nurses; 2 physiotherapists (who also worked on Discharge to Assess) 1 service lead	3 occupational therapists 2 physiotherapists 4 social workers (including 1 service lead) 5 members of the reablement team – social services (2 service leads; 3 care workers)	3 district nurses (including 1 service lead) 2 physiotherapists (including one service lead) 1 occupational therapists 1 care navigators 1 social worker 1 GP	3 hospital clinicians 1 Occupational therapist 2 in-reach nurses 1 hospital nurse 1 service lead hospital discharge team
Borough B **23 interviews** **(including 3 group interviews, two including with 2 participants and one including 3 participants)**	3 nurses (including 1 service lead)	1 service lead 2 occupational therapists 1 physiotherapist 2 service lead reablement team (social services)	6 community nurses (including 2 service leads) 1 physiotherapist 1 occupational therapist 3 social workers (including 1 service lead)	3 hospital nurses 1 service lead hospital discharge team 2 support workers 2 social workers in the hospital
Borough C **22 interviews** **(including 1 group interviews with 3 participants)**	4 nurses (including 2 service lead) 1 physiotherapist 1 GP	1 physiotherapist 1 occupational therapist 1 social workers 1 Service lead enablement team (social services)	3 district nurses 2 physiotherapists 2 occupational therapists 2 care navigators 1 service lead	1 consultant 2 hospital nurses 1 hospital nurse (discharge team) 1 hospital social worker